2SLGBTQ+ Community Health Needs

An Advanced Practicum Report

by

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Abstract

This Advanced Practicum Report outlines activities, learning goals, and experiences of an advanced practicum placement working with the Public Health Sudbury & Districts (PHSD), part of the Ontario provincial chain of health agencies that oversees public health. This paper summarizes the unique experience of a Master of Social Work Student Working as a Queer research assistant, conducting data analysis and policy development for 2SLGBTQ+ population community health within a public health agency.

Roles of the student while working for PHSD included: analysis of secondary data from a study of 2SLGBTQ+ community health conducted the previous fall, scanning of existing policies of PHSD for any that pertain to this population, suggesting policy and programing to promote the safety of 2SLGBTQ+ people, writing briefing notes and researching training programs and creating presentations to promote new policy development and programing.

This experience highlighted community and individual health disparities for 2SLGBTQ+ people. The lack of useful policies and programs within the PHSD indicated a clear need for better public health approaches for health service agencies in Northern and rural geographic locations like Sudbury and Districts.

The outcome of this placement was a clearer knowledge of the needs of queer populations in rural and Northern Ontario, a stronger insight into the relationship between social justice and health equity in public health programing and policy, and a better vision of Social Workers' roles in promoting health equity and social justice in the development of public health policy.

Résumé

Ce rapport de stage avancé décrit les activités, les objectifs d'apprentissage et les expériences d'un stage de stage avancé en collaboration avec Santé publique Sudbury et districts (PHSD), qui fait partie de la chaîne provinciale d'organismes de santé de l'Ontario qui supervise la santé publique. Cet article résume l'expérience unique d'un étudiant à la maîtrise en travail social travaillant comme assistant de recherche queer, effectuant l'analyse de données et l'élaboration de politiques pour la santé communautaire de la population 2SLGBTQ+ au sein d'un organisme de santé publique.

Les rôles de l'étudiant pendant qu'il travaillait pour le PHSD comprenaient : l'analyse des données secondaires d'une étude sur la santé communautaire 2SLGBTQ+ menée l'automne précédent, l'analyse des politiques existantes du PHSD pour tout ce qui concerne cette population, la suggestion de politiques et de programmes pour promouvoir la sécurité des personnes 2SLGBTQ+, la rédaction de notes d'information et la recherche de programmes de formation et la création de présentations pour promouvoir de nouvelles politiques et de nouveaux programmes.

Cette expérience a mis en évidence les disparités en matière de santé communautaires et individuelles pour les personnes 2SLGBTQ+. L'absence de politiques et de programmes utiles au sein de la DSSP a indiqué un besoin évident de meilleures approches de santé publique pour les organismes de services de santé dans les régions rurales et du Nord comme Sudbury et les districts.

Le résultat de ce stage a été une meilleure connaissance des besoins des populations queer dans les régions rurales et du Nord de l'Ontario, une meilleure compréhension de la relation entre la justice sociale et l'équité en santé dans les programmes et les politiques de santé publique, et une meilleure vision des rôles des travailleurs sociaux dans la promotion de l'équité en santé et de la justice sociale dans l'élaboration des politiques de santé publique.

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A special note of acknowledgement for Dr. Karen McCauley whose belief in social justice and a structural social work approach came through in her teaching and gave me the permission to pursue my own passion for social justice in health equity for 2SLGBTQ+ People. I will ever be grateful for her early mentorship – she is missed.

I want to express my gratitude for the individuals from my 2SLGBTQ+ community who came forward to take part in the community health study; by sharing your stories you have given voice to the health needs of our community – I hear you.

I offer a word of appreciation to my classmates throughout my BSW and MSW experience for their support. I felt part of the group, and that made a difference - memories were created.

Special recognition goes to the Louise Picard Public Health Research Grant for funding the original study on which my advanced placement efforts were focused.

Contents

Chapter One - Introduction

This chapter describes the practicum placement, the agency (location of the practicum), the role of the student, and the rationale for having a Social Work research placement with a public health agency. Included is some explanation of the theoretical lenses that were used as they pertained to the placement and the learning process. This chapter also outlines the various elements of the Advanced Practicum, including the physical environment, agency agreement, supervision, learning goals, and duties in the position. This chapter with also address social location and the student's unique position as participant researcher.

It has been some good fortune to be able to experience an advanced practicum placement with the research team at Public Health Sudbury & Districts (PHSD). The position included working as a research assistant analysing the data from a recent study on Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, plus (2SLGBTQ+) community health. Dr. Suzanne Lemieux from Public Health Sudbury & Districts (PHSD) partnered with Dr. Tanya Shute from Laurentian University to conduct a study to better understand the 2SLGBTQ+ people's lived experience in Sudbury. The purpose of their study was to satisfy the need for knowledge and understanding of Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, plus (2SLGBTQ+) public health needs. The Professional Practice Committee at Public Health Sudbury & Districts (PHSD) had identified a need for an agency-wide policy and procedure for an inclusive, safe, and equitable space for 2SLGBTQ+ peoples. The unique opportunity of this practicum has been to translate the evidence from the 2SLGBTQ+ Sudbury populations' public health needs study into actual policy and procedure for Public Health Sudbury & Districts.

The desire to take part in a practicum with PHSD began a few years prior. In 2016 the Health Equity team at Public Health Sudbury & Districts had conducted a yearlong engagement

process to create a Northern Ontario Health Equity Strategy: A plan for achieving health equity in the North, by the North, for the North (Health Quality Ontario, 2018). The Strategy outlined four foundations: Addressing the Social Determinants of Health; Equitable Access to High-Quality and Appropriate Health Care Services; Indigenous Healing, Health, and Well-being; Evidence Availability for Equity Decision-making. During the engagement and consultation phase of the development of this strategy, it was apparent that there was a need for inclusion of 2SLGBTQ+ population in shaping the actions of this strategy. A focus group for 2SLGBTQ+ people was conducted. The resulting published draft had a minor mention of 2SLGBTQ+ populations and some admission that more research needs to be conducted in several areas of health services to ensure equitable quality healthcare for people in Northern Ontario (Price, Lemieux, Pajuluoma, & Wilson, 2017). A Health Equity Summit took place on May 25th, 2017, because of this strategy. The summit had no formal 2SLGBTQ+ content. The experience of taking part in this Health Equity process has shown that 2SLGBTQ+ people are invisible and silent in some policy and research processes. It was observed that the needs of the queer population lack recognition in policy, support in the community, and funding for programs. One focus of this practicum is aimed at correcting this lack of recognition and support through needs assessment and policy creation in Public Health Sudbury & Districts that is inclusive and supportive of 2SLGBTQ+ people's health.

Through this practicum, an understanding and experience was gained about working within a large public health service agency as a social worker and a researcher. In addition to gaining experience in policy development, the process of assessing 2SLGBTQ+ population needs and the promotion of health equity for this marginalized population were major focuses.

Obtaining experience in qualitative data analysis was also an aspect of the learning goals in this placement. The role as a practicum student and research assistant, afforded the opportunity to work within a research team in the Knowledge and Strategic Services Division at Public Health Sudbury & Districts. Support for those aspects of public health assessment requirements from the Ontario public health standards as they pertain to 2SLGBTQ+ persons and communities were developed through the use of secondary data and a review of existing programs. This support included the development of inclusive policies and procedures for Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, plus (2SLGBTQ+) populations, and included the promotion of a staff training plan and awareness programs for Public Health Sudbury & Districts. It was fortunate that reimbursement for some of my time in this placement was made possible through the Louise Picard Public Health Research Grant funding. I have been working with PHSD in a contract position since the placement. Payment for my time and the subsequent employment is understood not to influence my placement outcome nor does it create a conflict in my approach to this practicum report.

2SLGBTQ+ Terminology

It is useful to make some note about terminology regarding the focus of this research placement as we are dealing with an evolving understanding of terminology and identity. The understanding of what it means to be part of this community and have an identity of Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, or some other non-heteronormative or cis-normative self-understanding, has been a shifting reality in recent times as history and knowledge evolves (Lee & Kanji, 2017). The researchers responsible for this study have used the initials 2SLGBTQ+ to denote the intended population focus of this research. The rationale for

this was to be as inclusive as possible given the broad and flexible identity potentials that compose the sexual and gender divergent realities of Queer people.

Two Spirit (2S) has been placed at the front of the initialism to recognise the position of Indigenous people as the first people of this land and to promote a valuable cultural and traditional understanding of what it can mean to be queer in a cultural context other than western colonial ideals (Baskin, 2016; Driskill et al., 2011). “The creation of the term “two-spirit” is attributed to Elder Myra Laramee, who proposed its use during the Third Annual Inter-tribal Native American, First Nations, Gay and Lesbian American Conference, held in Winnipeg in 1990. The term is a translation of the Anishinaabemowin term niizh manidoowag, two spirits” (Dalla Lana School of Public Health. (n.d.)). It is considered a concept that correlates with Indigenous world views and embodies a certain interrelatedness of all aspects of one’s identity, including sexuality, sex, and gender fluidity (Baskin, 2016; Driskill et al., 2011).

A caution must be made in terms of categorizing terminology as it relates to labelling people in the 2SLGBTQ+ communities. These identities are often fluid and/or resist/defy the heteronormative thinking that functions to separate people according to gender expression and sexual behaviour, and separate identity from social activism and social change. Other initialisms appear in the writing of this practicum report as they come from the research and writing of those other sources cited and referenced. The term Queer is used as an inclusive label for individuals and community who identify outside of the heteronormative and CIS normative binaries.

Social Location and Queer Identity

In the interests of full transparency, it is necessary to explain that the student in this placement was also a participant researcher in the study which produced the data that was analyzed as part of the placement duties. This part time, research position with PHSD included

recruiting the participants from the 2SLGBTQ+ community and helping with the process of organizing and conducting digital stories' data collection workshops. These workshops entailed two focus group discussions and the creation of digital stories by 2SLGBTQ+ people over two digital story telling workshops. These workshops were a part the larger research project on 2SLGBTQ+ public health needs, from which this practicum stems from. As a researcher and participant, I also created one of the digital stories and my voice was part of the focus group discussions. This is an important acknowledgment. The position as a participant situates this research assistant within the research. The work of this advanced placement put me in the position of analyzing data content from which I see and hear my own Queer voice as well as the voices and life experiences of members of my community. Some of the participants were known to me, some even friends, while others were newly acquainted having been recruited through social media and posters in the community. The positioning as participant researcher and now analyst of data called for specific considerations while conducting the placement as research assistant. Social location as a Queer gay man in the social arena of Northern Ontario affords a perspective, a critical lens through which to observe, relate to, understand, and analyze familiar stories and geo-cultural realities.

Care was taken to maintain objectivity throughout the research procedure and not dominate the study process. This writer's voice was included in the data and so this voice was included as part of the analysis. Yet care was taken to ensure that all the other participants voices were equally integrated into the process. Insider analysis, in this situation a resistance and a change perspective that left little room for dispassionate objectivity. It is just the opposite. The objective for this work included aspects of resistance to the Queer-negative social understandings and some movement towards social change (Absolon, & Willet, 2005). The research supervisors

felt this enriched the data and welcomed active participation of the participant researcher. The lived experience offers the authority to speak and interpret the data from the original study. Queer identity as a social location offers a specific vantage point from which to share life narratives and conduct research that is both informative and encouraging of social change (DeJean, 2010; Dickey, Hendricks, & Bockting, 2016). This was a unique, challenging, and useful position from which to create authentic knowledge about a little researched population.

Description of the Advanced Practicum Environment

The Master of Social Work Advanced Practicum Placement was completed from March 16, 2020. To June 30, 2020. This Advanced Practicum began at the main office of Public Health Sudbury & Districts. Because of the COVID-19 pandemic and health and related safety actions most of the hours required for completion of the placement were conducted from the home office of the student. This chapter continues with description of the process of qualitative data analysis and the resulting policy formation on 2SLGBTQ+ community health needs. The learning goals and questions from onset will be discussed. Agreements, supervision methods, and my role as a practicum student will also be reviewed.

Public Health Sudbury & Districts

This practicum was completed within Public Health Sudbury & Districts (PHSD), specifically within the Knowledge and Strategic Services Division. PHSD's main office is located at 1300 Paris Street, Sudbury. Public Health Sudbury & Districts describes itself as "a progressive public health agency committed to improving health and reducing social inequities in health through evidence-informed practice" with a vision statement of "Healthier communities for all" (PHSD, 2019). About 250 employees work out of seven locations throughout the

Sudbury and Manitoulin districts. PHSD is one of 34 public health agencies across the province of Ontario, funded through both local and provincial levels of governments (PHSD, 2019).

The PHSD Knowledge and Strategic Services (KSS) division leads and supports research and evaluation projects. The main function of this division is to provide information and share knowledge with the purpose of supporting better public health practice. At the time of this practicum, Dr. Suzanne Lemieux was Manager of the Research, Evaluation, and Knowledge Exchange team of the KSS. Dr. Lemieux is also an Adjunct Professor in the School of Social Work at Laurentian University. The agency supervisor for this placement was David Groulx RN, BScN, MPH, CCHN(C). At the time of this practicum, Mr. Groulx was the Manager of Professional Practice and Development within the Knowledge and Strategic Services division. His expertise in training and policy development were very supportive of the success of the practicum learning goals.

Working with Knowledge and Strategic Services included interacting with other research assistants and various other staff at the PHSD. Especially supportive and useful were the Health Equity Team managed by Dr. Dana Wilson. Interacting with the Health Equity Team offered experience with the internal processes of developing training modules for allyship and racial equity.

Health Equity is a focus of programing for PHSD. In a May 2013 document, the Public Health Sudbury & Districts established the importance of the social determinants of health (SDOH) and the resulting health inequities to the wellbeing of all citizens in the districts. This commitment to health equity was firmly announced as a component of their “Vision -2020” mandate (Sudbury & District Health Unit, 2013). Note that Sudbury & Districts Health Unit is the original name before changing to Public Health Sudbury Districts (PHSD). In a later

webpage topic, PHSD clearly include Gender identity and expression, sexual orientation and attraction, and social inclusion/exclusion in the list of social determinants of health. (PHSD, 2019). The Ontario Public Health Standards defines the role and responsibility of Public Health agencies to assess and address the social determinants of health. Another document, the Health Equity Guideline addresses the mandate of four requirements that Health units must meet. In this document the Ministry of Health include assessment and reporting, modifying public health practices, collaborative engagement of stakeholders, and lead/participate in making changes (Ministry of Health and Long-Term Care, 2021).

It is within these parameters that the task of fulfilling learning goals and the list of deliverables as the role of research assistant within PHSD were conducted. Between 21 and 35 hours a week were put towards this work until the required hours of the placement were completed.

Process of the Practicum Placement

The focus of this advanced practicum was centered on a qualitative analysis of data from a previously conducted assessment study of 2SLGBTQ+ community health needs in the Sudbury area. The role as research assistant was to conduct the analysis using methods of thematic analysis. In addition to the data analysis, there were tasks associated with researching policy and programing possibilities for PHSD. Various training resources from across Ontario were explored. These being developed by a variety of health agencies.

Advanced Practicum Learning Goals

Three learning goals formed the approach to this Advanced Practicum:

- Develop skills in secondary qualitative data analysis

- Strengthen skills in policy development
- Strengthen skills in developing equitable processes in public health care.

Duties of the Placement Student

The above learning goals were achieved while working on the Public Health action plan to develop a PHSD policy and procedure for an inclusive, safe, and equitable space for 2SLGBTQ+ people. Duties during the placement were as follows:

1. Conduct analysis of data produced from the two 2SLGBTQ+ digital storytelling workshops conducted in November 2019.
2. Develop a clearer and more focused understand of the 2SLGBTQ+ community's needs related to public health.
3. From analysis, propose a series of recommendations for Public Health Sudbury & Districts:
    a) agency-wide; b) programming specific.
4. Use the evidence produced through secondary data analysis to inform organization-wide policy and procedures that are equitable for and supportive of the needs of 2SLGBTQ+ people. Procedures will include agency actions recommendations, a training plan, including identified recourses, and a staff training module.
5. Validate and finalize the policy and procedure with the Professional Practice Committee (PPC).

Guiding Questions

As the above action plan was conducted and skills honed as outlined in the learning goals, the guiding questions from the start of this proposal were kept in mind. The needs of the 2SLGBTQ+ population were always foremost in the order of priority. Social justice guided and motivated the promotion the health needs of the Queer folk who live in the Sudbury and Districts. Fundamental through this process were the voices of 2SLGBTQ+ individuals to articulate those needs. This was a unique opportunity to bring together qualitative data from a

grassroots origin as a participant researcher to be used in motivating a Public Health agency to support the health of Queer community individuals. This analysis was and is being used to inform and validate organizational policy and procedure and to guide professional practice towards more equitable community healthcare for the queer population of Sudbury and Districts.

This advanced practicum thesis report outlines the learning and experience of working as a research assistant on the project of 2SLGBTQ+ community health study. The following questions guided the learning throughout my Advanced Practicum:

- How can Public Health Sudbury & Districts integrate social change and social justice within agency policy and procedure?
- What are the public health needs of the Sudbury 2SLGBTQ+ populations' and how can they be addressed in policy and procedures?
- How could the voices of 2SLGBTQ+ populations in the Sudbury and Districts area inform the development of a policy and procedure for Public Health Sudbury & Districts that will support their public health needs?

Agreements and Supervision

All required forms and documents were provided to both Laurentian University and Public Health Sudbury & Districts. Dr. Tanya Shute, Assistant Professor with the School of Social work at Laurentian University is the designated first reader of this Practicum Thesis.

Dr. Suzanne Lemieux is the second reader for this practicum. At the time of the Practicum placement, Dr. Lemieux was Manager of Research, Evaluation, and Knowledge Exchange with PHSD as well as she is Adjunct Professor, School of Social Work at Laurentian University. As manager of the research team at PHSD Dr. Lemieux was also direct supervisor and co-lead of the team responsible for the research study that produced the data on which part of this placement stemmed from. David Groulx RN, BScN, MPH functioned as the agency

supervisor. At the time of this Practicum placement, He was the manager of professional practice and development in the Knowledge and Strategic Services Division at PHSD.

Meetings with the readers and supervisor were conducted regularly and as needed. With the onset of the COVID-19 pandemic it became necessary to hold all meetings over internet programs such as Zoom, Skype, and Google Teams. Regular email contact, with the supervisor and readers provided guidance throughout this placement.

The next sections of this placement thesis are a review of the literature covering some theoretical perspectives and then outlining key themes emerging from the literature review. The advanced practicum thesis report will describe the advanced practicum experiences.

The literature review, Chapter Two, explores the theoretical perspectives and approaches that emerged from the literature covered.

Chapter Three follows with a more in-depth analysis of the advanced practicum environment and process of the learning goals. Chapter Three will also provide some critical reflections regarding the advanced practicum, including some personal reactions to these experiences that impact the topics of the study and the student role. This chapter will also describe my growth as a practitioner throughout the advanced practicum experience.

The final chapter will conclude the advanced practicum thesis and answer the questions that guided my placement. Chapter Four will also describe the implications for social work practice with recommendations.

Chapter Two Literature Review

This chapter outlines the research that informs the conceptual and theoretical approaches that motivated this placement thesis. Review of the literature includes two parts. One is the theoretical perspectives that drive the inquiry and understanding of 2SLGBTQ+ community health and health equity. The theoretical approaches that were employed included structural social work theory, the social determinants of health framework, minority stress theory, Queer Theory, and activism, as well as concepts of intersectionality.

The second part of chapter two explores the themes that emerged from the literature that impact the study and implementation of Queer health equity in a Northern and Rural geosocial location. This second section of this literature review focuses on themes such as health [in]equity, social determinants of health, 2SLGBTQ+ identity, people under threat, invisibility and social isolation, mental health for 2SLGBTQ+ people, community building, educating (queering) staff, linking social justice with policy, and includes rural and northern considerations.

Introduction

There has been a steady growth in the development of research and literature on issues pertaining to Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, plus(2SLGBTQ+) people (Alessi & Martin, 2017; van Eeden-Moorefield et al., 2018). Understanding and knowledge of 2SLGBTQ+ service practice in the fields of healthcare and social work has expanded over the past few decades. The development of the concepts of Queer Theory, Minority Stress Theory, and the framework of social determinants of health (SDOH) now offer better insights into the social situation and health care of gender and sexual diverse minority populations. National data demonstrates that those who are 2SLGBTQ are at a 14x greater risk of committing suicide

(Benibgui, 2010) and experience increased rates of violence and bullying (Bauer & Scheim, 2015; Statistics Canada, 2016). Despite the many different lived experiences that separate the diversity of 2SLGBTQ people, they all share remarkably similar experiences related to stigma, discrimination, rejection, and violence across cultures and locales (Meyer, 2003).

Theoretical Perspectives

A clarity of theoretical perspectives was a focus for this literature review. The theories referred to in this review are intended to guide the thought process and the analytical perspective that drives the approach for this placement and the report this report that it produced. These theories explain the issues and aspects of Queer realities in terms of structural social work approaches and oppressive realities in social systems such as social work and health care. This first section outlines the conceptual and theoretical approaches of this placement report. The approach to this practicum reflected a structural social work viewpoint and a social change perspective. This theoretical stance includes a critical and transformative approach to social work and, by extension, all the helping professions including and especially public health (Mullaly & Dupré 2019). For the purposes of this placement, the following theoretical perspectives were engaged: minority stress theory, queer theory, social determinants of health (as an analytical tool for framing oppression). These were utilized with an intersectional lens that explicated the interaction of varying identities and social locations.

Published research on 2SLGBTQ+ people and health has been a growing body of knowledge from the middle of the last century when homosexuals were considered criminals and mental patients (Kirby, 2003). For the purpose of this placement thesis a search of current literature used Laurentian Google Scholar Articles and ProQuest Platform databases. Current literature includes that which has been published in recent years, preferably since 2015, but older

writings that are seminal to the thesis are also cited. In addition, a scoping of the references of articles and texts was used to access pertinent reference materials. Search terms included the 2SLGBTQ initials, and the terms individually and their synonyms. These were linked with terms such as, health, social determinants of health, and minority stress. These searches helped to form the basis of and understanding of 2SLGBTQ+ social experiences and resulting health consequences and best practice in community health approaches. Care was taken to find current or recent publications and scholarly articles throughout the search. A variety of both qualitative and quantitative sources were reviewed, and a preference was made for those that pertained more to Canadian, and other western societies where the results would correlate more with Canadian cultural understandings. There are some texts published in the last decades that focus attention on social work and health care of 2SLGBTQ+ persons.

Throughout the placement and in the writing of this report the focus was on applying structural analytic frameworks to multiple areas of practice. These frameworks include social justice, human rights, and anti-oppressive approaches (Mullaly, & West, 2018; Lundy, 2011; Baines, 2011). These framework approaches are meant to challenge mainstream understandings and promote real change in social systems. Queer theory and minority stress theory are key aspects of developing an understanding of the reality of 2SLGBTQ+ experiences in society and understanding social change as necessary to promote and improve community health. Queer Theory challenges our socially constructed notions of sex, sexuality, and gender norms (Mulé, 2016; Mulé, 2015; Mullaly & West, 2018). Both queer theory and minority stress theory address the social construction of gender and sexuality as well as the structural nature of oppression and violence towards 2SLGBTQ+ people. These theoretical frameworks are critical and transformative in nature and support social change and social justice perspectives (Aguinaldo,

2008; Mulé, 2016; Mulé, 2015; Mullaly & West 2018). Research and inquiry into issues of social construction of oppression and changing oppressive norms require radical and transformative theoretical approaches. For example, Aguinaldo (2008), uses an analytic thematic approach of social constructionism to analyze medical literature for evidence of oppressive ideologies identifies homophobic and heterosexist oppression as a significant determinant of heath for gay men. (Aquinaldo, 2008). The critical piece here is that a social constructionist approach takes the focus from individual medical intervention and highlights societal constructions that marginalize and medicalize the individuals from certain groups. Queer theory is a useful way to critique heteronormative and cis-normative social structures. The social determinants of health as a framework approach or a theoretical perspective invites policy makers and healthcare practitioners to include understandings of structural aspects of societal inequality when addressing healthcare and practice procedures (Mikkonen & Raphael; 2010; PHSD 2019; Aquinaldo, 2008).

Queer theory, minority stress theory and a social determinants of health approach combine functionally to form a theoretical critique of traditional health care attitudes. Intersectionality as a theory is a necessary addition as it functions to acknowledge the complexity of the interplay of minority identities both within and without the 2SLGBTQ+ initials. Intersectionality, as a theoretical framework, stems from the interplay of feminist approaches, and race theory (Crenshaw, 1989). These theoretical frameworks, as applied to health research of minority communities, invite a structural analysis that encourages real social change. The social determinants of health approach is a primary perspective of Public Health Sudbury & Districts and as such invites critiques that support proactive models that encourage community health initiatives.

Social Determinants of Health

PHSD uses a social determinants of health (SDOH) perspective for their research and policy development (PHSD, 2019). This approach is a key perspective of the research that has been undertaken. Social determinants of health are factors beyond an individual's biology and behaviours. These are health influences that people grow up with and live with in family, community, and work situations. They "are social and economic factors that impact people's health: income and income distribution, education, employment, job security, working conditions, early childhood development, food security, housing, socio/ inclusion, socio/ safety network, health services, Aboriginal status, gender, race and disability" (O'Neill, 2012, p. 261).

Addressing health promotion though the social determinants of health approach is an emerging area of practice. Social determinants of health are linked to health outcomes in several ways. Subgroups of the population with less socioeconomic status are less empowered and experience more challenging environmental factors and more exposure to disease and physiologic chronic stress (Andermann, 2016). Medical treatments and lifestyle choices are not primary in the health of Canadians; it is the conditions under which we live that have the greatest influence on our health (Mikkonen & Raphael, 2010). The medical model operates on a risk factor paradigm focusing on behavior of individuals. This approach is not effective for minority individuals who do not have control of their social situations; they require more supportive environments that offer greater opportunity for healthier choices (Andermann, 2016).

The social determinants of health approach can be used at all levels of health care, with the patient, in agencies and in the community. Medical treatment in the form of drugs (legal or illegal) or other therapeutic treatments are only good for relieving the symptoms of physiological level chronic stress that stems from the stigma and strain of a marginalized existence (Mikkonen

& Raphael, 2010). Social change is necessary to effect a real change in the structural causes of social inequity and the associated health disparities.

There is some critique of the social determinants of health approach from a more critical and structural social work perspective. Mullaly & West (2018) use the term "movement" (p. 216) to describe how this concept is being promoted in the health care systems. According to Mullaly and West (2018) these social determinants are factors outside of the health care system. Social determinants relate more to the structural aspects of society and the organization and distribution of economic and social resources. Social justice and social equality need be included in the list of social determinants of health for 2SLGBTQ+ populations. The social determinants of health framework can be criticized as a liberal humanist approach. Focusing too much on social policy change and not enough on social inequity. The social determinants of health approach when used in health care can miss the real potential for social change at the community level. Enlightened social policy alone may not be enough to reform society. Anti-oppressive social work practice should be integrated within healthcare, as a more radical and critical approach to changing health inequities. A structural social work approach suggests that equal health outcomes for all can only come about through real social transformation that decreases social hierarchy, wealth inequity, and social domination (Mullaly & Dupre, 2019; Mullaly & West, 2018). Education about the social determinants of health and their impact on the health of Canadians is a consistent recommendation (Andermann, 2016; Mikkonen & Raphael, 2010).

Research on the social determinants of gay men's health and the linguistic conceptual issues in medical literature highlights three findings that illustrate how healthcare uses the SDOH ineffectively. Finding one indicates that gay oppressions in gay men's literature was conceived as psychological phenomenon like homophobia and internalized homophobia; finding two

identified that the damaged psychologies of gay men resulting from minority stress were a determinant of gay men's health. Finding three contradicts the evidence as it shows that the proposed solution for gay men's oppression is individual therapy (Aguinaldo, 2008). The problem is the individualistic nature of this approach to healthcare does not solve the social construction of oppression. This critique targets the nature of this approach to healthcare and suggests societal homophobic and heterosexist oppression as a significant determinant of health for gay men. The focus of research needs to change direction. Rather than be victim centered researchers, we must adjust our sights on the heterosexist aspects of oppressive social constructs (Aguinaldo, 2008). The recommendation is that the prevalence of heterosexism be a topic of quantitative research targeting the oppressor rather than targeting the experience of the oppressed.

Work is another important social determinant of health which intersects with 2SLGBTQ+ identity, income, and social acceptance. In a recently published study of LGBTQ2S+ Work and Inclusion in Sudbury and Windsor, it was reported that almost three fourths of 2LGBTQ+ participants indicated some mental health issues related to their work over the previous year (Mills et al., 2020a). Most commonly reported diagnoses were anxiety, depression, and panic attacks. Almost 50% of the respondents reported using substances to cope with work and they were more likely to use substances if their workplace did not support their gender or sexual identity. It was also noted that union involvement had a positive effect on mental health while intersectionality of race and Indigeneity with 2SLGBTQ+ had a negative effect on mental health. Initial results suggested the need for comfortable and inclusive 2SLGBTQ+ safe spaces to develop community (Mills et al., 2020). The promotion of health equity for 2SLGBTQ+ communities is a significant challenge that will require a complex approach. This approach must

include agency and service worker education, public awareness and education and support for 2SLGBTQ+ community along with safe space promotion. Minority status is one of the aspects of the social determinants of health that must be considered when exploring policy for public health.

Oppression must be acknowledged as a significant SDOH (McGibbon 2012). Oppressions impose differential access to society's resources and relations of power. This results in differentiated economic opportunities, loss of social engagement, unequal political relations, less life chances, and poorer health outcomes. Social and historical processes produce social inequality and Canada lags compared to some other countries in governmental program provision and state interventions in social institutions. Part of the issue is poor public awareness and a disconnect between SDOH related policy documents and actual public policy making. The result is a reluctance in policy makers when it comes to identifying the implications and potential around SDH in policy making. The result for queer and other minority groups is that policy makers lack the means to address the specific situations that need to be addressed to promote a movement to real health equity (Galabuzi, 2012; Raphael, 2012).

The concept of "People under threat" (McGibbon, 2012, p. 32) becomes a clear episteme for understanding the experience of queer people in Sudbury through the framework of SDOH. There are many ways that being a person under threat influences health of individuals in a community. Social exclusion is one way that social threat is manifested in the lives of queer individuals. In addition to the obvious threats of violence, verbal harassment, bullying and sexual harassment, social exclusion is an outcome that negatively influences the potential for a productive, happy, and healthy lifestyle (Galabuzi, 2012). The next section will focus on

minority stress theory and outline how minority stress is the mechanism that causes the health inequities of 2SLGBTQ+ people.

Minority Stress Theory

The literature review found multiple sources of research regarding the health consequences of having an 2SLGBTQ+ identity. Dentato (2012) refers to the minority stress approach as a model and as a theory. Minority Stress Theory (MST) adds insight into the impact of homophobia and correlated health risks for men who have sex with men and other sexual minorities. Minority Stress Theory (MST) is an approach that is used to recognize the magnitude of stressors for 2SLGBTQ+ persons experience in everyday life (Meyer, 2003; Alessi, 2014; Prendergast & MacPhee, 2018). The main thesis of this theory is that sexual minorities experience oppressive pressures from their negative interaction(s) with their social surroundings (Meyer, 1995; Meyer, 2003; Dentato, 2012). These negative interactions cause stress on the individual and therefore increases their likelihood of exhibiting stress related indicators such as anxiety, depression, addictions, risk behaviour, as well as related physical symptoms. In addition to negative reactions to oppression, minority people can also demonstrate positive coping behaviours to minority stress experiences (Alessi, 2014; Meyer, 2003). MST identifies that the 2SLGBTQ+ community experiences continuous and unique social stressors that contribute to impacts on physical and mental outcomes (Cox et al., 2010). Studies suggest there are four sources of social stressors associated with MST and the 2SLGBTQ+ community including: discrimination, hiding sexual orientation, anticipating events of prejudice, and internalized homophobia (and homonegativity) that can be communicated from individuals, family, and institutions (Cox et al., 2010; Sterzing et al., 2017). Collective trauma is also a concern for both

individuals and queer populations that challenge the healing potential for 2SLGBTQ+ persons and their community (McGrath et al., 2015).

Personal interactions are one mechanism that minority stress is enforced in society and imprinted on the Queer psyche. Microaggressions such as social snubs, homophobic slurs and other negative social interactions are identified as making a significant contribution to 2SLGBTQ+ persons developing an internal narrative of inferiority to heterosexuals. They are often considered unintentional, but over time, do influence individuals' sense of self esteem (Gartner & Sterzing, 2017; Sterzing et al., 2017). A decreased sense of safety and confidence in one's environment will impede the coming out process and challenge or reinforce internalized homophobia (Cox et al., 2010; Terrell & Dugger, 2018). This leads to negative outcomes for 2SLGBTQ+ individuals over time.

Minority Stress Theory creates a framework from which to base a healthcare approach that supports the healing of individuals and communities. It furthers the understanding that culturally ingrained and structurally systemic oppression is the origin of the 2SLGBTQ+ population's statistically high scores in poor health. Social change is the answer, theories and approaches that challenge the social status quo and encourage activism are necessary.

Queer Theory and Queer Activism

The word Queer is a term of some contention among 2SLGBTQ+ community members and academics. The meaning can be variable depending on the contexts and intent of the user. For this writer the word Queer is a broad terminology that functions as an umbrella and inclusive identifier for all gender nonconformist and sexual divergent people (Lee & Kanji, 2017). Queer is, at once, a political rallying cry, a moniker for a community, and an academic theory that can unify the diversity of ways that people can express themselves sexually and through gender

behaviour. Queer is a reclaiming of negative pejorative as term of activism and political empowerment, a unification of people into a community. It must be understood as an attempt at creating community and fostering a sense of social unity amongst 2SLGBTQ+ people.

Queer theory is also an academic approach that challenges the binary notions of distinct male and female genders. Queer theory questions sexually rigid ideals of heterosexual normativity and distinct categorizing of sexual identities (Mulé, 2016, Yorke et al., 2016). The combination of these approaches can create real social change potential when used by Queer and allied social workers and activists to inform policy and practice.

Queer theory parallels critical race theory as it links the cultural with the political and allows serious critiques of the structural nature of oppression in society (Mullaly & West, 2018). There needs to be some interrogation of mechanisms of queer marginalization and the social construction of heteronormativity in the disenfranchising of queer communities and queer activists (Mulé, 2016, Mullaly & West, 2018). Politicized queers are not afraid to question the social order and are more prone to enacting real advocacy and real social change (Mulé, 2016; Argüello, 2016; Rumens, De Souza, & Brewis, 2019). Queer theory offers the critical approach necessary to the analysis of 2SLGBTQ+ research and the development of 2SLGBTQ+ supportive policies and programs.

Intersectionality

The theory of intersectionality stems from an interplay of Black Feminism and Critical Race Theory as developed by Kimberlé Crenshaw (1989) who posited that structural oppression and discrimination can happen on several different factors at the same time. It is an approach for challenging social injustice. Structural inequality places one form of discrimination over another and so decentralizes both. By categorizing social struggles as singular issues and ignoring the

multiplicity of identities, dominant conceptions of discrimination undermine potential for collective action (Crenshaw, 1989; Carbado et al., 2013). In these ways, intersectionality creates multiple problematic issues for persons who identify as two spirit, lesbian, gay, bisexual transgender, queer, or some other sexual or gender divergent category. Variance in race, ethnicity, class, and multiplicities of genders create complex histories that compromise political and social cohesion (McGrath et al., 2015). 2SLGBTQ+ people organizing for social support, activism, and political purposes, are impeded by emotions of shame, anger, and trauma as they struggle with conflicting identities (McGrath et al., 2015). The reality of intersectionality and the accompanying complications need be observed when developing equitable policies and processes.

Burnes and Singh (2016) wrote about intersection of lesbian, gay, bisexual, transgender, queer, questioning (LGBTQQ) and social class. These intersections effect mental health and the ability to access medical service. They identify the unidirectional nature of oppression towards minorities that are non-heteronormative and highlight the need to challenge the status quo. At issue is the fact that poor queers are invisible in a society that caters to the middle classes. Lack of social space and inter group classism are identified as challenges to building the community needed to create a social voice for these people (Burnes & Singh, 2016).

For this placement, aspects of intersectionality for 2SLGBTQ+ individuals included, but were not limited to, identifiers such as geographic location (urban versus rural), age, gender, sexual orientation, race, Indigenous status, and class (Hulko, 2015; Swan, O'Neill & Mulé, 2015). Intersectional approaches are necessary when developing better understanding of the diversity of persons with such varied identities when developing policy and programming around any groups targeted for oppression (Levac et al., 2018).

In the next section themes that emerge from the literature review will be examined.

Themes from the Literature

This second section of the literature review focuses on themes from the literature that link theoretical perspectives as they frame this practicum project. The purpose of this literature review was to explore ideas like minority stress and the social determinants of health as they pertain to the health of 2SLGBTQ+ persons and populations. These themes function to develop a clearer comprehension of the realities of the Queer experience in a hostile and oppressive social location. In this second piece of chapter two we will look at themes like the treat of oppressive action, social exclusion (invisibility), mental health issues, lack of safe community, the lack of knowledgeable health care staff and being Queer in a northern and/or rural setting. Also included is a brief mention of social justice and healthcare policy, which will be further explored in following chapters.

Health [In]Equity

The framework for public health programs and services focuses on four primary domains: social determinants of health; healthy behaviours; healthy communities; and population health assessment (Ontario Ministry of Health and Long-term Care, 2018). 2SLGBTQ+ populations have been flagged as having higher incidences of poor health (Rainbow Health Ontario, 2015).

Lesbian, Gay, Bisexual, and Transgender people's major advances toward equality in recent years have not reduced the alarming rates of victimization that this minority experiences. Minority stress is identified as the developmental impact of homophobia and transphobia. It is a useful theory to explain the connection between Post Traumatic Stress Disorder (PTSD) and traumatic and non-traumatic events in the lives of queer people. Community wide trauma links concepts of minority stress and health and wellbeing help to highlight the unique healthcare

needs of LGBTQ people (Alessi & Martin, 2017). A limitation of this approach and something to guard against includes the tendency of medialization of the LGBTQ population. We must acknowledge that minority stress is a result of societal oppression and not ignore the community potential to support a health focus that is more preventative (Alessi & Martin, 2017). The implications are those interventions, such as public health messaging campaigns and cultural competency training are necessary to help in addressing health disparities within the LGB population (Durso, & Meyer, 2013; The Joint Commission, 2011).

Mulé (2016) interrogates the heteronormative and oppressive social structure of conventional society that marginalizes queer people. It is the non-profit industrial complex (NPIC) that limits the identities of LGBTQ people and narrows the social construction of their communities. Recognising the intersectional diversity of LGBTQ people and the importance of social workers embracing a critical perspective and being open to progressive ideas, queer liberation, and the existence of politicized queers (Mulé, 2016).

The literature suggests that healthcare providers need to address experiences of minority stress, like internalized homophobia, when addressing issues of disclosure, to better support patient comfort and engagement with the healthcare environment (Cosis Brown & Cocker, 2011; Durso & Meyer, 2013). They need to accomplish this while acknowledging the heterogeneity of the LGB population in terms of race, socio-economic level, and other characteristics unique to sexual minorities. See the subsection on intersectionality for a fuller discussion on this.

Mullaly (2007) addresses “modern day oppression” (p. 259), placing its origins in the scientific age when formalized theories of race, sex, and national superiority supported the dominance of white heterosexist patriarchy. This social construction of privilege and oppression in contemporary society is structured, “occurring through systemic constraints on subordinate

groups [in the] form of unquestioned norms, behaviours, and symbols and in the underlying assumptions of institutional rules" (Mullaly, 2007, p. 261).

Subordinate groups experience higher morbidity rates, less access to resources that promote health, and more stress related illnesses. This coupled with considerable discrimination within the healthcare system creates a perfect situation for greater health statistics occurring in various minority populations (Mullaly, 2007).

Health equity is an approach that is promoted within Public Health Sudbury & Districts. PHSD has identified 2SLGBTQ+ communities as been highlighted for specific attention because of significant health disparity and inequities (Rainbow Health Ontario, 2015). Health equity and population health inequity collide in this policy project. Community involvement and social interaction are joint aspects of healthy 2SLGBTQ+ persons and contribute to healthy and resilient persons. Education for healthcare providers is another theme that has been observed in the literature. Invisibility and the lack of community voice for 2SLGBTQ+ communities are serious issues that have arisen from reviewing current literature. Lack of community, lack of safe social places and the ever-present reality of systemic oppression pose a real threat to the wellbeing of queer individuals and the 2SLGBTQ+ population.

People Under Threat

Elizabeth McGibbon's concept of "People under threat" promotes the idea that health inequity for queer people is more than just placing sexual orientation and gender expression on the list of SDOH (McGibbon, 2012, p. 32). This concept becomes a clear episteme for understanding the experience of Queer people (see Appendix B for diagram). Threat becomes a real variable in in the understanding of how oppression as a social determinant of health acts on the lives of queer individuals. The idea of people under threat is an excellent analytic tool to

explore the intricacies of how oppression is manifest in the structural systems of society. It is invaluable as method of showing how oppression manifests to become a significant influence on the health outcomes for specific populations. This social determinant of health (SDOH) approach creates a functional framework from which to begin a discourse about the health of 2SGLBTQ+ people in Northern Ontario with the understanding that oppressive social threat influences the health of people.

There are many ways that being a person under threat influences health of individuals in a community. Social exclusion is one way that social threat is manifested in the lives of queer individuals. In addition to the obvious threats of violence, verbal harassment, bullying and sexual harassment, social exclusion is an outcome that negatively influences the potential for a productive, happy, and healthy lifestyle (Galabuzi, 2012).

Invisibility and Social Exclusion

Invisibility is a result of and is connected to social exclusion for 2SLGBTQ+ people in general. Invisibility contributes to social inequity especially when it comes to sexual and gender diverse people and health care. Perhaps this is even an aspect of lack of intersectional lens when observing queer people. Their existence often goes unnoticed within the social milieu. Invisibility is one of the mechanisms of marginalization and the social construction of heteronormativity in the disenfranchising of queer communities and queer activists (Mulé, 2016). Specific mechanisms for this include forced or enforced closeting through subtle and not so subtle social pressure from family, coworkers, and friends (Stern, 2015). Emotional lives of people are linked to their social networks. Invisibility blocks people from developing healthy and functional social networks. Invisibility precludes recognition and valuing while marginalization encourages invisibility. This is a vicious cyclical process that pushes individuals and small

groups into isolation (McGrath et al., 2015). Youth and the elderly are most vulnerable to this because they require greater support but often family and community support is withheld. Educational institutions and older adult residences become locations where invisibility is enforced trough isolation and silencing and lack of acknowledgment (Stern, 2015; Hulko, 2015; McGrath et al., 2015; Müller, 2018). Invisibility makes asking for equity in health care and community health support impossible.

Social exclusion is listed as one of the social determinants of health (Ontario Ministry of Health and Long-Term Care, 2018). Social exclusion is one aspect of oppression as a SDOH that involves minimal or reduced access to economic, political, and social power (Galabuzi, 2012). Exclusion from economic power represents the intersection of minority status with other social determinants like employment, income, poverty, education, and housing. This exclusion effects one's social economic status and makes it difficult to insure healthy outcomes. Social power is part of the social exclusion framework. Lack of social power causes individuals to miss adequate social interaction and the ability to develop social cohesion. The inability to create functional social institutions and the isolation from existing institution results in personal and community distress. Entire populations suffer from a lack of community support and community well-being when suffering under exclusionary oppressive forces (Galabuzi, 2012).

The social exclusion of Queer people must be addressed in policy and programing if agencies like PHSD are to positively impact health outcomes for those who are disproportionately affected. This includes a focus on the oppressions that compound these health disparities. The public health systems need be mobilized to implement interventions with 2SLGBTQ+ persons and their communities that mitigate instances of social isolation and the health disparities that result (Galabuzi, 2012).

Socio-economic determinants of health are important influencers of mental health and wellbeing for all but are particularly important for marginalized populations. Three significant determinants of positive mental health and wellbeing for LGBTQ persons are: social inclusion; freedom from discrimination and violence; and access to economic resources. All three of these factors impact LGBTQ individuals and communities in Ontario (Canadian Mental Health Association Ontario, n.d.). LGBTQ people experience stigma and discrimination across their life spans, and are targets of sexual and physical assault, harassment and hate crimes; all of which cause stress and influence mental health (Canadian Mental Health Association Ontario, n.d.). Trans people are more likely than other queer people to experience greater degrees of economic deprivation, violent threats, and harassment (Canadian Mental Health Association Ontario, n.d.).

Exclusion from economic, political, and social power promotes invisibility in the economy and labour market as well as limited access to political clout and social presence creating a voiceless and invisible minority whose needs and existence are not acknowledged or understood by service agencies and health care providers in general.

Mental Health for 2SLGBTQ+ People

Multiple factors impact the mental health and well-being for LGBTQ people including the process of coming out, gender transition, internalized oppression, isolation and alienation, loss of family or social support, and the impact of HIV. Queer people are double the risk for post-traumatic stress disorder (PTSD) than heterosexual people (Canadian Mental Health Association Ontario, n.d.). LGBTQ people face higher rates of depression, anxiety, obsessive-compulsive and phobic disorders; they experience more incidences of suicidality, self-harm, and substance use. LGBTQ youth face approximately 14 times the risk of suicide and substance abuse than heterosexual peers. 77% of trans respondents in an Ontario-based survey had

seriously considered suicide and 45% had attempted suicide (Canadian Mental Health Association Ontario, 2020). Some research suggests that use of alcohol, tobacco and other substances may be 2 to 4 times higher among LGBT people than heterosexual people (Canadian Mental Health Association, Ontario, 2020; Rainbow Health Ontario, 2015).

For many 2SLGBTQ+ youth and young adults school remains a problematic environment in which victimization is encountered (Erhard & Ben-Ami, 2016). However, previous research has also indicated that youth who are able to disclose their identity, and 'come out', experience enhanced psychosocial well-being despite the victimization encountered (Russel et al., 2014). The impact of homonegativity and hiding one's identity is significant. The negative outcomes of this include isolation, depression, suicidal ideation, addiction (Benibgui, 2010). Social supports and familial acceptance have been shown to increase the resilience of LGBTQ youth to the homonegative atmosphere and stigmatizing experiences of campus life (Benibgui, 2010).

> In 1996, the Canadian Human Rights Act was amended to specifically include sexual orientation as one of the prohibited grounds of discrimination. This inclusion was a clear declaration by Parliament that gay, lesbian, and bisexual Canadians are entitled to an opportunity equal with other individuals to make for themselves the lives they are able and wish to have (Government of Canada, n.d., section 2).

North American Society, specifically, is one of the most progressive when it comes to tolerating sexual and gender diversity. Homosexuality, since the 1960s, is no longer illegal in this country, nor is it considered a mental illness. Yet there is great stigma attached to being queer. Homonegativity in societal attitudes, heteronormative social structures, and heterosexist values are the source of negative behaviour towards LGBTQ people. CIS genderism and

transphobia are attitudes and behaviours that are prejudicial towards trans and non-binary persons. The resulting prejudicial actions cause serious distress for 2SLGBTQ+ people.

The Need for Community Building

Literature is suggesting that community building is a significant action in promoting community and individual health. McGrath et al. (2015) links the emotional lives of minority people to their social networks and interactions. Drawing on research conducted with indigenous as well as 2SLGBTQ+ minority groups these researchers conceive trauma as a socially shared experience felt in a personal manner. Emotional and social effects of trauma are experienced through direct and indirect means as individuals relate to or identify as part of a subcommunity or population demographic (McGrath et al., 2015). The impact on individuals and community of trauma is less a medicalized individual issue, but more of a reaction to the wounding effects of injurious social events experienced or observed. The most profound effects of social trauma on an entire community of people include loss of identity, damaged social fabric, and perpetual sense of victimization (McGrath et al., 2015). Outcomes of experiencing collective trauma for the individual include marginalization, including social exclusion, material deprivation, and underemployment. LGBTQ people experience being blocked from being valued, recognized, and respected because of their social definition and marginalization (McGrath et al., 2015).

Sharing one's gender identity or sexual orientation is strongly associated with life satisfaction, and that hiding one's identity is associated with depression and negative adjustment in young adulthood (Durso & Meyer, 2013; Russel et al., 2014). Hiding one's identity in early life is a significant predictor for young adult depression and youth who hid their identity at school often reported higher levels of victimization, especially if they were unsuccessful at hiding their identity. Thus, neither being out, nor hiding, minimized the potential for LGBT

victimization but being out had a positive and resiliency producing influence (Russel et al., 2014). Fassinger and Arseneau (2007) highlight of the importance of community and identity as a model for lesbian identity development but site internal tensions between the various queer identified people as problematic. They call for unity within Queer communities, suggesting that all 2SLGBTQ+ people are gender transgressive sexual minorities (Fassinger & Arseneau, 2007). The importance of this link between community and identity highlights the necessity for a healthy community to be there to support all queer people. It seems that the challenge may be in how those within this umbrella think of and treat each other. The next link includes creating voice for 2SLGBTQ+ people from a community healthcare approach. Such a voice would be capable of having dialogue with healthcare provider agencies and informing policy and programming.

A community approach aimed at reducing social isolation and social exclusion would also be an opportunity to create a voice for queer people and partner for PHSD to include in health policy development. A venue for community health programming for improving the health of 2SLGBTQ+ people is necessary.

Educating (Queering) Health Professionals

Public awareness campaigns and staff education on cultural competency are necessary to help in addressing healthcare disparities for the LGB population (Durso & Meyer, 2013; The Joint Commission, 2011). Vinjamuri (2017) suggests that the need is to promote a pedagogical model that expands and deepens what it means to create a “safe” environment for learning about LGBT issues. There is a growth processes as individuals commence deconstructing their beliefs about sexuality, gender, religion, and family. Providing forums for personal reflection and dialogue support learning through sharing. For many, using their voices as they overcome their

personal discomfort through a process of deconstruction was both an uncomfortable and rewarding learning process. Specific pedagogical approaches can overcome prejudice and discomfort stemming from heteronormative and heterosexist values. This offers hope for future social work and healthcare services. Addressing the issues around heterosexist and homophobic thinking offers providers realistic actions for improving services for LGBTQ service uses (Vinjamuri, 2017). Müller (2018) advocates for including queer health within the education of service providers as a means to reduce invisibility of 2SLGBTQ+ persons and improve their health potential.

When conducting education or awareness programs there is a caution to guard against unequal focus on one gender or another and ignoring trans, nonbinary or intersexed experiences in social work education (Chinell, 2011). The intent is to promote a more fulsome understanding for social work students and future practitioners around issues and challenges of queer health, social struggles, and community experiences. There needs to be educational opportunities to foster understanding of self as well as insight into the complexities of what it means to have such an identity as 2SLGBTQ whether one is a client/service user or a service provider in any field. This is an opportunity to develop strategies and best practice skills that support the healing and health of all clients and service users as well as a chance to work towards the eradication of healthcare inequities that stem from social ideals that include hetero-normative, cis-normative, heterosexist and homonegative values (Chinell, 2011). The suggestion is that education of healthcare providers must include anti-oppressive and queer positive frameworks that move beyond culturally competent models to understand the ontological discussions as well as lived experience that can inform best practice and community health care approaches that best suite 2SLGBTQ+ persons (Fassinger & Arseneau, 2007).

Urban versus Rural/Northern Considerations

Northern and rural populations of 2SLGBTQ+ are under-researched and healthcare providers need to understand more about this demographic (Yorke et al., 2016). Sudbury is a small, northern city and this forms the context for this practicum. From a healthcare perspective the northern context makes this project significant as an initial foray into healthcare equity for a little understood and poorly researched community.

Much of the discourse on LGBTQ people is about those that live in urban settings (Wienke & Hill, 2013). There is a link between Cities and LGB populations. There are specific reasons for this. Stigma and prejudice force LGB people to seek the support and anonymity within urban environments. These environments create a relative sense of safety for developing social, cultural, and political networks that can reinforce LGB identity. A critical mass of LGB population creates social and health networks and related health benefits in urban centres (Finkelstein & Nederland, 2005).

Rural and northern 2SLGBTQ+ populations not only exist, but some may even be healthier and happier than their urban counter parts (Wienke & Hill, 2013; Yorke et al., 2016). Other researchers have posited contradicting ideas about rural 2SLGBTQ+ people's experience (Daley, 2015). Lack of diversity and greater intolerance due to religiosity and conservatism in rural areas result in less acceptance towards 2SLGBTQ+ people. It would be more necessary for queer GLBT folks to maintain some invisibility. The resulting identity issues, isolation and lack of services or support can make growing up or living in rural communities challenging for 2SLGBTQ+ persons (Daley, 2015).

Social Justice and Healthcare Policy

Social work that is structural and critical of social inequalities uses a framework for practice that emphasises an analysis of social problems. These approaches understand that individual experiences are part of common problems, shared by larger sections of a population and are socially constructed. Understanding this connection between the individual and socially constructed material inequality move social work practice and strategies to support social justice as well as individual change. Fifty years ago, this was considered a radical development in social work theory and practice. Still today structural approaches to social justice practice are often titled radical perspectives or radical social work (Lundy, 2011).

Today the very definition of social work includes ideals of human rights, social justice, and social change as fundamental principles that are meant to guide practice (Hicks, 2010). Social and historical processes produce social inequality. Canada lags compared to some other countries in governmental program provision and state interventions in social institutions that address social inequality. Part of the issue is poor public awareness and a disconnect between SDOH related policy documents and actual public policy making. The result is a reluctance in policy makers when it comes to identifying the implications and potential around SDOH in policy making. The result for queer and other minority groups is that policy makers lack the means to address the specific situations that need to be addressed to promote a movement to real health equity (Galabuzi, 2012; Raphael, 2012).

Conclusion

2SLGBTQ+ populations have been identified as a priority for research by Public Health Sudbury & Districts, but there is a gap in knowledge and evidence regarding the needs of the local Queer community. Using a structural social work viewpoint and a critical social change

perspective as a theoretical stance the goal with this literature review was to access literature that promotes a critical and transformative approach to community health and research around 2SLGBTQ+ populations in Sudbury.

As this literature review demonstrates, heterosexist, cis-normative, trans-negative, and homonegative attitudes in society and in healthcare practice are barriers to promoting healthy 2SLGBTQ+ communities. Ranging from micro aggressions to socially structured procedures in practice and research, queer minority persons are marginalized, silenced, and refused equal access and equal voice when it comes to community health. By ignoring the nature and source of minority stress and oppression as significant social determinants of health for queer people healthcare systems miss key opportunities for building equity into their services. This literature review has highlighted these issues and offered ways that integrate social change and social justice within agency policy and procedure. Service provider education can help to create safe spaces. This will enable queer service users and queer service providers to work together towards healthier communities. As the literature shows community development allows queer people to have a voice in the development of policy on community health approaches as they pertain to 2SLGBTQ+ people.

This literature review brought together several theories and themes that support the link between social determinants of health and the minority experience of 2SLGBTQ+ people. Theories from the review include minority stress theory and queer theory, both of which can relate to critical frameworks that challenge existing social structures and support a move towards social change. SDOH can be used to frame concepts of minority stress and health and wellbeing as social constructs while highlighting unique healthcare needs of LGBTQ. The link between abstract notions of social determinants of health and the negative social experiences and poor

health outcomes becomes evident as these themes are explored. The social determinants of health suggest that belonging to a sexual or gender variant minority creates risk for poorer health outcomes. Oppression, when considered as a social determinant of health for those under threat of negative actions, is the link between SDOH and the health of 2SLGBTQ+ people. The results of living with threat are social isolation and poor mental and physical health. Poorly educated and informed healthcare workers further marginalize Queer people, separating them from competent and understanding healthcare. The themes of this chapter create working models around which policy and programing can be constructed.

The information emerging from this literature review was used to guide the practicum placement inquiries and help answer the initial questions on issues of social justice while developing policy and procedures for supporting the community health needs of 2SLGBTQ+ populations in Sudbury and Districts. Social work theorists clearly illustrate how social justice approaches in practice are meant to ameliorate marginalization and disempowerment, maintain an anti-oppressive stance and work towards equitable access to resources (Rothery, 2016; Baines, 2011). My questions from onset revolve around whether healthcare and medicine have equity guided principals that support a social justice approach within the policy documents and processes at PHSD. This discussion continues in Chapter three where my critical reflections linking social justice and policy are outlined.

Principles of affected interest suggest that those who are most affected by policy should be active in the forming of that policy or at least be consulted in the process (McKenzie & Wharf 2016). Given that there is some professional responsibility to consider issues of social justice in policy analysis, community voices must be included when developing healthcare policy (Westhues & Wharf, 2012).

Chapter three continues with more detailed descriptions of the practicum process and reflections of the placement experience.

Chapter Three - Process and Critical Reflections of the Practicum

Chapter Three will outline the process of this placement as well as reflective observations, learning, and experiences as a Master of Social Work student through the progress of this Advanced Practicum Placement. This chapter of the advanced practicum thesis offers personal and professional actions and reactions of a structurally oriented and critically thinking social worker and research assistant within the Public Health Sudbury & Districts. This placement process was guided by three specific questions from the onset and three related learning goals. Response to these will form an integral anchor for this section. The three related learning goals will be discussed here as well as the tasks that were the focused work of the placement. The chapter continues with more personal reactions in the form of reflections. The reflections are meant to evidence the experience of learning about public health agency structure and process as this bureaucracy navigates attempts at changing approaches and understanding towards the 2SLGBTQ+ population. As a gay man, a Queer academic, researcher, and social worker my responses to 2SLGBTQ+ focused health equity practice and policy in this agency are coloured with personal and poignant reactions and reflections. My challenge was in developing an approach to researching and promoting appropriate policy and programs for a population that I relate to, in a community that is in a specific geo-social location, and a cultural matrix that is often less than supportive. This was a daunting task for one, lone, Queer research student to identify policy changes for a population in a small Northern Ontario City that may be less accepting of 2SLGBTQ+ people. A brief outline of the duties that were part of the work of the research assistant prefaces this discussion.

Duties of the Student Research Assistant

There were four main duties associated with he research-assistant's position; analysis of the data from the 2SLGBTQ+ community health study, identifying training and resources for PHSD staff, working with staff to understand the current approaches to health equity, and recommending policy and procedures for improving health equity for 2SLGBTQ+ people.

The primary focus of this placement was the analysis the 2019 2SLGBTQ+ Public Health Community Needs Study data. The qualitative data was in the form of digital stories that were recorded using the voices of the participants and combined with pictures to form viewable and analysable productions. Several hours of audio recordings and transcripts of focus groups discussions were also analysed. Meetings with Dr. Tanya Shute, who was the Laurentian University lead on the study project, helped focus the thematic process and build interrater reliability into the data analysis process. The goal of the study and the subsequent analysis was to develop a clearer and more focused understand of the 2SLGBTQ+ community's needs related to public health.The process will be outlined in depth under the associated Learning Goal One, under Learning Goals.

Some of the other duties of the research assistant placement included researching training and accessing 2SLGBTQ+ resources for PHSD staff and employees. Via online searches and scanning queer web pages and media for educational resources and opportunities. These were collected and documented in digital folders and data libraries for future reference.

Interacting with other teams and team members was an integral part of this placement. An invitation from the lead of the Health Equity Team allowed attendants at Health Equity Team huddles. Huddles are a brief meeting for updating and communication with and amongst team members and leads. This opened opportunities for dialogue and meaningful interaction with

representatives of other equity-seeking groups. There was also a chance to take part in and observe how the PHSD has organised and planned around offering community health programing for these other minority populations.

The Health Equity team was a source of access to people of like purpose, allies if you will. Involvement with this team was both rewarding and educational. Activities with the Health Equity Team included meetings where programs, policies, and processes would be discussed. This team focused on plans made to increase both internal activities and broader community actions to create more equitable healthcare and healthier communities. Activities undertaken with this team included supporting the allyship training module/presentation for the anti-Black racism committee. This was done through review and advisory input in preparation for the rollout of this training module as a required professional development for the staff of PHSD.

Another pair of activities that was a central focus of the Health Equity Team was Bridges Out of Poverty© and the Circles® program. Attendance to planning meetings and community meetings of this program became a small part of the placement time but offered the opportunity to interact with other placement students as well as community members that were committed to creating social change and community health improvement for people experiencing poverty. Through activities with the Health Equity Team there were opportunities to meet and interact with Indigenous health promoters and Indigenous community engagement workers. The intersectionality of Two Spirit ideals was a key part of these discussions. These connections offered insight into how programing and policy in the PHSD can be structured to benefit minority populations and improve the community health of oppressed people.

The fourth duty of this placement, and perhaps the most significant, was to use the evidence produced through secondary data analysis to inform organization-wide policies and

procedures that are equitable for and supportive of the needs of 2SLGBTQ+ people. The goal of the recommended policy and procedures for improving health equity for 2SLGBTQ+ people in the Sudbury Districts. Then the plan was to validate and finalize the policy and procedure with the Professional Practice Committee (PPC) of the PHSD agency.

The following questions from onset were an integral component of the duties and learning process of this placement These questions guided, were intertwined with, and informed the process and actions of this practicum.

Questions from Onset

Specific questions from the placement proposal guided the learning throughout the Advanced Practicum. Answers to these questions have evolved through the literature review in Chapter Two as well as from the voices of the study participants in the data analysis. The following are these questions which guided the learning through the experience of this advanced practicum:

- How can Public Health Sudbury Districts integrate social change and social justice within agency policy and procedure?
- What is Sudbury 2SLGBTQ+ populations' public health needs and how can they be addressed in policy and procedures?
- How could the voices of 2SLGBTQ+ populations in the Sudbury and Districts area inform the development of a policy and procedure for Public Health Sudbury & Districts that will support their public health needs?

Answering Questions from Onset

The questions from onset and the corresponding answers are below and are then followed by some discussion of the completion of learning goals. Though these are dealt with separately it is important to understand that questions from onset and learning goals do interrelate and the answers for one will also assist in satisfying others. Critical and personal reflections follow the questions and goals discussion.

Question One

How can Public Health Sudbury Districts integrate social change and social justice within agency policy and procedure?

PHSD uses a social determinants of health perspective for their research and policy development (PHSD, 2019). This approach is a key perspective of the research that has been undertaken. Social determinants of health are factors beyond an individual's biology and behaviours. These are health influences that people grow up with and live with in family, community, and work situations. They "are social and economic factors that impact people's health: income and income distribution, education, employment, job security, working conditions, early childhood development, food security, housing, socio/ inclusion, socio/ safety network, health services, Aboriginal status, gender, race and disability" (O'Neill, 2012, p. 261). It is important to note that the Ontario Ministry of Health adds two more determinants to the list: gender identity and expression; and sexual orientation and attraction (Ontario Ministry of Health and Long-Term Care, 2018). It is a simple observation that gender identity, gender expression, sexual orientation and sexual/romantic attraction are defined as social determinants of health by the Ministry of Health and are therefore legitimate focuses for public health policies, and programs. Mullaly & West (2018) use the term "movement" (p. 216) to describe how this concept is being promoted in the health care systems. According to Mullaly and West (2018)

these social determinants are factors outside of the health care system. Social determinants relate more to the structural aspects of society and the organization and distribution of economic and social resources. Social justice and social equality need be included in the list of social determinants of health for 2SLGBTQ+ populations. From a more critical and structural social work perspective the social determinants of health framework can be criticized as a liberal humanist approach, focusing too much on policy change and not enough on social inequity. The social determinants of health approach when used in health care misses the real potential for social change at the community level. Enlightened social policy alone is not enough to reform society. More radical and critical approaches to changing health inequities are necessary. Anti-oppressive social work practice should be integrated within healthcare using a structural social work approach. Social transformation that decreases social hierarchy, wealth inequity, and social domination will help to ensure more equal health outcomes for all (Mullaly & Dupre, 2019; Mullaly & West, 2018). Education of service providers, policy makers, and health care staff about the social determinants of health and their impact on the health of Canadians is a consistent recommendation (Andermann, 2016; Mikkonen & Raphael, 2010). Integrating the SDOH frameworks with a structural social work approach will help to develop a clearer understanding of what is needed to create policy that promotes social justice and healthcare equity. Policy development that includes social justice approaches will better address the issues that promote ill health for minority people.

Systemic heteronormative and cis-normative cultural systems are barriers to changing policy development and interagency approaches to equitable practice. This was evident in many systems within health care. It was observed in the gap of Queer inclusion in the original 2016 health equity study (Price, Lemieux, Pajuluoma & Wilson, 2017). This is also evidenced in the

dearth of 2SLGBTQ+ policy in PHSD. The exploration of the existing PHSD policies and data base provided no indication that there were any policies or programming that pertained specifically to the provision of health services geared to 2SLGBTQ+ populations. From this, one could conclude that Queer people and their issues are invisible throughout the PHSD bureaucratic structure. This of course is correlative with the greater cultural realities of the geosocial area of Northern Ontario. Rural and northern 2SLGBTQ+ populations face greater intolerance, increased identity issues, isolation, lack of support, and lack of services (Daley, 2015). As such, living in a community like Sudbury can be very challenging for Queer people.

At this point it is worth mentioning that part of PHSD's reflective practice in continuous quality improvement had identified this gap. The Northern Ontario Health Equity Strategy Engagement Report made this lack of 2SLGBTQ+ focus evident. This was the impetus of the 2SLGBTQ+ public health needs study on which this analysis was based.

As a placement student and as an employee, I had access to the complete database of PHSD policies. My informal scans of existing documents and policies, done as part of this placement, exposed limited 2SLGBTQ+ content. As a preliminary approach to developing policy from the 2019 study data that were analysed, the PHSD database was searched for any wording or policy that pertained to Queer community or 2SLGBTQ+ individual health. All the individual identity labels from the initialism were used to search the General Administrative Manual (PHSD) as well as the exiting policy documentation. Nothing was found that could pertain specifically to Queer populations or individuals. This population was however considered at part of the agency's overall SDOH framework and policy and addressing social inequities in health. Social change and social justice in policy as stated in the question would be invoked by adding

explicit mention, and explicit consideration, of this population to the policy documentation and the programming and planning process.

The challenge for most mainstream health and social service organizations is to understand that flagged populations are more than just people at risk or vulnerable populations; we must see them as "People under threat" (McGibbon, 2012, pp. 32-59). By shifting this understanding service providers in the health and social service fields can begin to see the true location of the problem (McGibbon, 2012). The health problems do not stem from the target population, but from the targeting of the population. In fact, the problem is not with the 2SLGBTQ+ community at all. The problem is with the rest of society and how they treat queer folks. This includes the people that are responsible for providing the most necessary services.

The change must occur in the hearts and minds of people who are not Queer and those who are. The solution to the problem is education and training. It is especially crucial that healthcare and public health staff are trained to provide equitable service. Radically open acceptance of training and thinking around issues of heterosexism and transphobia are required if social justice and health equity are to be worked towards. Social change and social justice come hand in hand with education and awareness. This quote from one of the study participants states it well:

> *"The change we need is so much more than a singular solution. It needs to be hand in hand with educational, justice, political, cultural and health institutions. Change starts with self-awareness. Are you part of change, or supporting systemic barriers?*" (Quote from Study participant)

Question one revolved around was how to increase social change and social justice within policy and procedures within the PHSD. The answer is simply and directly put; the agency must proceed with policy development, staff training, queer health promotion, and 2SLGBTQ+ community engagement. Social Justice and social change come with organizational approaches and adjustment to policy as well as programming. Action towards making the change is necessary if true social justice is to be achieved.

Question Two

What are the public health needs of the Sudbury 2SLGBTQ+ populations and how can they be addressed in policy and procedures?

Through the secondary analysis of the data collected from the 2SLGBTQ+ community study the needs of the Queer population in the Sudbury Districts became apparent in the stories and the voice of the participants. The public health needs of the 2SLGBTQ+ population are multifold and are tied to stigma and oppression that comes at them from the social realities they inhabit. These health needs are linked with the experience of oppression as a social determinant of health. The digital stories outlined experiences of Queer participants as they must contend with being the lifelong targets of homonegative, trans negative and queer phobic behaviour from the people within the social systems they inhabited.

The data analysis from the original study found the distress of the participants in their social surroundings and the negativity they experienced from others was significant in influencing mental health. This suggests the benefit of using a structural social work approach that highlights societal relations that marginalize and medicalize the individuals from certain groups. Queer theory is a useful model from which to critique heteronormative and cis-normative social structures as they pertain to health outcomes of oppressed people. The social determinants of health as a framework approach or a theoretical perspective invites policy makers and

healthcare practitioners to include understandings of structural aspects of societal inequality when addressing healthcare and practice procedures (Mikkonen & Raphael, 2010; PHSD, 2019).

From analysis of the data, it became clear that stronger community-based support is needed for the 2SLGBTQ population in Sudbury. The list of needs for the 2SLGBTQ+ community include social engagement for support and to combat isolation, peer interaction and peer support to normalize and encourage healthy queer identity development.

One participant stated that we need to

> *have a program or initiative or something that could give the LGBT community in Sudbury a sense of community, it's like a support group or something for transgender people, or a social thing for elderly LGBT people, or a place for people to feel a sense of community and be able to get information about research or about programs and other initiatives that are here.*

Another participant from the 2019 study voiced their need for community.

> *We need that place where we're not the one, we're part of a group, where you can recharge. Where's that place? I mean it's either out in the community with straight people or alone at home. It's the isolation and that always being alone is really challenging and draining.*

One participant was more specific about their needs: *"We need to have more of a network." [*And a*] "list of mental health advocates" [*that we can access who will support us.*] "The other thing we need in Sudbury is a 2SLGBTQIA+ health clinic."*

Education for service providers, queer community members, and the public is necessary to develop improved social environments and healthcare services. Education for all sectors would support visibility and understanding. Visibility functions to normalise queer realities in the Greater Sudbury community. Visible 2SLGBTQ+ people help Sudburians of all descriptions to adjust to the reality of sexual and gender diversity.

Improving the safety of Queer service users is a clear request from the participants of this study. Many shared stories where health care provider spaces could not be trusted to be completely safe. All people come to health service providers when are vulnerable or in need, but some such as Queer people are more vulnerable to the power exchange than others. Entering these spaces opens one up to oppressive targeting from other clients or patients. Provider staff who do not understand the safety needs of 2SLGBTQ+ patients may mistreat a person from this community. Workers who do not have a Queer positive or trauma informed awareness of Queer people will not be able to offer the safe spaces needed for equitable assess for all clients from this population. From a public health perspective, safe space training and trauma-informed practice training for all staff who are responsible for providing respectful and safe service is a necessity.

The community health needs of 2SLGBTQ+ people in Sudbury and Districts can be broken down into three basic perspectives. One involves professional, service provider and community environments that offer better safety for 2SLGBTQ+ staff and guests. The second is a better opportunity for quality social interaction to combat loneliness and isolation. The third is an opportunity for Queer communities to have a better voice in how healthcare and other service are provided. Better policy and program development will be the result of further research and collaboration with the Queer community members. We are called to work together on drafting

policy, creating safe space, community development, and community engagement for partnership. The overall result will be a better serviced and healthier Sudbury 2SLGBTQ+ population.

Question Three

How could the voices of 2SLGBTQ+ populations in the Sudbury and Districts area inform the development of a policy and procedure for Public Health Sudbury & Districts that will support their public health needs?

The PHSD is committed to working collaboratively with community partners and stakeholders to develop and implement strategies for learning about and improving the health of people in these districts. Many of the participants in this study were interested in working towards building community capacity within the queer population in Sudbury. There was a motivation amongst most of the story tellers to offer help and support to those they considered part of their community. They wanted to help young people coming out and older folks needing support in the community as well as educating non-queer folks in various venues. The desire for social connection and productive involvement with others who shared similar identities was evident in the stories and in the recommendations after the stories were shared.

The results of the current study have yielded several recommendations. Community voices will emerge when support for community development is offered. The voice of queer people in the 2019 study made it very clear how systemic oppression throughout the Public Health Sudbury & Districts impacts the wellbeing of individual queer folk. To do this we must satisfy the safety needs of 2SLGBTQ+ individuals so that they can feel secure enough to come forward to be that partner and community voice.

One recommendation is to make the Queer community part of the shareholders in health promotion through processes of community organizing and community development. This would

include encouraging a 2SLGBTQ+ community to form from a grassroots position to become a community partner in voicing the needs for better 2SLGBTQ+ community health. A community voice is a validating factor in the development of policy and procedure. A community voice promotes community health initiatives that fit the needs of the community. McKenzie and Wharf (2016) invoke the concept of principles of affected interest suggesting that those who are most affected by policy should be active in the forming of that policy or at least be consulted in the process. There is some professional responsibility to include community voices when developing healthcare policy, especially when considering issues of social justice in policy analysis (Westhues & Wharf, 2012). One participant made their desire clear when asked what they wanted to come out of this study: *"Learn from the past to improve future generations, my hope is that from my story you will learn to be inclusive and accepting, and to enhance the strengths of transgendered peoples."*

Posing questions from onset of the placement experience was meant to provide guidance for observation and learning as this practicum unfolded. They revolved around how PHSD engages with principles that are equity guided and support social justice in policy and program development. Though this agency has many programs that are for promoting health with various minorities there is still room for developing policy and programing to improve the health of the 2SLGBTQ+ community withing the Sudbury & Districts. This practicum has offered this student the opportunity to highlight some of the ways social justice and health equity for Queer people can be improved.

The reflections on learning goals which follow continue to outline both the learning outcomes of this practicum and the promotion of 2SLGBTQ+ community health.

Learning Goals

The three learning goals for the placement experience are meant to direct the learning experience of this practicum placement. These goals focus the practice within the placement in PHSD to make use of the valuable opportunities for learning. These learning goals include improving skills in analyzing qualitive data involving the needs of a 2SLGBTQ+ people in the Sudbury districts; developing policy and programing from data analysis and research; and health promotion and social justice in community healthcare needs of the Queer community.

Learning Goal One-Develop skills in qualitative data analysis

Data analysis the 2019 2SLGBTQ+ Community Health Study was a primary focus of this placement. This created an opportunity to build skill capacity around qualitative analysis using a thematic method. To facilitate learning around data analysis articles and textbooks whose subjects focused on qualitative data analysis were reviewed. Specifically, targeted information on thematic analysis of qualitative data to enhance skills and knowledge of that method was studied. Thematic analysis is an accessible and flexible method if structuring and examining qualitative data. To initiate skill development, a quick review of research and literature was undertaken as a refresher of previous learning. Past texts and some new literatures were studied to foster a specific and focused understanding of the thematic analytical process (such as Heinonen, Halonen, & Krahn 2019; Lambert, 2010; Creswell, 1994; Mason, 2018).

Data was in the form of digital (audio) recorded stories that were accompanied by picture images combined to form 3-to-5-minute videos. These stories narrated the specific experiences of 2SLGBTQ+ participants of the community study that was conducted in November of 2019. There were also several hours of audio recordings and transcripts of focus groups discussions that took place during the story circle and introduction times of the workshops.

A six-phase approach to thematic analysis was recommended by some of the articles (Braun & Clarke, 2012). The analysis was conducted by me and Dr. Tanya Shute who was the Laurentian lead in the original study and acted as the interrater in analysis to ensure a high level of reliability in the analysis process.

A phased approach begins with familiarising oneself with the data. This early phase includes reviewing digital stories and the recorded focus group discussions. Reading the transcripts is also an early phase activity. In phase one, data was first engaged through some sense of immersion by watching the digital stories and reading the focus group transcripts. This was accomplished without any coding activity, but a few notes were jotted down. Phase two involved rereading, reviewing, and listening to the focus group audio recordings. Some generation of initial coding and picking out poignant quotes and comments from the data. Quotes and comments relating to codes were places in tables, one for each digital story. More complex tables were developed for the focus groups.

Phase three involved the development of themes. At this point quotes from all the tables were organised and brought together into larger groupings according to themes. In an iterative analysis process involved constant reviewing and reorganising of data was occurring as the fourth phase was entered. During phase four a review of the data with the themes and codes in mind offered more opportunities for refining the process and strengthening the themes.

The fifth phase progressed into naming and defining themes so that each can be clearly summed up and seen as distinct from the others. Working with the Laurentian lead in this study helped ensure that a certain level of reliability was achieved through an interrater process. Phase six includes the write-up of the report. Braun and Clarke (2012) are clear in how the phases are not overtly distinct and operations from one phase merge with those of others. Phase six includes

an interweaving of writing and research and indeed may occur throughout one's analysis as notes, memos, and research help to tell a coherent story about the data (Braun & Clarke, 2012). The analysis writeup developed organically as notes, and quotes, and research concepts came together to form a cohesive first draft report of the study.

Next was the task of generating initial codes. I experimented with techniques of structuring data in table form with the intent of making sense the story details from many digital stories and focus group discussions. Using a table facilitated the building of codes into themes and forming structures and connections within the data. Conceptual interpretations and moving the coded pieces into thematic blocks helped me develop themes that answered the research questions in relevant ways. Collaboration with the Laurentian lead on this study on inter-rater coding was helpful in establishing succinct themes and subthemes. Working with two sets of analytical perspectives helped narrow the focus of the coding process and increased the reliability of the results. Interrater reliability is a tool to increase confidence in the findings and improve consistency in the methods (Belotto, 2018).

The thematic analysis approach allowed for a systematically organized, individualized structuring aspects of the transcribed words creating patterns that offered insight into the specific realities of the Queer experience in Sudbury Ontario. By bringing the quotes and comments together it became possible to identify key themes relating to oppression in the social interactions that impact the lives of the participants throughout their life course. The inductive methodology of thematic analysis allowed for the development of themes from the content (Braun & Clarke, 2012). In this way the voices of the participants were primary in driving the analysis, discussion, and conclusions of the study.

The next section reflection on the experience of conducting research that one has taken a part in creating as a participant and insider researcher.

Reflections on Insider Research and Researcher-As-Participant

The analytic approach for the work in this part of the placement included a researcher as participant stance. The Digital Storytelling is considered a form of participatory action research which puts the participants in the roles that are active and reflexive in the process of data generation (Mason, 2018). Questions of objectivity can be made regarding the closeness of this analysist to the content. In the case of such qualitive data, objectivity is less a goal than an obstacle. Being so close to the data helped develop an intimate sense of understanding of the life experiences that were being exposed. Having similar and shared social realities with the other participants granted this research assistant the authority of lived experience to interpret the data and inform the resulting policy. I this analysis objectivity was not the goal, but a genuine immersive understanding of the data was the point. While analysing communicative digital creations as expressive and creative qualitative data it was possible to use the insider vantage point and self-reflection to explore the social phenomena of minority stress and living under oppressive threat (Heinonen, Halonen, & Krahn, 2019).

The personal reality of being a gay man and part of the Queer community in Sudbury since coming out at age 19 offers some authority of one with lived experience to conduct this work. This research and analysis are informed by the lifelong experience of a participant researcher with insider knowledge. This is the kind of understanding that brings together the needs of 2SLGBTQ+ people and the responsibility of PHSD to meet those needs. Personal understanding of what is to be queer in Sudbury allowed a real sense of emersion into the data and a clear understanding of the content and self-reflexive narrative in this document permits me

to elucidate in deeper ways the experience of a Queer researcher working within the heterosexist confines of a Northern Ontario healthcare agency. Familial abuse, school bullying, and the emancipatory revelations of connecting with like others are part of many of our stories. When speaking of being part of the community, it is not just referring to the 2SLGBTQ+ community I am also a product of the culture and socialisation of the broader community of Sudbury & Districts. This social location offers a multifaceted lens through which I see and observe and reflect on these locations and the ramifications of culture power and equity across multiple social locations and positions. I have witnessed the homonegative attitudes of non-Queer members of this community; have heard the comments, and know the mind set of the family and community in which I was raised. I understand from a place of lived experience the nature of homonegativity in the systems of family, education, labour, and the various services. Some of the personal reflective pieces of this thesis echo the data of the study, illustrating how even in the experience of the placement the student is living out the experience of the Queer individual within this social matrix This is the useful nature of being an insider researcher.

Being embedded in the population and in the study offers a tacit understanding about the power relations and social dynamics of being queer in this community and being a queer researcher in this agency. When conducting analysis on the themes as they emerged from the narratives of the participants, one sees himself in the position of key informant. The experience of this location gives one authority to speak using both one's voice and the voices of the other participants. In effect, the practicum placement continued the original study in that my experience as the graduate student in the context of a 2SLGBTQ+ individual experiencing that lived reality and becoming the troubled minority individual in society.

The experience of analysing data that are so very qualitative was truly a skill building experience. My role as participant researcher and analyst offered insight into the research focus as well as a deeper understanding of the Queer experience in Sudbury. This was a unique and valuable skill-building process.

Learning Goal Two - Strengthen Skills in Policy Development

To further better understanding and prepare to enter the process of policy development another quick review of past texts and resources on policy was undertaken. I reviewed text such as: Lightman & Lightman (2017), McKenzie & Wharf (2016), and Westhues & Wharf (2012). I engaged in this review with a developing understanding that Canadian policy ideals of acceptance of diversity, and social justice in academic journals are in direct conflict with more traditional Canadian values based on religious beliefs and traditional colonial ideologies that are less supportive of 2SLGBTQ+ people (Daley, 2015; O'Neill, 2012).

Knowing that organizational policy was to be developed from the findings of the 2SLGBTQ+ Community Health Study it was necessary to find where to begin the policy development process. In addition to the above research review it was necessary to understand where the PHSD was in relation to Queer health policy. To this end, some in-house research of existing policy was undertaken. A policy scan was conducted beginning with informal interviews with key informants from the staff of the PHSD. The direction was given to locate policy documents in the PHSD data bases. Searches were conducted using all the terms of the 2SLGBTQ+ initialism and well as related terms. Broad searches were undertaken using the digital data bases of the PHSD policy document and General Administrative Manual (GAM). No actual policy documents were discovered that pertained specifically to 2SLGBTQ+ people and practice or training around servicing Queer clients. The database search as undertaken yielded no

results of policy documents that make explicit mention or consideration of this population. There was nothing written in the databases that indicated Queer health was considered within this agency. It should be noted that 2SLGBTQ+ health has been included in recent research and within this current (Fall 2019) study so, the only documentation found in the share point database that included 2SLGBTQ+ initialisms were those that pertained to the 2019 Community Health Study.

The only other instance that I could find sexual orientation was mentioned was in relation to the *Ontario Human Rights Code*. That one example would be in PHSD policy C-I-40.

> The Health Unit promotes respect by providing an environment that allows for independence, integration, equality and opportunity as outlined in the Accessibility for Ontarians with Disabilities Act (AODA) and will provide an environment and services that are free from discriminatory harassment and discrimination due to age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status (including single status), gender identity, gender expression, receipt of public assistance (in housing only), record of offences, sex (including pregnancy and breastfeeding) or sexual orientation as these terms are defined and interpreted in and by the Ontario Human Rights Code. (PHSD, 2015)

The policy statement adds that

> staff shall be held personally accountable and responsible for abiding by and enforcing this policy and must make every effort to prevent discrimination and/or harassing behaviour. This includes any behaviours observed of clients, or others who are visiting the Health Unit. (PHSD, 2015).

What is concerning here is that the policy makes all staff "personally accountable and responsible", yet the agency does not seem to have any policy or procedure to support their practice through education, protocol, process, Queer positive practice or even trauma informed training in working with minority individuals like 2SLGBTQ+ people. Change in this case would involve the development of 2SLGBTQ+ supportive policies and procedures to increase the likelihood that PHSD could in the future become more supporting of Queer community health and the health of 2SLGBTQ+ individuals in Sudbury and districts. Policy development skills were to be necessary and developed very quickly to satisfy the obvious need for this agency to develop policy and related programing. Translating research findings and study results into workable policy recommendations became a focal point during this placement. My reflection on this discovery will be forthcoming in the next chapter.

From the research findings and the literature review it was possible to develop clear recommendations for policy and program development for both internal changes within PHSD and for community development programs. The result of this analysis was the creation of two background documents by this placement student. These included the results and recommendations from analysing the data. Care was taken in ensuring that the words of the participants were emphasized. One focused on themes of safe spaces in agency venues and public areas. The second document emphasised the need for designated social space or events that would promote community engagement and social connection. Training for staff and education for the public were aspects of the recommended programing. The process of connecting data and research with policy development became very tangible. Background documents and presentations were developed to support policy formation.

Near the end of the placement, another PHSD employee who had many years of experience with the agency was recruited to support the policy development process. Brenda Stankiewicz is a registered nurse who has 30 years of knowledge and experience of how the PHSD agency works through policy creation and program development. She supported the efforts in editing policy briefing notes and creating a presentation slide deck that was to be presented to the Professional Practice Committee. The background documents were condensed into one briefing note that offered the recommendations in a more succinct format.

Unfortunately, the actual presentation did not take place until after this placement had ended. I was able to be present and helped in my role as the Health Equity team member, a result of being hired into a contract position post-placement. The redeployment of managerial and administration to the COVID-19 pandemic response and the secondment of staff made scheduling a presentation meeting problematic and this resulted in the postponement of the briefing presentation promoting policy development for Queer community health.

Through this process a significant understanding of how policy is developed and promoted within an agency. I have experienced a greater proficiency in developing, writing about, discussing, and presenting policy. The process of producing briefing notes and background documents used to inform policy makers and decision makers has become more understood. The addition to my skillset is significant. What follows is a self-reflection on my struggle with policy development and implementation in the context of my placement. I include this because policy is a challenging issue, and the process of policy development includes power dynamics that are not always easy to discern.

Personal reflection on understanding policy

A clearer understanding of the nature of policy through the experience of this placement has been gained. In the past the struggle was around how to appreciate what policy was and the understanding was confused by beliefs that policy was complicated and beyond the imaginings of the average person. The notion was that policy work required a specific set of complex skills and intensive training. The way I see it, this is only partially true. It is clearer now, after this placement experience, that policy is a much less complex entity than originally thought. The reality of policy is still intricate and nuanced in development and implementation. It is not just a piece of writing, but a process and a directive based on ideals and values of the people writing it and those that read and implement them. A policy can be a statement of belief or a directive for organising actions. But always policies are products of a cultural imperative or social value system of the people that develop them and more directly the people that approve them. Policy is a tool of those that have the power to control the governance of an agency, institution, or government. Policy is both a product of and a controller of social, political, and institutional activity (O'Neill, 2012; Mulé, 2005).

One must confront class-based values and belief systems to come to terms with the reality of what the true nature policy is (Lightman & Lightman, 2017; McKenzie & Wharf, 2016). As a person with working-class roots and values, there was an urge for one to believe that there is some higher order to the formation of policy within the systems and institutions of society. The reality is that there seemed to be that there was no secret formula or code that gives these governing documents jurisprudence over the daily activities of common folks. It took some comprehensive restructuring to understand the work of power in the system, and that the words of policy are just the decisions and ideals of the people that occupy the spaces in the system. My

simple understanding of policy is that it is just someone's opinions or beliefs, ideas put on paper to guide, advise, and control the people who choose to observe that a specific value, belief, or notion as a governing ideal of the system. People make the policy and people give it power. Decisions are made about wording and subtleties in text and information guided to best effect. Much effort it put into making policy documents palatable for leadership to understand and easily digest. Notions that challenge the status quo need to be formulated carefully. I witnessed how others promote policy by adjusting the working and structuring the concepts to be as unchallenging as possible. Once the documents are accepted, they have power to divert energy to certain actions. The most difficult work is getting the attention and support of those persons who have the power in the system to approve the written policy.

I have come to understand policy as a tool that supports or blocks activity according to the understandings, needs, and desires of those who wield that power. This is the observation that is possible to work towards systemic change when one is in the process, though it is not a simple or easy task.

In addition to observation a structural social work approach has informed these ideals and thoughts around policy development. Carniol (2010) takes a critical social justice stance on the inequities of our society. He states that "many social agencies have adopted policies that prohibit discrimination based on sexual orientation [but], for the most part social services do not provide services that support the lives of Queer people" (Carniol, 2010, p. 33). There is a relation between public policy and oppression. The link is in how systemic oppression influences policy in systems that are meant to support people's wellbeing. Heterosexism as an oppressive ideology is systemic in public attitudes and policy (O'Neill, 2012; Bryant, 2012; Mulé et al., 2009). Oppressive ideologies like homophobia, transphobia, cis-genderism, and heterosexism are

engrained in values and ways of understanding the World. A systematic examination of policy and practice is needed “to determine how they subtly silence, ignore, and disadvantage people who are oriented to members of their own sex” (O’Neill, 2012, p. 326). When social exclusion makes minorities invisible and powerless in the policy making process the resulting policies will not improve the conditions of those minorities. Making policy that includes provisions for marginalised minority groups like the Queer community will require efforts to understand and create representation of minority populations in the policy development process (Bryant, 2012).

The work of this placement was a step in the direction of more Queer friendly policies. Much more effort and attention will be needed to complete the examination and promote inclusive and supportive policies and programming for 2SLGBTQ+ populations within the PHSD catchment areas. With this understanding comes the realization of how places like Sudbury and Districts and the cultures that flourish here are mired in decades old (it could be said millennia old) heterosexist prejudices and homonegative oppressions (Mulé et al., 2009). Rural and Northern locations have more traditional and religious pressures as opposed to urban environments (Daley, 2015; Carniol, 2010). Social systems such as education, government, security services, social services and healthcare are balanced by beliefs and values that have always been heterosexist, cis-normative, as well as homonegative and transphobic. The interaction between policy and oppressive social and cultural values and behaviours has become clearer as one contemplates the nature of both.

This placement experience has taken this student to the realisations that skills in policy are developed through the immersive experience of policy development. More than just research and study this placement brough this student right into the process and action of how policy is formed. I continue to question why Queer health policy is missing and I continue to be visible

and progressive in the effort to make 2SLGBTQ+ community health a focus of practice within PHSD and the broader community that is Sudbury.

Learning Goal Three - Strengthen Skills in Equitable Processes in Public Health

This goal has evolved into an overarching principle and focus of this practicum placement. This is to suggest that the point of this placement became an exercise in developing more equitable processes in public health care for 2SLGBTQ+. All the pieces that have come together within this experience and the subsequent practicum thesis support the general goal of developing skills in equitable processes in administering and supporting the health promotion of 2SLGBTQ+ people. Equitable processes in public healthcare include actions like research, education, policy development, social change, and social justice within the public health agency (Vinjamuri, 2017; Müller, 2018). Equitable health care is a social justice issue and requires the promotion of knowledge and awareness with agencies like PHSD.

Education and training are necessary to develop and promote best practice and Queer positive approaches within agency staff and service providers. The needs of lesbian, gay, bisexual, trans, and queer people are often overlooked in our health and social service systems, and there are gaps and inequities in services and in the health status of LGBTQ people. Broadly offered educational and training opportunities for both service provider employees and community members are a recommendation that came directly out of the 2SLGBTQ+ Community Health Study. Staff training across departments is necessary for service providers to gain Queer positive and trauma informed care practices.

Much of the time spent in this placement was spent researching and accessing education and training sources for myself, PHSD staff and less directly other community partners or service providers. The sourcing and promotion of training opportunities was also a part of the

duties associated with this placement. Some examples include the Dalla Lana School of Public health which offers 2SLBTQ+ competent trauma informed care training (http://buildingcompetence.ca/resources.php), Sherbourne Health Rainbow Health Ontario's LGBT2SQ Health Connect (https://learn.rainbowhealthontario.ca/) and the Safer Spaces (https://saferspaces.ca/).

Creating dialogue and beginning conversations was part of the developing a presence in the PHSD. This presence was necessary to make the queer person visible in an agency where 2SLGBTQ+ people were not very visible. Lack of visibility of Queer people is problematic in that without visibility and presence there is less incentive on the part of PHSD staff to act on improving 2SLGBTQ+ community health. Developing awareness of 2SLGBTQ+ experience includes sharing the stories of those participants of the study as well as researching and accumulating resources that may eventually be accessed by PHSD staff, employees, and policy developers. Queer staff and employees are a significant aspect of the equity process. Visible presence of Queer people counteracts the social exclusion of the minority and supports the development of an inclusive and safe place for 2SLGBTQ+ service users. It was the hope that the presence of this queer placement student would promote the acceptance of 2SLGBTQ+ clients and policies that promote the health of Queer people in the Sudbury community.

It is understandable how health equity and social justice are linked in this dynamic between a culture of oppression and the production of policy from within systems that are prejudiced against 2SLGBTQ+ people. Those facing targeted threat for being sexual or gender diverse persons are kept suppressed both by the policies within social and cultural systems and the oppressive action of people around them (McGibbon, 2012). Queer people have been taught to stay quiet, hidden, silent and invisible by the oppressive systems and actions of society (Stern,

2015). The oppressive actions of people towards 2SLGBTQ+ people are the mechanism that teach queer people to stay oppressed (Sterzing et al., 2017). Visibility in all aspects of one's work-life for this student/research assistant, and perhaps others who are part of the system, may be one way to support efforts of equitable and just processes in Queer health programming.

Conclusion

Establishing learning goals for the placement experience were intended to direct the educational experience of this practicum placement and are an established practice for graduate placement experiences. The experience of having a placement with a public health agency such as PHSD was laden with opportunities for learning about the process of researching and analyzing the needs of a 2SLGBTQ+ people in Northern and rural locations like the Sudbury districts. The learning around developing policy and programing from data analysis and research greatly enhanced my knowledge and ability in the areas of public health policy. Doing thematic analysis of the data from the 2SLGBTQ+ Community Health Study provided a valuable experience in enhancing research analysis skills. Significant experience in the internal processes of community health promotion and social justice in healthcare has been gained. It has been observed by this writer, in clear detail throughout the process of the study, its analysis, and the literature that the needs of the Queer community are in areas of reducing oppression, building community safety, and promoting safe access to health services.

Reflections on the Learning Experience

In this practicum the attempt was made to be visible and vocal as an out Queer person. The learning goals and questions from onset illustrated the motives of this student. Social justice ideals informed by structural social work approaches guided the goals and direction of this

placement. I took the stance of an openly gay social worker and Queer activist seeking visibility, and awareness for 2SLGBTQ+ community health. From the beginning, critical approaches, social justice, and policy change were part of the learning goals. This was done as a lone individual using myself, my learning, my research, and my own voice as tools for creating space for Queer health equity and Queer visibility in the public health sphere in Northern Ontario. The following reflections are highlights of how the vulnerability of this experience reflects the reality of being a victim of social oppression. Being an individual who has suffered from minority stress and the placed in such a stressful situation a has prompted personal and emotional responses. Outlining the personal response is necessary in this report as these reactions are, perhaps, indicative of the Queer experience in this professional arena and geo-social location

Isolation and the COVID-19 pandemic

Working and living through these times of COVID-19, social isolation, and social distancing feels like an infinity mirror of isolation. As the COVID-19 pandemic began, working from home became necessary. This was an intensifying of the isolation of being the only queer working on this project. I became the only Queer working in my home alone, on this project. The work became more academic and introspective. The loss of social interaction with others who worked at PHSD inflicted an even greater social isolation from the source of any workplace motivation. Working in isolation and separation from interactive work and peers became a further barrier to workplace placement satisfaction.

As a scholar, I am not dispassionate or removed from my subject matter; in fact, I am immersed as part of the data along with the rest of the participants of the study. My daily experience is that of a queer/gay man in in a small Northern Ontario city. When I research and write about social isolation as a social determinant of health for queer people, I am writing from

the perspective of one who experience the reality of social isolation and exclusion as a very tangible oppressive threat. This is not surprising as 2SLGBTQ+ people are often subjected to social isolation as an aspect of the oppression they experience (Galabuzi 2012; Stern, 2015).

The level of isolation extends through layers of social systems including family, educational institutions, workplaces, and all other social institution where people are supposed to experience cohesion with others (Galabuzi 2012; Stern 2015; Mills, Owens, Guta, Lewis, Oswin, 2020). The behaviour of always having to hold back who I am, withhold my story, and subdue my character has an impact on how I experience connectivity with others. Whether I am out or not in a situation, I must maintain a constant state of hypervigilance, watching for signs of homonegativity and queer rejection in those around me. Holding back and staying vigilant protects me from experiencing the more intense realities of negative oppressive interactions. This behavior may keep me safe from harassment, but it also keeps me complicit in my own erasure. I maintain the heteronormative culture by remaining invisible as a queer person. This placement offered this writer the chance to reverse this behaviour and offer visibility to the agency that was the location and focus of this placement.

As a co-researcher, I was also part of the study's data collection processes as a participant. I have been a target of social stigma and homonegative actions. It is necessary to reflect on the mental health impact of being and outsider in one's own life and so be able to comment with insider knowledge on the reality of the Queer life experience. The social isolation is now compounded by the further isolation that the COVID-19 pandemic has enforced on society. Friends and acquaintances speak about the extra isolation that this COVID-19 epidemic has created dissolving the fragile social networks that connected isolated Queer individuals in

Sudbury and the surrounding districts, and many disclose being forced into negative self-coping strategies.

For those who have the privilege to experience social inclusion and social networks, the stay-at-home orders related to the pandemic imposed a new sense of social disconnect for many people. This new experience is reminiscent of the already isolated realities of many 2SLGBTQ+ individuals (Galabuzi, 2012; Nelson, 2015). The sense is that there are many opportunities for research into social isolation and comparative studies with a myriad of population demographics. Benefits for this research include having a broader population experiencing and maybe understanding what social isolation feels like for those who have lived it each day of their lives. This experience of disconnection from family, friends, community, and all other social connection is regular life for many Queer people (Galabuzi, 2012).

My experience of social isolation and exclusion in this placement and throughout my life echoes the experience of several of the participants in the study data and is illustrative of the Isolation and trauma as outlined in the Literature review (Stern, 2015; Mulé 2016). Social exclusion is listed as one of the social determinants of health (Ontario Ministry of Health and Long-Term Care, 2018). So theoretical themes become reality in the process of this unfolding of this placement.

Reflections on the Mental Health Impact of this Placement Experience

My mental health suffered and eventually improved because of being involved in this placement. Despite the pleasure of being able to work on topics that are personally and academically important and satisfying to me I found myself coming face to face with my own pre-existing, post traumatic stress disorder. The violent and abusive themes that I was observing in the data triggered a vicarious traumatic response in me. Isolation as a queer person, combined

with the added isolation imposed by the COVID-19 pandemic, placed me in some jeopardy as I faced real mental health symptoms with limited, Queer positive, accessible resources (McGrath et al., 2015).

Dwelling on these realities and reliving the traumatic experiences of my own life placed me in serious threat of mental illness. During this placement, one of the duties was reviewing and analysing the experiences of the participants of the 2SLGBTQ+ study as they narrated their digital stories. The oppressive acts and experiences of these narratives impacted me. I have experienced violence, harassment, rejection, verbal abuse, and the limitation of employment opportunities. I am hypervigilant and fearful in my daily life, always aware that a negative incident could occur at any time regarding my being Queer.

Every attempt was made to be visible and welcoming of communication around 2SLGBTQ+ issues in health and in work. This kind of visibility and vulnerability adds some pressure for the lone individual who exposes their identity as a workplace example. This was felt in significant ways and triggered PTSD symptoms (McGrath et al., 2015; McGibbon, 2012).

During the worst of the reaction to the stress of this placement I was waking up in panic attacks from horrific fear and anxiety fueled dreams. I wrote out the details of one such dream and the related thoughts as I awoke to a full panic attack situation, not being able to breath, and weeping from the anxiety of it. What follows is my writing from one early morning experience.

The voice of someone experiencing Minority Stress

I wake up in an anxiety attack.

Trapped and panicking.

The image is a bird in a glass bell jar.

Struggling against the glass,

In vain, beating at the glass, suffocating,

Wanting, desperately, to escape…

To be anxiety free… panic free…

No longer needing to struggle to catch my breath –

Maybe to die.

What I am turning up in my research triggers my isolation and my panic about being trapped in this life in this town, culture, society.

I have nowhere to turn, nowhere to go, no one to bring my anxiety to, no support around my issues.

I have been trapped in a queer life within a homonegative social milieu. I am destined for failure, marked for death.

My pathological emotional, psychological, and behavioural reactions are self damaging and need addressing.

The only support I can find are about medicating or treating the symptoms. There is nowhere, no one to turn to about addressing the cause.

The voice inside my head is telling me to 'just get over it… move past it… focus on the smaller things and get stuff done', but I am afraid.

I am distrustful and paranoid. I expect rejection and failure at every turn. (self-fulfilling prophecies)

I reject others before they reject me.

I sabotage my own success before I need feel the rejection and failure from others. I struggle to move past the anxiety, to function, to be productive, to focus. How can I focus when I feel like I am dying? How can I feel like functioning when I am sure my work will be discounted?

More discussion follows in the next sections with deeper exploration of the levels of trauma that are experienced by Queer individuals in workplace scenarios.

Personal Trauma, Community Trauma and Vicarious Trauma

The previous personal reflection was an example of how a Queer person can experience the results of levels of trauma when regular life events and processes become triggering. They are reactions to my own past trauma and the cumulative, ongoing trauma of living in, and aware of, the heterosexist, homonegative, and cis gendered culture of Sudbury. Researching the idea of community and other types of traumas has helped me comprehend the nature and impact of minority stress in with both a cultural and individual lens (Keating & Muller, 2020.; Livingston, Berke, Scholl, Ruben, & Shipherd, 2020; McGrath, Lee, Moffatt, Carranza, & Lagios, 2015). Reflecting on my own trauma experiences and symptoms throughout this placement had offered me a chance to come to terms with some of the impact and even lessen some symptoms. This has also reinforced the importance of this work and how necessary is the focus on these issues. Individuals struggling with the impact of oppression and ongoing homonegative or cis-normative threat cannot do this on their own. Healthcare support and community support are both essential for healing (Logie & Lys, 2015). Education and workplace situations are regular events of the lives of everyone. But for minority people, working through education and employment that concerns social justice for the population/community to which they belong, the hurdles are not just academic exercises. This experience within PHSD for this writer is evidence of the formidable challenges that minority people face when tasked with social justice, equitable change, and policy deliverables in agencies and social systems that impact us.

The next piece is a further example how workplace expectations rooted in majority identity normativity exclude the experience of minority individuals from work team activities.

One workplace example of heteronormativity

The reaction of this placement student/employee to a simple work team building exercise helps to illustrate how systemic oppression is demonstrated as the expectation that all employees are working from an equal footing of cis-normative, heteronormative, and white/colonial bias. Those that "fit" into the dominant race gender and sexual social location would not necessarily experience this situation in the same way (Rwigema, Udegbe, & Lewis-Peart, 2015; Mills, Owens, Guta, Lewis, Oswin, 2020).

As an example, when asked to read and think about the work priority tensions for a team discussion a very emotional response arose. It was disturbing how challenged I was by a simple team building activity with the research group to which I was attached. The following tensions: Acceptance and Accountability; Collaboration and Independence; Task and Relationships were topics for a team meeting. The concern was from an outsider perspective of the Queer person who was not part of the team and could not relate with the pairs of health tensions in the diagram. (see appendix C) the article that explained these tensions did not relieve any concerns. The tensions outlined in the article that were the basis of the discussion were nothing that could be relatable to myself, a minority person feeling the stance of an outsider. First reactions were: "What's wrong with me"; "I don't fit in."; "I am no good." This response was painful and was unacceptable. Some personal work was indicated and necessary to promote a move through guilt and self-blame to come to some constructive understanding of what was happening within the experience of this exercise.

With more focused analysis and serious personal reflection, clarity emerged, illuminating the problem. This team building model does not consider the level of diversity that can impact

the tensions that it is trying to illustrate. The aspects of work behaviour and relationships here seem to assume a level playing field with a potential of equitable membership from each participant. It is to be assumed that we are all starting on an equal footing as white, middleclass, CIS gendered, heterosexual, same age workmates. It is the heteronormative cis-normative expectation that we will all fit in socially as equals and the team is not inclusive of any diversity that disadvantages minorities. Looking for 50/50 balance in these tensions assumes that everyone is 100 % invested as team members. The outsider position of a minority person holds within it a very real tension that feels overwhelming and takes an emotional precedence. This exercise of self awareness and workplace teambuilding ignores the very real tensions that various social locations carry with them.

It is clear from my experience that there is a heteronormative culture here in Northern Ontario (North America) and it permeates our values and our culture including the corporate and agency cultures where we work. This activity highlighted a gap in the understanding of how minorities experience their work life. These are not the tensions the queer person, as participant in daily workplace activities needed to deal with. The expectation that a team needs to only manage these three tensions is a very simplistic exercise that ignores the real tensions of minority stress and the social isolation of minority individuals. The tensions of being a minority individual in this workplace needed to take priority over the less significant or usual workplace tensions that are expected within the workplace.

Reflecting on Systems Change

My experience as a research assistant with the identity of the minority population that we are researching has offered me specific insight to the interpersonal mechanisms of systemic oppression within a public agency. As an isolated individual in a challenging position, I was

faced with the dilemma of having to perform professionally while struggling with the lack of support and understanding that one in my position needed. I was in working for an agency, in an environment that both wanted my input while isolating me with the trauma of exploring the very oppression that I also experience. My struggle was with the vicarious abuse and retraumatizing experience of analysing the narratives of abuse and oppression of others like me. I was expected to reduce the struggle of people under daily threat of abuse to the concept of deliverables. In effect I was exploring the link of social justice with health inequity while experiencing the oppressive reality of my study focus

The sad truth about this experience is that any queer or minority person asked to research the nature of their own oppression may experience the same thing. Our goal is to improve the overall situation by having an impact on the social construct that forms the structural oppression that threatens us. I was expected to be a professional who functioned in a space that, to me, embodied cisgender normativity and heterosexual privilege. This agency is part of the northern culture that is systemically rife with heterosexism and trans negativity. People in these organisations lack the understanding of what their normative interpretation of sex and gender looks like to those of us from outside.

For this writer there has always been a desire to explore the nature of oppression and dissect the mechanisms that keep minorities oppressed and uncomfortable in their daily lives. I have worked through the performance anxiety and fear of judgment from cold professionalism and production expectations. This experience was permeated by having to work with, about and within a place of identity. As a singular individual tasked with deliverables that have never in the past been accomplished in this organisation there was significant trepidation around this job and the systematic change that was expected. The production expectations were to develop a clearer

and more focused understanding of the 2SLGIBTQ+ community's needs related to public health. In addition, there was a direct ask around proposing recommendations that were agency wide and program specific the included training and educational resources. There was personal discomfort when it was known that the status quo had to be interrogated from the position of Queer identity. Some push back was expected, and it did occur as a passively aggressive lack of understanding from the subjects of my critical gaze. The action plan that was to recommend change in the PHSD agency that was novel to the system. It becomes the job of the politicised critical Queer social worker to interrogate, challenge, and transform aspects of the agency to create 2SLGBTQ+ policy and programing that is supportive of this minority community health (Mulé, 2015). The procedures and rules of the agency, some written and some unwritten and unspoken function to maintain the status quo. The effort of change requires a great deal of personal learning and change on the part of individuals. Change also requires effort at policy and agency procedural adjustments. Systemic structures can play a role in oppressing the most marginalized and progressive radical Queer voices. These voices are needed to challenge the existing social order (Swan, O'Neil & Mulé, 2015).

Theoretical perspectives in real time

Throughout the writing of this report there has been a continuous interaction with theoretical underpinnings and research themes from the literature and research that both preceded and continued through the placement. Subjects like structural social work and social justice are echoed in the questions from onset and learning goals (Mullaly, & West, 2018; Lundy, 2011; Baines, 2011). The social determinants of health join with theories such as minority stress and oppression as a SDOH to form frameworks to better understand how Queer oppression and ill

health of 2SLGBTQ+ communities are connected (McGibbon, 2012, Dentato 2012; Meyer, 2003; Alessi, 2014).

The lived experience and reaction of this student in this placement illustrate in very authentic ways how these theories manifest in real time. The struggle of individuals and communities are linked with trauma and oppression (Alessi & Martin, 2017; McGrath et al., 2015). A quest for visibility, inclusion, and representation in policy and practice become goals that are challenging to achieve within agencies and systems (Galabuzi, 2012; Mulé, 2005; O'Neill, 2012). It is the young and the elderly that are most vulnerable, but the entire Queer community experiences social exclusion and stigmatization (Stern, 2015; Hulko, 2015; McGrath et al., 2015; Müller, 2018).

Being an out and vocal queer activist within the structural realities of agencies and systems dictates a certain amount of interrogation of said systems. Challenging the agency to change is part of the process of creating real social change (Mulé, 2016, Yorke et al., 2016; Lee, & Kanji, 2017). Promoting safe environments in the community, Queer cultural competency in staff, and trauma informed care in practice necessitates both public awareness campaigns and employee education (Durso & Meyer, 2013; The Joint Commission, 2011; Vinjamuri, 2017). This must include anti-oppressive and queer positive frameworks that may be more than cultural competence to develop ontological awareness of lived experience to inform better healthcare approaches for 2SLGBTQ+ communities and individuals (Fassinger & Arseneau, 2007).

The work of this placement was to promote social justice and health equity for Queer communities and 2SLGBTQ+ people in the catchment area of PHSD. The tasks of data analysis, policy development, and developing Queer positive training for staff was directed at the over arching work of building better Queer community health. The professional development of this

individual included a deeper understanding of the theoretical underscoring from the literature review and how these frameworks for social justice and health equity need be used to impact change in real time.

Chapter Four follows with the conclusion of this placement report.

Chapter Four: Conclusion

Chapter four provides a concluding section for this placement thesis. First is a piece on how this placement and the preceding literature review identifies implications for social work practitioners within public health, Queer community health and social justice for minorities in general. Following an over all conclusion for this placement thesis including some remarks on the experience of this placement, and then some final statements on the outcomes, questions and goals of this paper.

This practicum placement was spent working inside Public Health Sudbury & Districts (PHSD). This public health agency is part of the Ontario provincial chain of health units that oversees public health across this province. The focus of the practicum activities revolved around the community health of Queer persons in the City of Greater Sudbury and surrounding districts. Tasks associated with this placement included the analysis of data from a study of 2SLGBTQ+ community health and the health needs of Queer people as expressed digital storytelling and focus group discussions. The subsequent policy recommendations and critical review of PHSD policy resulted in significant preliminary work on policy development. Recommendations from the study included safe space and trauma informed staff training opportunities for PHSD employees and potential programing for community health development. This was all for the

purpose of understanding and improving services for 2SLGBTQ+ people and bettering queer community health in this part of Northern Ontario.

The guiding questions from onset revolved around social justice and health equity for marginalised minorities, specifically 2SLGBTQ+ people, in the Sudbury districts. The literature review in chapter two documented the growing body of research on the health inequities of queer people and the social determinants of health that help to identify a population at risk for poor health. Research also highlights how oppression must be understood to be a SDOH and that social rejection and isolation threaten this population. The constant threat of oppressive experiences are the cause of minority stress and all the related symptoms that impact the mental and physical health of Queer people (McGibbon, 2012).

Health equity and the associated policy creation processes were a significant aspect of learning goals of this practicum experience. This student took the stance of a critical Queer theorist/researcher and structural social worker to undertake some interrogation of mechanisms of queer marginalization and the social construction of heteronormativity in the disenfranchising of queer communities and queer activists (Mulé, 2016; Mullaly & West, 2018). This marginalization and related disenfranchisement are located specifically in the rural localities and small city of Greater Sudbury and related districts of Northern Ontario.

Data analysis of the 2019 2SLGBTQ+ community health study was a large part of this placement's duties. Skill development around qualitive data analysis was the first learning goal in the proposal and took up much of the focus. There was significant opportunity for learning and reflection when looking back on the data analysis process. The possibility for a clearer understanding of analysis processes became evident while reviewing notes and research sources. Gubrium & Harper (2013) review several approaches to including participants in the analysis

process. They describe the process of including participants in youth photovoice project to evaluate, organise and present the data, including authoring the final draft of the study report. Following these approaches with the guidance of the co researchers was a significant learning experience and created a strong understanding of the process of thematic analysis as a method of organizing and analysing qualitative data.

This placement experience has been inextricably intertwined with the 2SLGBTQ+ community health study, its analysis, and the social justice and health [in]equity issues it has exposed. The data from this study represents a closer look at the SDOH as they pertain to a specific minority population. The data and the results of the analysis expose a significant area of health inequity. The new detailed information can improve our understanding of the mechanisms of socially determined health inequity. We can now challenge the status quo ideas of SDOH as seen through the medical model. We can leave behind individualised notions of what we need to be healthy and visualise a community-based model that offers individuals and groups a chance to become partners in their own safer and healthier communities. It is indeed time to reinvest in our community to create a health focused dialogue with voices that promote communication and program support for safer public and provider spaces.

Immersion in the voices and stories of queer people of this community was both illuminating and retraumatizing. I am a gay/Queer man native to this geo/cultural location and experienced in the lived realities of the 2SLGBTQ+ struggle here. Being involved with this placement was personally felt. My professional, personal, and academic understandings have all been advanced through having this placement experience. I have developed experience in the thematic analysis methods of qualitative data and the use of thematic analytical processes through inductive methods. I have worked within a community public health agency towards the

development of policy and programing for the promotion of a healthier Queer community in Sudbury. I have explored the needs and gained specific understanding of community health requirements of the 2SLGBTQ+ people in this district.

Through this process it has become evident how the voices of queer people can be used to promote policy and programs that encourage better practice and understanding of their needs. These needs include safe spaces in community and agencies across the city. The study data illustrated how the threat of oppression impacts queer people throughout their life course and creates a complex and serious negative influence on the health of this population.

Education and training opportunities are needed for healthcare staff and professionals. This was made very clear from the literature research and the recommendations of the 2SLGBTQ+ study participants. Policies need to be developed. Programs must be created to encourage engagement and develop the voice of the Queer community in Sudbury. More participant action research is needed to bring people together to articulate the unique needs of 2SLGBTQ+ people in northern and rural areas. More effort needs to be put towards promoting social justice and health equity in Public Health agencies that oversee rural and northern communities.

Social Justice and Healthcare Policy

In previous sections the concept of health equity was discussed as it pertained to 2SLGBTQ+ people. The realisation that equity in both social and in healthcare terms is a social justice issue is promoted within this placement process. Work in this practicum has brought to light the connection between social justice and policy as it addresses the ideals of health equity. The questions from onset inquire about the relationship and nature of social justice in a community healthcare agency. These questions revolve around whether healthcare and medicine

have equity-guided principles that support a social justice approach within the policy documents and processes at PHSD. This discussion continues as my critical reflections linking social justice and policy are outlined. The ideals of health equity and social justice in public health policy are of primary concern in for this practicum thesis. And for the sake of social justice health equity must be of primary concern in the development of healthcare policy as it addresses the needs of the queer minority.

Implications for Social Work Practice

> Healthcare is an important place to practice and elevate the role of social work. Poor, [Q]ueer, Black, Indigenous, and racialized peoples face health disparities - social workers, especially those from communities that face marginalization, have a valuable perspective and role in addressing the social determinants of health and advocating for access to care. (Srikanthan, 2020, p. 1)

This quote from an article in the online journal of the Ontario Association of Social Workers is a clear statement of how social work as a professional occupation has a place in healthcare and a role in linking the SDOH and advocating for more equitable healthcare practices. The definition of social work includes ideals of human rights, social justice, and social change as fundamental principles that are meant to guide practice (Hicks, 2010). Social work theorists clearly illustrate how social justice approaches in practice are meant to ameliorate marginalization and disempowerment, maintain an anti-oppressive stance, and work towards equitable access to resources (Rothery, 2016; Baines, 2011). According to the principles of affected interest those who are most affected by policy should be active in the forming of that policy. Community voices must be included when developing healthcare policy (Westhues & Wharf, 2012).

Some social work writers and researchers describe social work approaches as needing to be radical and critical promoting the deconstruction of past practice with 2SLGBTQ+ people. Being critical of past oppressions and discriminatory attitudes and behaviour creates room for new and better approaches. Structural social work approaches can deconstruct past practice with all minority populations and more specifically reconstruct social work and healthcare practice around 2SLGBTQ+ populations. This can be done by developing new knowledge and better practice approaches (Cosis Brown & Cocker, 2011).

A structural understanding of social inequity was initially considered a radical development in social work theory and practice. Still today structural approaches to social justice practice are often titled radical perspectives or radical social work (Lundy, 2011). The importance of social workers embracing a critical perspective and being open to progressively radical ideas revolves around these critical interrogations. The effectiveness of these criticisms to promote 2SLGBTQ+ equity in policy is enhanced by the ideals of queer liberation, and the existence of politicized queer social workers (Mulé, 2016).

The term “movement” (Mullaly & West, 2018, p. 216) is used to describe how the SDOH concept is being promoted in the health care systems. These social determinants are factors outside of the healthcare system. Social determinants relate more to the structural aspects of society and the organization and distribution of economic and social resources (Mullaly & West, 2018). Public health practices can be guided by a health equity perspective linked to a social determinant of health (SDOH) framework. Social work practice that is structural and critical of social inequalities uses the same framework for practice that emphasises an analysis of these exact social problems. This includes the understanding that individual experiences are part of common problems, shared by larger sections of a population and are socially constructed. In the

context of linking social work approaches to healthcare equity oppression must be acknowledged as a significant SDOH for minorities facing stigma and oppression (McGibbon, 2012).

Social inequity is a product of social and historical processes that result in poor public awareness and a disconnect between SDOH related policy documents and actual public policy making. The consequence is a reluctance in policy makers when it comes to identifying the implications and potential around SDOH in policy making. Socially excluded minorities like 2SLGBTQ+ people are marginalized and invisible to the development of public health policy (Galabuzi, 2012; Raphael, 2012).

The most profound effects of social trauma on an entire community of people include loss of identity, damaged social fabric, and perpetual sense of victimization (McGrath et al., 2015). Outcomes of experiencing collective trauma for the individual include marginalization, including social exclusion, material deprivation, and underemployment. LGBTQ people experience being blocked from being valued, recognized, and respected because of their social definition and marginalization (McGrath et al., 2015). Social exclusion is listed as one of the social determinants of health (Ontario Ministry of Health and Long-Term Care, 2018). Social exclusion is a SDOH that involves minimal or reduced access to economic, political, and social power (Galabuzi as cited in McGibbon, 2012). Exclusion from economic power represents the intersection of minority status with other social determinants like employment, income, poverty, education, and housing. This will affect one's social economic status and makes it difficult to insure healthy outcomes. The social determinants of health approach when used in healthcare can miss the real potential for social change at the community level. Queer and other minority groups lack the visibility and social presence that would make them understood and recognized by policy makers. This means that policy makers will lack the means to address the specific

situations that need to be addressed to promote a movement towards real community-based health equity (Galabuzi, 2012; Raphael, 2012).

A structural social work approach suggests that equal health outcomes for all can only come about through real social transformation that decreases social hierarchy, wealth inequity, and social domination (Mullaly & Dupre, 2019; Mullaly & West, 2018). Education about the social determinants of health and their impact on the health of Canadians is a consistent recommendation (Andermann, 2016; Mikkonen & Raphael, 2010).

Social workers are equipped with education and skills that can open a broader approach that focuses beyond the sexualized and medicalized nature of care. This broader, social work approach will help create a balance between sexual health and other health or developmental needs. Social workers are trained to lead the sophisticated debates that occur between polarized views of traditional or religious values and anti-oppressive structural values. These skills include the ability to think simultaneously about: individual uniqueness, the social circumstances of the client, provider/individual relationship, and the socio-political context (Cosis Brown & Cocker, 2011). The “skills of engagement, integrity, warmth, reliability, and clarity are particularly important” components of the social worker’s repertoire. (Cosis Brown & Cocker, 2011, p. 160). Structural Social Work approaches can help community health agencies like PHSD to focus on the social determinants of health that do impact the health inequities of 2SLGBTQ+ populations.

This placement has been a primary example and a great opportunity for structural social work methods to enact the potential for how this approach can support research and policy/programing within healthcare systems. This is especially true as the focus of the placement and the student responsible represent the interaction between healthcare and 2SLGBTQ minority issues from the framework of SDOH. There has been a great deal learned on

the professional and the personal level. It has also been made evident that there is still lots of ground to cover in promoting health equity and a more just approach in the practice around Queer community health. This is most true for a Northern and rural area like that which the PHSD services.

Final Thoughts

I am grateful for this opportunity to enhance my professional abilities and skills in social work and public health research and practice. I am grateful for the significant personal growth and self understanding that has come from this practicum placement. There were struggles and these were a necessary part of the process. The literature review in this paper summarizes the solutions for healing communities and individuals. The research as outlined in the literature review has been used to continue healing as a personal journey as well as a professional journey.

Part of the professional journey is promoting change in the policies and programming at PHSD. This experience has highlighted the necessity of having structurally oriented critical social workers involved in the development of public health policy and programing. More precisely social workers with lived, minority, experience who are qualified to support public health policy and programing for the minorities they represent need be utilized. Queer voices and Queer informed knowledge can only support the best 2SLGBTQ+ healthcare and community health programing. A structural social work understanding enforces the social determinants of health approach to focus the attention on the social nature of oppression and how it impacts minority health. The potential for change, growth, and social justice is real personally, professionally, and for the healthcare system.

I look back, post placement and months deeper into the pandemic, and I am forced to report that no significant movement has occurred in the development of policy or programing

within my placement agency. Feelings include dismay and frustration as the COVID-19 pandemic has consumed the time and resources of PHSD to the exclusion of support for 2SLGBTQ+ community health. PHSD, along with other healthcare and social service systems are obliged to focus on addressing a global public health crisis. This placement report has focused on linking Queer health equity with social justice and social change that is supportive of the individual and community health of this population. It is difficult to accept that social justice and social determinants of health approaches can be suspended for any reason, pandemic included. I maintain some positive attitude and a cautious hope that the work that has been done will result in more equitable health care, in the near future, as this pandemic subsides.

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Appendix A – Statement of Approval

Research Ethics Review Committee

Statement of Approval

Public Health
Santé publique
SUDBURY & DISTRICTS

Project title:	SLGBTQ Sudbury Populations' Public Health Needs
Date:	September 30, 2019
To :	Suzanne Lemieux
Decision:	Approved
Final report due date:	August 31, 2020

Thank you for submitting the above research proposal for ethical review. This project has been approved and the study may now proceed.

Please note that the Research Ethics Review Committee (RERC) requires that you continue to adhere to the protocol as last amended and approved by the RERC. The RERC must approve any further amendments before they can be implemented. If you wish to modify your research project, please contact the RERC Committee outlining any changes to your proposal.

If there is a change in your source of funding, or a previously unfunded project receives funding, you must report this as a change to the protocol.

Adverse or unexpected events must be reported to the RERC as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants and the continuation of research.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and approvals of those facilities or institutions are obtained and filed with their respective Research Ethics Board (or equivalent) prior to the initiation of any research protocols.

The Tri-Council Policy Statement (TCPS) requires that ongoing research be monitored. A final summary report is required for all projects. Researchers with projects lasting more than one year are required to submit a report annually.

Please quote your project title on all future correspondence. If you have any questions, please do not hesitate to contact:

Michael King

Chair, Research and Ethics Review Committee (RERC)

705.522.9200, ext. 519 – kingm@phsd.ca

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New X / Modifications to project / Time extension

Name of Principal Investigator and school/department	Tanya Shute, School of Social Work, Suzanne Lemieux, Public Health, Sudbury & District
Title of Project	2SLGBTQ+ Sudbury Populations' Public Health Needs
REB file number	6019415

Date of original approval of project	Sept 11, 2019
Date of approval of project modifications or extension *(if applicable)*	
Final/Interim report due on: *(You may request an extension)*	Sept. 11, 2020
Conditions placed on project	

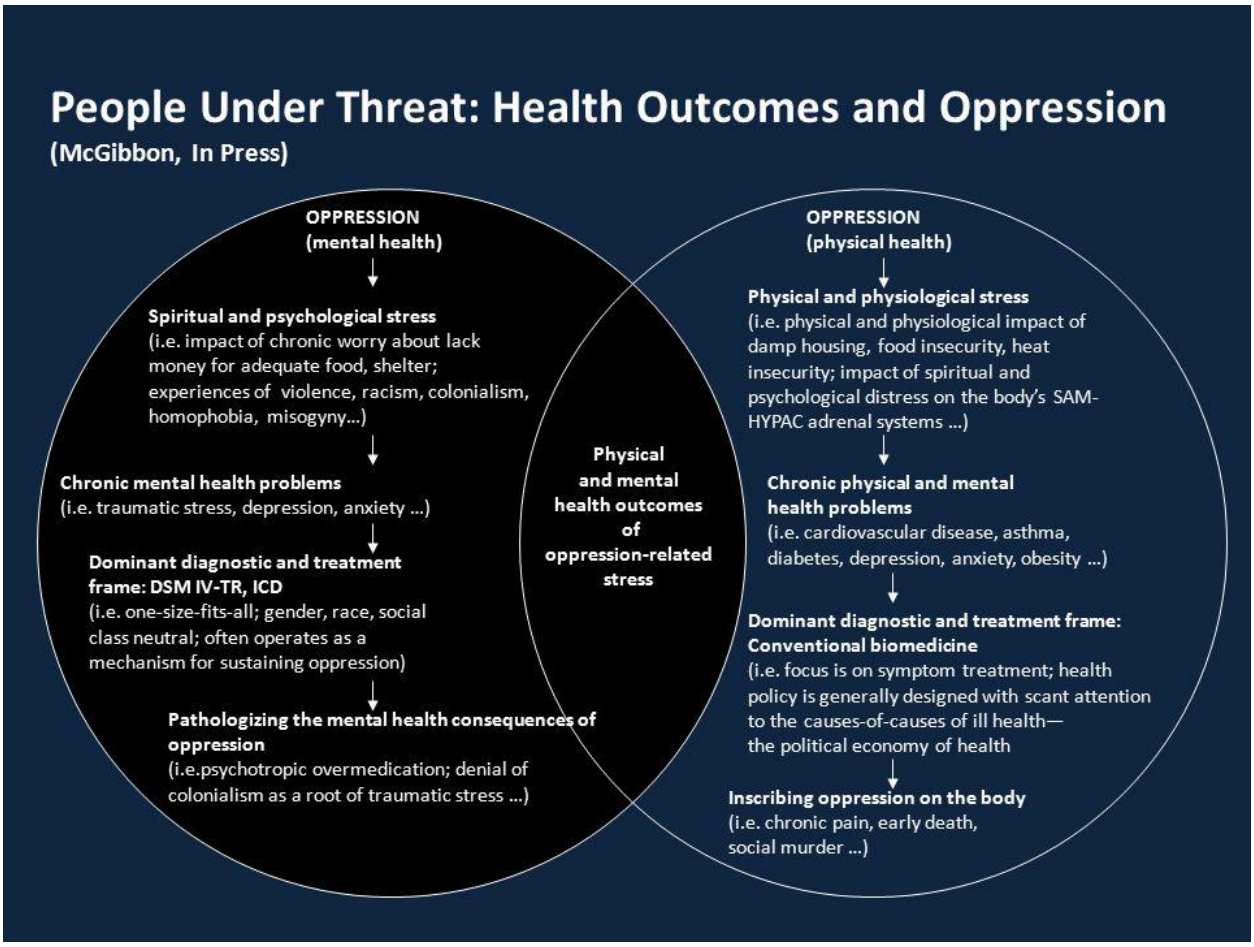
During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix B – People Under Threat Diagram



Appendix C – RHO Certificate

sherbourne HEALTH

rainbow health ontario

Rainbow Health Ontario
333 Sherbourne Street
Toronto, Ontario
M5A 2S5

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This is to certify that Paul Pasanen attended
LGBT2SQ Foundations Course
23 June 2020
ONLINE

This online course was hosted by Rainbow Health Ontario, a program of Sherbourne Health. **Rainbow Health Ontario creates opportunities for the healthcare system to better serve LGBT2SQ communities**. RHO offers training for healthcare providers across the province to feel more clinically and culturally competent in caring for their LGBT2SQ service users. RHO also supports system change by producing evidence-based print and web resources, contributing an LGBT2SQ health perspective to public policy processes, acting as a research catalyst and hosting Canada's largest LGBT2SQ health conference.

College of Family Physicians of Canada, Ontario Chapter

This program **192644-001** has been accredited by the College of Family Physicians of Canada and the Ontario Chapter for up to 3.5 Mainpro-M1 credits.

Hazelle Palmer,
President & CEO, Sherbourne Health