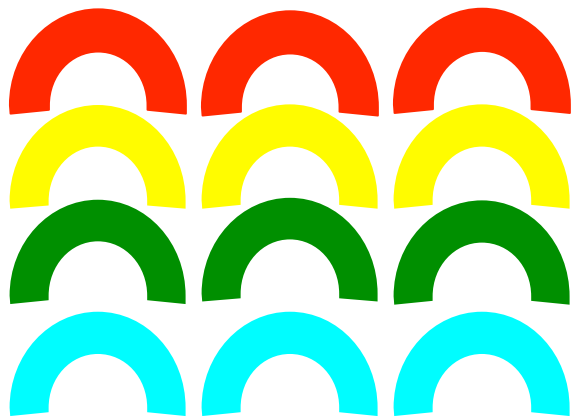


Training for Change:

Practical Tools for Intersectional Workshops



Acknowledgments

Rainbow Health Network initiated the “Training for Change” project in 2008 with a discussion forum for trainers, co-sponsored by Among Friends, as part of our Anti-Racism / Anti-Oppression Initiative. RHN’s entry point is sexual and gender diversity. LGBT people’s identities are made up of numerous intersections - sex, class, ability, ways we process information, racialization, status in Canada, and many more. In order to relate successfully to our communities in their totality, an integrated anti-oppression framework is necessary. It provides a method to relate to the whole person, not just one or two aspects of their identity.

The project took part in two phases, from 2008-2010, with funding from Toronto's Access, Equity and Human Rights program, and support from Rainbow Health Ontario. The goal was to develop educational materials, based on an intersectional framework, for training health and social service providers about LGBT issues. These materials were developed through a community consultation process, which included forums, focus groups, key informant interviews and an Advisory Committee.

***Training for Change: An Integrated Anti-Oppression Framework*, is a tool for trainers and community**

service organizations. It was written by Margaret Alexander and Fran Odette, of Springtide Resources, and was based on community input from various discussions and forums.

***Training for Change: Practical Tools for Intersectional Workshops* is a guide to two workshops, putting into practice the analysis contained in the *Framework*. It was written by Deidre Walton, Project Coordinator. Community input was obtained through an Advisory Committee, consisting of: Bill Gayner, Mt. Sinai Hospital; Ellen Hibbard, Ontario Rainbow Alliance of the Deaf; Lynn Anne Mulrooney, Registered Nurses Association of Ontario; and Anna Penner, Planned Parenthood Toronto.**

The RHN Education Committee members who supervised the project were: Jackie Boyce, Dick Moore, Fran Odette and Phyllis Waugh (Project Lead), working in partnership with Devan Nambiar of Rainbow Health Ontario.

Funded by:



About the Rainbow Health Network

Rainbow Health Network (RHN) was founded in 2001 by the Coalition for Lesbian and Gay Rights in Ontario (CLGRO). RHN was created to pursue the recommendations of CLGRO's 1997 research report "Systems Failure: A Report on the Experiences of Sexual Minorities in Ontario's Health-Care and Social-Services Systems."

As a volunteer run forum since 2001, RHN has developed a vibrant listserv, a website and a number of educational and advocacy projects that leveraged the relationships and partnerships our members brought to RHN. In 2008 our work was recognized with a Pride Toronto Gala Award.

The work undertaken by RHN through different initiatives and committees is intended to ensure that the following objectives remain central to how we do our work:

Equity - RHN works collaboratively through partnerships to address health disparities experienced by LGBT communities which are further marginalized by oppression such as racism, sexism, ableism and classism. RHN works toward increasing access, equity and inclusion in healthcare, supports and social services.

Networking - through the exchange of information, resources and opportunities for collaboration, RHN strives to create and sustain an accessible, inclusive network of volunteers committed to promoting health and wellness for people of diverse sexual orientations and gender identities.

Education - RHN acts as a resource to health and social service providers, community groups, researchers and academics. Through a variety of initiatives, public education resources are produced and made available, along with providing education and training to health professionals.

Advocacy - RHN advocates with government, agencies and the public on initiatives regarding health and wellness needs, strengths and priorities of LGBT communities.

Training for Change: Practical Tools for Intersectional Workshops

Workshop #1

Power, Privilege and Identity Politics: An intersectional approach to serving the LGBTQ community

This workshop focuses on service providers as the first point of contact between an organization and its service users. Service providers will examine how social identity is constructed through a process of stereotyping, and the impact that this can have on service users. We will look at how our organizations inadvertently create barriers for different groups of people, and will situate LGBTQ experiences within a continuum. We will further challenge common assumptions that frame our work and explore how our individual social conditioning may interact with our professional experience.

Duration: 90 minutes to 2 hours, including a break

Number of participants: up to 25

Required materials: Flip charts/markers, photos of people from magazines, tape

Handouts: Stereotyping Exercise questions, Where I'm At, Glossary (as reference material/optional), Evaluation Forms

Objectives:

- **to understand power and social privilege from an individual perspective**
- **to become aware of how social power can be and has been used by institutions to marginalize particular groups, and how this impacts LGBTI people's access to essential services**
- **to assess how we use our power as individual service providers, and begin to learn more equitable ways of working with all our clients**

AGENDA: (based on 2 hours)

15 min Introductions

10 min Agenda review and group guidelines

15 min Small group: Stereotyping Exercise

(Exercise #1)

15 min Debrief 15 min BREAK

25 min Large group discussion: (Exercise #2)

Power Triangle

10 min Self-Reflective Exercise: (Exercise #3)

Where I'm At

10 min Debrief, Q & A

5 min Evaluations

Small Group:
Stereotyping Exercise
Exercise #1

Time: 15 minutes, plus 10 to 15 for debrief

Prep: Clip/photocopy photos from magazines that depict people of a range of ages, genders and racial identities. Try to find photos that do not have context in the background of the picture or what the person is wearing that may speak to their identity/profession. E.g do not use a photo of a person in hospital scrubs, or standing in a school yard. One person per sheet. Tip: ask for these back at the end of the exercise, and you can have them to use repeatedly. (Some examples are available as part of this workshop package.) Have enough to give each group a photo, based on the size of your group. Make enough copies of the Stereotyping Exercise questions handout (see page 26) so that each participant can have their own. They can write their responses on the back of the question sheet.

Set up:

Put participants in small groups of three to five. Give each group a different photo; all participants get all the same questions.

Preface the exercise

“Using common stereotypes from our culture, answer the questions on your sheet. The idea is not to *avoid* common stereotypes, but to *use* them to provide your answers.

There does not have to be consensus among members of each group; where there are differing opinions, groups should record both sets of stereotypes.

It doesn't matter if you use these stereotypes yourself; the purpose of the exercise is to become aware of what exists, and what people may be subjected to in their day to day lives

You have only five minutes to answer all the questions. Stereotypes are often made at-a-glance.”

During the exercise:

Circulate through the room and answer questions as they come up. Listen to discussions to identify places where people are expressing resistance to the exercise, and address it.

Possible responses to resistance

- **It is important to be aware of these stereotypes (even if we do not [think we] use them ourselves) because:**
 - **How we think about marginalized peoples as a society tells us important and useful things about our society as a whole**

- **We can learn the types of oppression that our clients/colleagues are faced with; this may allow us to have more empathy**
- **Sometimes we ‘take in’ ideas subconsciously, and don’t realize that we’ve internalized a way of thinking**
- **We may hold bias/prejudice around some identities/intersections but not others. This exercise helps us become aware of where we might have learning/unlearning to do.**
- **This is safe learning space, in which for the purposes of personal/ professional development, we may have to think in ways that do not feel familiar so we can expand our skills.**

Remind participants to move through the questions, and not get stuck.

After the five minutes are up, direct the participants’ attention to the last section on the question sheet.

Repeat the instructions aloud, using gestures to enclose the word ‘gay’ in parentheses. Explain that the tone is meant to give context about how the co-worker used the word, and does not reflect your own opinions. Explain also that the usage of the word ‘gay’ in this instance could be meant to include genderqueer identities.

Give participants two more minutes to think about their new responses.

Debrief

Ask the group

A) How it felt to do the exercise and/or What they learned about themselves.

Be prepared for feelings of discomfort, guilt or even anger.

- **Validate discomfort by reminding folks that thinking and feeling are linked and impact each other. Learning how to think differently will bring up feelings of discomfort and insecurity. These are normal, and show that change is really taking place.**
- **If people admit to guilt (i.e. they feel ‘bad’ or overwhelmed by realizing that they make stereotypes) congratulate them for their honesty in admitting this in front of the group. Once we are aware of the process that we were previously engaging in subconsciously, we can change it, and re-condition ourselves to avoid automatic generalizations. Also, categorizing or making assumptions isn’t the problem. We all do that. More important is what we do with the information. If we recognize that we have made an assumption, we can then put that aside, remain open and begin to learn about the individual. When we**

treat someone according to what we think of them, we are ignoring the actual person. Now that we are aware of the problem, we can take steps to fix it; we have already begun on the journey; awareness is the first step.

- **NB. Some people may insist that the exercise is flawed since it forces them to think in ways that they never do because they don't make generalizations/are good people/meditate every day and/or stereotypes are bad. Suggest that there is a difference between a) not making stereotypes and b) not knowing the common ones that exist. Use other comments from the section on addressing resistance, as appropriate. If the person persists, open up the issue to the rest of the participants to elicit their thinking about whether or not the exercise was useful and why.**

B) How/ If their answers changed when the person in the photo was assumed to be queer. Why? What do these changes tell us about how we think about LGBTI people?

Common responses:

Question b: racial identity. Participants may comment on surprise or resistance to the idea that the person could be queer based on their assumed identity, or other traits.

Question d: place of origin/length of time in Canada. Participants may decide that the person was born in Canada or has been here since they were a small child.

Question e: religiosity. Person may become atheist, non-practicing or pagan.

Question f: # of children. Assumed parents become non-parents/pet-people.

Question g: occupation. Women, particularly if they are white, become social workers; men may be fashion or interior designers.

Question h: pastimes. Women may spend their free time at rallies/demo's, fixing things or play soccer/baseball. Men spend their free time in bars/at the gym/at the bathhouse/ redecorating.

More in-Depth:

Ask the group how/if the organizations where they work would respond to the co-workers problematic comment about the client being 'gay'.

Ask the group what questions are missing from the exercise i.e. what other questions could have been asked?

Optional

At the beginning of the exercise, give each group a flip chart sheet, marker and some tape. When they are done ask them to record their responses on the flip chart and post it around the room. If

time permits, ask each group to read out the ‘story’ that they constructed about their person, so everyone can benefit from knowing what problematic stereotypes are being made about different groups of people.

Large Group Discussion

Power Triangle - the Three I's: (big Ideas, Institutions and Individuals)

Exercise #2

Time: 20 to 30 minutes

Set up: on a flip chart, draw a big triangle. Put a big letter 'I' at each corner.

Preface:

“Using the information that we have just gained in the previous exercise, let’s discuss some of the big ideas that we learned about how our society thinks about LGBTI people and identities.” (No handout.)

A) Label one of the 'I's “big Ideas” and ask for suggestions. Write the responses briefly at that corner of the triangle.

Common responses:

- **Non-religious, non-practicing, ‘heathen’, ‘sinners’, can’t maintain a religious affiliation after coming out because communities of faith are not welcoming.**
- **Don’t have children and/or shouldn’t parent**
- **Gay men are pedophiles, and promiscuous**
- **Queer people are abnormal, perverted**
- **People of colour are not queer, OR queerness is a ‘white thing’**

- **There is a ‘gay look’ i.e. queer people can be identified on sight; queer folks are assumed to be white; women look ‘butchy’ and men look effeminate.**
- **Queer people of colour are Canadian, because it’s not safe to be out in other places (especially developing countries) and so they would not have come out if they had grown up there; queerness is a white/Canadian thing and doesn’t exist in other cultures/parts of the world**
- **Either/or gender categories**
- **Bisexual people don’t exist/ are just confused (this can come from hetero- or L/G identified folks)**
- **Deaf people and people with disabilities are not queer**
- **Queer folks do not form long term meaningful partnerships, or only lesbians do**
- **Queer people are diseased, or sick**

B) Label another corner “Institutions” and ask for ideas on the way the institutions where we work replicate and perpetuate these ideas that marginalize LGBTI people. If participants seem stuck for ideas, widen the question to include societal institutions as a whole.

Common responses:

- **Policies vs. practice**
- **Organizational culture**
- **Same-sex benefits might not be available or might be a hassle to get**
- **Workers not trained to be knowledgeable about LGBTI issues or resources**
- **Assume client pool are all straight and cis-gender**
- **Managers are not trained to handle human rights complaints**
- **Workplace bullying/ harassment/ ostracization**
- **Binary gendered washrooms**
- **Intake forms/ check boxes around identities**
- **Religion demonizes queer people**
- **Police may target LGBTI communities e.g. bathhouse raids**
- **In health-care settings, patients may be neglected, misdiagnosed or denied treatment**
- **Lack of training of service providers can lead to an unwillingness to seek treatment, leaving LGBTI community more at risk for health and mental health concerns**

C) Individuals

Preface

“The organizations where we work reflect what we bring to them. We may be the first point of contact for clients, or responsible for supervising those who are, or making the rules that govern their work. It is important to know what we bring to our positions. As we learned earlier, sometimes we take in ideas or information that we didn’t realize had seeped in to our ways of thinking. We also learned that we can make assumptions about one area, but not another. We need to become aware of where problematic ideas about LGBTI people exist within our thinking, the better to be able to deconstruct and remove it. In order to do this, we are going to use a self-reflective tool to cover the ‘Individuals’ part of the power triangle.”

Self-reflective Exercise

Where I'm At...

(Exercise #3)

Time: 10 minutes, plus 10 minutes to debrief

Prep: Make enough copies of the “Where I’m At” handout sheet so that each participant can have their own copy. (See page 27.)

Set up: each person gets a copy of the handout.

Preface:

“This is a blunt tool, and may seem very simplistic to some of you. It is useful to help us remain aware of the assumptions that others may carry, and which we may have to confront or challenge from time to time. For others it might be the first time you’ve ever had to think to about some of these ideas, or been presented with them in a systemic way. How you react to the statements will help you to see where problem ideas have sunk in, and perhaps what you might have to change or work against.

Feel free to jot your answers down on the page: it’s yours to keep. You can tally your scores if you choose to, but they mean absolutely nothing. Don’t forget the questions on the back of the page.”

Debrief

Ask people for reactions to the exercise as a whole, then elicit comments about specific statements from the sheet. Only give the responses to the specific statements that they mention, or this will take too long.

If people admit to feeling discomfort about the statements, validate their honesty and courage to bring it up in the group. Ask them to explain why they feel uncomfortable.

Tip: Monitor other participants to make sure that no one's body language causes others to feel unwilling to speak.

The statements in this exercise cover/reflect some broad themes, and many of the same arguments can be made to address several of them, from slightly different perspectives.

Major themes

A) Sexism and Heterosexism: Sex, gender and sexual orientation collide

- Sexism/patriarchy dominates our culture and social interactions, and underpins heterosexism. Often, feelings of discomfort or disapproval of queer identities stem from the place where these identities defy these social norms. See statements # 2, 5, 6, 7, 8, 26, 27**

- **Heterosexism is that body of ideas that, using “sex=gender=roles” as a normative template, insists that different ways of being sexual (which defy these gender roles) are bad, undesirable, inferior or unnatural. See statements # 1, 5, 6, 8, 26, 27**
- **Because heterosexism dictates that queer people are abnormal, the notion exists that children need to be protected from LGBTI folks, which is then reinforced by the completely untrue thinking that gay men are often pedophiles. See statements #3, 5, 11, 13, 21, 22, 24**
- **Moral disapproval of queerness can still exist in instances where people see themselves as open and accepting. The meter is often around how ‘close’ queerness comes to them. “It’s okay for others to be queer, but not me/my family/my friends/my children/my community” etc. Similarly, “it’s okay for you to be queer, so long as you don’t talk about it to me.” But straight and cis-gender people always get to bring their straight and cis-gender related conversations anywhere. For example, ciswomen will commiserate with each other about menstrual cramps – at work! – where the conversation is clearly inappropriate. Statements # 5, 7, 9, 13, 14, 16 to 19, 23, 24, 26,**

B) Race, Religion and Culture/Ethnicity

- **Culture of whiteness built up around queer identities limits options of being for racialized people who may not see themselves reflected culturally/racially in queer spaces and/or see themselves reflected ‘queerly’ in ethno-cultural community spaces. NB: this ‘culture of whiteness’ includes connotations for Christian identity, e.g. “WASP”. See Statement #10, 20**

- **Racism and religiosity (which is closely tied to race) combine to suggest that in the communities of racialized peoples (particularly those from backgrounds or nations that are not Christian), these assumptions are often made**
 - **religious strictures are much more strident**
 - **racialized people have/produce cultures that are deeply homo- and trans- phobic**
 - **white/European people are more accepting of queer identities**
 - **while queer white folks may choose to continue to go to church (NB, ‘whiteness’ = Christian, in the way our society constructs stereotypes) queer people of colour have no choice but to give up their communities of faith when they come out/transition into the queer community.**

- **See statement # 10**
- **NB: Religious morality is also used to denote queer people as abnormal or unnatural, using specific doctrines around procreation, etc, and forms part of the basis for not wanting queerness to “come too close” (see above), or it may corrupt. See Statements # 11, 13, 14, 16 to 19, 23, 24**

C) Ability

The notion that people living with disabilities (particularly those with congenital or generative conditions) are not queer runs deep. It reflects highly ableist thinking that speaks more to common ways of thinking about folks with disabilities than it does about ‘queerness’. There exists the notion that people with disabilities are asexual and have no sexual drives or motivations, of any kind. This is cleverly veiled but closely related to the idea of normality. “Normal” adults have sex lives, people with disabilities do not. Here, disability ‘trumps’ sexual orientation, and the person gets seen entirely through the lens of their dis/Abilities.

There are many other common negative stereotypes about people living with disabilities, and Deaf, deaf and deafened people, such as:

inability to work and take care of themselves, assumption that someone with a physical disability or who is Deaf also has an intellectual disability, etc.

See # 25, # 27, and note below:

NB: Deaf Culture: People who identify themselves as part of the Deaf community (written with a capital D) perceive themselves as members of a culture (one predicated on different ways and means of communicating) not as a disability identity group. However, since deafness is seen as an ability issue by hearing society, the ways of thinking about Deaf, deaf and deafened people, and the ways in which these communities are marginalized follow similar patterns of thinking as those for people with disabilities. This acts as a further layer of invisibilization faced by Deaf people in general, which can be further compounded by LGBTI identities.

Common responses to the statements:

#1: People may be confused or angry about the wording, OR they may agree that ‘queerness’ isn’t a problem until it becomes ‘too “in your face”’.

Reflects moral disapproval. To deconstruct, use this statement: I don’t have a problem with Black people, unless they flaunt their lifestyle.

#2. Directly related to sexism. The idea that being a man is better, so why would a man want to be a woman? i.e. people are often more upset about the existence of transwomen than of transmen because of patriarchy. (Also part of the reason why some people may feel strongly negative about gay men, whereas lesbians may be tolerated, or even eroticized.) If the person thinks that their relationship with their adult child would change as a result of a gender-identity change, then that also reflects that they believe that you interact differently with people based on their gender/sex.

#3. a) If children are exposed to different types of people, they develop the skills to deal effectively with various types of people. This skill will only serve them well as they move through life. b) the assumption that LGBTI people are an automatic 'bad influence' on children or that our children are not safe around LGBTI people ignores the fact that many LGBTI folks have/raise (and used to be!) healthy, well-adjusted children themselves. If someone is really strident, ask if they would prefer *not* to know that their child's teacher was queer. The existence and presence of queer folks will never change; other people's level of awareness and ease are the only things that can change.

Make the point about how upset white parents were when schools were desegregated, because they didn't know what impact being around Black people would have on their children.

#4. Again, ask if they would prefer *not* to know. The existence and presence of queer folks will never change; other people's level of awareness and ease are the only things that can change. The real issue is about the level of professionalism and service that the person provides. Thinking a queer-identified doctor would somehow be less competent than a straight or cis-gender identified one is the same as thinking women doctors are less competent. Sexism and heterosexism intersect.

#5. Find out if it would be different if a) the child was a girl OR b) the teacher was a lesbian. Talk about the 'sexism' in heterosexism, as it relates to people's idea that a gay man is somehow 'worse' than a lesbian.

#6. In families, people of varying genders and gender expressions use the same bathroom, sometimes even at the same time. Most everyone has had the experience of being in the washroom with a differently-gendered person at some point in their lives and usually very early, while they are young and impressionable. They seem fine.

Separating public washrooms by sex is highly artificial and wholly unnecessary. And expensive?

#7. Rephrase: “I would feel uncomfortable knowing that my neighbour was Jewish.” Those statements are equally oppressive. The only reason why one seems more shocking than the other is because most people know that it’s not okay to be anti-Semitic, while most people give themselves permission to be transphobic.

#8. Deconstruct with comments about the difference between gender identity and sexual orientation. “Who a person is attracted to and wants to do sexual things with” is separate from “who a person feels they are and how they choose to express their sense of self”. There is a range of human behaviour that coincides with gender expression and another separate range for sexual orientation. A person can fall anywhere along the gender expression line, and then situate themselves anywhere along the sexual orientation line. When we put the two together, or assume that they must go together, heterosexism is born. Tip: Compare yourself to participants of the same (assumed) sex in the room to make the point about varied gender expression, even among people of the same sex, all of whom may be attracted to a different ‘type’ of person, even if they are also persons of the same sex.

#9. to be insulted suggests that being queer is a bad thing or that there is something wrong with 'queerness'. If being mistaken for queer were seen as a good thing, like, say, being mistaken for a rock star, we wouldn't be insulted. This is really an indication that we have taken in some negative messaging about LGBTI folks.

#10. Indicative of the common stereotypes that suggest that a) LGBTI people do not share or practice religious faiths, either because religious groups reject them, or because they are without morals; b) LGBTI identities are limited to white or Eurocentric cultures. Remember that LGBTI people come from all walks of life, all abilities, all racial and ethnic backgrounds and all parts of the world. And we, like any other people turn to religious or spiritual beliefs and practices to help us make sense of our existence, and deal with the stressors of everyday life. Many people continue to practice their faiths even in the face of contradictions or outwardly oppressive belief systems and doctrines, and queer people are no different just because their reasons may be.

#11. Speaks to the stereotype that queer people are bad for children, bad influences on children, prone to molesting them and/or that queer parents will 'turn' the children queer also. This

returns to the argument that there is something wrong with queer identities, or that queerness is somehow inferior, and abnormal, and further suggests that people can be made queer by inadequate parenting. It also speaks to the idea that queer people should stick to themselves and not be allowed to corrupt others with their ways. Many years ago the same argument would have been made about Jews, Black people, and women who were menstruating.

#12. A common reaction, even within the LGBTI community, and a problematic one. Our society tends to view sexual preference or orientation as exclusive and permanent, vs. the more simple idea that most people prefer and orient toward sex. Sexual identity and sexual behaviour are not the same, and may not coincide from one relationship/partner to another. Both are fluid, and can change and shift throughout a person's life. Furthermore, being attracted to people of all or more than one gender is a perfectly normal and legitimate way to be. and, according to the Kinsey report, most of us are.

#13. Children are exposed to a lot of heterosexual sex, even in cartoons, and there is no concern. This is NOT about the safety or well-being of children. It is about the narrow and biased

thinking of their adults. See notes on Christian morality, above.

#14. See notes about queerness ‘getting too close’ to deconstruct this statement.

#15. Cis-gender women have had breast reductions and/or augmentations covered by OHIP, by successfully making the argument that having their breasts too small or too big impacts on their physical and mental well-being. People whose internal sense of gender identity does not match the gender they are assigned by society (transgender and transsexual people) experience very high rates of emotional distress, anxiety, depression, suicidal thoughts and actions, and violence. Studies show that a sense of relief is a very common response among people who have had Sex Reassignment Surgery (SRS).

#16, #17, #18, #19 “Getting too close” comments apply here.

#17, #19. See also comments under #9.

#18. See also notes on #13.

#20. Comments of the whiteness of queer identities apply here. Address the racism: people from racialized communities have all the same

options for sexual identity and gender expression that anyone else has.

#21. Speaks to ideas about the origin of queer identities. See #11.

#22. See also #5.

#23. See notes about race and religion above.

#24. See comments about getting too close.

#25. See the section on the intersection between ability and queer identity.

#26. See comments about getting too close.

#27. See comments under section on disability. Be sure to inform participants about the distinction between Deaf culture and people with disabilities.

General comments:

Remind participants that the ‘score’ is meaningless, and the exercise is more useful to be aware of which areas of our thinking have been influenced by negative societal ideas about LGBTI people. There is never a point at which we can stop learning or challenging problematic ideas

and this tool gives us clear indications of some of the ideas that we still need to address.

Workshop #2

Queering Space: A Positive Move For All

This workshop examines our workspaces and institutions. We are challenged to ask ourselves who gets left behind, or falls through the cracks of our current understanding of service provision, or our organizations policies, procedures and usual ways of doing things. We will evaluate our work spaces for their level of accessibility to the LGBTQ community, understanding that this community is one that also encompasses differences along the lines of race, class, ability, gender, religion, etc., and discuss strategies for change.

Duration: 2.5 to 3 hours

Number of Participants: up to 25

Required Materials:

Flipchart and markers, strips of paper with definitions (can be found in *Rainbow Health Educational Toolkit*, tape, notepaper, posters or postcards depicting women who have sex with women (can obtain through www.check-it-out.ca.)

Handouts:

Glossary, Patient Profiles, Inclusive Workplace Checklist (from Ont. Public Health Association, can find it in *Rainbow Health Educational Toolkit*), generic/vetted copies of intake forms (name of organization and other identifiers are blanked out).

Special Notes:

When booking the workshop with the organization, ask people to bring copies of the intake form(s) that they use in their workplace. Request one to be faxed or mailed ahead of time so it can be vetted and copied. Collect these during the introduction to the workshop. Be prepared by bringing a form you've obtained, vetted and copied.

Objectives

- **to develop a working understanding of the language most commonly used to describe the LGBTTTIQQ community, and its limitations**
- **to assess our workspaces for their level of accessibility or inclusivity**
- **to generate an 'inclusive workplace' toolkit of practical strategies that we can put in place in our places of work,**

AGENDA (based on 2.5 hours)

10 min Intros, agenda review

10 min Guidelines

30 min Large Group Exercise: (Exercise #4)

Rainbow Spectrum

40 min Small Group Exercise: (Exercise #5)

Barriers to Health

10 min BREAK

30 min Large Group Discussion: (Exercise #6)

Inclusive Spaces

**15 min Self-reflective exercise: 3 small changes
(Optional)**

5 min Evaluations

Large Group Exercise

Rainbow Spectrum

(Exercise #4)

Time: 10 minutes, plus 20 minutes to debrief

Prep:

Cut up a copy of the glossary from the *Rainbow Health Educational Toolkit* (section 2, pages 2 and 3) into strips, keeping the individual definitions that coincide with the LGBTTTIQQ acronym, plus Cis-gender, LGBT (etc), MSM and WSW. i. e. keep the definitions numbered 2, 3, 5, 9, 10, 12 to 15, 18, 21 to 23.

Set up:

Turn two sheets of flip chart paper so that they are wider than they are long. Label one 'sexual orientation' and the other 'gender identity'. Draw a line across each, to represent the range or axis along which the identities could fall. Label one end of the sexual orientation spectrum 'homo-' and the other end 'hetero-'. Label one end of the gender identity spectrum 'cis-' and the other end 'trans-'. Post these prominently on the wall, right next to each other.

Hand out the strips – depending on the size of your group, some people may have to pair up with one definition.

Have pre-cut pieces of tape ready.

Preface the exercise

“This exercise is meant to give you language with which to talk about the LGBTTTTIQQ community, and help you figure out who we mean when we use this acronym. These terms are not set in stone, and may (and will, and did) change from time to time. Nor are these the only terms that are in use, but they are the most common in our cultural context, and so they are useful to know. After we’ve discussed these terms, we’ll talk a bit about what is missing.

On the wall are posted two spectra. One represents the range of ways of being that we call ‘sexual orientation’ and the other represents the range of ways of being that we call ‘gender identity’. (Provide the definitions for both terms, found in the glossary). On our sexual orientation axis, one end may represent people who are exclusively heterosexual, and the other those who engage exclusively in same-sex activities. On our gender identity axis, one end represents people whose gender identity conforms completely to their assigned sex i.e. how they were labelled at birth, and at the other end, we have people whose gender identity doesn’t conform at all to their assigned sex.

(Gesture to indicate the appropriate end of each axis as you speak)

Each person (or pair) has a slip of paper with a definition on it. Your job is to read your definition, be sure that you understand it, then, when you are ready, stick your definition on the appropriate chart, based on where the spectrum you think that identity belongs.”

Give the group 5 to ten minutes to get their definitions on the charts.

Debrief

Begin by explaining that gender identity and sexual orientation are separate facets of one’s personality, and have no bearing on each other. Remind the group that gender expression/identity and sexual orientation are both fluid, and may change, or not fully encompass the range of that persons gender or sexual behaviour. Explain that each person, regardless of how they express their gender, has all the same options for possible range of sexual behaviours and orientations. Any person can be of any sexual orientation, regardless of how they present themselves to the world.

“To assume that how a person looks or presents their gender identity to themselves or to the world is an indication of who they want to do sexual things with is flawed. For example, fifty years

ago, this workshop would have been seen as a hot-bed of lesbianism, because most of the women in this room are wearing pants. Just as we've learned over the past decades that if a woman chooses to wear pants today that doesn't mean she's a lesbian, so we can come to break down the correlations between other expressions of gender and what they supposedly mean for sexual orientation."

Start with the 'sexual orientation' chart. Pick the definition closest to the 'homo-' end of the spectrum and read it aloud. As you read each definition, ask the group if there is general consensus that it is on the correct chart and location on the spectrum.

Several patterns should emerge:

- **Many of the sexual orientation terms have connotations for gender, e.g. lesbian, gay**
- **The term bisexual can be problematic if we assume that gender is more than binary. Other terms in use: 'pan-' or 'omni-' sexual, are more representative**
- **The terms 'two-spirit', 'queer' and 'questioning' rightfully belong on both charts**
- **The word 'straight' is missing from the glossary**
- **An intersex person has the right to any gender identity (including cis-gender) and any sexual orientation (including straight), as does anyone else, and may or may not identify as part of the queer community**

- **These are the terms in use in our cultural context, and reflect a primarily white experience/voice**
- **New immigrants to Canada who are queer may have other terms that they use to identify themselves, and may not feel reflected in the language here**
- **The language in use is complex, ever-changing, and reflects a majority (and often younger) voice**
- **The word ‘homosexual’ is not on the list, because it is no longer used as an identity term. It has connotations of medicalization and traumatic, intrusive ‘treatments’. It used to be a diagnosis term in the DSM. Though it may still be used by some older folks for whom that was the term when they were coming out/up, it is not appropriately used by a heterosexual person. It can be used as an adjective, but not to describe people. For example: ‘the homosexual man’ or ‘the homosexual community’ are both considered highly offensive. However, it could be okay to say “Being openly homosexual in downtown Toronto could ”. Never use the term ‘the homosexual lifestyle’.**
- **Some terms have connotations for sexual behaviour and not sexual identity. Some terms have connotations for sexual identity and not sexual behaviour. Both are fluid.**
- **The term ‘queer’ is currently the umbrella term of choice, however, it has history. Many**

- members of the LGBTI community still remember when ‘queer’ was an ugly word that was thrown at them to remind them that they were ‘freaks’. However, the younger generations are embracing this language more and more, as the multiplicity of the community becomes more apparent. It can refer to both sexual orientation and gender identity, and may be used for one or the other (or both) at any time. It is not recommended that people who are not queer use the language of queer in everyday conversation, unless they are reflecting back the language being used in conversation with a LGBTI community member.**
- **LGBT/LGBTI/LBGQTQ are versions of the acronym used most commonly when people are discussing our community.**

Small Group Exercise

Barriers to Health

(Exercise #5)

Time: 10 to 15 minutes, plus 20 minutes debrief

Prep: Copies of Patient Profiles (see page 29), one per small group based on number of participants; one generic/vetted intake form per group; copies of handout ‘Barriers to Health’ (see page 30), one per person

Set up:

Put participants into small groups of up to five members each, depending on the size of the group. Hand out copies of the “Barriers to Health” exercise. Give them a moment to look at the questions.

Preface the exercise

“We are looking at the ways in which our organizations inadvertently create barriers for members of the LGBTI community. But keep in mind that members of the LGBTI community come from every other community, so as you engage in this exercise, feel free to point out barriers to other groups, because the first thing we know about a queer person might not be their sexual orientation or gender identity.”

Give each group a vetted intake form (or have them use the ones they brought). Direct everyone’s attention to the instructions on the “Barriers to Health” handout. Read the instructions aloud. Tell the group they have 5 minutes to look at their intake form and answer the questions on the sheet.

Hand out Patient Profiles and explain that this is a brief outline about a service user who has just come in for the first time. Have them examine the intake form again, with this person in mind, and if they notice any new issues.

Give the group an additional 5 minutes to wrap up.

Debrief

NB. Responses to this exercise will vary based on the specific intake forms being used.

Ask what things were noticed immediately, or seemed glaring.

Common responses:

- **Intake form is written in English, on paper – marginalizes Blind community, Deaf community (who’s first language might be ASL), people who are not functionally literate, including non-English speakers and possibly ESL speakers/newcomers**
- **M/F checkboxes**
- **Health cards necessary**
- **Checkboxes for race/ethnicity, and not usually representative/inclusive**
- **Sexual orientation information not elicited**
- **Sexual behaviour information not elicited**
- **Privacy not available in waiting room/area while people are filling out very sensitive information**

Ask what other barriers became evident once after looking at patient profiles.

Common Responses for Patient Profiles:

Trevor:

- **since client identifies as straight, health care providers may not inquire about same-sex activities/relationships;**

- **client is Black, and may be assumed straight and cis-gender as a result of stereotype about equating queer identities/behaviours with whiteness/white culture;**
- **if intake forms do not elicit sexual behaviour info, person might feel awkward about bringing it up face to face; or may feel judged if they do**
- **Trevor may be misdiagnosed if service provider a) doesn't know that engages in same-sex sexual activities or assumes that his sexual behaviours are hetero- encounters and b) isn't aware of health risks for men who have sex with men.**
- **This may lead to everything from a worsening of his condition to being prescribed and taking the wrong medication, which might have other effects on his physical health**
- **Most likely Trevor would search for a new health care provider**

Anita:

- **Participants may comment on the level of physical accessibility of their home organizations; NB many buildings that can be accessed by wheelchair users do not have accessible washrooms, or other barriers inside the locations e.g. internal doors without accessible buttons, bathroom fixtures that are out of reach, etc;**
- **Anita may assumed to be straight, as there exist notions that a) abuse doesn't happen in same-**

- sex relationships and b) people with disabilities are not sexual, and if they are, somehow can't be queer;**
- **Anita may be assumed to be cis-gender**
 - **As a two-spirit person, she may exhibit sexual behaviours that could be labelled/perceived as lesbian, bisexual/WSW, and/or exhibit gender expressions that might be perceived as butchy, genderqueer or trans, according to Canadian culture, regardless of whether she uses or identifies with any of these terms**
 - **language use/climate in the group may prevent her from identifying as two-spirit in that setting and may feel left out in the group;**
 - **unable/unwilling to come out in the environment, which will impact the benefit that the program will have for her;**
 - **she may stop attending if she feels she can't be open about her relationships in a space designed for healing from bad relationships;**

Susan:

- **If intake forms do not elicit sexual orientation and sexual behaviour info, then she will be assumed straight;**
- **if client reveals that she is/has been a lesbian, it may be assumed that she is with a female partner, and in extreme cases, even that she would not require STI testing as a result;**

- **service provider may decide to label her as bisexual regardless of how she herself identifies;**
- **assumed cis-gender**
- **Susan would probably have her physical health needs met through the STI testing, but might have reservations about the level of service and professionalism of the staff**

Raymond:

- **Since Raymond passes well, he will be assumed to be cis-gender, especially if (as some forms do) they have options for sexual orientation but only M/F for gender/sex, i.e. since he's straight, then he can't be trans, since many people confuse gender and sexual identity/behaviour;**
- **Cis-gender identity may be reinforced once he reveals that he has a female partner, again because people don't often understand that gender identity and sexual orientation are different;**
- **Some organizations may refuse to provide the service, due to lack of training, information and fear OR turn this procedure into a training exercise for all of their staff, impacting on level of service, right to privacy and dignity of the client**
- **If any of these events occurred, Raymond could rightfully choose to file a complaint under the organization's Anti-discrimination policy, or**

even human rights* if a satisfactory resolution is not reached

***NB: gender identity is addressed by OHRC under the prohibited grounds of ‘sex’; nevertheless, some transgender individuals have had good outcomes there; RHN is involved in the legal battle to have ‘gender identity’ added to the Human Rights Code as a clear and separate grounds.**

JC:

- **JC may be assumed to be straight because she has children and/or because she is from a non-white background, despite her butch appearance**
- **She may be read as a lesbian because of her butch appearance**
- **NB – these first two points are not mutually exclusive, and competing stereotypical assumptions may result in confusion for service providers.**
- **Because sexual orientation is assumed to be fixed, people may assume that she is not the biological mother of the kids, because she has never had sex with a man or that she had children through a sperm donor**
- **Because she is butch, it will more likely be assumed that her (femme) female partner carried the children, since butch is seen as masculine, not ‘womanly’, unfeminine, and unmotherly**

- **Other people may assume she was previously married and came out after having children with her husband**
- **If people realize that she is a lesbian, they may express open disapproval of her attending the location with her children – service providers or other parents**
- **Some parents may go so far as to want their children isolated from her/hers**
- **If the children pick up on the adults' sentiments, JC's kids could get bullied or teased at school or daycare**
- **JC may not see herself and her family reflected in the materials, if only items/curricula depicting hetero-normative families are displayed**

Large Group Discussion:
Inclusive Spaces
(Exercise #6)

**Set up: during the break, post copies of the posters of women from the Check It Out! Pap Test Campaign (www.check-it-out.ca) around the room, but folded in half so the photos don't show. All the photos except the poster with the sole white butch lesbian should be hidden.
Have flip charts and markers at the ready.**

Preface the discussion:

“Now that we have talked about some of the barriers or challenges that LGBTI people might face in getting access to professional services, let’s begin to think about what changes or steps we could take in our home organizations that might address some of these issues.”

A) “Let’s pretend that we have learned that our organization is not the most welcoming for LGBTI folks, and so we inquire about some resources and get this poster (indicate the one poster that is visible) to put up in our office space. Which members of the LGBTI community are left out if this is the only resource that we choose?”

When the discussion winds down, or people seem to have given all their responses, reveal the other posters in the campaign. Mention the attention to making sure that a multiplicity of identities (including race, ability, gender, age; also body size and relationship status/structure) are all represented in the series.

B) “We’ve just talked a little bit about the kinds of things to keep in mind when it comes to promotional or display materials. Now let’s look at our organizations more broadly. Think about our physical spaces, because we now understand that leaving out people with mobility issues also leaves out Muslims, Black people, and

queer people and newcomers etc. Think about not only the building facilities, but also the way the space is set up/arranged. Think about the processes that we use when we work with our colleagues and clients, and about the climate or culture in the places where we work. What practical changes would you suggest to begin to address any of these areas?

If people have a hard time getting started, ask the group what they have learned about inadvertent barriers from the exercise before the break. What strategies could we use to try to change or address some of the issues that we identified earlier?

If people really seem stuck, they can refer to copies of the Inclusive Workplace Checklist in their handouts for ideas that seem like they could work at their organizations.

Record responses on the flip charts. Leave these visible for the next exercise.

Common Responses:

- **Display rainbow flag and LGBT brochures, posters**
- **Get positive space training (individual or organizational)**
- **Use gender-inclusive language, e.g in job postings, position titles**
- **Barrier-free design, accessible washrooms**
- **Accessible buttons and ramps on all entrances**

- **Language accessibility e.g. multi-lingual services/printed materials**
- **Anti-discrimination policies/ complaint procedures with explicit language around sexual orientation and gender identity**
- **Manager training on how to handle complaints**
- **Training for staff/volunteers on issues and resources for LGBTI community members, appropriate language**
- **Peer dynamics/coalition building**
- **Publicize job vacancies in queer publications**
- **Benefits for same-sex partners are clearly stated and easy to access**
- **Statement of confidentiality on all forms/waivers**
- **(Option of) Privacy when filling out/ discussing sensitive personal information**
- **Organizational culture discourages and addresses homo- or trans- phobic comments**
- **Managers model non-discriminatory behaviour and inclusive language**
- **Queer/trans members on staff are out at work**
- **Include Pride celebration on social committee roster, if there is one, regardless of whether or not the organization employs 'out' queer/trans staff**

Self-Reflective Exercise (Optional)

3 Small Changes

(Exercise #7)

Set up: This exercise can be done individually, in pairs or groups of no more than three. Determine the ideal size for your group, and arrange people accordingly. Hand out notepaper, or have folks re-use the blank backsides of handouts.

While people are doing the exercise, copy the reflection questions (see bottom) onto a flip chart.

Preface the exercise:

“We’ve come to that point in the workshop where we’ve talked about the barriers of various types that impact on the diverse group of people and identities represented by the LGBTTTTIQQ umbrella. Because we enjoy our work and care about the people we work with, it’s been difficult to realize that we might not be serving some of them to our best capacity. Now it’s time to think about what happens after we leave this workshop and return to our workspaces. Will we say ‘that was great’ and then go back to the usual ways of doing things, feeling a little guilty this time around? Or will we begin to make the small changes that we are able to make?

At RHN, we hope you will start to make changes, but we understand that sometimes after you return to your hectic workplaces, there might not be room to think about what to do, and then we feel powerless

to change it because everything is happening at once and the issues are so big.

This exercise will give you the opportunity to think about what you can do while you are still in this head space, and can take the free time to really assess where you have some power within your organization to create space.”

A) Have people divide their sheet into three parts. Label the first section ‘this week’, the next section ‘this month’ and the final section ‘this year’.

“in each section, think of two things that you can do differently in your professional life in order to create more inclusive work environments for yourselves and your service users. Let one of your two items in each section be something that address inclusion specifically for the LGBTI community, and the other can be more general.

“ In the ‘this week’ section, think of something you can do immediately when you return, like put up a rainbow flag sticker and order some multi-lingual resources.

In the ‘this month’ section, think of something you can do within the next couple of weeks. E.g, research some LGBTI resources for your service users, and at the next department meeting, ask folks to stop smoking in front of the accessible buttons at the main entrance.

For ‘this year’ ideas, think of what you could put in place in a year. Start a committee to draft a new version of the anti-discrimination policy, with more

up-to-date and representative language? Organize a poster display for your work area on International Day Against Homophobia (May 17th)?” Register for and take a more indepth training on LGBTI community issues?

If folks have a hard time getting started, they can look at the OPHA’s Personal Assessment Tool which has been included in their handouts for reference.

Encourage people to be creative, and take some professional risks, but still think of things that they could reasonably accomplish within the time frame.

B) When people have recorded their suggestions, direct their attention to the questions you have written on the flipchart.

There is no large group debrief of this exercise. If done individually, folks get to contemplate their answers to the following questions in a moment of quiet reflection. If done in pairs or threes, each person gets to talk with their partner(s) about the reflection questions. You can choose to use any or all of these, or others.

- Which of your ideas seems most risky to you? Why?**
- Which is the easiest? Why?**
- What kind of support will you need to get these done?**

- **What changes might these actions bring for you, personally? Professionally?**
- **What impact might these changes have on your relationships with your service users? Your coworkers? Your manager?**

Handouts and Materials for Exercises

These workshops have been developed as resources that can be used on their own or in conjunction with the *Rainbow Health Educational Toolkit*, produced by RHN in 2006, and available for download at www.rainbowhealthnetwork.ca.

You may want to consult the *Toolkit* for:

Group Guidelines

Definitions (glossary)

Ontario Public Health Association (OPHA) self-assessment and organizational assessment tools

Evaluation Form

Handout

Workshop 1, Exercise 1 - Stereotyping Exercise

You have been given a photo of an individual. This person has just walked into your place of employment looking for service/for a pre-set appointment. Considering your photo, please answer the following questions about that individual. Your responses should be based on common stereotypes.

If it is difficult to get started, imagine that you are a news reporter or police officer. What stereotyped assumptions would you make about this person based on your perception of their racial or ethnic identity?

a) What is this person's name?

b) What is their racial / ethnic background?

c) What is their first language? What other languages do they speak?

d) Where is this person from? How long have they been in Canada?

e) What is their religious background?

f) How many children does this person have?

g) What is this person's occupation and/or where do they get their income?

h) What does this person do for fun/ to pass time?

Now imagine that just before this individual arrived for their appointment, a co-worker told you that your next client was 'gay'. Would any of your above answers change? Which ones and why?

Handout

Workshop 1, Exercise 3 - “Where I’m At”

Respond to the following statements with True or False.

- 1. I am comfortable around queer people, unless they flaunt their lifestyle.**
- 2. I would feel uncomfortable if I found out that my adult son feels he is actually a woman.**
- 3. LGBTQ teachers shouldn’t be ‘out’ to their students at school.**
- 4. It would disturb me to find out that my doctor is a lesbian/gay man.**
- 5. I would feel uncomfortable knowing that my son’s male teacher is gay.**
- 6. I would feel uncomfortable to see a person I assumed to be trans (TS or TG) in the same public washroom I was in.**
- 7. I would feel uncomfortable knowing that my neighbour is a transsexual.**
- 8. I would be disturbed if I found out that my sister’s husband likes to dress in women’s clothing.**

- 9. I would be insulted if someone mistook me for a gay, bisexual or lesbian person.**
- 10. I would be surprised to meet a Muslim lesbian wearing hijab.**
- 11. I'm okay with same-sex marriage, but it bothers me that queer couples are allowed to adopt.**
- 12. I would be confused if I saw a queer (LGB) friend of mine with a heterosexual partner.**
- 13. I would be very upset if I saw my child's daycare worker kissing their same-sex partner before work.**
- 14. I would feel uncomfortable seeing two lesbians/gay men holding hands at my gym.**
- 15. I feel outraged that Sexual Reassignment Surgery is covered by OHIP.**
- 16. I would be upset if my child told me that they were lesbian, gay or bisexual.**
- 17. I would feel offended if someone mistook me for a trans person.**

- 18. I feel uncomfortable if my co-worker divulges information about his same-sex relationship.**
- 19. I feel scandalized when a colleague invites me to go the Pride parade with them and their friends.**
- 20. I would be surprised to meet a Black transperson or lesbian.**
- 21. One would expect a child raised by LGBTI parents to be queer also.**
- 22. I would be upset to find out that my child is learning about LGBTI identities/communities/families as part of school curriculum.**
- 23. I would be uncomfortable if I learned that my church, temple or other religious group was welcoming to people with LGBTI identities.**
- 24. I would be upset if my child brought home an openly gay/lesbian/bisexual friend.**
- 25. I would not expect a man using a wheelchair to be gay.**

26. I would feel uncomfortable if someone of the same gender expressed romantic interest in me.

27. If I saw two women communicating in sign language, I would be surprised to learn that they are lesbians.

Sub Total: T _____ F _____

28. I would feel comfortable working with clients/patients who identify as LGBTI.

29. I feel knowledgeable about LGBTI issues as they pertain to my area of work.

30. I get upset and speak up if someone tells a homophobic joke.

31. It bothers me when people say “That’s so gay!”

32. I do/have done research on LGBTI issues to educate myself.

33. I use gender neutral language to describe my own sexual partner/ relationship status, e.g partner vs. wife/boyfriend, etc

34. I am comfortable working with colleagues of all sexual orientations and gender identities.

35. I encourage education about sexual orientation and gender identity in my workplace.

Sub Total: T _____ F _____

Total: T _____ F _____

Handout

Workshop 2, Exercise 5 - Barriers to Health

Patient Profiles

Trevor: Straight, Black, 20, in a relationship with a woman, also has sex with men, comes to community health centre with a sore throat

Anita: First Nations, 2 spirit, late thirties, wheelchair user, long term female partner, attends women's group for survivors of domestic violence

Susan: White, mid fifties, lesbian for 25 years, currently living with a male partner, comes to sexual health clinic for STI testing

Raymond: Straight, white, transman, 40's, long-term committed relationship with a woman, doesn't associate with LGBTI community, 'passes' very well, comes to sexual health clinic for Pap test

JC: Filipina, 30's, butch lesbian, single mother of two, comes to parenting group for families with children under 6.

Handout

Workshop 2, Exercise 5 - Barriers to Health

Intake form review and ‘case scenarios’

You work for a broad-based health agency that provides a number of health and wellness services to a diverse community. The organization collects crucial information at each point of access to allow them to provide more holistic services. Critically examine the intake form samples, and then answer these questions as a group.

Take note of how language is used, and also what language is not used.

Can you identify any barriers health care access that might be present?

What social identity group(s) might be marginalized from a service that uses this intake form?

Look at your patient profile.

Can you identify any reasons/issues that may prevent this client from comfortably accessing the service?

Look at your intake form again. Do you notice any new/different areas that may be barriers for this individual?

What form could that marginalization take?

What is the impact of these barriers on a) the clients physical health?

b) the client's mental health/wellbeing?

c) their relationship to your organization?

d) On the organization/service provider?