Daniel Major - Discovery Snapshot

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Changing Minds:
Creating Culture Change around Queer Inclusivity within Long Term Care in Alberta

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A US survey with 764 total respondents revealed that 78% of queer and 84% of non-queer older adult respondents believe that queer older adults **cannot be open with staff of a long term care home about their sexual and/or gender identity** (NSCLC, 2011).

Methods

The Catamount Fellowship is an 8 month co-curricular program and transformational learning experience which enables senior level undergraduate students to explore complex social issues from a systems thinking approach. The purpose of this research was to explore the systems level influences and solutions around queer inclusivity in Alberta's long term care context in partnership with the Brenda Strafford Foundation.

What is long term care?

In Alberta, long term care specifically refers to facilities which provide medical services for patients with "highly complex and unpredictable health needs whose care cannot be safely provided in their own home or in supportive living" (Alberta Health Services, n.d.)

Background

Harrowing anecdotes exist of queer older adults "going back into the closet" when entering long term care (McIntosh, 2016; SAGE, 2014). This is hardly surprising considering that throughout much of the 20th century, queer people have been subjected to blatant discrimination by every institution of Western society. Favorable social attitudes toward queer people have only become mainstream and widely accepted in Western European and North American democracies within the last ~15 years, and many parts of the world maintain disparaging attitudes or persecutory approaches toward the queer community.

They are the generation who brought us out of the closet forever. We need to do better for them now.

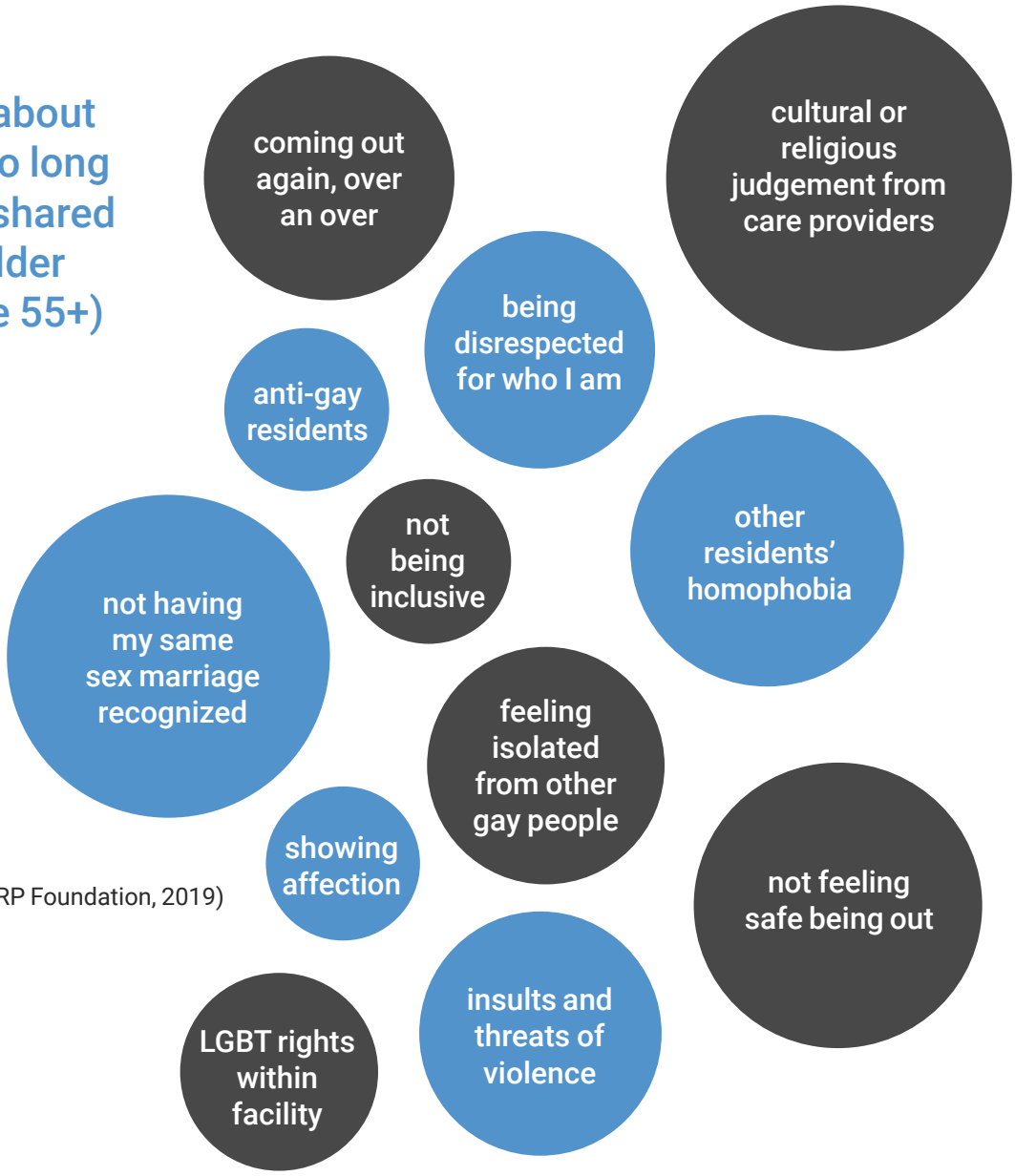
The single greatest barrier to queer inclusion in long term care homes is heteronormativity.

What is heteronormativity?

Heteronormativity refers to the social norms and assumptions which elevate heterosexuality and gender normativity as the exclusive identities in social institutions and theory; and includes the disparagement of anyone who deviates from these assumptions (Warner, 1993).

85% of Canadians surveyed in 2019 believe that homosexuality should be accepted by society (Poushter & Kent, 2020).

Concerns about moving into long term care shared by queer older adults (age 55+) in Calgary:



(SHARP Foundation, 2019)

The oblivious attitude that queer residents don't exist in long term care has an impact equivalent to stigma in that it creates a positively amplified feedback loop which **prevents meaningful recognition, discussion, knowledge acquisition, and action around improving queer inclusivity.**

Some physicians and nurses, in an effort to avoid the perception of discrimination or because they don't perceive sexual and/or gender identity as relevant to care, attempt to maintain neutrality and avoid assumptions; however, **this was perceived by queer patients to reinforce a heteronormative healthcare system** (Baker & Beagan, 2014).

Shipwrecked Analogy of Research Findings

At the early stages of my investigation, especially when immersed in the literature, I began to believe I was on a sinking ship. I remember thinking that redeeming queer inclusivity within long term care was like bailing out the ocean using a cup with no bottom. After speaking with community stakeholders, advocates, and allies, including staff from the Brenda Strafford Foundation, I realized that the ship of queer inclusivity in long term care isn't sinking, but it is full of holes and in a precarious position.

Why are we shipwrecked?

What contributing factors enable this current context?

- Historical social context
- Discriminatory laws
- Stigma-generating attitudes
- Dogmas from religious institutions
- Oppression and stigma from healthcare
  - Psychiatry
  - AIDS crisis
  - Transgender consideration
- Current organization of long term care
- Growing awareness and advocacy

What is blocking the holes?

How is the system coping with this situation?

- Staff who are taking it upon themselves to create inclusive outcomes for residents
- Advocacy and investment from community organizations
- Resilience of residents and staff
- Sporadic delivery of training programs at the request of progressive organizations

What is creating turbulent waters?

What is causing tension and contributing to the issue?

- Lack of inclusive policies
- Persistence of discriminatory policies, behaviors, and mental models
- Fear and a legacy of discrimination
- Heteronormativity, ambivalence, and ignorance
- Internalized stigma and shame
- Lack of awareness of the existence of queer residents
- Lack of training
- Employment practices

Who is coming to our aid?

What current solutions or partners exist?

- Research and understanding needs and perspectives of older queer adults, including current and future residents of long term care
- Active development of training programs
- Provincial advisory groups (e.g. SOGIE)

What do we need to repair our ship?

What solutions are needed to shift the system?

- Assess culture, awareness, and willingness to change within the organization
  - Get a sense of where our crew (staff) is at
  - Get a sense of where our passengers (residents and families) are at
- Develop overarching and queer-specific policies on inclusivity
- Form a queer advisory body within the organization (representative of all stakeholders)
- Have a specific policy regarding queer inclusivity on intake
- Create provincial strategy around enhancing queer inclusivity in long term care
- Educate (staff), educate (residents), educate (families)
- Demonstrate affirmative symbols, statements, and actions of inclusivity (only if reflective of the organizational culture)
- Seek out partnerships with community organizations
- Explore the use of innovative, integrative, intersectional, and multigenerational problem solving strategies
- Invest in technologies to enable aging-in-place

Resources

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Daniel Major - Creative Work

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Daniel Major - Scholarly Output

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Changing Minds: Creating Culture Change around Queer Inclusivity within Long Term Care in Alberta

Daniel Major

Mount Royal University and the care homes of the Brenda Strafford Foundation are situated in the traditional territories of the Niitsitapi (Blackfoot) and the people of the Treaty 7 region in southern Alberta, which includes the Siksika, the Piikuni, the Kainai, the Tsuut'ina and the Iyarhe Nakoda (comprised of the Wesley, Bearspaw, and Chinikee First Nations). We are situated on land where the Bow River meets the Elbow River. The traditional Blackfoot name of this place is "Mohkinstsis", which is also home to the Metis Nation III of Alberta.

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Introduction

As highlighted in the documentary *Gen Silent* (2010), many queer people face enormous inequities in finding safe and empowering placement within long term care. In Alberta, long term care specifically refers to facilities which provide medical services for patients with "highly complex and unpredictable health needs whose care cannot be safely provided in their own home or in supportive living" (Alberta Health Services, n.d.); and that is the definition used in this review. The most harrowing anecdotes resound around older adults going "back into the closet" for their own protection when being introduced into these healthcare-based institutions (McIntosh, 2016; SAGE, 2014). By analyzing the healthcare context that queer people have endured, and eventually fought back against, we can begin to understand how we ended up in this place and realize what leverage points exist to help shift the system toward a better place.

There is a generationally stratified population of two-spirit, lesbian, gay, bisexual, transgender, questioning, intersex, asexual, and other non-heterosexual/ non-cisgender identities (herein referred to as queer) people in North America created by the contexual experiences faced by each generation over the past 60 years. While Canadian, and to a lesser extent Albertan, society has slowly gained momentum toward greater inclusion of queer people, shocking violent attacks and hate crimes still happen and shake the community (Rieger, 2020). More typical, however, are the constant inequities and prejudices that persist for queer people trying to live and thrive in society.

Systems level thinking acknowledges the complexity of certain problems and emphasizes the need to identify relationships and patterns without the convenience and oversimplification of isolating variables. This review is not a comprehensive systems-level analysis, but aims to take the first systems-level steps of providing background, enhancing knowledge, and inspiring change. This review summarizes current literature and offers different perspectives on the influential factors affecting the queer community requiring living placements in long term care facilities. It also highlights the need for system-influencing change, and provides suggestions to help long term care providers in Alberta (and beyond) facilitate culture change around queer inclusivity in these settings.

Methods

This report was written by a senior year undergraduate student participating in the Catamount Fellowship at Mount Royal University located in Calgary, Alberta[1]. The review focuses on the systems level influences and potential solutions around queer inclusivity in long term care from an Alberta, Canada perspective. A community partnership was formed with the Brenda Strafford Foundation and this topic was selected independently by the researcher from the theme of enhancing equity, diversity, and inclusion in long term care settings. This review is composed of academic sources, including peer-reviewed primary literature, case studies, and meta-analyses from academic journals; and non-academic sources, including reports by advocacy organizations and non-governmental agencies, news articles, and documentaries. No constraints on timeframe of publication were considered, although the primary scope was limited to US and Canadian sources. This work was also partly informed by a set of community conversations hosted over virtual meetings in January 2021 with stakeholders, advocates, and allies. Two one hour public consultations and one 45 minute consultation with representatives from Brenda Strafford Foundation's network of long term care homes were conducted. Potential "participants-of-interest" (i.e. members of the community with experience, interest, or expertise in this area) received personalized invitations and requests to share the invitation within their networks. The result was a diverse and multigenerational array of participants. These consultations helped inform areas of further exploration and consideration for the researcher. No specific outcomes of these conversations are mentioned in this report as their purpose was to hear perspectives and not gather data.

[1]An 8 month co-curricular program and transformational learning experience which enables senior level undergraduate students to explore complex social issues from a systems thinking approach.

1. Influential factors affecting the current status of queer aging in long term care

1.1 Societal context: laws, attitudes, religion, and healthcare

Throughout much of the 20th century, queer people were subjected to blatent discrimination by every institution of Western society. In Canada, same-sex sexual activity was nationally decriminalized in 1969 and ten years later Quebec became the first province to include sexual orientation in its provincial charter of human rights (Government of Canada, 2017). Prior to this hard-won and heavily contested legislation, police would frequently raid lesbian and gay establishments, and queer people had no protections in the eyes of the law. Alberta refused to include queer people in the Alberta Individual Rights Protection Act, which lasted until the Supreme Court of Canada ruled against the province in 1998 after a lab instructor was fired from King's College (now University; a private Christian institution) because of his sexual orientation *(Vriend v. Alberta, 1998)*. Numerous bills failed to pass in the national House of Commons in the 80s and 90s which would have extended essential rights and protections to queer people and couples (e.g. marriage, protection from distrimination). The term "spouse" could not be legally used by married same-sex partners until 2004 (CBC News, 2012). In 2002, after the Ontario Superior Court ruled that prohibiting same-sex marriage was unconstitutional, the province of Alberta took a further step toward defiance of queer inclusion by adopting a law which banned same-sex marriage and explicitly defined marriage as a union between a man and woman (CBC News, 2012). Although many of these legislative wrongs have now been made right in Canada, the legacy of overt disrimination lingers in the memories of those who endured them. Some protections are more recent than others, as it was only in 2016 where transgender people finally received protections from discrimination under the Alberta Human Rights Act (Luhtanen, 2017). Gender-inclusive washrooms and gay-straight alliances also began to emerge within the education system around this time. In the United States, there is no explicit anti-discriminatory legal protections for people based on sexual orientation, although a recent landmark Supreme Court ruling extends employment protections to queer people under the Civil Rights Act *(Bostock v. Clayton County, 2020)*. Despite the legislative progress made in North America, Canada and the US are two of only twenty eight countries where same-sex marriage is permitted (Felter & Renwick, 2020), in contrast to the approximately seventy countries where same-sex sexual activity is still criminalized (UNAIDS, 2019).

Favorable social attidues toward queer people have only become mainstream and widely accepted in Western European and North American democracies within the last ~15 years. According to the Pew Research Center, the percentage of Canadians who believe homosexuality should be accepted by society has risen from 69% in 2002 to 85% in 2019 (Poushter & Kent, 2020). However, also in 2002, a CBC commissioned poll indicated that only 45% of Canadians would be willing to vote yes on a referendum to enable same-sex marriage (CBC News, 2012). This could be reflective of a prevailing attitude of tolerance, but not genuine acceptance - especially if seen as compromising the religious construct of marriage. In 2019, the Government of Canada surveyed Canadians on their attitudes toward queer people in society (Akin, 2019), which revealed that 92% of respondents stated they would be very or somewhat comfortable if a next door neighbor was gay, lesbian, or bisexual; and 88% if transgender. This proportion was notably lower when respondents were asked whether they would be very or somewhat comfortable if they had a doctor who was gay, lesbian, or bisexual (88%) or transgender (80%). Although rapid social change regarding queer acceptance has swayed the opinions and attitudes of every demographic category (Fetner, 2016), the language used and populations studied in many articles and reports are exclusive to same-sex or certain sexual identities. This highlights the disparities that exist in collecting data for some identities within the queer community, such as transgender.

Abrahamic religions (mainly Christianity, Judiasm, and Islam) are implicated in the historical and perpetuated mainstream demonization of queer people, and the damaging views of religious institutions on queer identity persist to this day. In Canada, the proportion of people who state that homosexuality should be accepted by society is only 60% among the respondents who also stated that religion is a very important part of their life (versus 93% for people who say religion is not important) (Poushter & Kent, 2020). In 2011, Canadians mainly identified as Christian or non-religious, with notable populations identifying as Muslim, Hindu, Sikh, and Jewish (Government of Canada, 2011). In 2020, the Catholic church under the reign of Pope Francis has been the most tolerant of queer people in the history of its existence, however, many statements by the Pope himself, including on gender theory, leave much to be desired in terms of queer reconciliation (Human Rights Campaign, n.d.-a). However, any legacy of reconciliation appears to be largely resolved as the Roman

Catholic Church released a statement in March 2021 which continues to acknowledge that marriage is exclusive to heterosexual couples and that same-sex unions are sinful (Winfield, 2021). There are several notable exceptions within Christianity, including the the United Church of Canada - a comparatively enthusiastic and early supporter of queer rights (Summers, 2008). Supportive religious institutions, such as the United Church, are important to help queer people harmoniously bridge the gap between keeping their faith and expressing their authentic selves. The Reform Movement of Judiasm (Human Rights Campaign, n.d.-c) and certain muslim groups in the US (Human Rights Campaign, n.d.-b) are also progressive allies.

Many stories around queer liberation in Canada start in the mid 20th century, which not only discounts the oppression and experiences before that time, but also erases the impacts of colonization on any queer identities that existed within the First Nations and Inuit of Turtle Island prior to first contact with Europeans. There is essentially no written literature on the history of North America prior to colonization, and the first written accounts come from first contact with Jesuit priests in the 17th century. However, some insights into the manner in which queer people may have been regarded within First Nations and Inuit lives on in the languages of these cultures (Filice, 2015). The oral histories containing broader insights into how queer people may have been integrated into these societies have been largely decimated by colonization (Ristock et al., 2019), although there is evidence of alternative gender roles in pre-European North America (Roscoe, 1991). With the necessary disclosure of using a broad brush to paint many individual cultures, it appears that Indigenous peoples generally did not regard sexual and gender diversity to be deviant from heteronormative expectations (like Eurocentric-Christian cultures), but instead, respected and valued these identities within their social fabric (Hunt, 2016). The recognition of and disposition toward varying sexual and gender identities would have been as diverse as the cultures of the First Nations themselves, in contrast to the modern "two-spirit" term adopted by many pan-Indigenous cultures. The impacts of residential schools and attempts at assimilation further degraded any traditional indigenous mental models around queer inclusion (Pember, 2016).

Within the scope of healthcare, it appears the pathologization of homosexuality began in Western medicine from the writings of Aristotle (384 - 322 BC) and subsequently by the physician Soranus (2nd century AD), and persisted until the 1970s (Bullough, 2019). Mental health associations began removing homosexuality from their list of mental illnesses in 1973 (Conger, 1975), but it wasn't until 1987 after the publication of DSMIII-R (a reference manual for categorizing mental illness) that homosexuality was fully redacted as a mental illness in the context of Western psychiatry (Drescher, 2015). The World Health Organization removed homosexuality as a mental disorder in 1990, however, "transsexualism" persisted as a gender identity disorder in their eyes until 2019 (World Health Organization, 1992). Ironically, part of the fuel for change may have been the very acquired immunodeficiency syndrome (AIDS) crisis which further stigmatized and decimated gay male communities around the world[2]; but also offered a mainstream view of the injustices faced by queer people. This time saw a new height of protest and awareness related to queer liberation borne out of a grave necessity because so many gay men were dying from infection of the sexually transmitted virus, including in Canada (Hogg et al., 1996). Many appalling practices were committed by the health and legal systems against not only the victims of the virus, but also their loved ones, who were famously denied spousal rights in San Francisco and other parts of the United States. These experiences likely spawned further distrust between the healthcare system and the queer community. The AIDS crisis may have also significantly diminished the number of gay men who, had they not died, may have otherwise accessed long term care as older adults. This may contribute to the perceived invisibility of this population in long term care settings.

[2]Among other populations - human immunodeficiency virus (the virus that causes AIDS) is still epidemic in Africa and endemic around the globe.

1.2 Fear and a legacy of discrimination

A major source of trauma and stigma internalized by older queer adults results from the harms of the medical community treating homosexuality and other queer sexual and gender identities as "deviations" from "normal" heterosexual development (Drescher, 2015) and the discriminatory and dispassionate response of governments to the AIDS crisis. Beyond the nascent years of queer liberation in the late 1960s, generations of queer people alive today may have faced many apalling practices, including conversion therapy[3] (McGeorge et al., 2015). In late 2020, Canada became the first and most progressive country in the world to introduce legislation that would ban this practice, and the bill is currently before parliament (Phillips & Walker, 2020). Although many overt discriminatory practices have been discontinued, a US online survey with 1,857 queer respondants (including 137 who identified as transgender) revealed that many queer people remain distrustful and reluctant to share sexual identity with health care providers (SAGE, 2014). Part of this mistrust may be the result of an enduring or perceived social stigma and internalized shame. This is eloquently expressed by an exchange between two characters in the miniseries *It's a Sin* (Hoar, 2021), reflecting on the experiences of gay men in England in the 1980s during the peak of the AIDS pandemic: "He was ashamed, and he kept on being ashamed… 'Cause that's what shame does… It makes him think he deserves it. The wards are full of men who think they deserve it. They are dying, and a little bit of them thinks, yes, this is right. I brought this on myself. It's my fault because the sex that I love is killing me. I mean it's astonishing. The perfect virus came along to prove you right." In addition, 65% of transgender adults believe they will have limited access to healthcare as they grow older (SAGE, 2014). The same survey also revealed that many queer people believe that disclosing sexual or gender identities may result in receiving inferior healthcare, diminished employment or volunteering opportunities, and discrimination in long term care environments. One in eight lesbian, gay, or bisexual and one in four transgender people who participated in this survey believe they have been discriminated against based on sexual ot gender identity, respectively, while seeking housing. Another US survey with 764 total respondents revealed that 78% of queer and 84% of non-queer older adult respondants believe that queer older adults cannot be open with staff of a long term care home about their sexual and/or gender identity (NSCLC, 2011). As reviewed in Furlotte *et al.* (2016), queer seniors have expressed unique fears of having to go back into the closet and feeling compelled to conceal their sexual identities. When asked an open ended question about concerns in moving into a "senior's facility", older queer adults in Calgary disclosed answers which fell into the top three themes: discrimination related to to gender or sexuality, general comfort, and affordability (SHARP Foundation, 2019). The following concerns were expressed about the prospects of moving into long term care by older queer adults living in Calgary: anti-queer residents, insults and threats of violence, not feeling safe, feeling isolated from queer community, lack of acceptance, cultural or religious judgement from care providers, being disrespected, not having partnerships recognized, showing affection, and coming out over and over again (SHARP Foundation, 2019). Older queer adults may have a lasting impression of adverse experiences when seeking medical care; and may be reluctant to seek healthcare or healthcare-integrated housing options until circumstances become desparate.

65% of transgender adults believe they will have limited access to healthcare as they grow older

(SAGE, 2014)

Queer seniors have expressed unique fears of having to go back into the closet and feeling compelled to conceal their sexual identities.

Older queer adults may have a lasting impression of adverse experiences when seeking medical care; and may be reluctant to seek healthcare or healthcare-integrated housing options until circumstances become desparate.

These unique factors also demonstrate the heterogeneity and intersectionality of older adults. Unfortunately, it is common to disregard the myriad of identities and attributes which compose older adults and reduce this population down to a single time-bound construction - "the elderly". This stereotyping and prejudice exists in many structures and attitudes throughout North American and Western European societies, including within healthcare. An interesting manifestation of this is highlighted in the Unmasking the Future Report by James Stauch (2021), where he discussed a study that assessed the global moral preferences of different societies regarding decision making of autonomous vehicles (Awad et al., 2018). Without any additional information, many societies (including North American) were significantly more likely to opt to spare younger people and kill older people. To what extent do these attitudes trickle into policy? Ageism is a significant barrier to listening to, anticipating, and responding to the needs of diverse groups of older adults.

[3]Attempts by healthcare or other social service providers to change, repress, or reduce the sexual and/or gender identity of a queer person to a heterosexual and/or cis-gender orientation.

1.3 Cultural Factors

Aging queer people also face a unique set of circumstances. A series of surveys conducted in major US cities and reviewed in Stein et al. revealed that up to 75% of older queer adults live alone, gay men were twice as likely to live alone as straight men, and lesbian and bisexual women were 1/3 more likely to live alone as straight women (Stein *et al.,* 2010). Many queer people from this generation are estranged from their families because of stigma upon disclosure of identity, therefore, electing to remain outside of long term care with the support of family and/or friends may not be an option. Certain older queer adults may also be at higher risk for social isolation. Queer people, and especially older queer adults, derive many important social connections from friends and partners (Furlotte et al., 2016), "chosen family"[4], queer community groups, and affirmative religious institutions/ groups (Choi & Meyer, 2016). The risk of estrangement from these connections may also be a deterrent for seeking long term care. Therefore, queer people may need long term care placement at a greater rate than heterosexual counterparts (American Society on Aging, 2018), but are also less likely to seek out care because of perceived discrimination by service providers (Pelts & Galambos, 2017). As reviewed in Sussman et al. (2018), queer older adults are at greater risk of being admitted to long term care facilities as older adults because a greater proportion live alone, may have smaller support networks, and have less financial resources on average than their heterosexual counterparts. The financial aspect is especially concerning as long term care is paid out of pocket in Alberta. However, no studies to date have explicitly assessed proportional admission rates of queer older adults. Although proportions of queer people in the total population are not known, they are estimated to be between 2 - 13% of the older adult population (Baral et al., 2018), with considerable numbers choosing to remain "closeted" (Pachankis & Bränström, 2019). These contexts provide some insight into the complexity of long term care considerations for older queer adults.

Reports from Calgary (SHARP Foundation, 2019) and Edmonton (Pride Seniors Project, 2015) provide some common insight into the type of aging support that is desired by current older adults. At least 85% of survey respondents in each report were minimum 55 years old and ~80% identified as lesbian or gay. Respondents expressed the desire to live at home and in their community for as long as possible, but if housing placement was required, the majority preferred[5] intentionally queer-inclusive living arrangements open to allies and friends (57%) as opposed to queer-exclusive housing (16%) or non-queer specific (32%) (SHARP Foundation, 2019). While acknowledging that certain identities, such as non-binary gender, have unique needs within the queer community, the most important attributes of a queer-inclusive residence reported by respondents were: partner respected as caregiver, allowed to share suite/ room with partner, the existence of policies against discrimination based on sexual orientation, respect of relationship status, permitted to show affection with partner, training for staff in working with queer residents, queer-inclusive social activities, and the ability to approach staff if feeling excluded/ disrespected. Notably, when answering a survey question about whether they were open about their gender identity and/or sexual orientation to certain groups of people, 82%, 65%, and 58% of Calgary respondents > 65 years old reported "yes" with family doctors, other healthcare professionals, or social services professionals, respectively (SHARP Foundation, 2019). In addition, a large proportion of respondents reported that being open about gender (61%) or sexual (68%) identity was either extremely or very important (and ~25% reported it is somewhat important). As one might expect, there is a diversity of preferences and no single, homogenous solution exists for queer people in long term care. The following factors were described as contributing to participants' housing preferences or viewed as important qualities: experience with their own sexual and/ or gender identity, experience with the queer community, health status, relationship status, affordability, access to amenities, having agency, respectful attitudes, and being culturally safe (Pride Seniors Project, 2015).

While acknowledging that certain identities, such as non-binary gender, have unique needs within the queer community, the most important attributes of a queer-inclusive residence reported by respondents were: partner respected as caregiver, allowed to share suite/ room with partner, the existence of policies against discrimination based on sexual orientation, respect of relationship status, permitted to show affection with partner, training for staff in working with queer residents, queer-inclusive social activities, and the ability to approach staff if feeling excluded/ disrespected.

[4]Chosen family, in the context of the queer community, is a term used to describe a group of people who foster a deep sense of social connection and support - roles typically fulfilled by biological family members.
[5]Presented to participants as a ranking and choices were not exclusive.

1.4 Heteronormativity, ambivalence, and ignorance

Once older queer adults have been admitted to a long term care environment, the single greatest barrier to queer inclusion in these settings is heteronormativity[6] (Brotman et al., 2003; Schwinn & Dinkel, 2015). A study assessing the reactions of long term care home frontline staff in Colorado to a written scenario involving a sexual encounter with varying genders revealed that the staff were significantly more likely to be surprised by a male-male sexual encounter, less accepting of homosexual encounters, and react less positively to homosexual encounters (Hinrichs & Vacha-Haase, 2010). Anecdotes exist of blatantly hateful behavior towards openly queer residents moving into long term care facilities and the shuffling of queer residents to placate the hateful outcry of others (Gross, 2007). However, the most frequent discrimination reported from an online survey of older queer adults (and friends, family, and caregivers) in US long term care facilities was verbal or physical harassment from other residents (23%) and refused admission or re-admission/ attempted or abrupt discharge from facility (20%) (NSCLC, 2011). This overt discriminatory behavior, although devastating, is far less frequent than covert discriminatory acts which propagate heteronormativity through silence, lack of affirmation, lack of acknowledgement, or failure to recognize the possibility of a same-sex relationship (Croteau et al., 2005; Furlotte et al., 2016). Some physicians and nurses, in an effort to avoid the perception of discrimination or because they don't perceive sexual and/or gender identity as relevant to care, attempt to maintain neutrality and avoid assumptions; however, this was perceived by queer patients to reinforce a heteronormative healthcare system (Baker & Beagan, 2014). Interviews of 12 queer long term care Canadian residents revealed burdens of having to constantly assess the environment for safety in disclosing identity, selectively hiding their identities, and placating others (Furlotte et al., 2016). As reviewed in Sussman et al. (2018), hiding sexual orientation can negatively impact care delivery and mental health of residents; and especially impacts the health and safety of transgender residents in long term care. Importantly, the lack of sexual or gender identity disclosures likely does not describe the absence of these identities, but may suggest the environment enables microaggressions[7] and heteronormative dominance (Nadal, 2013).

Although not unique to the queer community, the effects of inappropriate systems, strategies, and practices to enable meaningful and necessary sexual expression in long term care disproportionately affect queer people in Alberta (Brassolotto & Howard, 2018). Because residents are both living and receiving care in long term care environments, many conflicts can arise between the needs of the institution and the resident. Many current residents of long term care homes in Alberta express fear and anxiety about being "out" in long term care, and several reports from nursing staff in these care homes admit to policies which avoid controversy and do not embrace diverse sexual orientations (Brassolotto & Howard, 2018). This can include the lack of accommodation for same-sex couples staying in the same room (Brassolotto & Howard, 2018), despite Canadian laws which mandate the recognition of same-sex relationships.

The oblivious attitude that queer residents in long term care don't exist has an impact equivalent to stigma in that it creates a positively amplified feedback loop which prevents meaningful recognition, discussion, knowledge acquisition, and action around improving queer inclusivity.

A recent meta-analysis concluded that long term care providers admit a lack of knowledge and training on queer health issues (Caceres et al., 2020). This view is widely held during anecdotal conversations with frontline care providers. A very common response to the question about the state of queer inclusivity is: "we don't have any queer residents here", "we aren't aware of any queer residents in our homes", or, "we don't consider the sexual or gender identity of the residents". Seniors' housing stakeholders who participated in surveys for a needs assessment report generated for the Calgary context could identify few or no residents who self identified as queer in any respect (SHARP Foundation, 2019). It is obvious that these residents do exist, but for reasons including personal readiness to disclose, institutional homophobia, organizational barriers, or personal choices to maintain secrecy (SHARP Foundation, 2019), these residents are silent. The oblivious attitude that queer residents in long term care don't exist has an impact equivalent to stigma in that it creates a positively amplified feedback loop which prevents meaningful recognition, discussion, knowledge acquisition, and action around improving queer inclusivity.

[6]Heteronormativity refers to the social norms and assumptions which elevate heterosexuality and gender normativity as the exclusive identities in social institutions and theory; and includes the disparagement of anyone who deviates from these assumptions (Warner, 1993).
[7]Common, everyday behavioral indignities suffered by marginalized people.

1.6 Growing awareness and advocacy

As indicated in this report, the literature around queer inclusivity in long term care is a growing area of study that has received enhanced attention from provocative media, such as the documentary *Gen Silent* (Maddux, 2010) and the awareness campaign *Not Another Second*[9] (2021). Practical guides and books also exist for leadership and direct care providers to read and gain insight into what can be done within their own organizations, such as *Welcoming LGBT Residents: A Practical Guide for Senior Living Staff* by Tim Johnston (2019). Many jurisdictions participate in surveying the local populations and assessing attitudes and needs of older queer adults, including in Calgary (SHARP Foundation, 2019) and Edmonton (Pride Seniors Project, 2015).

[9]This US based campaign is an interesting example of a collaboration between a community advocacy group (SAGE) and an organization providing retirement living services (Watermark).

2. Creating culture change around queer inclusivity through a systems lens in long term care settings

The road to change will be an unstable and likely contentious one. Applying an ecological framework called the adaptive cycle suggests that long term care in Canada is currently enduring an extraneous "creative destruction" phase (collapse, releasing energy as opportunity) precipitated by the COVID-19 pandemic. While queer inclusivity may eventually benefit from this rebuilding process, independently, queer inclusivity in long term care is more representatively established at the height of conservation (the steady and mature state of the system), although with a diminishing slope. This is because the system in general is unresponsive and/or unaware of the needs of queer residents, but awareness is building and the status quo is becoming stale. Some jurisdictions and homes are at different stages along this cycle.

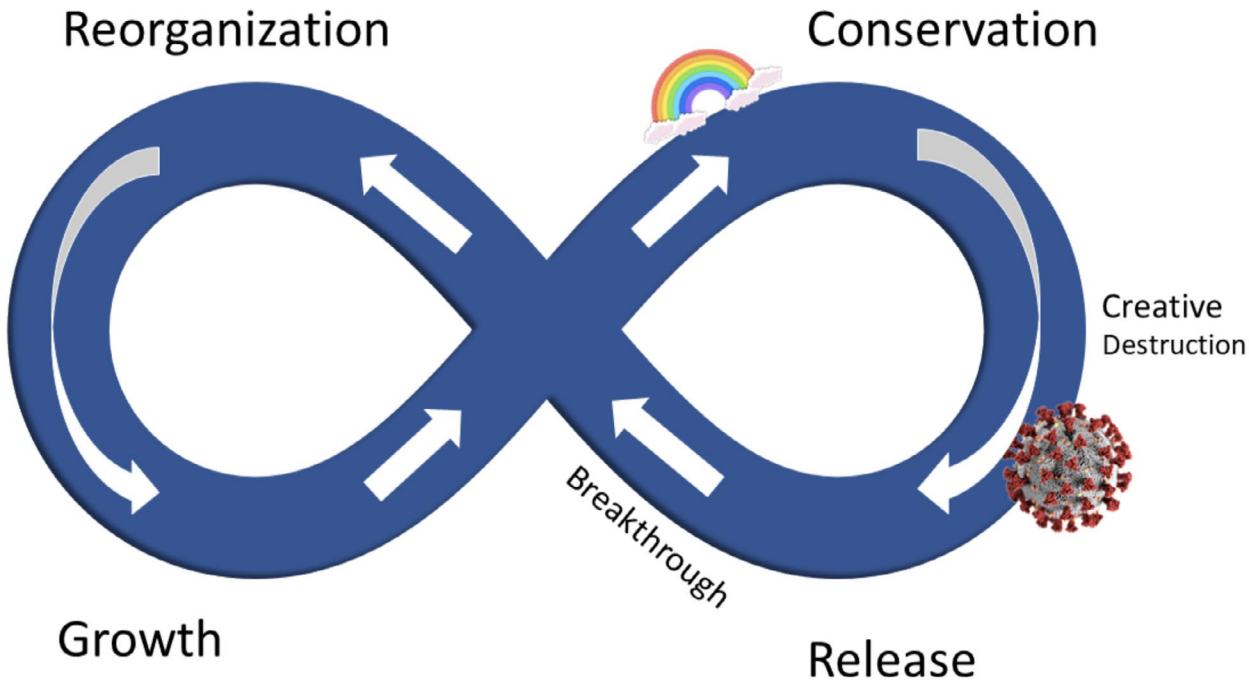

Figure 1: The long term care system along the adaptive cycle in general (virus) or as it pertains to queer inclusivity (rainbow). Modified from Angeler et al. (2015)

Long term care organizations wishing to influence and shift their own culture toward queer inclusivity must make sustained and comprehensive efforts. The solution space has been well developed for queer inclusivity in long term care, and some of the potential actions are presented here, including: assessing the organizational culture; building awareness, promoting education, and delivering culturally safe care; developing policy and advocacy within the organization; innovating inclusively; and contributing to the potential of ageing-in-place. For ideas on a comprehensive province or federal-level strategy to support older queer adults as they age, SAGE and AARP (2021) have developed an excellent resource for New York State. The solutions proposed here are not exhaustive, and while the needs of the generation currently accessing care are paramount, we must also consider the diverse and dynamic care needs of aging generations in Canada who will inevitably be accessing future long term care systems. The need for this consideration is imminent as the baby boomer generation approaches old age (Deloitte, 2021) and one quarter of Canada's population is expected to be over the age of 65 by 2031 (Kumar, 2019).

2.1 Assessing the current culture

To what extent do the views of employees represent the necessary culture needed to facilitate cultural change? An organization must hear the perspectives of the day-to-day stakeholders to learn about how the community perceives queer inclusivity (Schwinn & Dinkel, 2015). Most approaches to perspective gathering are qualitative, however two validated surveys used in a 2017 study in Wales to assess and quantify the views, attitudes, and competency of long term care home staff in interacting with queer residents are the Ageing Sexuality Knowledge and Attitude Scale (ASKAS) and Lesbian gay Bisexual-Knowledge Scale for Heterosexuals (LGB-KASH) (Willis et al., 2017). Vitally important are the voices of queer people themselves, as older queer adults living prior to the late 1960s faced overt stigma and blatant discrimination from healthcare systems in particular (Brotman et al., 2003). A diverse sampling of queer residents with experiences in long term care is essential to understand the experience of living in that setting. Also important to note is that it may be difficult to accurately assess the professional vs. true disclosure of staff or resident attitudes. This is a phenomenon known as organizational silence, which can confound the ability of organizations to change (Morrison & Milliken, 2000). Survey responses need to be anonymous and de-identified from management, and managers must be open to hearing this feedback, even if it is uncomfortable. Organizations may also be subject to change resistance, where the system is immovable because of forces that prevent desired change (Harich, 2010). Identifying and resolving these forces within the organization will be essential before pivoting toward planned actions for change.

On a larger scale, and as indicated by a report from UCLA that also applies to the Canadian context, the majority of studies conducted with the queer older adult population are not sufficiently powered and do not employ representative samples to objectively assess and characterize this population (Choi & Meyer, 2016). Some groups are notably underrepresented in the literature, including bisexual, trans, two spirit, and intersectional populations. Additional advocacy and funding of research to learn the perspectives, attitudes, and needs of the queer population on a more global scale are needed to complement the work being done at a local level.

2.2 Awareness, education, and culturally safe care

A widely accepted solution to enhancing queer inclusivity is the implementation of training programs. The literature suggests that continuous education around this topic is necessary, but not exclusive, to facilitate culture change within these organizations (Choi & Meyer, 2016; Furlotte et al., 2016; Schwinn & Dinkel, 2015; Stein et al., 2010; Sussman et al., 2018; Willis et al., 2017). However, queer content in Canadian nursing curricula is highly inconsistent and often marginal (Shortall, 2019). Recently, both long term care and less medically intensive care homes in Vancouver, Toronto, and Montreal were polled for adoption of queer inclusivity initiatives (Sussman et al., 2018). The most popular interventions were staff training (unknown if specific to queer inclusivity or broadly encompassing diversity; 69%), followed by queer-themed programming (e.g. screening of films pertaining to queer issues or barbeques honoring Pride Week; 44%), queer advisory committees (34%), participation in queer events/ networks (25%), and displaying queer symbols (e.g. hanging rainbow flag; 25%). Less than 15% of homes were involved in queer community outreach, partnership with queer organizations, or a comprehensive approach involving a blend of the above strategies. Of the homes adopting comprehensive approaches, three were private homes in Quebec specifically designed for queer residents, and three were publicly funded long term care homes. Two of these long term care homes reported that the comprehensive approach enabled the creation of an inclusive environment and disclosures of sexual orientation and gender identity. This attitude is highlighted by the following quote from the president of an assisted-living housing developer in Boston: "Many times gay people avoid seeking help at all because of their fears about how they'll be treated. Unless they see affirming actions, they'll assume the worst" (Gross, 2007). While symbols of queer inclusivity (including rainbow flags and door stickers) are inviting sentiments, they must be representative of the culture and environment. The queer inclusive attitudes and culture of an organization should be supported and promoted through training to ensure that these symbols are earned and not haphazardly displayed in environments which are not truly queer friendly spaces.

"Many times gay people avoid seeking help at all because of their fears about how they'll be treated. Unless they see affirming actions, they'll assume the worst"

(Gross, 2007).

Toronto's long term Care Homes and Services developed a recently updated toolkit in 2008 to help long term care homes become queer inclusive (City of Toronto, 2008). Explicitly mentioned areas of importance for facilitating this change include: hosting queer-sensitive programs and services, championing queer-inclusive governance, developing hiring policies friendly to queer people, creating a queer-friendly enivronment, consulting with queer members in the community, and partnering with queer people and organziations. Training programs are an essential component to this process, and should specifically address human sexuality and aging, homophobia and heteronormativity, sexual diversity in long term care, fears and experiences of long term care residents, review of relevant legislative requirements, and any current effective practice (Schwinn & Dinkel, 2015). However, residents should also be included in these training practices, as staff have reported fear of negative reactions of residents as obstacles to building a queer-friendly environment; which are a reality in some contexts, but may also be a reflection of ageist attitudes toward older adults in their care (Sussman et al., 2018). The most effective training will be delivered periodically and supplemented with organizational engagement and commitment (e.g. mentoring, partnering and engaging with queer organizations in the community). In addition, true cultural change within an organization will not limit the delivery of training to resident-facing staff, but will involve each and every staff member in the organization, including management and senior leadership. Although not assessed in the long term, participants of queer-inclusivity training reported significantly greater awareness and improvement in attitudes after a single queer cultural competency training session (Porter & Krinsky, 2014). One highly effective strategy in particular pertains to intergroup contact theory and involved the use of storytelling from older queer adults to long term care staff (Pelts & Galambos, 2017), although longitudinal evaluation is needed. Gamification and game-based learning are also effective training strategies (University of Waterloo, 2016). Taken together, these findings outline the necessary high-level content for continuing education in long term care settings. Although several options exist (with others in development) for long term and general healthcare queer inclusivity training for Albertan organizations, a comprehensive, high quality, interactive, gamified, story-based, widely available, and consolidated training option would greatly benefit stakeholders.

Culturally safe care involves treating older queer adults with specific and knowledgable care that considers social and structural factors and avoids further discimination and stigmatization (Bass & Nagy, 2021). Failure to consider the sexual and gender identity of queer patients can perpetuate the marginalization of this community (Baker & Beagan, 2014). Bass & Nagy (2021) have published an excellent stepping off point for considering how to integrate culturally safe care for queer patients into practice.

Awareness generation is not created through a single mechanism (such as offering a training session to staff), and providing a discrete effort is not enough to shift the system (such as inviting a queer guest speaker to the home). The effort must be broad and dynamic, thoughtfully considered, managed well, and continuously evaluated. Facility-appointed champions for queer inclusivity with decision making power, and who take on this role as part of their job and not off the side of their desk, can help with facilitating the kind of approach needed to bring awareness, education, and culturally safe care to long term care homes.

2.3 Policy and organizational shifts

Policies are necessary where attitudes and systems can be difficult and unreliable to shift. The types of policy and organizational ideas needed to bring about change within long term care settings are well identified in the SHARP Foundation (2019) needs assessment. Specifically, it is important that an organization consider creating an overarching framework and committee for equity, diversity, and inclusion which explicitly acknowledges how queer populations have been historically, persistently, or systemically marginalized within healthcare systems. Organizations can assemble queer-focused advisory groups within or tangent to that committee. As an example, Alberta Health Services maintains a Provincial Advisory Council on Sexual Orientation, Gender Identity and Expression. In addition, a committee, working group, or other responsible body should evaluate current policies and practices from a queer inclusion lens to ensure no harm is being done through discriminatory behavior, whether intentional or not. These could include policies around intake, rooming (e.g. ensure same-sex partnerships are considered), family and visitation, and continuing education requirements. Policies around intake of residents and consideration for sexual or gender identity (e.g. statements of inclusivity, confirming how patients would like to be addressed or identified) are inconsistent at best. There is no evidence to suggest that this affirmative action currently exists beyond the independent and voluntary behavior of select care providers. Crafting an intake policy that does not assume sexual and gender identities of residents is essential because it sets the tone during an uncertain and anxiety-provoking transitionary period. A coordinated provincial strategy on enhancing queer inclusivity in long term care is necessary to provide the framework, coordination, and resources to bring consistent change to a fragmented system, however, this would likely not be enforceable under the current system encoded by marginal regulation. A provincial or national standard could be developed and incentivized to encourage adoption and participation by existing long term care organizations.

2.4 Interdisciplinary innovation and community partnerships

There should be no "wrong home" for queer people to find themselves in should they need the support of long term care in Alberta.

In the pursuit of enhancing queer inclusion, each environmental and organizational context will have unique features and challenges to address. To prepare for and gain agency over flexible and homegrown solutions, long term care organizations can adopt problem solving strategies to become innovative and responsive to the needs of queer residents. One way to generate ideas is the implementation of Design Thinking (Ziegler et al., 2020). Adapted from the computer science and technology industries, design jams are informal processes where intersectional and interdisciplinary perspectives are brought together to innovate in an empathetic way (Liedtka, 2018). See Appendix B for an example activity. Another way to shift thinking in long term care organizations is by pivoting away from conventional, dichotomous agree/disagree and zero-sum mental models; and pivot towards integrative thinking. Ken Wilber has been the most influential developer of integral theory (Duffy, 2020), which permits the viewpoint that every perspective contains at least some partial degree of a desirable outcome. The goal of an integral thinker, therefore, is to assess multiple perspectives and try to generate solutions which integrate the best parts of the different points of view. Queer inclusivity in North American society may be complicated by the mental models that have been taught for generations and which prevail in our society. The education system implicitly teaches that there is a dichotomy of choices: a right answer and a wrong answer; and this does not build the foundations to think integratively. Long term care homes can apply a lens of queer inclusion when redesigning their systems, and community partners should be invited to the table to ensure current and future perspectives are considered. This includes partnerships with queer futurists who anticipate and help plan systems to prepare for the needs and contexts of queer people in the future (Tester, n.d.). This type of thinking could help move long term care facilities which are snagged in a trap of stagnant complacency. At least part of interdisciplinary problem solving should incorporate these innovative thinking practices.

Another potentially beneficial consideration within long term care is the importance and implementation of services that are specific to queer populations who need them. For example, Ottawa is launching mental health services which specifically target certain populations, including the queer community (CBC Radio, 2021). These services are incredibly important as queer people are more likely to experience mental health concerns and suicidality than heterosexual, cisgendered counterparts (Canadian Mental Health Association, n.d.). Suicidality is a special concern for the transgender community. These services are unique in that they are also composed of professionals who identify within those communities, which may improve access and enable stronger connections within the therapist-patient relationship.

Intergenerational living is a concept which could help long term care homes integrate their services into the community, help build mutually beneficial relationships between community members, and save money in the healthcare system (happipad, 2019). Intergenerational services could also be considered on site, and may have a number of benefits, including: helping to bridge the generational divide that exist between older and younger queer adults, providing mentorship to younger queer adults, and reducing lonliness in older queer adults (Redden et al., 2020).

The *Not Another Second* awareness campaign is an example of a collaboration between a senior's residence housing organization and a community queer advocacy organization (Not Another Second, 2021). These kind of partnerships simultaneously highlight ongoing issues, bring agencies together, and effectively advertise the recognition of queer older adults in these spaces. This kind of affirmative action is essential to promote meaningful acknowledgement and inclusion. Although older queer adults in Calgary have reported desires to live in queer-centric housing (SHARP Foundation, 2019), this attitude will undoubtedly shift as generations age. What ideas can we incorporate into the delivery of care that will timelessly set the standard for queer inclusion? There should be no "wrong home" for queer people to find themselves in should they need the support of long term care in Alberta.

2.5 The potential of ageing-in-place

While we will need some form of facility for residents with very complex and dependent needs in the immediate future, investing in the technology and resources to keep people at home predominantly aligns with their wishes and goals. The overwhelming majority (76%) of Calgary and area older queer adult respondants ranked living in their private residence while aging as their top choice for housing (SHARP Foundation, 2019). In Ontario, at least 8% of newly admitted long term residents could have avoided admission with the right supports implemented at home (National Institute on Ageing, 2020). A combinatorial approach of bolstering community resources and investing in necessary home care technology could save the long term care and surrounding systems (e.g. hospitals backlogged with long term care patients awaiting placement) billions of dollars (National Institute on Ageing, 2020). This type of efficiency-seeking intervention will be imperative as roughly one quarter of Canada's population is expected to be over the age of 65 by 2031 (Kumar, 2019). As the dynamics and delivery of long term care changes, a lens of cultural safety must be applied to these reimagined systems. The implementation of long term care solutions within people's homes will greatly shift the focus of how queer inclusivity must be considered. Staff will still require training and policies around culturally safe care will be vital, however, many of the aforementioned efforts will have to be reimagined to take place within the community. The role of community partners (including charities, social organizations, and health advocates) will be essential in reformatting queer inclusivity in home-delivered, ageing-in-place long term care. Investing in ageing-in-place solutions will concordantly create economic efficiencies at the same time as enabling human-centered care.

The importance of withholding judgement and abandoning heteronormativity when engaging in care services for older queer adults becomes even more important as traditionally considered "gay enclaves" are no longer mecas for queer people that they once were (Cain, 2017); and perhaps never were for many racialized, female-identifying, and transgender queer people (Adamson & Sandilands, 2017). In addition, strategies which shift resources to ageing-in-place must consider how this will impact the most vulnerable, including homeless populations.

Conclusion

The need for culture change within long term care settings is evident and there are many roads to achieving this, including: assessing the current climate, working with community organizations, taking affirmative action, providing meaningful education, shifting policy, and encouraging innovation. Efforts should be continually evaluated and organizations should monitor the impacts of these interventions over time. Residents and families should also be included in the consideration, design, and implementation of any changes, including education. Older queer adults have been heard and the time has come to shift priorities from perspective gathering to affirmative action. Long term care homes have the capacity to either delightfully surprise aging queer adults as allies and advocates for queer inclusivity, or confirm suspicions and fears by driving this community back into the closet. Sexual and/or gender identity expression is often a hard-won achievemnt in a queer person's life, with years of living "closeted" described as "years lost" by the *Not Another Second* project. This celebration should not end at the final chapter. The COVID-19 pandemic has offered an incredible opportunity to "build it back better", and after experiencing two thirds of total COVID-19 deaths in Alberta by February 2021 (Jeffrey, 2021), there is a spotlight on long term care to fulfill this vision. Dismissing the necessary changes as a "generational inevitability" disregards those who need affirmative action now and prevents the system from anticipating the needs of future care seekers. Albertans, and particularly Calgarians, were generally far from being leaders in the story of Canadian queer liberation. Historically, many in the queer community opposed the movement to flagrantly protest and visibly advocate against the treatment of the queer community by heteronormative and homophobic forces (Allen, 2016). We have the opportunity to stop the diaspora of remarkable queer people from our communities and build a system where queer people can age with the confidence that they will be authentically welcomed and accepted whenever and wherever they may need to access long term care in Alberta.

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Appendix A: List of influential organizations, community supports, and advocacy groups

Current as of February 2021

Advocacy groups

SHARP Foundation: Calgary
"The SHARP Foundation maintains or enhances quality of life by providing non-judgmental housing, providing safety and security for our clients, and reducing risk behaviors preventing further transmission of HIV in the community or deemed to be at risk of contracting HIV"

Pride Seniors Project: Edmonton
"Edmonton Pride Seniors' Group strives to ensure that all queer seniors' services, activity centres, and housing – assisted and independent senior housing complexes long term care facilities, lodges and palliative care centres – are a welcoming, safe, and caring environment for LGBTQ2S+ older adults aged 55+ in Edmonton and area." NOTE: Their library contains a number of useful reports and community conversations.

Outlink: Calgary
"Calgary Outlink is a community-based, not-for-profit charity dedicated to providing support, education, outreach, and referrals for the LGBTQ2IA+ and allied community in Calgary, Alberta."

Alberta Health Services and other care providers

SOGIE PAC: Alberta
"We work in partnership with Alberta Health Services (AHS) to create a safer and more welcoming healthcare environment for sexual and gender minority (lesbian, gay, bisexual, transgender, queer, and 2 Spirit, or LGBTQ2S+) patients and their families."

Community-based groups for queer older adults

Rainbow Elders: Calgary
"An enthusiastic group of LGBTQ+ folk dedicated to strengthening the ties and connections between different generations of LGBTQ+ citizens in Calgary while also being advocates for LGBTQ+ seniors."

50+ LGBTeaQ2IA+ Time! Calgary Outlink: Calgary
"In collaboration with the Kerby Centre, Outlink invites Older Adults 50+ who identify as an LGBTQ2IA+ community member or ally to join us for friendly conversation in a safe, supportive, and welcoming online environment."

Community-based arts

Calgary Queer Arts Society
- Fairy Tails Film Festival
- The Coming Out Monologues

Consultants

Habitus Collective

Existing training

Outreels Allyship Education & Training: **Calgary Queer Arts Society**

SOGI Nursing Education Course: **Queen's University**
The SOGI nursing education course integrates game-based learning and intergroup contact/ storytelling strategies into a toolkit designed to enhance culturally competent care (Luctkar-Flude et al., 2020).

AHS training - facilitated in partnership with Rocky Wallbaumof the Rainbow Elders

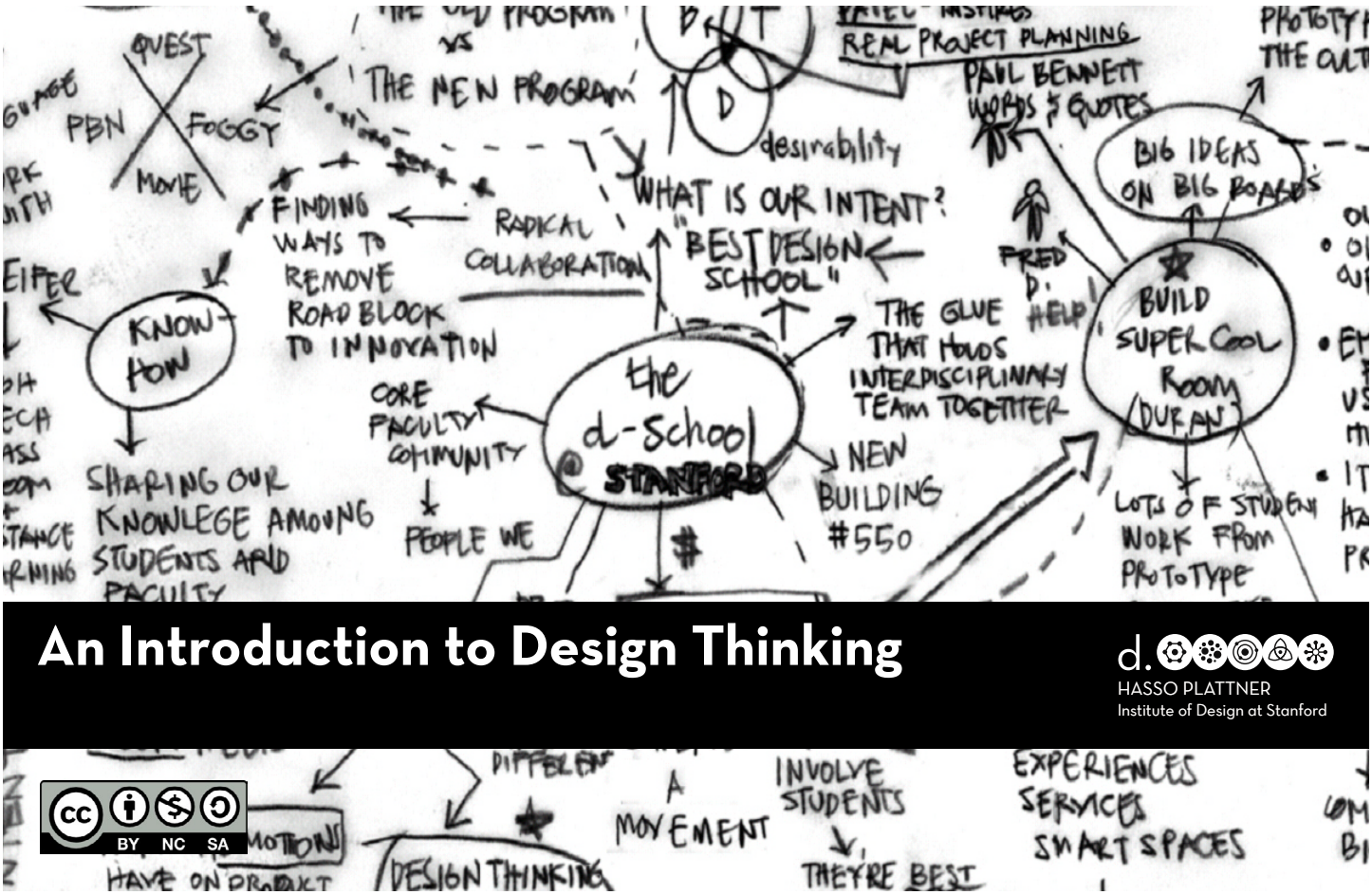
Media

Gen Silent: Documentary
Not another Second: Exhibition, Documentary, and Book
Legislative Love, The Everett Klippert Story: Play
Cured: Documentary

Researchers

Dr. Jacqueline Gahagan: Dalhousie University
Dr. Karen I. Fredriksen Goldsen: Washington University
Dr. Brian de Vries: San Francisco State University
Dr. Julia Brassolotto and Dr. Lisa Howard: University of Lethbridge

Appendix B: Introduction to Design Thinking - Design School Lunch Activity



Before we start this design challenge, take a minute to reflect about your own experiences. Chart your lunch experience below.

d.

5min

Your Mission: Redesign your partner's school lunch experience. Start by gaining empathy for your partner.

1 Interview

8min (2 sessions x 4 minutes each)

Notes from your first interview

Switch roles & repeat Interview

2 Dig Deeper

6min (2 sessions x 3 minutes each)

Notes from your second interview

Switch roles & repeat Interview

d.

Reframe the problem.

3 Capture findings 3min

Goals and Wishes: What does your partner need to accomplish during lunch?
*use verbs

Insights: New learnings about your partner's feelings and motivations. What's something you see about your partner's experience that maybe s/he doesn't see?*
*make inferences from what you heard

4 Take a stand with a point-of-view 3min

_____
partner's name/description

needs a way to _____
user's need

because (or "but . . ." or "Surprisingly . . .")
[circle one]

_____

_____
insight

d.

Ideate: generate alternatives to test.

5 Sketch at least 5 radical ways to meet your user's needs. 5min

_____
write your problem statement above

6 Share your solutions & capture feedback. 10min (2 sessions x 5 minutes each)

Notes

Switch roles & repeat sharing.

d.

Iterate based on feedback.

7 Reflect & generate a new solution. 3min

Sketch your big idea, note details if necessary!

d.

Build and test.

8 Build your solution.

Make something your partner can interact with!

[not here]

7min

9 Share your solution and get feedback.

✚ What worked...

- What could be improved...

? Questions...

! Ideas...

8min (2 sessions x 4 minutes each)

d.

Reflect on your work.

10 Headline TWO next steps 2min

From Step 9 feedback, what are TWO aspects you would prototype next?

1)

2)

11 Redefine your point-of-view 3min

How does your interaction alter your P.O.V. from Step 4? Craft a new P.O.V. informed by testing.