

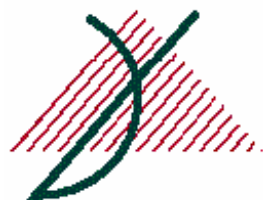
SWIMMING UPSTREAM: MAKING PLACES WELCOMING

**A REPORT ON THE NEEDS OF GAY, LESBIAN AND BISEXUAL
PEOPLE IN 'HARD TO REACH' GROUPS**

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A note on use of terms related to Aboriginal communities.

The terms 'Koori', 'Aboriginal' and 'Indigenous' are used throughout this document reflecting and respecting broad usage across the community and government. (Department of Human Services 2006 *Building Better Partnerships* Melbourne: State of Victoria)

BACKGROUND TO THE PROJECT

Australia's first Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) was established in Victoria in April 2000, following a period of consultation around health issues for this community. The Committee was set up to advise the Minister for Health and the Department of Human Services on action required to promote and support the health and wellbeing of gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians. It also aimed to ensure optimal access to relevant mainstream and, where appropriate, specialist health services. In line with current government and departmental policy, the committee adopted a social model of health and a broad agenda of social and legislative reform.

In its first term of office the Committee produced an evidence-based policy framework for the development of GLBTI health and wellbeing programs and services. Its report, *Health and sexual diversity: A Health and wellbeing action plan for GLBTI Victorians*, was launched by the Minister for Health, Bronwyn Pike, in July 2003. The report's plan was based on a previously commissioned series of research papers that outlined the evidence base for GLBTI health needs and described the experiences of GLBTI people in relation to the health system. The irrefutable nature of this evidence of adverse health outcomes for GLBTI people grounded the action plan's assertion that sexual orientation and gender identity were themselves social determinants of health.

Further to this acknowledgement, the action plan argued that the impact of ethnic and racial background (including indigeneity), and of living with disability on GLBTI people was poorly understood. The action plan made specific recommendations about this issue. These have not as yet been implemented, partly because further specific evidence to direct appropriate action has been required. The Ministerial Advisory Committee, in its second term of office, has therefore commissioned the Australian Research Centre in Sex, Health and Society, incorporating Gay and Lesbian Health Victoria, to carry out a small study of the needs of GLBTI people with disabilities, from Culturally And Linguistically Diverse (CALD) and indigenous communities.

In the early stages of recruiting for this project it became clear members of these groups would be difficult to reach and require intensive work for the purposes of recruiting them into the study. In light of the limited resources available to the project it was therefore decided that this report would focus on gay and lesbian people, dealing only with transgender and intersex people if information on them emerged as the project progressed.

INTRODUCTION

The diversity of Victoria's population is well recognised. People are different from one another by virtue of many factors including those of gender, age, cultural and ethnic background, Indigeneity, religious belief, sexual orientation and (dis)ability. At the same time, individual and collective identities are drawn from shared characteristics and a sense of membership of, or belonging to, different social groupings. Increasingly, respect for and a commitment to cultural and social diversity, to the diverse make-up of peoples' identities, is being used to form the foundations for a fairer, more equitable society.¹ It is enshrined in recent legislative reform and reflected in government policy developments articulating an agenda of equality.²

The concept of 'multiple identity' is a useful way to understand the complexity of individual and social identity. It recognises that a person's everyday experience is characterised by overlapping memberships of multiple social groups. At the same time, it also suggests that people can experience multiple barriers to equality through the processes of marginalisation, exclusion and discrimination. While diversity and difference are often celebrated, the experiences of people who fall within multiple minority identities - described by participants in the research project as *a minority within a minority* - is less clear. This project aims to give visibility to these perspectives that have remained largely invisible.

PROJECT OBJECTIVES

The objective of the project is to examine issues of health and wellbeing through the intersections of sexuality, cultural and ethnic background and (dis)ability. Anticipating that identity and difference are implicated in these experiences, it seeks to explore the experiences of Victorian gay and lesbian people from three 'hard to reach' minority groups - those who have a disability, those from culturally and linguistically diverse (CALD) backgrounds, and those from Indigenous backgrounds. The implications of this research will be used to form recommendations for health and community service organisations.

RETHINKING HARD TO REACH

In calling for this research the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) brought together the minority groups identified under the term

¹ See for example, 'Growing Victoria Together' (State of Victoria 2005).

² In Victoria these include the Equal Opportunity Act (2001), Health and Sexual Diversity Action Plan (2003), Cultural Diversity Guide – Multicultural Strategy (2004), Aboriginal Services Plan (2004), A Policy Framework for the Development of Disability Action Plans (Department of Human Services 2004), A Fairer Victoria - Disability Action Plan (2005), Personal Relationships, Sexuality and Sexual Health Policy Guidelines – Disability Services (2006)

'hard to reach'. As Zwart et al. (2005:4) argue, it is a term that is commonly used by institutions to describe individuals or groups that are 'difficult to contact or engage for a particular purpose'. The term expresses an institutional perspective that focuses on the specified group's characteristics of disadvantage and disengagement. However, this report questions the utility of the term. As others have argued, the notion of hard to reach is problematic because it is often used inconsistently, and it is misleading and potentially stigmatising (Jones and Newburn 2001, Doherty et al. 2004, Fisher, Wang and Wagner 1997). Instead, this report shifts the perspective. Rather than examining the characteristics of hard to reach groups it turns to the institutions and organisations of health and community services to ask: What are the characteristics of these services that make it hard for individuals and groups to participate? Do these organisations work hard enough to reach, and serve, minority multiple identity groups? It is a subtle but important shift that recognises individuals and groups may appear to be hard to reach when in fact their engagement has not been sought in an adequate or appropriate way. As one participant commented *people out there don't know they're hard to reach*.

RESEARCH METHODOLOGIES

The project was undertaken in three stages.

Stage 1: A literature review scanning the relationships between multiple minority identity, marginalisation and health and wellbeing was undertaken. The review canvassed both published academic and ‘grey’ literature³ and was used to inform and develop thematic areas of interest for Stage 2.

Stage 2: This involved primary research (consultations) on the experiences of gay and lesbian people holding these multiple identities. While exploring issues of health and wellbeing the research focussed, in particular, on the social interactions with, and sense of belonging to, different social groupings – within participants’ own communities, within gay and lesbian communities and within the health sector more generally.⁴ The use of ‘community’ here is not intended to suggest some unified identity within these groupings.⁵ Each is marked by difference both within and between. Understanding that gay and lesbian people, like other minority identities, are not a single homogenous group, also dictated that different consultation processes were required. Initially, focus group interview (group discussion) was the proposed method to be adopted for each grouping involved in the project. However, at times this was not possible or appropriate. In some cases there were no obvious community organisation or focus grouping in operation, nor could they be readily formed. Some participants were not comfortable discussing the issues in a group situation. Consequently methodologies included both group discussions and one-to-one interviews. Ethics approval was obtained through the Human Research Ethics Committee of La Trobe University

Stage 3: A final report was completed on the research findings. It discusses the shared learnings, documents recommendations and lists the contact details of organisations consulted (where agreed upon).

RESEARCH METHODOLOGY AND RATIONALE FOR EACH IDENTITY

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)

One focus group was held involving nine members of the Australian GLBTI Multicultural Council (AGMC). It comprised 4 women and 5 men from a

3 Grey literature refers to any information that is not commercially published. It is produced both in print and electronic format usually by government, academia, industry and community sectors. It includes, for example, government reports and legislation, conference proceedings, research reports, community newsletters and pamphlets.

4 The definition of health in this context follows the social model of health that underpins the development of current government health policy (MAC 2001, 2002).

5 Zion (2003:2) suggests that, although the notion of community is represented ‘as a warmly persuasive word, often denoting support, unity and friendship, many groups that are known as communities are in fact composed of diverse groups and individuals with different beliefs and values’.

range of ethnic and religious affiliations, all of who identified as gay or lesbian. Two participants lived in regional Victoria. The AGMC was considered a key organisation for recruitment of participants. It has an ongoing interest in the intersections of ethnicity and sexual identity and has an established relationship with members of the Project Team. The AGMC represents a wide selection of Victorian multicultural communities. It had also been involved in an earlier consultation project with GLHV (Mohummadally and Mitchell 2004), and, significantly, many of the issues of interest to the project emerged during the inaugural 'Living and Loving in Diversity' conference organised by AGMC in 2004 (AGMC 2005).

Important: please note that members of the discussion group highlighted their discontent with the acronym CALD. Instead 'multicultural', 'ethnic', 'Non English Speaking Background (NESB)', 'whatever, we know what we mean' were offered. This report uses these terms interchangeably.

DISABILITY

Clearly gay and lesbian people who have a disability do not form a single homogenous group – difference can be found within both identities. The methodological approach for this grouping was determined by two main factors. First, 'disability' incorporates a wide spectrum of impairment.⁶ Second, it was affected by the small number and poor visibility of gay and lesbian disability advocacy groups and community organisations available to facilitate the consultations. Rather than an approach determined by impairment category (for example, recruiting participants across a range of intellectual, physical or sensory disabilities) the project team focussed on the impact of independence/dependency in everyday living. The team was interested in comparing and contrasting the experiences of gays and lesbians living in, for example, residential support units (CRUs), those requiring attendant care and those living independently. This approach allowed a more general focus on the rights of individuals and related issues of privacy - issues that may be shared across the disability community.

Two focus groups were held. The first involved 4 young males, all identifying as gay. The second involved 5 GLBTI members of AccessPlus⁷ (1 woman and 4 men). In addition, one-to-one interviews were held with 3 women, all identifying as lesbian.

⁶ The disability framework utilised by Victorian Government Departments includes physical, intellectual, psychiatric, sensory and neurological impairments in its definition. It also covers physical disfigurement and the presence in the body of an organism capable of causing disease, such as HIV (Department of Human Services 2004).

⁷ Access Plus Spanning Identities (APSI) is a community support and advocacy group for GLBTI disabled people in Victoria.

INDIGENOUS

The *Onemda* VicHealth Koori Health Unit⁸ collaborated with the project team to formulate an appropriate methodology. An Indigenous man and an Indigenous woman were responsible for recruiting participants. A weekend residential camp for Indigenous men and an informal discussion group for Koori women were initially proposed. However, recruitment to both groups proved to be difficult. While this provided important learnings for Indigenous collaborative research (see Findings for further discussion), participation in the project was consequently reduced to two individual interviews with Indigenous gay men; and individual and group interviews with three lesbian women. While small in number, these participants included key stakeholders in Indigenous health. A telephone interview was also conducted with an interstate Indigenous health service provider working with Same Sex Attracted Indigenous Women.

It is important to note that the consultations for all three identity groups were both small in number and exploratory in nature. Consequently the findings do not claim to be representative of the multiple minority groupings interviewed. The contradictions and complexities raised could not be explored in more detail. A rural perspective in particular was also difficult to obtain, given the small-scale nature of the project and its time constraints. However, representativeness was not the intention of the research. The participants were invited to ‘tell their stories’ in relation to who they are (identity) and what they experienced (issues of health and wellbeing). Their stories highlight the intersections of identity and diversity; they reveal glimpses of the marginalizing and discriminatory experiences that these groups deal with in their day-to-day lives; and they point to recommendations that may improve the health and wellbeing for gay and lesbian people in all their diversity.

⁸ *Onemda* was a key stakeholder in the development of the NH&MRCs guidelines for research involving Aboriginal groups. See also Dunbar and Scrimgeour (2005), McAullay et al. (2002), Waples-Crowe and Pyett (2005).

LITERATURE REVIEW: INTERSECTING WITH DIVERSITY

Following social epidemiology's broader interest in the social, economic and environmental causes of persisting health inequality⁹, the MACGLH Action Plan (2003) highlights the key social determinants of health for GLBTI communities. Socio-economic status, ethnic and racial background, gender, geographic location, disability and age are all identified (MACGLH 2003:11). What remains less clear, as the Action Plan also points out, is just how the social determinants intersect with notions of identity to shape health and wellbeing (MACGLH 2003:42). The existing frameworks fail to capture the complexity of causal explanations of health inequality, particularly in relation to multiple minority identities.¹⁰

A review of the literature, both locally and internationally, reveals the paucity of research and analysis that has been directed towards these complex intersections of gay and lesbian health.¹¹ The lack of research is highlighted in the Irish National Disability Authority's (2005) discussion paper on disability and sexual orientation, one of the few reports by a public body that has addressed these issues. What research has been undertaken has tended to focus on issues of disability¹² and more general intersections with indigenous and NESB (Non-English Speaking Background) people.¹³ The combined effects of multiple minority identities and gay and lesbian experiences of invisibility, marginalisation and exclusion have been the thematic focus of a number of conferences, reports and discussion papers.¹⁴ Issues of privacy and confidentiality for rural same-sex attracted youth have also been canvassed.¹⁵

The common theme running through these studies is the need to foreground the experiences of multiple identity groupings, to address related issues of visibility and discrimination and to examine the implications for public policy and practice. As the Action Plan identifies, gaps in our understandings remain. In a diverse society, it is no longer sufficient to develop policies and strategies that assume homogenous

⁹ Berkman and Kawachi (Berkman and Kawachi 2000, Eckersley et al. 2001)

¹⁰ See critiques by Dixon and Sibthorpe (2003) on evidence-based policy; Kelly and Charlton (1995) on the knowledge base of health promotion; and Macintyre (1997) on the polarisation in explanatory models.

¹¹ See for example Fukuyma and Ferguson (2000); Green (2000); Pallotta-Chiarolli (1996) in education, Diaz et al. (2001), Katz et al. (2002) on the intersections of homophobia, racism, poverty and mental health; Cahill and South (2002) on ageing and discrimination; van Dam (2004) on stigma and health service provision; Harper and Schneider (2003), Green (2005), Yip (2004), Mays et al. (2002) on race, ethnicity and health.

¹² See for example, Appelby (1994), Clare (2003), Cook (2000), Samuels (2003), Tilley (1998), Vernon (1999), White (2003), Shakespeare et al. (1996), Whitney (2006), Shuttleworth and Mona (2000).

¹³ See for example, Blackwood (1986), Gays and Lesbians Aboriginal Alliance (1994), Hodge (1993), Roscoe (1988) (1998), Williams (1992).

¹⁴ For CALD issues see Moutou (2004), AGMC (2004), Mohammadally and Mitchell (2004), Genovesi et al. (2000). For disability and mental health see National Disability Authority (2005), Dyson et al. (2002), Clare (2002). For indigenous HIV/AIDS and sexual health see (Walcott 1994, AFAO 2002, AFAO 1998). See also Hillier et al. 1998, Queensland AIDS Council (2005), Hillier et al. 2005

¹⁵ Hillier et al. (1996), Edwards (2005)

groupings of these identities of ‘disabled’, ‘Indigenous’, ‘women’ or indeed ‘GLBTI’. The categories need to shift to begin to accommodate difference and complexity. The recommendations that followed the AGMC ‘Living and Loving in Diversity’ Conference (AGMC 2005) also pressed for more research:

There is a need for a more in depth understanding of identities within the GLBTIQ community. In particular, to understand the intersections between issues of race, culture, religion, class, disabilities, spirituality, age, and sexualities and genders (AGMC 2005:2).

For multiple minority identities that may well face experiences of *multiple* exclusion and marginalisation, the issues are particularly salient. This research project begins to fill those gaps.

FINDINGS: SOCIAL SITUATION, EXPERIENCE AND IDENTITY

This section reports the findings emerging from the discussion groups and interviews conducted with each of the three groupings involved in the project. It highlights the primary issues of identity and experience affecting gay and lesbian people in their everyday lives. In particular, it examines relationships with close-knit family networks, with the identity community, with the gay and lesbian community and with health services.

1. CALD, MULTICULTURAL, ETHNIC, NON-ENGLISH SPEAKING BACKGROUND (NESB)

The discussion with members of the AGMC began with a sharp focus. The participants suggested that, while *the government knows we're around ... the general ethnic communities have to recognise that we exist, to accept us. People have to be accepted in the group – diversity has to be accepted, that's the first step.* Not surprisingly, given the intersections of sexual orientation and ethnicity identified at the AGMC conference in 2004, the discussion concentrated on issues of acceptance by, and inclusion within, family and ethnic communities.

FAMILY AND ETHNIC COMMUNITY

There is increasing pressure on us that is different from the mainstream because our parents have come out here as migrants to succeed in another country. Therefore anything that shows them or their community that they have not succeeded in terms of having a gay son or lesbian daughter is ... a smack in the face for why they came out here. That is one of the biggest things. Even though they love you and would do anything for you there is that pressure from them to perform, to live up and hold face within the community. And that is very, very big ... Because our parents have come out here, even though they've been here for 30, 40, 60 years, there is still that pressure that we remain invisible, that we do not exist, that it can't be true that our son or daughter is lesbian or gay.

For many first and second generation migrant groups, care and respect for parents and the older generations, loyalty, strong family, kinship and community ties, as well as socio-economic position, form a master narrative of successful migration (Rapport and Dawson 1998). For these minority ethnic groups the narrative reinforces the remembered (imagined) traditions and socio-cultural beliefs from their countries of origin. Even though, as one participant argued, these 'home' societies may be liberalising and *you see more freedom than here, our families' mindset is what it was when they left.* For many ethnic communities it is a cultural defence that, in turn, generates expectations of cohesion, integration and conformity. In this context, gay and lesbian identity is seen as a failure that threatens cultural heritage. Importantly participants also recognised that the response to defend the culture is mediated not

only through socio-cultural factors of ethnicity but also through religious identification. In particular, participants pointed to Islam and Catholicism - orthodoxies that construct homosexuality as deviant and morally decadent - as religions that are intimately interwoven with ethnic formation (Yang and Ebaugh 2001, Yip 2004, Green and Numrich 2001). These socio-cultural and religious characteristics impact on the way gays and lesbians from ethnic backgrounds manage their sexuality.

Participants reported that for many ethnic families and communities, homosexuality was perceived as a problem arising from a liberal Western society. One commented, *I have heard parents blame Australia, the white people, the Australian influence, is why you are gay*. Another noted:

They have to blame someone ... They probably believe it is partly because of all the freedoms and excesses and everything that this country has allowed families and the way they live and everything that have caused it.

While another, ironically pointing to this research project, suggested that, *in fact, linking health to gay and lesbian reinforces that we are sick. Health for my mother is physical health – your body is sick. They'll say 'see they are sick, they've got GLHV looking after them'*.

INVISIBILITY, SILENCE AND CONCEALMENT

Participants who had 'come out' to family members generally reported being met with tolerance. However, rendering gay and lesbian people invisible emerged as the common strategy employed to maintain the boundary of family and cultural/ethnic integrity. It is a strategy, one participant noted, that *revolves around the concept that it is a choice. Being gay's a choice and you can hide it*. Within many ethnic families and communities, high levels of stigma continue to be attached to sexuality: *That's what they say – I'd rather you were drugged, drunk than gay!* However, another participant suggested the silence and concealment reflected the importance of respect, family honour and avoidance of shame within families.

The problem is that as long as no-one else knows about it, no-one else in the family knows about it and they can shame them, saying your son is like that, then it's alright. But once it's out and in the public that's when they start thinking about it in a bad way.

However, the silence surrounding sexual orientation presents a contradictory picture. While some participants suggest that ethnic communities in Australia *are time warped, we're back in the 1950s when these things didn't exist* and that it is Western culture that is 'to blame', other responses of parents and close family to their sons and

daughters 'coming out' suggest another picture.¹⁶ The following comments reveal that the unspoken identity has a long history in the countries of origin:

In the past, back in those days, if you had any tendencies, like you were on the local football team and you fancied that bloke over there, they just hid it because it was wrong and you made the most of it. You married the girl next door and you didn't mention it ... you put it behind you.

My parents said to me, 'why can't you just be satisfied with going to the beats like we [as a community] did 30 years ago?'

My mother said to me, because I was married, when they found out, 'why didn't you just do what someone in our village did? [He] stayed married with his wife. Everyone knew in the village and he left the village when he wanted to have it off with other guys? So it did exist and they knew it existed but it was something that wasn't talked about.

Today gay and lesbian identity continues to be something that isn't talked about in many ethnic communities. Silence and concealment persist as strategies employed by both close family and participants. Again, respect for parents and family underpins the strategy:

Sometimes I find it hard with the family. If it is just mum and dad at home then they will accept it. But some gay guys, they took the advantage. Like they start to go out, they start with different hairstyle and different look, they start to get a little obvious. [But] you have to respect your parents, or your family or house you live in. Like you come in 4 or 5 o'clock in the morning or drunk, you have to have little bit of respect for family as well, because you still live with them.

I know some people who, when their parents know they are gay, they think I can bring my boyfriend home ... OK we shut up but be easy. We accept you because you are our son but don't, like, overdo it!

I've known guys who have come out, mainly younger ones though, that are so glad that they have finally come out that they just broadcast it to the world. They flaunt it, camp it up as much as possible. It's not so much the direct family that gets affected directly, but the direct family being affected indirectly by the extended family. The cousins find out and the second cousins find out and it all comes back and it's a big hoo-ha.

¹⁶ This time-warp or 'two world' duality has been challenged (Karakayali 2005, Anisef and Kilbride 2003). However the complexity and diversity of migrant experiences could not be explored further in this project.

MORE RECENT MIGRANT GROUPS

Ethnic communities are not a homogenous group. Participants recognised that, for some of the more recent refugee and migrant communities, it was not only silence that surrounded homosexuality. Depending on the ethnic community's socio-cultural-religious beliefs, the visibility of homosexuality was both deferred and, at times, totally denied. As one participant explained:

In terms of the newer arrivals, not only do they have to deal with their sexuality, but we've got these newer migrant groups coming out here trying to make a living. Therefore the son or daughter comes out to them, it's another load on their priorities. They've got to set up house, got to find accommodation, all these things. I suspect for a migrant family, a refugee family coming to Australia now having to deal with sexuality or sexual identity, it's one more problem. A problem they can deal with later. They have to worry about living, work, school ...

Another reflected:

But I am talking about the main groups that are coming which are Horn of Africa or Iraq, they are more unlikely to acknowledge sexuality. I work with someone who is from the middle of Africa and he just fervently denies that there are any gays in his country. It just doesn't exist.

The invisibility and denial of homosexuality amongst many asylum seeker and refugee groups further compounds the distinct difficulties, including issues of health and wellbeing, experienced by these ethnic groups (McNally and Dutertre 2006).

GENERATIONAL CHANGE

Participants also pointed to the generational change occurring in ethnic communities. Younger generations are becoming more integrated into a wider Australian multiculturalism. Increasingly straddling an ethnic-Australian identity, many are integrating a western cultural bias more open to sexual diversity. As suggested previously, participants pointed to the 'time-warp' that encapsulates older generations of migrant communities. This was contrasted with a *changing multiculturalism* experienced by younger generations. The participants described this changing environment:

Even till the age of 24 all of my friends were Greek. Everyone we visited was Greek. I see in my kids they have embraced all cultures. It's a different era now. We are more liberated than our parents.

The broader community is changing – more nationalities, more talking, more education. Used to be only Poms, Italians and Greeks.

Now my daughter's best friend is Asian. Now multiculturalism is normal.

However, while suggesting a process of change, participants also mounted a cultural defence (as the older generations had done). They pointed to the perceived differences between Anglo-Australian and ethnic minority traditions, highlighted the significance of, and desire for, the close-knit family and community obligations that forged a sense of connection and integration. While these socio-cultural beliefs and practices held the threat of rejection, they also marked belonging.

The family usually from our background, they support you. At the end of it, when you get married, they help you. The house, they help you set up everything. But once they know you are gay you are denied everything. They [Anglo-Australians] don't understand the family ties. To Mediterranean or Arabic groups it is the most important thing to be accepted, to be loved by the family.

In the multiculturalism imagined by participants, both continuity and change is desired. Participants do not want to lose the socio-cultural practices that form and maintain strong family ties. However, those family ties need to accept and include gay and lesbian identity.

GENDERED RESPONSES

Significantly, the participants also highlighted that the response of family members was gendered. *It's different with boys, one suggested, because the boy carries the name and the name is the most important thing.* Or, as another commented, *the family wants to see you have kids and settle down.*

For daughters who identify as lesbian, the family's *biggest concern is 'who's going to look after me in my old age?' My mother can't see that a female can go through life and be single as an older person. And the assumption is that there can be no children. Absolutely.*

And for gay men:

My mother's relying on me because my sister is responsible for her in-laws with her husband and I'll be responsible for her. A few years ago she cracked up about 'how are you going to look after us, how are we going to live together if you've got someone else?' They have their assumptions because nursing homes don't exist in the Greek community.

GAY AND LESBIAN COMMUNITY

When asked about their experiences within the gay and lesbian community, the responses of participants were also gendered, and conflicted. While most agreed that generally gay and lesbian events and services – such as the Queer Film Festival, the Pride March, 'Midsumma Festival' and the Victorian AIDS Council/GMHC – are *very inclusive*, one participant commented *there is a lot of prejudice even within the gay community.* Another argued:

As a Greek man I can say the broader gay and lesbian community has opened up their arms and welcomed me. Sure you get your weirdos. Although I think there is prejudice towards the Asian gays - the Indians, Sri Lankans. Probably the same type of discrimination the wider society has towards the newer immigrant groups.

For other participants, gay community interaction is less to do with racial discrimination and more to do with sexuality/sexual preference.

I think with guys it mainly boils down to sex. There are preferences. I mean someone will say 'I don't like Asian guys', but it doesn't mean they don't like Asians as such. It is more to do with the build, how they present themselves – you know body shape, body beautiful is important for some gay guys.

When you go to a gay venue your main purpose is to hook up with someone. It's not your purpose to get to know someone, to make friendship. I go to these places just to hook up. You don't even ask what his name is. It's just an individual body preference thing.

Other participants highlighted the borders between ethnic and gay communities:

Gays and lesbians are separate, trans are separate. The GLBTI community seems quite closed within themselves. As far as race goes, I'm not sure. Perhaps it happens so often that I don't notice it anymore. I think there are definitely preferences, like whites not wanting to go out with Asians, or it could be the other way round.

I think historically all our groups have kept separate and don't come together at a deep level at all.

Again the boundaries between socio-cultural groups were highlighted. For one participant, the gay and lesbian community was seen as *the richest people, the most educated people and the most wealthy people. You talk to them and they say we have to support ourselves.* Again, as with the wider Anglo-Australian community, Anglo-Australian gays and lesbians *don't understand family ties.*

HEALTH SERVICES

Invited to talk about their experiences with health and medical services, participants again raised concerns relating to family and community ties. One commented, *that's the thing in ethnic communities, everything is everybody's business. Confidentiality is lost in family business.* As another participant explained:

I don't have a problem going to my GP. He happens to be Greek and very, very religious. When I told him I was gay I could see the difference in him, but he is fine with it. He just says to me 'make sure you have regular AIDs tests and other STI tests'. But a lot of guys have the family

doctor that the whole family goes to. They will not go to that doctor for anything sexually or gay related. One guy who called me up to say he didn't want to go to the doctor where his parents go because [the doctor] will probably tell them.

Participants sought out a range of medical services. Some attended specific gay and lesbian GP clinics and services, while others avoided them.

If we meet at VAC then people think we have HIV. That's why I have my tests privately, not tell anyone I am going to do it. I don't know why but I don't tell anyone.

I have no problems with health services. I go to a gay and lesbian clinic Of course some GPs are great: inclusive, non-judgemental, informed, helpful. We live in this small country town and our GP, an Asian woman, is brilliant. We're probably the only lesbian couple she's got on her books. So if GPs are willing to access the information, it's there. Depends whether they are interested or not.

Significantly, a number of participants highlighted the high levels of stigma ethnic communities attached to depression and mental illness.

The sensitivity of the workers within the mental health services to be able to deal with ethnic differences/backgrounds is a big one. There is a stigma with mental health. It is different from going to your GP for a check up if there is something wrong physically. It is tough when you are dealing with a culture that won't recognise that depression exists, and many within CALD and gay and lesbian communities suffer from depression. There is an understanding that mental health is an evil thing, so they won't access it. Young people from these backgrounds who are dealing with issues of coming out and the stresses of that. It's bad enough that they can't talk to their parents in their teens that they are different, but it hasn't been modelled to them that you can avail yourself of different resources. Because their parents don't either.

Although not specific to gay and lesbian health, the difficulty in accessing interpreters for family GP consultations was also raised. Again it highlights issues of confidentiality.

Some of our parents have language difficulties. So children often act as interpreters. Doctors often automatically assume they have the consent of our parents to speak to us ... and the reverse as well.

IDENTITY AND BELONGING: WHAT COMES FIRST?

While the borders between multiple, minority identities were recognised, participants also understood the boundaries were permeable, that they could shift between identities.

I don't think there is anything wrong with [separation] either. It becomes a problem when we do it all the time. I mean it becomes an issue when we don't include the trans, intersex whatever, but I don't think we do that. I love the space. Sometimes, and that's the qualifier, I love just being with Italian women. Sometimes I love it when I am with Italian men together. I love it when we come together as the multicultural group. I love it when I go to the Exchange or the Star when I'm with the broader GLBTI community. Everything serves its purpose.

It just takes a little step for each of us to come out of shells. Whether its our family shells or Greek and gay shells or whatever, we all have these different little pockets that we form part of and it's a matter breaking them up and intermingling with everything. I mean I'm as guilty as the next person. I love my Greek culture. But sometimes I like to take a step back as well and disappear from the Greek culture and intermingle with everyone else.

The ties between migrant/refugee groups are greater simply because we're not in our country. We have gone through the journey of being a refugee or migrant together so you need to stick together because these are the only people who know what you have been through. It is important to have those ties.

While participants pointed to their desire to mark the boundary of ethnic difference, they also recognised that the boundary needed to expand to be inclusive of gay and lesbian lives. The associated stigma and shame replaced by visibility and acceptance. *Just normalising [homosexuality], that would be helpful. It just is ... it's not good or bad it just is. It is just there.*

2. DISABILITY

Invisibility is the disability ... The disability is not in ourselves but in the wider community, including the so-called disability community.

On hearing about this project, gays and lesbians with a disability were eager to talk about their experiences. As one participant commented, *I am actually glad that someone is showing interest in these issues, they have been neglected for too long.* It was a sentiment frequently expressed. It was, many suggested, *about time we're asked* and that *we are listened to.* Most of the issues presented in the literature review re-appeared in the group discussions and interviews. The stories that participants told clustered around issues of 'coming out', experiences with family and social networks, with the disability community, with other gays and lesbians, as well as their interactions with the health system. As discussed previously, for gay and lesbian people with a disability, their everyday lives are shaped by both structural barriers (policy and practice) and by the social implications of varying impairments (difference). Their stories reflect a wide spectrum of experience.

FAMILY: COMING OUT

As a starting point, participants were asked about their experiences of coming out to close family. There are two points to make here. First, whether sexual identity is concealed or declared, self-identity as gay or lesbian remains. Second, coming out is not a single event (Oswald 2002, Noble 2002). However the stigma that is attached to both sexuality and disability – and the sense of isolation and fear of rejection that it brings - makes the process of coming out, on each occasion, a particularly difficult one. The following responses reveal the wide spectrum of experience.

I didn't tell my family when I first found out [at age 14]. I didn't tell anyone. I was just a bit flirty with other men. I lived in respite back then. And I was just coming out and finding out who I was ... But I didn't know I was doing anything wrong or anything ... One of the workers did ask me if I was gay. I'd just given someone a hug or something and one of them said 'are you a poof or something?' And I remember saying 'no'. [Now] my mum and dad both know. My brothers don't know. One of my brothers is a macho guy. He still uses the poof word and all that so I wouldn't tell him. My whole residential unit [CRU] know. Pretty much everyone, except my aunties and grandparents, know. [My parents] wish that I weren't gay, it's a hard life. They won't have grandkids; I won't have kids, stuff like that. My mum and dad are strict Catholics too. Now they still wish I weren't but they love me and treat me exactly the same ... But they are just worried about the HIV thing as well.

*I think [having a disability] has made it harder. Especially as my parents are Maltese. I was watching *Queer as Folk*. I was giving them hints that I was gay. My mum says 'you're not watching that dirty show are you?'*

And I said, 'yep, I'm the same, I'm gay'. I just came out with it. Mum and dad weren't happy. I was living at home and decided to come out. I said 'sorry mum and dad, but I'm gay'. My mum went haywire and my dad didn't want to know ... I came out pretty much after I was bashed. [My mother was] happy, but not happy first. Worried about HIV. She was scared because of HIV. Still happy that I am gay but worried about HIV. I tell all, everyone. I told my dad [and] he said goodbye. He was not happy. I told my brothers and they were OK. They were happy for me.

I suppressed my sexuality all of my life.

I've got the advantage of being middle-aged, having qualifications, earning decent money and having come out when I was 22. So I don't even remember what it's like not to be a lesbian and I've got really strong social networks and I have never had to be closeted about my sexuality.

Disabled gays and lesbians face a 'double prejudice', stigmatised by a moralising about what they might do, as well as by the fear and myth of what it means to be both disabled and gay or lesbian (National Disability Authority 2005:13). Irrespective of sexual orientation, until recently people with disabilities are assumed to be either asexual and in need of protection, or promiscuous and predatory (Horsley and Azzopardi 1990). As one participant commented, *the wider community folk 'switch off' when they see a disabled person*. Possibilities for sexual expression are either curtailed or, if they are expressed, labelled as deviant (Kaufman et al. 2003). For many families the presumed vulnerability of those with a disability, coupled with the risk of HIV/AIDS, pushes the culture of protection and concern.

A lot of committees of management of disability services, and parents as well, still maintain that people with disabilities ought to be wrapped up in cotton wool. That accessing stuff on gay sex, safe sex, whatever it might affect their moral fibre. Their halos would be tilted and something terrible would happen to them. A lot of parents ring up and say 'we don't want our son or daughter to have contact with x group, y group because those people will manipulate them and take advantage of them'. So people with disabilities are immediately characterised as being open prey and don't have any abilities themselves to know when they are being exploited.

Participants discussed the difficulties that gay disabled people, particularly those with limited independence or obvious disabilities, have in the community more broadly. They pointed to the censoring of their displays of affection in public places and the limited opportunities for consensual intimacy.

The wider issues are the difficulties people have being able to hold hands in public, express themselves with affection towards their partner and so forth. Even in shopping centres people in this group have discussed when

they have been told that they cannot kiss and cuddle because it is seen as inappropriate by the wider community.

I had a friend who likes to give cuddles and he said 'can I give you a cuddle?' And I said, 'no, not outside Frankston railway station!' I felt really bad that I said no.

RISK-TAKING

Violence, and the threat of violence, was raised by a number of participants. *A lot of the violence gets unreported*, one commented, adding *there's the fearing of the police because of the homophobia within the police force*. Much of the threat was associated with areas where local beats operated. A number of participants had been physically assaulted and bashed.

Around the beats in [locality] it's really bad. All the druggies and drunks are being moved on from the railway station down to the beach. There's a campaign now to abolish the toilet blocks down on the beach. They leave the druggies and go for the gay people on the beats.

Homophobia and prejudice can lead to risk-taking behaviour for gays and lesbians wanting to make social connections for sexual relationships. For those with a disability, the risks can be heightened. One participant commented

From personal experience I can say with certainty that I have been in some strange places! Sometimes connecting with people with similar low self-esteem and a sort of co-dependency, self-medicating with drugs and alcohol etc. This may be the case for others and there can be quite serious health repercussions arising as a result.

For gays and lesbians requiring attendant or support care, or living in residential units, issues of privacy and independence also impact on sexual expression. Opportunities for privacy and intimacy can be even more curtailed.

I remember last year that there was a guy who was interested in me for more than one time, one scene. I had seen him 3 or 4 times. When I told him I lived in a CRU, because I like to be honest, he cleared off. It scared him off. I didn't see him again after that.

The CRU housing for people with a disability is a joke because they're putting people down who are gay or lesbian. What if one day two guys end up living together in the CRU housing? It is ridiculous. For me as a disabled person I think the government should say 'right let's design another CRU house but for the gay sector only where the gay people can sleep together'.

Current government disability policies do stipulate that support workers must respect the rights and privacy of individuals who are in, or wish to develop, a same-sex relationship. However, as one participant noted, *committees of management come into play particularly as a lot of disability housing, CRUs are in the private or not for profit sector [and thus outside policy control]*. Participants also pointed to the wide variation in the attitudes of disability services to sexuality and sexual expression. While many were clearly uncomfortable and censoring, some organisations employed gay and lesbian support workers. As one participant pointed out, *I mean if you go into a CRU and look at who is on staff you'll find a lesbian – that's not unusual*. However whether or not those support workers are 'out' in those organisations remains unclear. The tensions of 'coming out' are present for all.

AN ISSUE OF ACCESS

The common thread that weaved through many of the discussions was the issue of access. Certainly physical access - ramps, wheelchair and walking frame access - to gay and lesbian events, support networks, nightclubs, toilets and other venues was highlighted. As one participant put it, *if you can't even get in the door how can you begin to talk about equality?* Another explained:

Access is something that needs to be in the forefront of people's thoughts. An able person's concept of 'what is just down the road' is quite different from mine. They don't even think about what is a distance. Just over there can be too far for me to walk ... I mean one step is a huge barrier if you can't get up that step.

The importance of communication access was also raised. One participant concluded:

Literacy skills are also so important. That sort of barrier for people with a mild intellectual disability, where English isn't the first language and who have literacy issues, how do they access services they are deserved of?

Making places friendly for people who have limited literacy, access to interpreters and texting facilities for the Deaf community, and the lack of accessible websites for disabled gays and lesbians were all highlighted. However, as Brothers (2003) has argued, access is more than 'just about ramps and Braille'. For participants in this study, issues of access that either built bridges, or barriers, to social connectedness were central. Practical, social and attitudinal barriers were raised.

For some it was the experience of education and peer group bullying:

I remember when I was at high school I was very stupid and silly ... [Other students] they'd get me to do stupid things and pay me to do stuff. So I got kicked out of high school because I was pretty bad. So I lost a lot of things education-wise and therefore if I wanted to get a job I don't have a lot of education and stuff ...

Or limited employment opportunities where low fixed-incomes further socially isolate people:

Sometimes with the jobs, people with disabilities just work in the workshops and you're not getting good pay. Like with one of my friends he just gets \$70 a week and that's not much ... and the disability pension doesn't get me that far.

I wanted to go to a gay nightclub but the prices were so stupid - \$15 just to get in which for a person with a disability on the pension is ridiculous.

Or issues of mobility and access to accessible, affordable and reliable transport:

I know some people with disabilities who can't go out to nightclubs because their house-staff finish at 10.00pm.

I have trouble going out at night because of public transport. If I had my own car I'd be all right but I don't. I'm not expecting my mum to come and pick me up. I know how to use public transport. But some trains stop right at midnight so it can be hard to get home and I don't have that much money for a taxi.

Transport is also critical. Public transport in Victoria is improving but the cost of taxis is huge. The taxi scheme capping has been very cruel. If you are on a fixed income how can you afford that? A night out with a taxi, even with a half price, and a cheap dinner - might as well forget it.

We have country members but rarely see them because of the cost of transport and accommodation. And anything arranged on Sunday is difficult for transport anyway.

Or the location of gay and lesbian venues:

There's also the centralisation of gay venues where if you live in the northern suburbs it's 20 or 30kms to get to this side of town [Pahran] to be able to access anything. It's so far. A lot could be done to encourage local accessible groups.

Or access to sexual health and general information:

I think one of the biggest barriers is the attitudes of service providers and councils that prevent people being able to access information about ... activities, even if the venue or clubs or societies were gay-friendly or disability-friendly. It's very difficult to find out where they are and who they are

There is a bit of a maze to find out what you are eligible for if you don't have your own resources.

Disabled folk often don't know what services/support are available. How do you disseminate information that can help connect disabled people to community?

These are all issues that affect opportunities for social interaction; issues that build barriers to social connectedness. As one participant concluded, it's *a mixture of low income and access and being forced into those positions and then the sexuality thing on top of it.*

MAKING FRIENDS - BOTH GAY AND STRAIGHT

A number of participants spoke about their difficulties connecting with mainstream gay and lesbian, and wider, communities, highlighting the limited opportunities to interact socially with others. Often a life-long separation from the able-world can increase social disconnectedness.

Very hard [at gay venues]. I always get stared at and they don't want to know me. Sometimes I go to the [gay hotel] with my partner and it's hard to have a conversation.

My social skills are very bad when I am with people my own age. They'll all have a joke and say all this stuff and have a laugh and I'll think 'what are they laughing at?' So I'd have to pretend to laugh with them. Or when they are talking with me privately I find it really difficult to talk back so they don't hang around with me for very long.

For the Deaf community communication is the issue. That's always the problem. I can use my voice, I can speak or write or mime. But hearing people often find that form of communication draws attention. So if I'm in a lesbian bar or with some Deaf lesbian friends, if I start signing, then of course everyone starts looking at you. It's a novelty for some people for a while. But to go into any depth the communication is difficult.

Sometimes it's hard for me to make friends as well and keep in contact. Both gay and straight friends. I go to a few other groups ... but it's difficult to make friends in those other [gay] groups.

A CULTURE OF THE BODY BEAUTIFUL

As in the wider society, the increasing consumerism of gay and lesbian culture places the abled-beautiful-body in opposition to the dis-abled. The disabled body is noticed:

I mean we [ethnic group] are so much better off than some gays and lesbians out there. I mean it's not so much prejudice but some people with disabilities don't get the chance to go to the venues. They're not accessible. But you see a guy in a wheel chair at a gay venue and I feel sorry for him, though I probably shouldn't.

And often excluded:

For a lot of gay people you have to have the right clothing, the perfect job and everything. You have to be wearing \$200 jeans, they have to be this brand ... so it's hard to make friends if you don't have them.

Although the experience can be gendered:

I'm glad I'm not a gay man [laughing]. I think what is most important to me is someone's politics – feminist values – not what they look like particularly. I've never been a bar-dyke or a sporting-dyke! But of course when you're not in a relationship I think you dwell on whether it's because of x or y. But everyone does that.

DISABILITY COMMUNITY

Participants also pointed to their sense of exclusion from mainstream disability services. Gays and lesbians, they suggest, remained largely *invisible* to service providers and disability organisations.

I don't think there is a gay disabled sector as such. It doesn't exist. There is a generalised view that there is a disabled sector and there is a gay sector but never the twain shall meet.

We seem to be fighting even at a local level for recognition - even the straight communities – of disability issues. In some places, for example, it is very, very difficult to meet openly because of the level of homophobia. And that's from young kids who are reflecting the ideas of parents and the wider community.

Invisibility is the disability ... The disability is not in ourselves but in the wider community, including the so-called disability community.

HEALTH SERVICES

Issues of confidentiality, particularly in rural areas and small towns, and the perceived homophobia of health practitioners, were raised by a number of participants.

I saw my family doctor first. I didn't tell him I was gay. I was [sexually active] but I didn't tell the doctor because I was nervous ... I was worried about negative stuff, what he might say.

Initially I had an Arabic doctor, a female, but she asked me sexual health questions and did pap smears and that sort of stuff. And the interpreter was provided, always female and that was fine. But then she'd ask questions about sexual health, just assuming I was heterosexual ... She was getting this look on her face and I said do you realise I'm a lesbian? She was like 'oh, oh', and looked really

uncomfortable and didn't know how to cope with that. And then I changed doctors, someone I could feel comfortable with.

Others criticised the continuing medicalisation of disability that effectively both *discriminates against people with mental illness* and:

undermines human rights because the moment that you categorise people and their abilities according to their medical description - what they can do and can't do according to a category the doctor identifies - is not to do with their actual ability. That's the philosophy. Eligibility is up to the doctor's opinion, not to do with the person's safety. None of the social elements are taken into consideration.

Others pointed to structural inadequacies within the health system, particularly in relation to the dissemination of information.

A lot of people with disabilities wouldn't know about this place, that they can get support and education here (VAC). I think that is partly due to the fact that the community health sector hasn't reached out into the disability sector. There aren't those links there [but] there is so much crossover and commonality. It is something that can be addressed through the public sector mechanisms.

However, the main issue raised in relation to health and wellbeing was that of mental health. Given the discrimination, violence, exclusion and invisibility gays and lesbians with disabilities experience in everyday life, it is not surprising that many participants highlighted issues of depression and mental health. As one participant summarised, *a life-long separation from the abled-world increases social disconnection*. For another *not knowing about [services], the affordability, getting there, access, all influence mental health*. Health is also about these social needs that *have a big impact on health and wellbeing and body image, presentation, feeling good about yourself. It all compounds to make a bad scenario*.

And also not just a disability but I look different [because of the physical disability]. I've had to do more work on that in terms of my mental health than I have done with being a lesbian ... I had to work to feel OK about myself because, particularly as a teenager when you look different – like way different – then that's really hard. At that time I hadn't worked out that it wasn't my fault, that it was society that was putting up the barriers. It was when I saw disability as more of a social issue that it started to make sense to me. It wasn't that I was bad or something wrong with me because I looked different or wasn't as able as other people. And that was stuff that took me years, like to take my clothes off in front of other people, [laughing]. You get over that stuff but for a while there that was incredibly challenging.

Being gay or lesbian is no different from being straight in the sense of what your aspirations are or what you want to get from a health service. What you don't need is someone to judge you based on your disability or sexuality ... And you have to remember that disadvantage or marginalisation is also about having enough money, education, class - it's about who you are and what your circumstances are.

IDENTITY AND BELONGING: MULTIPLE IDENTITIES? MULTIPLE MARGINALISATION

For gay and lesbian people who have a disability, multiple identities can also mean multiple exclusions. But 'identity' here is not restricted to sexual orientation and impairment. Ethnicity, gender, socio-economic status and class - at least - can all be added to the mix. A number of participants in this project, for example, identified as gay/lesbian with a disability and were from an ethnic/Indigenous background. From complex identities flows a complex array of prejudices. It also raises the question of how multiple identity groups negotiate the contradictions and confusions of marginalisation and disadvantage. Not surprisingly perhaps, participants negotiated their identities through the pragmatic demands of everyday life.

I inhabit different worlds, as lesbian, as Deaf, and as a mum. They all combine. My partner will come with me to some Deaf things but not all. I've been living in the country for a long time where I'm with my kids so I'm a mum, a worker. And I tend to speak more in that environment because there aren't many Deaf people. So I might come down to Melbourne for the weekend so I can sign and catch up with everybody, see what's been happening down here, have a good time, go to one of the lesbian venues.

I guess the disability is very significant to me because it is something I cannot hide whereas people don't have to know about my sexuality and they don't need to know about my religion, but it's not like I have to wear those 'out'. I have to, I can't not be someone with a disability. And also not just a disability but I look different in the sense that I've got curvature of the spine and limping and all that stuff. I've had to do more work on that in terms of my mental health than I have done with being a lesbian or my ethnicity. Ethnicity has always been a very important part of my upbringing. That's why it's really important that I've got connections with other ethnic lesbians. It doesn't mean all my lesbian friends are ethnic but it is that shared culture that is important.

I have always valued certain things in my life. One is having friends who have a disability because we have a shared vision of some of the barriers that society presents. Also I've also had friends who are [ethnic group], because I have an [ethnic] background, and I'm part of an [ethnic] lesbian group. So it's sort of like where are your allies? So it has always been really important for me to have someone with a disability in my life as a friend.

I'm happy to advocate for disabled people's rights, for lesbians, for Aboriginals, although I suppose lesbianism is last on that list for me. But I don't want to be the 'token' disabled person or whatever.

Participants in this project identified with the identity 'labels' of disabled person and lesbian or gay. However, clearly these are not necessarily the primary constructions of how they are seen – all of the time. People shift between identities depending on social and political contexts. As participants reminded the project team, people push against the borders of prejudice and marginalisation in their everyday lives.

Well, people themselves do not identify as disabled – more a human being. I think all people in the disability community would think like that. They want to be recognised for their ability.

I did a survey for someone looking at disability and spinal cord injury but it was so geared around assuming that I was depressed about my spinal cord injury. The questions were like, 'have you stopped taking anti-depressants yet? There must be a problem there somewhere so help me find it'.

At my cousin's place I logged onto the Maltese website about the Eurovision song contest. They had one song about Maltese gay men coming out. I was reading it and I found it really interesting. OK I'm Maltese and I'm proud of being gay.

3. INDIGENOUS

As discussed earlier, the methodology initially proposed for the Indigenous consultations resulted in very limited Indigenous participation. Consequently, it may be tempting to conclude that Indigenous gays and lesbians are indeed hard to reach, that is, they are 'difficult to contact or engage'. However, the project team does not take that path. The process, rather than the group, remains our focus. Before turning to the findings that emerged from the consultations that did take place, it is important to examine what was that didn't work, why Indigenous gays and lesbians did not want to take part in discussion groups or interviews. These learnings will help inform future consultation processes.

DESIGN GUIDE FOR WORKING IN PARTNERSHIP

The engagement between Indigenous people and the broader health research community in Australia is well documented (Humphery 2000, Humphery 2003, Anderson et al. 2003). Henry et al. (2004) argue that, over the past three decades, promoting Indigenous participation in all aspects of research has been a cornerstone of the movement to reform Indigenous health research activity. In Victoria the development of partnerships between mainstream and Indigenous organisations has also been examined (Waples-Crowe and Pyett 2005). The significant factor that emerges from each of these reviews is the importance of high levels of collaboration between Indigenous community members and researchers at all stages of the research process. For Waples-Crowe and Pyett (2005):pp.14-5) critical components of that collaborative process include a long time-frame, building trust, valuing each other, cultural awareness and training, community-initiated research and supportive work environments. If we take these to be the foundations of a 'design guide' for collaboration with Indigenous community members it provides points of comparison against which the methodology of the 'Hard to Reach' project can be examined.

Participants for the project were to be recruited by an Indigenous gay man and an Indigenous lesbian woman. Both were well-known, and 'out', within the Indigenous community. The gay man was an experienced Indigenous health researcher with both research and social connections to 'OutBlack'¹⁷. The woman also had long-term experience working in, and involvement with Indigenous and non-Indigenous health issues. A weekend camp involving members of OutBlack was initially planned to facilitate discussion of men's issues. Women were to be recruited through social and Koori networks to form an informal discussion group.

The camp with OutBlack did not eventuate. Nor was a further effort to organise an informal discussion night successful in attracting participants. Indigenous women were also reluctant to participate. A number tentatively agreed but only for the reason that they knew the project worker - 'because you asked me'. Others appeared uncomfortable talking about issues of sexuality in a group setting. Individual

¹⁷ 'OutBlack' is a Koori gay & transgender Sister Girls social/support group in Victoria.

interviews were offered but, again, these failed to attract participants. A number of factors could be operating here. The relevance of the research to Indigenous men and women, as well as issues of confidentiality for such 'private business', may have been questioned. Perhaps it would have been more productive to discuss lesbian health issues within the more inclusive framework of Indigenous family or women's health more generally. Perhaps suspicion of government bureaucratic processes and an unwillingness to criticise – or at least be seen to criticise - Aboriginal Medical Services, also contributed to peoples unwillingness to participate. These possibilities remain speculative. However, the 'design guide' provides us with a more solid direction. What's missing? Time-frame, relationship, trust and a community initiated issue. This was a project generated from the MACGLH, carried out over a short time period with the primary, non-Indigenous, researcher largely unknown to the Koori community. In comparison, the researcher was well-known, and trusted, by the key Indigenous stakeholders that did participate in interviews.

However, there may be other barriers to Indigenous gay and lesbian participation. In February 2006, ACON held a forum to raise the visibility of lesbians and bisexual women in Indigenous communities.¹⁸ It was initiated by an Aboriginal lesbian peer group and run by ACON's Indigenous SSAWomen Community Development Officer. The forum was promoted via Koori Radio and through Indigenous organisations. The venue was accessible by public transport, in an area with a high Aboriginal population and was women and children friendly. However, few women attended the forum. Clearly the methodology to develop partnerships with Indigenous communities needs more attention. It is a discussion that needs to involve both Indigenous and non-Indigenous players.

INTERVIEWS WITH INDIGENOUS GAYS AND LESBIANS

As with the previous groups, the discussions with Indigenous gays and lesbians concentrated on relationships with family, with the Koori community, with the wider gay and lesbian community and with both Aboriginal Medical Services and mainstream health services.

FAMILY AND COMMUNITY

The typical metaphor for Aboriginal life, one participant suggested, is the experience of family and friends, nation and countrymen. *They are all there somewhere ... they are all connected up.* Not surprisingly then, the starting point for the discussion was family. The Indigenous family *is constituted in complex ways. There are other spaces that people play because you don't have the sense of mother, father, two kids and a dog. That's not what family is.*

That narrative of kids growing up and leaving home, or getting married to leave home is not the Koori narrative. The older generations were Christianised to a certain extent but I don't know many Koori friends

¹⁸ Personnel communication, SSAWomen Community Development Officer, ATSI Project, ACON, 24 May 2006.

who got married. So there isn't that traditional narrative of parental success ... It's not that Koori parents don't have aspirations for their kids but they're not that sort of aspiration ... My mum said to me once she was really, really pleased now that we all had houses. That was, for her, a success narrative.

Are there spaces, then, for being gay or lesbian in this Koori constitution of family? One participant framed Koori family aspiration more in terms of a hope for survival. Although perhaps a flippant response, she suggested that *if you have a son or daughter who is gay or lesbian, well, at least they're not drunk, or drugged or dead.*

The experience of 'coming out' to family members can be a mixed one for Indigenous gays and lesbians. *You don't come out, you just transform somehow*, one suggested, *I can't remember once telling my mother I was gay [but] my partner is the favourite son-in law. He's the executor to her will ... That's the thing about Koori relationships, you're never really an 'ex'.* Another participant explained that she wanted her mother to know *who I really am so I wrote a letter explaining that I was a Koori lesbian woman. She told me she knew all along!* For others, identity ripples through family networks.

I told my daughters, that was my first priority ... My oldest daughter would have been about 13 at that time so she was like 'I already know mum' [laughing]. So they both accepted it. I had already separated from their father at that time. Then I told my brother who lives not far from my husband in the country, about an hour's drive away. I told him. He has a daughter who is a lesbian as well so he was like 'oh man, this is too much' [laughing]. The daughter had come out at about the same time so it was really intense for him – 'my sister, my daughter, my god!' That was a really good start to the process for us. Then I went home about six months later, went to my parent's place for the first time. I hadn't seen them for about eight or nine years. My father is a very quiet Aboriginal man. I have never been close to my father so if I want to talk to him I talk via my older brother. I don't go through mum but through my older brother. That's a cultural thing. When my father found out he was OK. He wasn't ecstatic about it but he was OK. He sort of took it on board. Mum, she was really happy! She said you should have told me a long time ago.

For others, the disclosure of sexual orientation is followed, not by rejection or exclusion, but more by a silence. Gay or lesbian identity may have been revealed but it is one that is not spoken 'out loud' again. Relationships and identity are rendered not quite visible – perhaps not invisible but more submerged, out of sight. One participant rhetorically raised the question of change: *How long do we have to do that? Why can't we start [being visible] now?* For some, it was an older generation's Christian values that hindered change. For another family relationships and individual identity were more historically placed, emerging from the fractured relationship between Aboriginal and white Australia:

Many Aboriginal people come from fractured families. For some sexuality and identity are bound up within a profoundly awful experience of abuse, both physically and sexually as kids. It is probably true that fractured relationships in that way probably figure more commonly in Aboriginal sexualities than they might in the broader gay and lesbian community. It's also true that, I know very few Aboriginal people of my generation that grew up with a close and intimate relationship with their father. Again I am over-generalising but in a sense that father loss and fractured relationships, and father relationships in particular, are quite significant in all of this. I'm not in any way making causal arguments but I am saying that into the mix in which personality, identity and self is formed are a whole range of factors that play out in quite complex ways.

GAY AND LESBIAN COMMUNITY

One participant reflected on the changing relationship between gay and lesbian people and the wider community, and the place of gay Kooris within it. It is now, he suggests, a more culturally complex world. The participant is quoted at length below.

When I first came out it was still illegal in Victoria. You went into a gay bar and I remember being bashed by a couple of blokes waiting for poofers as they came out. The bars then were probably the only space. Back then I can't remember seeing - at places like Mandate in St Kilda, the Anglers Bar - you might have seen one or two Aboriginal people there. A mate of mine when we were younger we'd go out exploring the bars and we'd have people come up and say 'we've never seen Italians in the gay bar before'. It's more culturally diverse than it used to be. And that makes it an easier space in some ways. Although that is not entirely true. You go down to places like the Exchange and Market Hotel, sure I generally see three or four Kooris, but most of the people there they are just too blonde. I've got nothing against blonde boys but it is a really particular world.

It's a pointless exercise trying to tell someone in a gay nightclub that you're a Koori. Back in the early days when I used to do this you would never tell anyone about your background because you just wanted to go to their place, sleep with them, then run away. Blackness has never been fetishised in the Aust gay community. Not Aboriginal blacks. Something more exotic like Polynesian or Asian perhaps.

The whole relationship between gay and lesbian people and the bigger world has changed over the past 20 years. We have Mardi Gras, things like MidSumma Festival. It's a much more public thing. There is greater diversity in the ways people can express their relationship. I think the public nature of it, rather than the private commercialised hide-away life that you had in the previous couple of decades, actually makes it possible to construct different forms of community.

OutBlack was an idea that came from a Koori drag performance and it created an opportunity for a social environment that connected up Aboriginal gays and lesbians. You know, there were certain uncles that lived together for 30 or 40 years where everyone knew they were gay but they were never a part of the gay community. That was a pretty middle-class white club. Not entirely white, but you have to have money and a certain position in the social world. I can't talk about that previous generation but their context was around beats and anonymous, more ephemeral relationships around sex, rather than that sense of a social community. You go to an OutBlack do now and half your [straight] family are there [laughing]. It's really bizarre. You go there and catch up with your old friends and mates and half the crowd's not gay but it's a gay event.

HEALTH SERVICES

When asked about their experiences with the health care sector, participants distinguished between Aboriginal Medical Services (AMS), gay and lesbian specific medical clinics and more mainstream health services. Clear distinctions were drawn **between** these services. They were seen largely in opposition, as either 'Aboriginal friendly' or 'gay/lesbian friendly'. While raising issues of continuity of care, that the services provided a choice was regarded as positive. Choice of service is *probably a good thing in the sense that, people can get to use the AMS for most things, then go and use other services for stuff that is private*. Perceptions of privacy and confidentiality were central issues in that choice and raised by all Indigenous participants.

It's hard not to have your business known in the Aboriginal community. That's the point; if you went to an AMS you would feel your business would be known. That's a perception but in some ways it's also the reality. Someone will say 'I saw so and so at the AMS'. That's not necessarily a disclosure of personal, confidential information but it is an observation and people may not want that known.

For a number of participants it was general concerns about confidentiality that directed their choice of a gay/lesbian friendly clinic in preference to an AMS. For others it was directly related to sexual orientation:

I think there are issues around for some people about disclosing their sexuality although a lot of the private business is done by white health professionals not by AHW. (Aboriginal Health Worker)

Choice was considered positive because it created different opportunities. However, two qualifiers to this claim were identified. First, as one participant noted, *you have to know about that choice*, and many Aboriginal gays and lesbians are not aware of the range of services available. And second:

In order to negotiate choice people need to feel welcome at gay and lesbian services as much as they feel welcome at an AMS. I'd neither

characterise one as racist or the other homophobic but I think those issues are nevertheless there in the services.

Both AMS and gay/lesbian specific clinics are, at the same time, welcoming and unwelcoming for Aboriginal gays and lesbians. On the one hand, the AMS clinics are 'friendly' for Koori people. However, as one participant suggested, with management dominated by *an older, more Christian generation of Kooris*, the culture of conservatism is not welcoming for Koori gays and lesbians. On the other hand gay/lesbian clinics may be welcoming for gays and lesbians, however, for many Koori's they are expensive and clinically sterile:

All I see is white, white people. No role models, no Koori faces working there, not even on posters. They don't understand 'Koori-ness'.

For many Kooris these services are neither overtly discriminatory nor overtly inclusive. However, as one participant noted:

It is one thing not to do bad things but it is another to make people feel welcome. You need a more active approach that makes it clear that gay and lesbian people are welcome in this service. And that this organisation is there for all members of the community. It's like the absence of discrimination doesn't equal ... inclusion.

As one participant suggested, *it's like turning up at a party without an invitation. No-ones going to kick you out but they mightn't want you there. You're not made welcome.*

Another participant highlighted depression and mental health issues in the Koori community. Particularly for Koori youth, coming out as gay or lesbian can compound underlying concerns of grief and oppression.

Koori youth can feel unhappy. Many young guys have been to prison. They may have issues with their sexual identity so the grief process brings that up. They may think this is what the government has done, my family was taken, they have a lot of anger, they are working through that.

IDENTITY AND BELONGING

As we have seen with the previous social groupings, people hold multiple identities choosing to express or assert the one most meaningful to them at a particular time and in a particular context. Expression of identity is often to do with how safe people feel. For gays and lesbians, *the world has shifted in some ways ... we have constructed a space in which it is safe.* But not necessarily welcoming. Kooris, like the other groups, negotiate these spaces of identity and belonging by shifting between identities, depending on social and political contexts. In answer to the question 'what comes first – Koori or gay/lesbian identity?' one participant stated: *Koori that comes first, because your Koori family is always there. At work, even going to see a doctor, my sexuality doesn't need to be upfront.* Another participant suggested

I don't know that I see or experience the world in such a boxed way. There are aspects of yourself that get brought out in some contexts and other aspects that get submerged in other contexts. The middle of gay nightclubs is a pretty monocultural place, where cultural difference gets washed away. I think in many ways those bits and pieces of who you are are a lot more seamlessly inter-connected and conflicted in your experience. Here I am as a gay man and here I am as a Koori. My life is not that compartmentalised – I don't live in the gay world but nor do I live completely in the Koori world either. I have a set of life experiences where at some moment I am more in some gay environment. [Other places] are more that white fella world. Even though I feel really safe in that environment I can also be quite alienated from it.

For other *Sistergirls*, sexuality itself can be gendered differently, constructing a space of ambiguity around sexuality and gender.

At times geographic location creates the borders of inclusion or exclusion. Safe spaces can be found in the metropolis but are more difficult to find in rural and remote regions. One participant noted:

It's the lack of anonymity in a small town, everyone knows what everyone is doing ... People in the country are conservative so it is hard for people to come out. Some people think all gays are easy to spot, gay men are so camp! They expect the stereotype. Lesbians wearing Blundstone boots, jeans, check shirt and short hair.

Another agreed:

There are gay men in remote Australia and, God, they have got fucking awful lives. Isolation and exploitation ... Most urban Aboriginals today have a rural connection, small country towns. 'Tumbleweed' I used to call the one I came from, or as my family joked the other day, the town I spent half my life trying to get out of. I had no consciousness of sexuality at that point, but I was always planning my way out.

SHARED LEARNINGS: MULTIPLE IDENTITY MULTIPLE EXCLUSION

Under the *Equal Opportunity Act 1995 (Vic)* it is against the law to discriminate against someone because of their actual or presumed: age ... disability/impairment, gender identity ... lawful sexual activity, ... race, religious belief, ... sexual orientation.

The task of this section is to examine more closely the experiences of health and wellbeing identified by participants, to draw out both the differences **between** social groupings as well as the diversity **within** each. The task is to identify difference, but also to think across the labels to search for shared learnings. These will then be used to inform and develop the recommendations that follow. In large part, this section has already been 'written' by participants. During the interviews they were asked to reflect on the question, 'what could be done to improve your experiences of health and wellbeing?' Their responses form the basis of the following discussion. A number of text boxes are also interspersed throughout this section. Each contains excerpts from a relevant government policy.

From the stories participants told, experiences of identity and difference are clearly implicated in health and wellbeing. The stories construct a complex picture. The objective of the project was to explore the intersections of two social identity categories - gay and lesbian alongside CALD, disability or Indigenous. But even here, as the project constructed its own borders of identity, participants crossed between these labels. Participants with disabilities, for example, were also from ethnic backgrounds; there were Indigenous participants who also had disabilities. The well-known 'silos' of identity - age, gender, race, ethnicity, sexuality, and disability - do not fit well with the multiplicity of identities that people experience. As Clare (1999) describes:

Gender reaches into disability; disability wraps around class; class strains against abuse; abuse snarls into sexuality; sexuality folds on top of race ... everything finally piling into a single human body.

Add to this numerous other factors that also shape the experience of health and wellbeing. The social determinants of health, geographic location, socio-economic structures, the imprint of history, the wider political economy, these all impact on identity, on the experience of inclusion and exclusion. Not surprisingly then, identity is not experienced as a fixed category. How people identify themselves shifts and changes.

SITUATIONAL IDENTITIES

Gifford (1998:1) used the term 'situational identities' to describe the way people move between labels, how they identify with one more than others depending on the particular occasion. An Italian lesbian spends time immersed in Italian culture in conversation with old Italian men and women; a Greek gay man wants to disappear from his Greek culture and intermingle with everyone else; a disabled woman who is a lesbian is also a mother, a worker, a sister; while, for a Koori gay man, the middle of a gay nightclub becomes a monocultural place. However, people do not necessarily ascribe equal weight to the identities they hold. For an Indigenous lesbian woman it was her Koori-ness that was most important; for a lesbian with a disability and from an ethnic background, it was the disability that held most significance. Further, what identity is called upon at a particular time may relate to issues of safety – a gay disabled man refuses to cuddle his friend in public because of the threat of violence. Or it may be concern for the anticipated consequences of disclosure – the fear of rejection from close family, or the breaching of confidentiality by the family doctor, or the loss of opportunities for intimacy and privacy for those with a disability living in CRUs.

People who live in residential supports have the right to have guests visit and stay over ... Homosexuality and bisexuality are as common in people with a disability as in people without a disability. Support workers must respect the rights of individuals who are in, or wish to develop, a same-sex relationship. Remember that individuals or couples who identify as gay or bisexual may face additional challenges in having their relationships accepted by family, friends or the community
(Department of Human Services 2006b)

Moving between labels of identity also means that social relations and social interactions can be infused with the tension of contradiction. As one participant stated, *my life is not that compartmentalised ... [however] the bits and pieces of who you are, they're interconnected and conflicted.* Gays and lesbians from ethnic backgrounds can be included and valued as members of their ethnic communities because of their shared ethnicity. However, their sexual orientation can also bring shame and exclusion from those same communities. Identity can be confirmed in one social interaction and negated in another. While the discussions with CALD, Indigenous and disability groups drew out different aspects of experience, for all groups the barriers of exclusion were found in systems of service provision and within social groups and community and voluntary organisations.

MULTICULTURALISM AND DIFFERENCE

The diversity of the Victorian population has already been stated. It is a multicultural, multi-identity community. Indeed, the policy of multiculturalism emerged as an apparent solution to the conundrum of wanting to acknowledge difference and

plurality - in ethnicity, culture, religion or class for example – while also wanting to frame some kind of unity through understanding and tolerance.¹⁹ Multiculturalism implies mutual respect, inclusion of difference and equal access to all rights and opportunities. Clearly this is not the experience of participants in this project. The previous section documents multiple accounts of exclusion, marginalisation and discrimination resulting from multiple identities. They occurred from within families and communities, from within the gay and lesbian community and from within the health sector. At times overt racism and homophobia were experienced.

The Victorian Government is committed to ensuring all Victorians enjoy equal access to services, and are provided with the opportunity to participate fully as members of the community. Human Services face particular challenges in ensuring all Victorians - including those who are from culturally and linguistically diverse backgrounds, or who have a low level of English proficiency - enjoy the same level of access to high-quality services.

(Department of Human Services 2006a)

More often, it was a passive discrimination, *like turning up to a party without an invitation*, more a sense of being out of place, unwelcome or invisible. Far from an inclusive multiculturalism, an ‘un-named axis of sameness/difference’ persists (Schech and Haggis 2000). It rotates around the nationally valued social and cultural preferences, tastes and behaviour of ‘Australian values’ (Commonwealth of Australia 2003). Its centre is dominated by the normalising principles of heterosexism and non-disablement, all anchored in middle-class, Anglo-Australian whiteness.²⁰ These are not the ‘hard to reach’.

SHARED LEARNINGS ACROSS CALD, INDIGENOUS AND DISABILITY

As discussed earlier, participants in this study were eager to tell their stories. They recognised that their perspective - from the intersection of multiple identities - remained largely unsolicited. However, in the discussion groups and interviews, participants offered more than their stories of identity and experience of health and wellbeing. Certainly they recognised they were *the minority within the minority*. They gave examples of multiple marginalisations experienced in everyday life. But they also articulated pathways for inclusion. To the question ‘what needs to change to improve experiences of health and wellbeing’, came clear answers. Furthermore, common threads emerged from the CALD, Indigenous and disability responses. Put simply, these involved the right of multiple minority identities to be visible, welcomed and included.

¹⁹ See, for example, Commonwealth of Australia (2003), Kymlicka (1995), Ferguson (1991).

²⁰ For discussion see Hage (1998).

MAKING SERVICES AND ORGANISATIONS INCLUSIVE

An organisation talks about their desire to create a program for gay and lesbian Aboriginal people [or ethnic group or disability group] but the government doesn't give them any funding for it. I think that kind of illustrates a whole mindset where the service, in a normative sense, is for a certain group of people and if you want to run a program for anybody else you have to run some kind of program, develop something specific.

Like some people say 'we don't have a worker here to support this person' or 'there's no money to redesign the building' or 'to build accessible websites' ... then you confront the real reason, they don't want to be an inclusive organisation.

Participants from each of the three groupings asked a similar question: Why are minority identities the 'add-ons' that sit outside mainstream constituencies, whose needs cannot be addressed unless there is a specific stream of resources? *Why aren't services oriented towards Kooris [or ethnic groups or people with disabilities] anyway?* In essence, each of the groups was demanding that services and organisations become inclusive of difference.

You need a gateway, a way of opening people up, welcoming people within that environment. Recognising all people in the community and making them feel welcome.

They need to ensure that whatever events they put on, or social strategies they are developing, that they include same-sex and people with disabilities and encourage, or send a message somehow, that they are welcoming, inclusive services and programs.

I think the distinction to make is that services are not overtly discriminatory but neither are they overtly inclusive. It is one thing not to do bad things but it is another to make people feel welcome. You need a more active approach that makes it clear that gay and lesbian people are welcome in this service. And that this organisation is there for all members of the community.

An inclusive process, the participants argued, involves services and organisations taking active steps to engage constituencies that are not present. *It requires you, one suggested, to swim upstream.*

Not passively wait for me to turn up, which is most organisations interpretation of inclusiveness. That may be non-discriminatory but it is passive, not actively doing those things.

THE STEPS TOWARDS INCLUSION

Participants also sketched what those ‘active steps’ might look like. As one Koori man described:

[The steps towards inclusion] are contextual, depending on the service. They are things like actually doing things to build relationships outside into that Koori gay and lesbian world. They are the employment of ATSI people in the program, the inclusion of ATSI in the policy making process, in the governance processes for the organisation, in the strategy development processes. Making sure that the broad range of services that are provided are not discriminatory ... You need to be creative, to set up caucuses within community that can campaign and lobby for board places, to resource groups of people to organise themselves, maybe not for direct board nomination but to actually get their views represented. Other ways to develop complementary governance structures – an Indigenous caucus to the board, for example, that can represent the views of a broad group of Aboriginal people. It doesn’t need to come within the strict legally defined definitions but is that active search for strategies. Some may not work or be feasible but, in a sense, the process of the search may create the opportunities. But until you begin that search, and until you stop taking for granted the nature of representation and the nature of the engagement, then you can’t create alternative possibilities.

The steps towards inclusion articulated here do not only apply to Koori gays and lesbians. Overlay ‘Koori’, ‘ATSI’ and ‘Indigenous’ references with ‘minority identity’ and a shared process can be identified across identity groupings. Read this way, it suggests there are common steps towards inclusiveness. ‘Swimming upstream’ points to a process of organisational and programmatic inclusive practice. It requires services and organisations to take steps to actively engage with all members of the community, including multiple minority groups. To reiterate, it is an active process of engagement rather than a passive one of ‘non-discrimination’.

**The Victorian Government has made a commitment that all government departments will develop Disability Action Plans, with the aims of eliminating discrimination and providing people with disabilities equal opportunities for inclusion and participation.
(Department of Human Services 2005): 5**

The discussion groups and interviews also drew to the surface some of the finer detail of these steps toward inclusiveness. Many of these cluster around issues of access.

ACCESS TO INFORMATION AND EDUCATION:

Each of the groups pointed to the need for information and education materials to be accessible and readily available. Resources and support groups, as well as sexual and general health issues would be addressed. It was a strategy aimed to increase the visibility of gays and lesbians within communities.

People could have more education, like a booklet and a pamphlet that talks about HIV for people with a disability; or how to make new friends. And [support] groups for everyone joining in together [not only disabled] ... education for both gays and people in the community, everyone.

Media's a really important one. Services need to be promoted through the ethnic media. There's no point putting it in The Age or The Herald Sun Wogs don't read it. You put it in the Greek newspapers, Jewish, Arabic newspapers.

There are ways to develop and target strategies around community media, community radio, that show best practice given that the community press is a really important way of communicating within communities, and the gay and lesbian press is culturally diverse, we need to think of specific educational strategies.

Dissemination:

Dissemination of information is important. Whose role is it to make it visible? ... It can be easy for someone like me to become forgetful of that, busy with my own disability quarter. But being mindful of that is really important because it informs everything I do. Whenever, planning or doing or making some kind of policy advisory work, I need to be mindful of the person who is dis-connected. The point would be that those people who are not connected to services must somehow be targeted. It would be up to governments to find a way to consult or develop some information dissemination or promotions. We need to remember that there are people who are not connected to the usual disability sector connections, in a sense more invisible in the wider community. That dichotomy is always there.

I think one of the biggest barriers people who are looking for same-sex recreational activities and so forth is the attitude of service providers and councils that prevent people being able to access information about those types of activities – even if the venue or clubs or societies were gay friendly or disability friendly.

Where:

So general practitioner clinics need to have literature there, pamphlets information that can be taken away. I mean there is a lot on the net these

days that makes it a lot easier but new guys coming out need somewhere where they are going to come across it in the family GP waiting room. Same with [ethnic] family seeing positive messages about gay and lesbian health. It's more likely that our parents would open up to their doctor than anyone else. So ethnic GPs need to be open to gay and lesbian health issues, help it to be normalised.

VISIBILITY ACCESS

We need leaders within our own multicultural communities and organisations who are willing to say 'I am' or 'I know and it's fine that your son or daughter is gay or lesbian'.

Also for Government policy not to leave disability, and sexuality for folk with disability, off the list.

State wise with health strategies I think it is really important to focus on areas of social isolation and depression and include the fact that people with disabilities need to express themselves as sexual beings and remember that same-sex relationships are part of that. That's a recommendation that is blindingly obvious.

ACCESS TO OWN SPACES

We need more public support from our ethnic leaders and multicultural bodies, especially State government ones for support and advocacy groups. They're providing a health and wellbeing service. We are one of the main support networks. We need to be more visible in the ethnic media and ethnic communities ... These organisations need to make it a priority to acknowledge that gay and lesbian groups within communities do exist.

PFlag needs to understand that not everyone is white from a middle-class suburb ... Our families need the support also, so don't just stop at the advertising, we need an ethnic PFlag or something like that.

To have our own ethnic [support] group is important. It helps you emotionally if you talk to someone ... who is from the same background. He knows what happens in your house and everything. Because he is Lebanese or Arabic. I mean if I go to a Greek group they will understand where I am coming from but not one hundred per cent because they have different stuff than what we have ... And the further you go the more it's going to be different. That's why having a group for each one it helps you more.

It has got to be the non-whites directing support and advocacy groups. Not because we want to be exclusive but if we show ourselves to be

proactive in helping our own than that will open the experience for them to reach out further. Specific ethnic-identity groups serve the purpose that we can understand what it is like to be an Italian lesbian. We can sometimes understand the experience of others but it is through that group that we have the support and the socialising that makes us stronger to go on.

Be aware. Be more noticeable. Maybe have more places like this one [support group for SSAY with disabilities] and advertise it more. [But] I reckon having a group only for disability is putting ... Us down. Yeah. I like to meet people without disability as well as with disabilities. I live in a residential unit so I live with people with disabilities already. So I would like to meet people who don't have a disability and I can talk to and try to make them understand what it's like for people with disabilities.

OutBlack was an idea that came from a Koori drag performance and it created an opportunity for a social environment that connected up Aboriginal gays and lesbians ... One of the workers at the VAC put a bit of time into getting OutBlack going, developing connectedness amongst Koori gays, building those social networks and social resources, social connectedness, in some ways social capital. That's what inclusivity is about, swimming upstream

ACCESS TO TRAINING AND CULTURAL COMPETENCY

The community itself needs to be educated. We need counsellors who share our ethnic background. Especially in mental health services. Also the sensitivity of the workers within the mental health services to deal with ethnic differences and backgrounds.

I think more training for service providers. More cultural awareness. Maybe have a consultant to train on cultural issues – for all cultures lesbian, gay, Deaf. More awareness of these things particularly in the mental health area. That you're a human being first and foremost. And that everyone has equal access and equal rights because everyone has needs. And also more access, more choice in services.

More work at the grass roots level, train at grass roots. To get from policy to the grass roots you need two-way communication, in both directions, and training. It has to occur at that middle level. People in the middle are the ones handling paper work and you need to work through them to get to the people on the ground.

The real reason places don't want to be an inclusive organisation has got to do with a lot of our cultural beliefs – and that's where education is important. But there are very few educators that are paid to speak about

this stuff. Never mind this volunteer stuff, too much exploitation goes on with people with disabilities anyway and then we're expected to go out there and educate people for nothing.

ACCESS TO WELCOMING SERVICES AND ORGANISATIONS

You need a gateway, a way of opening people up, welcoming people within that environment. Recognising people in the community and making them feel welcome so they can ask questions, not feel shy ... So that we let everybody in.

It's not about the service as such but about the whole organisational culture – from the governance structure to the service interface. It is not about being sensitive but about being affirming. And actively trying to support rather than just passively not trying to discriminate.

Services and organisations need to do more than cross-cultural training. It's attitudes, an appreciation of the culture, a real understanding of cultures. We don't make the health services available to fit people who come from CALD backgrounds. They just aren't on our books.

How do you go about connecting organisations up? For Kooris to move between AMS and gay and lesbian services there needs to be connections at an organisation and service level as well as people connections. Aboriginal Health Workers need to be able to get on the phone and talk to a worker at the AIDS Council. They need to know each other, to have a collegiate relationship. This is all without developing a specific program.

Achieving Improved Aboriginal Health Outcomes - An Approach to Reform (1996) (also known as the Koori Health Reform Strategy) resulted in a partnership agreement between VACCHO, and the department. It commits both organisations to work in partnership, to respect community input and to ensure that mainstream agencies meet their responsibilities to Aboriginal people in a culturally responsible and appropriate manner. It recognises the need for Aboriginal people to be involved in all stages of the health process from assessing community needs, planning of services and monitoring outcomes and for service providers to be assisted to improve their effectiveness.

(Department of Human Services 2004): 6

MAKING DIFFERENCE AND DIVERSITY VISIBLE

There is a strong desire for all people to determine their own identities, even when such identities are at odds with normative values. At times we shift between multiple identities depending on context and particular situation, and at other times, we freeze movement to mark a boundary of difference (Williams 1996). Against the marginalisation and exclusion experienced, participants in this project desired to make difference visible. One participant commented, *just normalising [difference], that would be helpful. Gay and lesbian just is. You know, one in seven, one in what ever, it's not good or bad it just is, it's just there.* It is a call to widen the umbrella of diversity to include difference – *to let multiple minority identities, everyone in.*

The participants in this project were from different multiple minority identity groupings. They were gays and lesbians from ethnic and Indigenous backgrounds, and they were gays and lesbians who had a disability. And within each of these 'labels' of identity there was also difference. However, it is important to understand the context of difference and the context of similarity. As one participant noted, *putting people in the box of difference really doesn't help when you have common needs and common ways of expressing them.* Or, to put this another way, 'same struggle, different difference' (Stein 2004). All participants in the project faced exclusion and marginalisation from many sectors: from the wider society, from within health services, from the gay and lesbian community, from within their own families and communities. Put simply, such discrimination harms health (Kreiger 2000). Social exclusion and marginalisation are all players in the production of health inequalities (Hawe and Shiell 2000). Here, as participants highlighted, issues of mental health loom large.

INCLUSIVENESS NOT HARD TO REACH

This study has only touched the surface. However, it has highlighted ways of making difference visible. In particular, it has called on health services and community organisations to think across the labels of identity, to develop a more integrated approach to diversity issues. Community and voluntary organisations representing ethnic groups could address issues for disabled people in their communities; gay and lesbian organisations could look to their inclusiveness of disabled or ethnic members; health services could de-centre 'whiteness' and take active steps to be inclusive of Kooris and minority ethnic groups. Information, training and education for service providers, access to interpreters and access more broadly, creating minority identity spaces, are all key ingredients identified. Participants also called for more research into these intersections of health and multiple minority identities, but only research in which they are active participants – *nothing about us without us.*²¹

Participants called for a more substantial shift towards inclusiveness. Understood within a framework of equality, it requires services and organisations to take the steps to actively engage will all its constituents; an approach that makes it clear that all

²¹ Research framework articulated by both Indigenous peoples and people with disabilities. See, for example, Waples-Crowe and Pyett (2005), Harrison et al. (2001),

people are welcome. Overlapping with concepts cultural competency and cultural safety, it is an approach that shifts thinking from specific 'add-on' programs to thinking that addresses organisational culture, from governance structures to the service interface (Thomson 2005). It is a shift to inclusive services and organisations that welcome everyone in.

A final note: In calling for this research, gay and lesbian Indigenous, CALD and disability groups were initially identified as 'hard to reach'. During the course of the research, however, the project team noted that many of the individuals taking part manifest considerable strengths, including being more accepting of difference and more tolerant of diverse and alternative viewpoints. Perhaps from experiencing marginalisation and isolation in their everyday lives, participants were more sensitive to oppression and consequently, more respectful of other people's rights. Participants also showed a willingness to challenge existing organisational structures and normative beliefs. And they revealed an enthusiasm and ability imagine alternatives. In many ways these 'hard to reach' groups modelled the inclusiveness desired for mainstream services and community organisations.

RECOMMENDATIONS

Note: since this report was finalised the Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) completed its second term. In 2007 a third term Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing (GLBTI MAC) was established. When MACGLH is referred to the GLBTI MAC will respond to the recommendations.

OVERARCHING RECOMMENDATIONS

We recommend that:

- ▼ Health services that specialise in meeting the needs of the Gay and Lesbian community be strongly requested to undertake service development so that they are more welcoming of, and proactively inclusive of, Indigenous and CALD identities as well as GLBT people with disabilities. The request letter should come from the MACGLH and should include a copy of this report.
- ▼ Materials or initiatives arising from the work of the MACGLH should ensure representation of the diversity of GLBT Victorians.
- ▼ A resource package be developed for Gay & Lesbian community organisations that incorporates information and resources to encourage and assist with greater inclusiveness of Indigenous and CALD identities as well as GLBT people with disabilities. The ALSO Foundation should be approached to explore the possibility of partnering in this work.
- ▼ A copy of this report be tabled at both the Ministerial Advisory Committee on Cultural and Linguistic Diversity and the Disability Advisory Council of Victoria and that a joint meeting of the MACs be convened to discuss recommendations of the report.

CULTURAL AND LINGUISTIC DIVERSITY

We recommend that:

▼ The Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) work with ethnic community councils towards the development of written materials for parents (and other family members) of GLB people to assist with coming out issues within CALD families.

▼ In order to progress the above recommendation, an initial project be undertaken with a specified council to develop and evaluate a collaborative model of resource production.

▼ Written materials produced for CALD families be made available electronically to enhance accessibility to families, GPs and other service providers, through channels such as the Clinicians Health Channel, Better Health Channel, Family Planning Victoria website and so on.

▼ Welfare workers who already have the trust of particular ethnic communities should be trained to provide advice and support on GLBTI issues, particularly to parents. Agencies experienced in working in the sector such as the Multicultural Centre for Women's Health and the Centre for Multicultural Youth Issues should be engaged to do such training.

DISABILITY

We recommend that:

- ▼ The implementation of existing policies - such as the Personal Relationships, Sexuality and Sexual Health Guidelines, Disability Services (2006) – be enhanced through appropriate training on sexuality, including sexual diversity. And that:
 - staff who care for people with disabilities in accommodation facilities be particularly targeted for such training
 - the development or implementation of such training involve the input of GLHV.

- ▼ The MACGLH and the Equal Opportunity Commission convene a one-day forum to discuss proactive strategies to enhance the capacity of GLBT people with disabilities to access their sexual rights.
 - the forum outcomes to include a report of the discussion and a draft action plan.

- ▼ All listed Gay and Lesbian organisations receive a resource kit that encourages them to address issues of access and discrimination involving GLBT people with disabilities. The package to include:
 - a brief summary of the findings of this report
 - a checklist of issues, information and relevant resources such as interpreter services contacts, TTY services, physical access requirements and key mental health information services.

- ▼ The MACGLH write to all disability peak bodies in Victoria requesting that the needs of GLBTI people in their client group be put on their agenda. A copy of this report should be sent with the letter and information about Gay and Lesbian Victoria and the support it can offer for this process.

- ▼ The MACGLH and Gay and Lesbian Health Victoria liaise with the Department of Victorian Communities to ensure that the specific needs of GLBTI people with disabilities are incorporated in all new initiatives.

- ▼ A copy of this report be sent to the Victorian Branch of the National Ethnic Disability Alliance and a meeting requested to seek their support in advocating for these issues.

INDIGENOUS

We recommend that:

▼ The development of inclusive service delivery is best addressed by organisations such as VACCHO, AMS, Victorian AIDS Council/GMHC and *Onemda* who have a strong profile in the Indigenous and/or GLBT communities. Therefore we recommend that a copy of this report be sent to these organisations.

▼ The MACGLH explore the possibility of a partnership with VACCHO, AMS, *Onemda* and GLHV to ensure that information about diverse sexualities is included in the context of Koori health more broadly and in a way that is directed by the family-based nature of GLBT Koori identity.

LIST OF COMMUNITY CONTACTS

AccessPlus Spanning Identities (APSI)

A community organisation for GLBTI, disabled people in Victoria

C/- Victoria Aids Council, 6 Claremont Street, South Yarra, Vic.

To subscribe to email group: AccessPlus-subscribe@yahoogroups.com

To email the group: AccessPlus-owner@yahoogroups.com

YAK (Action Centre, Family Planning Victoria)

YAK is a social support group for young people who are same-sex attracted.

Action Centre for Young People, Level 1, 94 Elizabeth Street, Melbourne

Phone: (03) 9654 4766

Toll free: 1800 013 952

Australian GLBTIQ Multicultural Council (AGMC)

<http://www.agmc.org.au/>

PO Box 342, Carlton South, 3053

Phone: +61 431 432 412

Email: contact@agmc.org.au

OutBlack

<http://home.vicnet.net.au/~outblack/>

C/- Victorian Aboriginal Community Controlled Health Organisation Inc.,

5-7 Smith St, Fitzroy, Victoria 3065

Phone: (03) 9419 3350

Email: outblack@hotmail.com

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