Cultural Humility Primer

Peer Support Specialist and Recovery Coach Guide to Serving and Supporting Diverse Individuals and Their Recovery Journeys

Developed by the Peer Cultural Cooperative for the Northwest Addiction Technology Transfer Center (ATTC), Seattle, WA, USA

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Peer Cultural Cooperative

The Peer Cultural Cooperative is a group of active Certified Peer Counselors (peer support specialists) and Recovery Coaches who have gathered out of concern for culturally relevant service delivery options from the field of peer support.

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MULTICULTURALISM OVERVIEW

In this primer the use of the term “Peer Support Specialist and/or Recovery Coach” refers to the individual providing services and the term “program participant” is used to identify the individual receiving services and supports. This primer was created as an entry level cultural reference for Peer Support Specialists and Recovery Coaches, working in both Substance Use Disorder and Mental Health fields. The stories and experiences are personal to the individuals who authored each section. The appendices contain definitions of words (glossary), acronyms, references, and tools.

The Cultural Humility Primer for Peer Specialists has adapted some of its components from Multicultural Counseling Competencies (MCCs) for this publication. MCC is a model in the counseling field that addresses three main domains:

- Peer *knowledge* about different cultures and cultural perspectives.
- Peer *skills* to utilize culturally appropriate approaches.
- Peer *awareness* of their own and their cultural heritage and the influence of culture on attitudes, beliefs, and experiences.

This overview explores two major areas:

1. The program participant’s perception of the Peer Support Specialist’s and/or Recovery Coach’s awareness of *cultural humility*, and,
2. The degree to which the Peer Support Specialist and/or Recovery Coach addresses culture and *cultural opportunities* in the peer support encounter and intervention.

Cultural humility refers to the ability to maintain an interpersonal stance that is “other-oriented” (or open to the other person) in relation to aspects of cultural identity that are most important to the person with whom you are engaging. Cultural humility contains both intrapersonal and interpersonal dimensions.

Intra-personally, cultural humility depends on the Peer Support Specialist’s and/or Recovery Coach’s openness to accepting that their own cultural identities and experiences will limit their perspective and awareness in understanding the cultural experiences of others.

The interpersonal dimension of cultural humility involves an “other-oriented” perspective that includes openness, respect, consideration, humility, and interest regarding the program participant’s cultural identity and experiences.

Be aware that it is usually much easier to empathize with people that are more like you than not. You must employ cultural humility and personal honesty and awareness so that you can see through your own bias.

DEFINITIONS

As a peer practitioner, you are encouraged to stay in your lane while doing all you can to educate yourself on best practices. Look for “cultural opportunities” in your work as a Peer Support Specialist and/or Recovery Coach. Cultural opportunities refer to moments in your work when you are presented with opportunities to address and focus on the program participant’s cultural identity. For example, a cultural opportunity may emerge when a program participant of a marginalized racial group discusses depression that is linked to being treated unjustly in the workplace. This presents an opportunity for you to explore potential discrimination, privilege, fragility, and micro-aggressions relative to cultural identity. Here are some definitions to help you further study culture as it relates to the work you do as a Peer Support Specialist and Recovery Coach. The definitions below are from Wikipedia.

White Privilege

White Privilege (or white skin privilege) is the **societal privilege that benefits white people over non-white people**, particularly if they are otherwise under the same social, political, or economic circumstances. “She doesn’t know she has white privilege because she has never had to worry about getting pulled over or targeted for shoplifting in a grocery store.”

White Fragility

White Fragility refers to discomfort and defensiveness on the part of a white person when confronted by information about racial inequality and injustice.

"Her indignant reaction comes off as the quintessential combination of White Fragility and White Privilege."

Implicit Bias

Bias that results from the tendency to process information based on unconscious associations and feelings, even when these are contrary to ones conscious or declared beliefs is called Implicit Bias.

Cultural Humility

The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person].[1]” Cultural Humility is different from other culturally-based training ideals because it focuses on self-humility rather than achieving a state of knowledge or awareness.

Cultural Appropriation

Cultural Appropriation, sometimes called, cultural misappropriation, is the adoption of an element or elements of one culture or identity by members of another culture or identity.

Micro-aggression

Micro-aggression is a term used for brief and commonplace, daily verbal or behavioral indignities, whether intentional or unintentional.

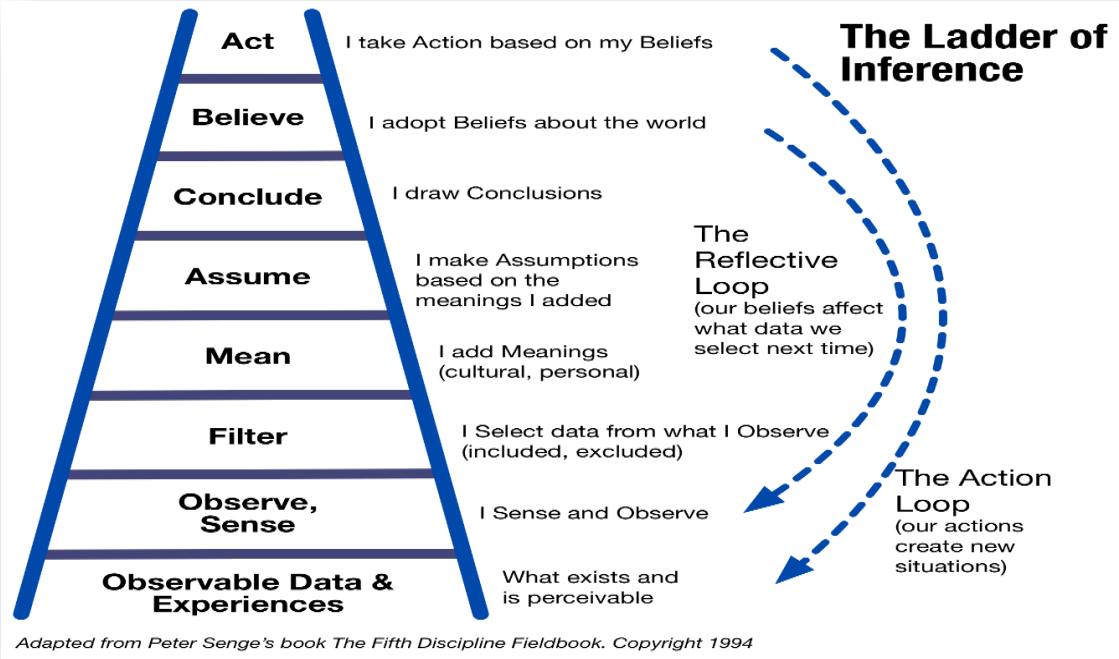
PEERING-IN, A MULTICULTURAL LENS

People with white skin have been the predominate population of mental health professionals in the counseling field in the United States (U.S.), as with most other professions during the first 200 years of the country's existence; yet this was also a time in which peer support did not exist. Like most institutions of higher learning that did not admit women and men of color, these institutional inequalities still influence the counseling, and subsequently the peer support fields today. In 2015, the American Psychological Association reported that 86% of psychologists in the U.S. identified as White, 5% Asian, 5% Hispanic, and 4% identified as African American. This distribution of identities among professionals doesn't reflect the country's overall demographics which are: 60.4% White, 18.3% Hispanic/Latino, 13.4% African American, and 5.9% Asian, according to 2018 census data. These disparities in representation also correspond to the demographic information available about Peer Support Specialists. Think about where you work right now as a Peer Support Specialist. Is it diverse? Do the people in charge reflect the individuals being served? The answer is likely, no.

In a world that does not represent, hire and promote individuals equally- what is your responsibility? Why should you care about cultural humility and multiculturalism?

Peer Support Specialists are often the first people that program participants meet. Engagement is crucial in the beginning of a peer helping relationship. Having a multicultural lens means that you are open, know your own bias, are flexible, and know when you do not know something. You understand how critical it is to feel like you are not alone and that someone "gets" you, as a peer. Feeling understood and "seen" is one of the most crucial components to recovery for both mental health and substance use disorders. In each of the scenarios we provide, we will present evidence to support the life and death impact that paying attention to a person's culture can yield. So how do you develop multicultural awareness and cultural humility as a Peer Support Specialist? By understanding how you process data.

The Ladder of Inference



The Ladder of Inference was developed in 1970 by Chris Argyris, a former professor at Harvard Business School. In 1992, *The Ladder of Inference* became popular after being described in the bestseller, The Fifth Discipline, written by Argyris in collaboration with scientist, Peter M. Senge.

When you are processing data, be careful not to jump to conclusions; these may lead to conflicts with others. The Ladder of Inference can help you avoid premature judgments and instead help you focus on the facts.

PRINCIPLES OF CULTURAL HUMILITY

Cultural Humility Principles

1. Lifelong commitment to learning and critical self-reflection;

2. Desire to fix power imbalances within provider-client dynamic;

3. Institutional accountability and mutual respectfully partnership based on trust.

Step 1: Assessment

- What do you need to know about other cultures?
- Why do you want to know about it?

Step 2: Awareness

- Be aware of your own bias and ignorance.

Step 3: Educate yourself

- Read about other cultures and ask questions when you have them. Make sure that you do not fall into a well-meaning trap of “Asking to teach.” Sometimes when we are educating ourselves, we go to the nearest person we know from the culture we want to learn about.

Step 4: Implementation of new knowledge

- We use the word humility for a reason when it comes to other people’s experiences of their culture. Everyone is an individual. Understand that just because you read about a culture in a book it does not necessarily (if ever) mean that you fully understand all aspects of a culture. There are cultures within cultures as well subcultures

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“Each person’s level of awareness is determined by their ability to judge a situation accurately both from their own viewpoint and the viewpoints of members in other cultures.”
– Dakota Steel

Cultural Encapsulation/Blindness

Gilbert Wrenn described individuals as "culturally encapsulated" when they define reality according to one set of cultural assumptions. Below is a table of cultural challenges defined by Wrenn that relate very well to Peer Support Specialists and Recovery Coaches when cultural humility and multiculturalism are ignored. Use Cultural Humility to combat Cultural Encapsulation, also known as Cultural *Blindness*.

The first step of developing multicultural competence is an assessment of your personal and professional cultural awareness needs. Becoming aware of culturally learned assumptions as they are both similar and different from members of other cultures is the foundation of peer support core competence. Try using the following table in uncovering and exploring errant strategies.

Become insensitive to cultural variations	Support system is not considered relevant	Depend on quick fix solutions for program participants
Disregard evidence disproving their assumptions	Linear cause and effect thinking	Professional boundaries narrowly defined
Judge others from their own self-reference criteria	Program participant is expected to adjust to the Peer Support Specialists style instead of the other way around	All people measured according to the same measuring stick

CLASSIFICATION OF DISABILITIES

Adapted with permission from disabledworld.com.

Every person has skills, abilities, and their own uniqueness, regardless of the challenges that they may face (check out the Tools in the Appendices for more information). The following pages will describe the eight Classifications of Disability according to disabledworld.com.

Categories of disability include various physical and mental impairments that can hamper or reduce a person's ability to reach their goals when working with a Peer Support Specialist. These impairments can be termed as a disability if the person struggles with his/her/their/zer, day to day activities. Disability can be broken down into the following eight broad sub-categories.

1. Mobility and Physical Impairments

This category includes people with varying types of physical disability, including:

- Upper limb(s) disability
- Lower limb(s) disability
- Manual dexterity
- Disability in co-ordination with different organs of the body
- Disability in mobility can be either an in-born or an acquired with age problem. It could also be the effect of a disease or accident.

2. Spinal Cord Disability

Spinal Cord Injury (SCI) can sometimes lead to lifelong disabilities. This kind of injury is usually due to severe accidents. The injury can be either complete or incomplete. In an incomplete injury, the messages conveyed by the spinal cord are not completely lost. A

complete injury results in a total dis-functioning of the sensory organs. In some cases, spinal cord disability can be a birth defect. It is not okay to ask, “What happened?” when you’re working with a program participant in a wheelchair.

3. Head Injuries – Brain Disability

A disability in the brain occurs due to a brain injury. The magnitude of the brain injury can range from mild and moderate to severe. An Acquired Brain Injury (ABI) is an injury to the brain that is not hereditary, congenital, degenerative, or induced by birth trauma. Essentially, this type of brain injury is one that has occurred *after* birth. The injury affects the physical integrity, metabolic activity, or functional ability of nerve cells in the brain. An acquired brain injury is the umbrella term for all brain injuries. There are two types of acquired brain injury: Traumatic and Non-Traumatic.

- Non-Traumatic Brain Injury (NTBI)
- Traumatic Brain Injury (TBI)

4. Vision Disability

There are hundreds of thousands of people that have various, minor to serious, vision disability or impairment. These injuries can also result in serious problems or diseases like blindness and ocular trauma. Some of the common vision impairments include scratched cornea, scratches on the sclera, diabetes related eye conditions, dry eyes, and corneal graft.

5. Hearing Disability

Hearing disabilities include complete or partial deafness. People who are hard of hearing can often use hearing aids to assist their hearing. Deafness can be evident at birth or occur later in life from several biological causes, for example Meningitis can damage the auditory nerve or the cochlea. People that are deaf or hard of hearing use sign language as a means of communication. Hundreds of sign languages are in use around the world. In linguistic terms, sign languages are as rich and complex as any oral language, despite the common misconception that they are not "real languages."

6. Cognitive or Learning Disabilities

Cognitive disabilities are impairments present in people who are living with dyslexia and various other learning difficulties. This category also includes speech disorders.

7. Psychological Disorders

These disorders of mood or feeling states can be either and both short or long in duration. Mental Health Impairment (MHI) is the term used to describe people who have experienced psychiatric challenges or illness such as:

- Personality disorders: Defined as deeply inadequate patterns of behavior and thought of sufficient severity to cause significant impairment to day-to-day activities.

- Schizophrenia: A mental disorder characterized by disturbances of thinking, mood, and behavior.

8. Invisible Disabilities

Invisible disabilities are those that are not immediately apparent to others. It is estimated that 10% of people in the U.S. have a medical condition considered to be an invisible disability.

INVISIBLE DISABILITIES

What are Invisible Disabilities?

An invisible disability is a physical or mental, or physic-mental (co-occurring) impairment that limits one or more major life activities. These conditions and their symptoms are not outwardly apparent to others. These disabilities may be hard for a Peer Support Specialist and/or Recovery Coach to identify. This can lead to extreme frustration and hopelessness for individuals living with the disability. Invisible disability is a broad term that covers several health concerns, including the following:

- Chronic fatigue syndrome
- Diabetes
- Fibromyalgia
- Mental Health Conditions
- Substance Use Disorders
- Arthritis
- ADHD (Attention Deficit Hyperactivity Disorder)
- Autoimmune disorders

…The list could go on…

Diseases such as cancer also can be considered invisible disabling conditions. Unless a person loses hair or drops a significant amount of weight, outsiders may not realize that they are ill. If a person is walking with a cane, vomiting, wearing a cast, gaining weight or any other number of signs that suggest a health concern, the illness is clear even to strangers. However, the flip side is that when a condition is not outwardly identifiable, some may have difficulty accepting that there is a challenge. How, as a Peer Support Specialist and/or Recovery Coach, can you best support an individual with a hidden disability? The next page provides a few tips.

As a Peer Support Specialist and/or Recovery Coach, you will likely work with someone with a hidden disability. Do not assume it. Ask about it.

Tips for Working with Program Participants Who Identify as Having Hidden Disabilities

- Do not assume that because you cannot see it, that it is not real and poses a regular challenge for someone. If they say it is a challenge- it is.
- Just because you may not have heard about it, does not mean it does not exist.
- Remain open-minded and ask yourself if there is more to knowing and understanding what the program participant is going through that would assist them in reaching their identified goals. Is the disability interfering with goal accomplishment? Does the person want assistance?
- Examine your personal bias and resist making judgements about what a person can or cannot achieve based on what you see. Continually check-in with them. Ask questions politely.
- Do not diagnose a potential or hidden disability. Make appropriate referrals. You are not a counselor or a doctor. Use appropriate boundaries and remember your ethics and boundaries training.
- Always be open to special or unique needs and be supportive.
- Trust and believe what the program participant is telling you.
- Co-research the hidden disability and provide education.
- Be curious, not critical. We tend to reject what we do not know or believe. Remember the ladder of inference?
- We may not be able to relate to a situation exactly, but we are all human and we have felt pain, joy, and sadness. Relate to the feelings being expressed.

Rather than thinking “disability,” let us think, “different abilities” or “differently abled.” Bear in mind that every person has skills, abilities, and their own uniqueness regardless of the challenges they may face.

Invisible Disability Scenario

Jose, he/him, is a Peer Support Specialist and Recovery Coach. He is working with Andreas, they/them, who has gone back to school. Andreas is 38 years old and has not been in school in a very long time. Andreas has told Jose about their fear of going back to school because they have been told their whole life that they have a learning disability. They do not really know what it -is. They know they are struggling and need to ask for help. They have been clean and sober for two years and have been working with Jose the whole time they have been in recovery. Andreas has reached out to Jose to get support in telling their new school that they need extra support. Jose has never had a hidden disability and will use cultural humility to find out more information.

If you were Jose:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Andreas?
- What would you do if you did not have personal experience with a hidden disability?

Suggested approach

Jose will approach the situation based on the trust built in this relationship. He will ask Andreas what questions are acceptable and what may make them feel uncomfortable. He will find out if they would like a referral to a specialist to further explore what is challenging them. He will refrain from diagnosing and playing the guessing game. He will use any part of his personal story he feels comfortable sharing. If he has not experienced a hidden disability, he will find a colleague or someone who has that is willing to share with Andreas, if that is something they are interested. He could ask the following questions:

- How can I best support you?
- How much support would you like?
- Would you like to set goals around this situation?

There is stigma surrounding hidden disabilities because of how people "look."

VISIBLE DISABILITIES

What are Visible Disabilities?

A disability is defined as a condition or function that is judged to be *impaired* compared to the standard of an individual or group. The term is used to refer to an individual's functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and other types of challenges. Disability is conceptualized as being a multidimensional experience for the person involved. Often people without disabilities make assumptions about what it must be like to live without sight, legs, or the ability to hear. Their assumptions are often negative, and the opposite is often true. People who live with disabilities, have a more positive outlook on their quality of life than do the people that they reach out to for help.

There are three dimensions of disability that are nationally recognized:

- Body structure and function (and impairment thereof)
- Activity (and activity restrictions)
- Participation (and participation restrictions)

The classification also recognizes the role of physical and social environmental factors in affecting how people with disabilities can recover from behavioral health challenges. Disabilities can affect people in different ways, even when one person has the same type of disability as another person. There are many types of disabilities (differing-abilities) that affect a person's:

Vision	Hearing	Thinking	Learning
Movement	Mental Health	Substance Use Disorder	Communicating
Memory	Social Relationships	Trauma	Historical Trauma

Supporting Someone with Visible Disabilities

As a Peer Support Specialist and/or Recovery Coach, you will likely work with someone who has a disability. Do not assume it. Let them tell you in their own time about it. Do not assume that what you perceive to be a barrier is a barrier to the program participant that you are supporting.

Tips for Working with Program Participants Who Have Visible Disabilities

- Always think accessibility. Can they see, hear, and participate in all the activities that others are participating in? Are any accommodations needed? How can you find out?
- Use proper language to describe the disability and the person. If you do not know- Ask!
- Partner with the individual you are working with to identify potential personal and societal barriers they are experiencing.
- Examine your bias and resist making judgements about what a person can or cannot achieve based on what you see, feel, and think.
- Avoid assuming that the disability is the root of all unhappiness.
- Do not ask family members to be interpreters if the person is deaf or hard of hearing. English as a second language is not a disability, although you may need an interpreter for language accessibility.
- Trust and believe what the program participants say to you.
- Help only when assistance has been requested.
- Service animals are accommodations. Request permission before speaking or touching a service animal. Do not judge what a person considers to be a service or support animal.
- Be curious, not critical. We tend to reject what we do not know or believe. Remember the ladder of inference.

Visible Disability Scenario

Belinda (she/her) is a 20-year old female. Chantelle (she/her) is Belinda's Peer Support Specialist. Eight months ago, on the way home from college for summer break, Belinda was in a multiple-car accident. As a result of the wreck, Belinda sustained a spinal cord injury, a mild traumatic brain injury, and a broken left wrist. She is in recovery and does not like to take the pain medication prescribed even though she needs it. Her wrist has healed but she still needs a walker to get around. Belinda came to see Chantelle for peer support because she noticed several personal challenges. She started feeling discouraged, angry, and overwhelmed. Her father (her primary natural support) from time-to-time, makes negative and hurtful comments about her disability. She want's Chantelle to help to set goals for independence and empowerment.

If you were Chantelle:

1. How would you approach the situation?

2. What questions would you ask?

3. How could you use your personal story to assist Belinda?

4. What would you do if you did not have personal experience with a visible disability?

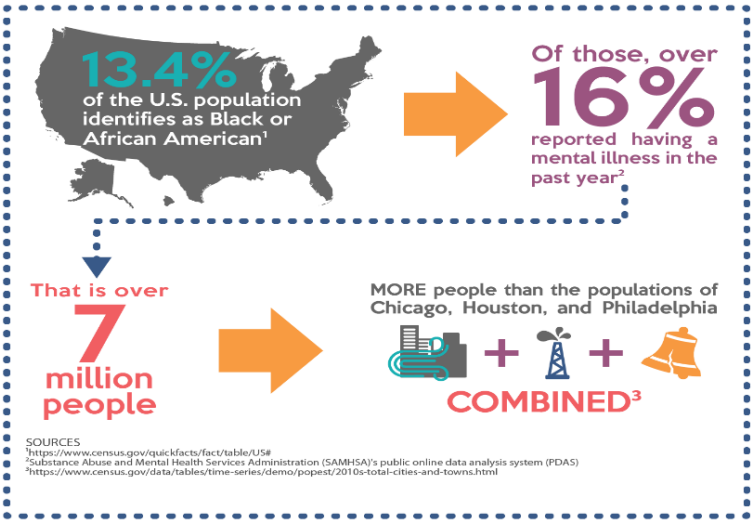
Suggested approach

Chantelle could use open-ended questions, reflective listening and the S.M.A.R.T. (specific, measurable, achievable, realistic, and timed) method to set goals. Chantelle will want to know what Belinda's primary concern is, in order to prioritize goals. She will co-create a plan with Belinda to determine which areas to address first. Chantelle can use her own personal story to help Belinda deal with potential differences in expectations held by herself and those of her family members.

Chantelle can approach the situation based on a trusted relationship with Belinda. Belinda's primary concerns are 1. Healing from her injuries at her own pace; 2. Her relationship with her father and his lack of support; and 3. She is feeling discouraged and overwhelmed, which may indicate depression. Peer Support Specialists never diagnose. Chantelle can use her personal story like a seasoning. Her story is the salt and pepper while Belinda's story is the main course. Chantelle will use any part of her personal story she feels comfortable sharing. If she has not experienced a disability, she will find a colleague or someone who has, and is willing to share with the program participant she is supporting. She will consult her supervisor anytime she has a question or is unsure of how to proceed.

BLACK AND AFRICAN AMERICAN CULTURAL PERSPECTIVE

Overall mental health and substance abuse challenges occur in Black and African American people in America at about the same or less frequency than in Caucasian Americans. Historically, however, the Black and African American experience in America has, and continues to be characterized by trauma and violence more often than for their Caucasian counterparts and impacts the emotional and mental health of both youth and adults.



When you are not African American or Black and you are working with a person of color, you must be aware of power dynamics, your implicit bias, and the potential micro-aggressions in the assistance you are providing. Historical dehumanization, oppression, and violence against Black and African American people has evolved into present day racism and cultivates a uniquely mistrustful and less affluent community experience. Using cultural humility, you can create a trusting relationship by asking a person about their experience in their culture and how it relates to their recovery.

Statistics

- Historical adversity, which includes slavery, sharecropping, and race-based exclusion from health, educational, social, and economic resources translates into socioeconomic disparities experienced by Black and African American people today.

- 13.4 percent of the U.S. population, or nearly 46M people, identify themselves to be Black or African American and another 2.7 percent identify as multiracial.

- Overall, 24 percent of Black and African American people have a bachelor's degree or higher, as of 2017.

- The Black immigrant population in the U.S. increased from 816,000 in 1980 to over 4.2M by 2016. 39 percent were from Africa and nearly half were from the Caribbean.

- More than 1 in 5 Black and African American people in the U.S. lived in poverty as of 2018.

- Socioeconomic status is linked to mental health and substance use and abuse, meaning that people who are impoverished, homeless, and incarcerated are at a higher risk of not getting their recovery needs met.

Despite progress made over the years, racism continues to have a negative impact on the mental health and substance use recovery of Black and African American people. Negative stereotypes and attitudes of rejection continue to occur with measurable, adverse consequences. Historical and contemporary instances of negative treatment have led to a mistrust of authorities and people in positions of power.

Some of the recovery challenges African Americans face are in overcoming the false assumptions held by some Peer Support Specialists and Recovery Coaches. One assumption is that African Americans all respond to getting help in the same way.

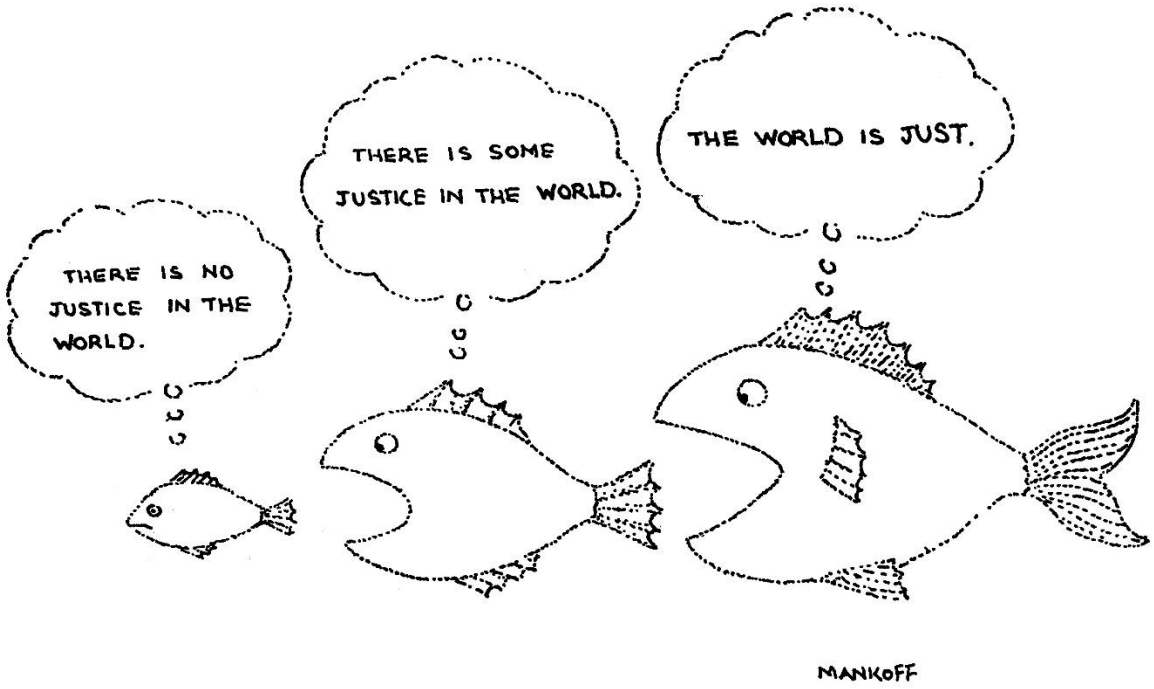
"African Americans are not all the same," Licensed Professional Counselor and peer, Danny Eagleton explains. "Many come from backgrounds where counseling and involving others is taboo. Ethiopians, Nigerians, West Indies, Ghanaian, Southern, Eastern, Midwest, West Coast, Suburban, Urban, rural, and low-income, all have different experiences."

It is important for Peer Support Specialists and Recovery Coaches to understand when they are making assumptions; and to more importantly, understand that people are not

all going to respond to peer support in the same way. Individualized and tailored care is the cornerstone of Cultural Humility.

It is important to understand power in relationships. Approach people of color with Cultural Humility always. If you are a person of color, it is also critical that you do not make assumptions. Do not think that because of the color of someone's skin, they will be a certain way. They will not. All people are individuals.

Think about ways you can even the playing field in your environment, words, and actions. Think about the concepts we have discussed and how they will apply to your peer support and recovery coach work. If you are working in mental health, substance use disorders, co-occurring disorders, or doing community work, there is a power dynamic. You have more power than the person you are healing. Recovery Coaching and Peer Support models are designed to create mutuality in the relationship. Mutuality means that both parties are enhanced positively by the relationship. Therefore, your work is not clinical. Your work is based on your lived experience.



Be aware of which fish in the above illustration you are in your helping relationship and watch for Implicit Bias and Micro-aggressions. **Implicit Bias** refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. **Micro-aggressions** are brief and commonplace, daily, verbal, or behavioral indignities, whether intentional or unintentional that communicate hostile, derogatory, or negative attitudes toward stigmatized or culturally marginalized groups.

Black and African American Cultural Scenario

Recovery Coaches and Peer Support Specialists help individuals feel safe and understood by being transparent and using their lived experience. This helps to create trust and instill hope. After you have educated yourself, please do not assume that every African American and Black person feels oppressed or limited. This is not the case. Treat each person you support as an individual.

Jackson, he/him, is a 6ft tall 270-pound ex-football player who identifies as Black. He has had challenges in the past with alcohol, but Jesse, he/him, his Recovery Coach, has helped him get into treatment and he has remained sober for 2 years. He has no record and has maintained a B average in college. Jesse has not seen Jackson since he was discharged from Intensive Outpatient Treatment six months ago. When Jesse asks Jackson why he made the appointment to see him, this is what Jackson said:

“Last week I was pulled over and the police officer put his hands on me. He slammed my head on the car and kidney punched me. My side still hurts. He did not give me a ticket or tell me why he pulled me over. I am in shock and I do not know what to do. I feel scared and angry. I do not want to make a complaint, but I… I just do not know what to do. I know a drink won’t make this better but right now it sounds really good.”

If you were Jesse:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Jackson?
- What would you do if you did not have personal experience with his culture?

Suggested approach

Jesse will approach the situation with cultural humility, knowing that they have a trusting relationship. He could ask Jackson if he has gone to the hospital or would like to go. His job is to make sure Jackson is physically safe as well as mentally safe. If he wants to go to the hospital, Jesse will talk to his supervisor to see if he can support him and how. He will use open-ended questions to talk about how Jackson feels about what happened. Jesse will let Jackson lead with vulnerability. Jesse understands that a Recovery Coach empowers individuals to share their own story in their own time. He is like a recovery Sherpa, who guides and plans but does not walk the walk for the people they are supporting. If Jackson does not feel he wants to go to the hospital, and Jesse believes he is safe, he will ask the following questions:

- How can I best support you?
- How much support would you like?

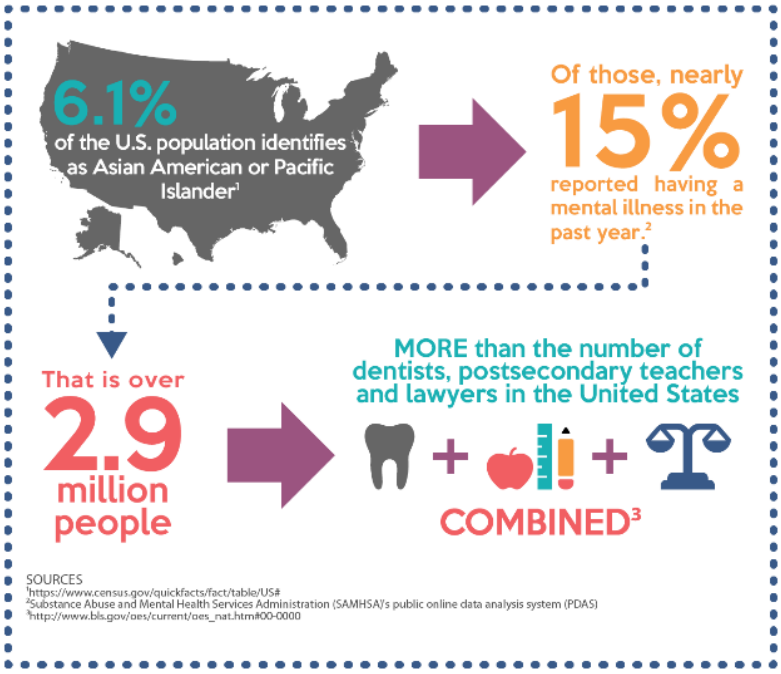
- Would you like to set goals around this situation?
- Is there any advocacy that I can partner with you on?

Jesse could use parts of his personal story that he feels comfortable sharing. If he has not experienced any related racism and trauma, he will find a colleague or someone who has, and that is willing to share about it with Jackson. He would only do this at Jackson's request. It is all about voice and choice!

ASIAN PACIFIC ISLANDER CULTURAL PERSPECTIVE

There are many cultures that fall under the Asian Pacific Islander (API) and Asian American Pacific Islander (AAPI) umbrella. The important thing, as always, is to not assume where someone is from because of how they look.

These communities in the United States have had to struggle to reconcile their identities and challenges while recognizing the privilege that comes with something called the “model minority” myth. The "model minority" myth is a micro-aggression known as “ascription of intelligence,” where one assigns intelligence to a person of color based on their race. It is important to recognize how the “model minority” myth plays into your personal bias and stereotypes as a Peer Support Specialist and/or Recovery Coach. Foreigner stereotypes occur when someone is assumed to be foreign-born or does not speak English because of the way they look. Stigma from the COVID-19 pandemic in 2020, resurfaced micro and macro-aggressions against Asian Pacific Islanders, especially for those perceived as of Chinese descent.



Statistics

- There are over 20M people in the United States who identify as Asian Pacific Islander (6.1 percent of the overall population).

- As of 2018, there were 5.2M people of Chinese descent, 4.5M of (Asian) Indian descent, and 4.1M of Filipino descent, followed by 2.2M of Vietnamese descent, 1.9M of Korean descent, and 1.5M of Japanese descent.

- Over 420,000 (2.5 percent) of Asian Americans and more than 76,000 (7.6 percent) Native Hawaiian and Pacific Islanders are veterans.

- Nearly 54 percent of Asian Americans and 24.4 percent of Native Hawaiian and Pacific Islanders have a bachelor's degree or higher.

- In 2018, 10.8 percent of Asian Americans lived at or below poverty level, and 6.2 percent were without health insurance. Hawaiian Natives and Pacific Islanders fared slightly worse with 14.8 percent at or below poverty level, and 8.6 percent went without health insurance.

There have been important studies on mental health and substance use disorders for the AAPI and API communities. The National Asian Women's Health Organization (NAWHO) sponsored a study called, Breaking the Silence: A Study of Depression Among Asian American Women. Here are a few findings:

- Conflicting cultural values are impacting Asian-American women's sense of control over their life decisions.

- Feeling responsible, yet unable to meet biased and unrealistic standards set by families and society, contributes to low self-esteem among Asian-American women.

- Asian-American women witness depression in their families but have learned from their Asian cultures to maintain silence on the subject.

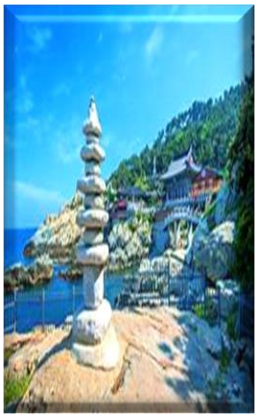
- Asian-American women fear stigma for themselves, but more so for their families.

According to SAMHSA's National Survey on Drug Use and Health, mental health issues are on the rise for Asian American/Pacific Islander/Native Hawaiian young adults:

- Serious mental illness (SMI) rose from 2.9 percent (47,000) to 5.6 percent (136,000) in AAPI people ages 18-25 between 2008 and 2018.

- Major depressive episodes increased from 10 percent-13.6 percent in AAPI youth ages 12-17, 8.9 percent to 10.1 percent in young adults 18-25, and 3.2 percent to 5 percent in the 26-49 age range between 2015 and 2018.

- Suicidal thoughts, plans, and attempts are also rising among AAPI young adults. While still lower than the overall U.S. population aged 18-25, 8.1 percent (196,000) of AAPI who were 18-25, had serious thoughts of suicide in 2018, compared to 7.7 percent (122,000) in 2008. 2.2 percent (52,000) planned suicide in 2018, compared to 1.8 percent (29,000) in 2008, and 7,000 more AAPI young adults tried suicide in 2018, compared to 2008.



Binge drinking, smoking (cigarettes and marijuana), illicit drug use, and prescription pain reliever misuse are more frequent among AAPI adults with mental illnesses which is similar to the rest of the U.S. population.

Language barriers, when present, make it difficult for Asian American Pacific Islanders to access mental health and substance use disorder services. Discussing mental health and substance use concerns are considered taboo in many Asian Pacific Islander cultures. Because of this, Asian American Pacific Islanders tend to dismiss, deny, or neglect their symptoms. Everyone has a right to accessible treatment. Consider interpreters, phone translators, and computer translation programs, etc.

Esther Kim is a Certified Peer Counselor in Washington State. She is from South Korea and identifies as being a Korean American, first-generation immigrant. When interviewed, she had this to say to prospective Recovery Coaches and Peer Support Specialists:

"A Peer Support Specialist and/or Recovery Coach, can best help someone who identifies as being from the Korean culture by taking the first step to understand (Step 3 from this Primer on cultural humility) Korean culture. Understand the stigma that surrounds their views and attitudes against people living with mental illness and substance use disorders. South Korea is a very conservative and homogenous country. Everything out of the norm is shunned and looked down upon. People living with mental illness are considered out of the norm and taboo. You do not mention or talk about it freely in public. You should practice strict confidentially as a Certified Peer Counselor and/or Recovery Coach when working with a person from Korea."

Many young Asian Americans tend to seek out support from personal networks such as close friends, family members, and religious community members rather than seek professional help for their mental health concerns. Keep this in mind as you read the scenario below.

Asian Pacific Islander Scenario

Jian Kim, he/him, is a new program participant and Davey Lamb, he/him, is his Peer Support Specialist. Jian goes by the name John since he moved to the United States. He is 23 years old and has never been to formal therapy. He made the appointment for peer support because he is very stressed out by school. He wants to change majors but does not think his family will approve. He cannot sleep and has started playing video games instead of doing his homework which has made him even more stressed out. He is looking for ways to tell his family that he wants to be a musician instead of a doctor. Davey is Chinese American and understands family pressure very well. He takes John's concerns seriously.

If you were Davey:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist John?
- What would you do if you did not have personal experience with his culture?

Suggested approach

This is Davey's first meeting with John. Davey must identify what peer support is and what it is not. Confidentiality will be stressed at the earliest appropriate time in the meeting as stated earlier. He will make sure John knows what Davey's role is and what John's rights are. Davey will let him know his personal approach to peer support and give him the code of ethics that Davey co-created with his supervisor. The first meeting is by far one of the most important meetings in peer support. When there are potential cultural barriers, Davey will not be afraid to ask if John would like assistance with them. These can range from techniques to talk to his family to getting an interpreter for an important meeting or school appointment. There may be cultural and accessibility challenges, but Davey would not assume to know what they are, he would simply ask. The four questions below are good ice breakers that will let John know he is in the driver's seat – don't be afraid to make them your own by changing the words to suit your personal style.

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals around this situation?
4. Is there any advocacy that I can partner with you on?

Davey can use his personal story quite a bit with John because he has gone through a similar experience. If you have not experienced a situation like this and feel like you cannot relate after the first meet and greet, what can you do? Here are some suggestions:

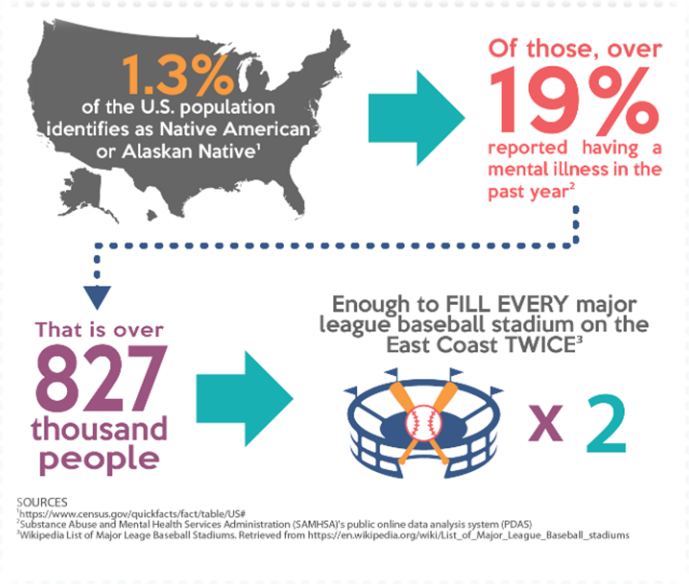
- Ask John if he would like to talk with someone who has this specific lived experience, and if he says yes, assist him in connecting with a colleague or someone he can better relate to.

- Say something like this, “Hey John, I don’t have this specific experience but I do know what it feels like to be stressed out about having to tell your family something they are not going to want to hear. Is there anything I can do to help you prepare for that conversation? Would you feel more comfortable talking to someone from a background and culture more like yours?”

NATIVE AMERICAN AND INDIGENOUS CULTURAL PERSPECTIVE

In the nineteenth century Native Americans were violently taken from their lands and homes to reservations, sometimes hundreds of miles away. Thousands died in such forced marches. Broken treaties, land frauds, and military attacks happened often. Some tribes responded with armed resistance, like in the “Indian Wars” of the 1880s, but they were defeated.

In 1887, the General Allotment Act (or “Dawes Act”) nullified tribal land holdings, assigning each Native American 160 acres “in trust,” while the rest was sold. As “trustee,” the US government stole legal title to the parcels, established an Individual Indian Trust, and assumed full responsibility for management of the trust lands. In all, 90 million acres of land, or about 67% of Native American land was seized and the communal property system was destroyed.



Many Native/Indigenous tribes embrace a worldview that encompasses the concept of connectedness; strong family bonds, adaptability, oneness with nature, wisdom of elders, meaningful traditions, and a strong sense spirit may often serve as protective factors against mental health and substance use disorders. While many people of Native American descent find strength in these cultural practices and traditions, do not assume that all tribes and tribal activities are the same. Tribes are very different and have different cultures within a larger culture. For example, there are different languages, food, and ways of dressing among tribes. As a Peer Support Specialist and/or Recovery Coach, be prepared to know where indigenous people can go to get culturally appropriate resources, including mental health and treatment services.

If you have not had trauma-informed care training, it would be important to do so. Learn how to approach people who are experiencing historical trauma by using a trauma-informed lens.

Access to mental health services is severely limited by the rural, isolated location of many Native American/Indigenous communities. Access is limited because many clinics and hospitals are located on reservations. Many Native American /Indigenous people in America live outside of tribal areas and reservations. Do not assume that a person is from a reservation because they identify as being Native American/Indigenous. Use cultural humility and open-ended questions when you meet people from another culture. Do not wear culturally appropriated clothing or symbols. Do not co-opt a part of a culture because it is trending on Instagram. Trustworthiness is one of the most important ingredients in a peer relationship.

Krista Mahle is from Lummi Nation in Washington State. She teaches Recovery Coaching and Peer Support classes. She says:

"We are proud of who we are and will not accept being looked down on in any way. We have current and historical trauma that we deal with every day. It is important to be trauma-informed and ask, "What happened?" rather than "what is wrong?" -this is a way to move the focus from the person to the situation."

Native American and Indigenous Scenario

Hiaqua, he/him, is a part of a peer-led group that focuses on sobriety. Hiaqua has 2 years sober and wants to go on the annual Canoe Journey. The last time he went on the journey he embarrassed himself and his family by getting really drunk and high. He is afraid to tell his Recovery Coach, Jason, that he has decided to go. He does not want to answer too many questions about his culture, and he does not know if the other group members will think it is a good idea for him to go.

Hiaqua also has a Peer Support Specialist that he likes, trusts, and has worked with for about a year. His name is Tobias. Hiaqua has made an appointment with Tobias in order to get help with his decision to go on the Canoe Journey and to process with Tobias the ways to tell the group his decision. He believes that Tobias will have a more favorable view of the Canoe Journey than Jason. Hiaqua had also been on medically assisted treatment for the first year of his sobriety. He wants to talk to Tobias about the possibility of getting back on it.

If you were Tobias:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Hiaqua?
- What would you do if you did not have personal experience with his culture?
- If, and when would you bring in Jason, Hiaqua's Recovery Coach?

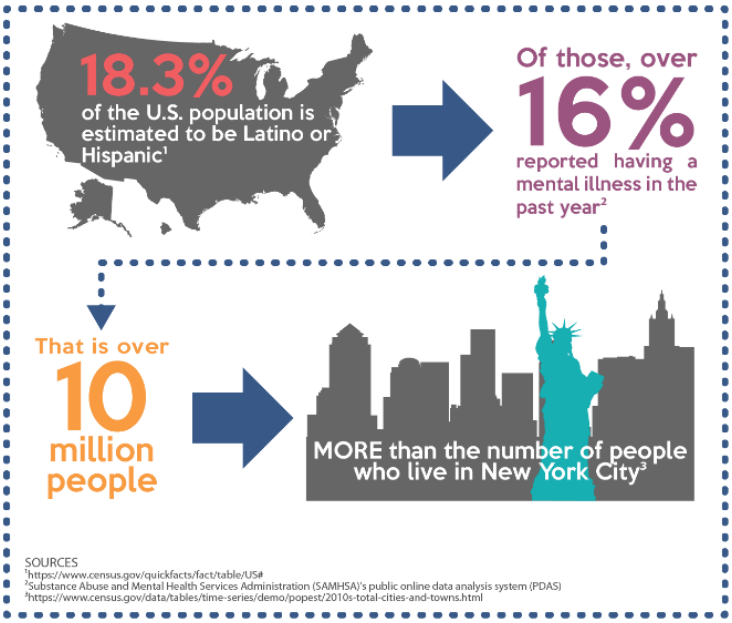
Suggested approach

It is a good idea to participate in active listening, reflection, and paraphrasing. Using open-ended questions, Tobias will explore Hiaqua's concern about what the group might think about him. Tobias will ask him directly if he is afraid that he will relapse if he goes on the Canoe Journey. He never offers advice. He will ask him what the Canoe Journey means to him. Tobias is concerned that Hiaqua wants to go back on medically assisted treatment. He believes in abstinence as he personally, works a 12-step program. Tobias has never given advice or discussed his preferred way of recovery with Hiaqua. He knows that there are many ways to recovery; and just because a 12-step program works for him it may not work for everyone. This is called recovery culture humility. Peer Support Specialists and Recovery Coaches do not have all the answers. They only have their own lived experience to offer. Tobias will ask him if he has any natural supports, like friends or family going on the Canoe Journey that support his sobriety. He suggests having a meeting with both he and Jason to discuss the situation. Tobias and Jason will offer to make a relapse prevention plan for the trip if that is something Hiaqua wants. Here are some questions they can ask:

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that we can partner with you on?

LATINX AND HISPANIC CULTURAL PERSPECTIVE

In the Latinx/Hispanic cultures family comes first, (usually after God). Traditional Latinx/Hispanic individuals are brought up very close to their immediate and sometimes even extended family members. Generally, elders are highly regarded, and children must respect their parents. Many families live in multigenerational households that include parents, siblings, and grandparents. Sometimes other extended family members also reside in the home at one point or another.



When working with Latinx/Hispanic individuals, it is best to remember that family may play a large role in their everyday lives. If working with someone from the Latinx or Hispanic population who has been separated from their family, it is important to start building natural supports right away. When working with the whole family, as a Peer Support Specialist or Recovery Coach, do not speak for the program participant. Do not ask a family member to translate. Do not assume that translation is necessary. Remember peer support is voluntary and about voice and choice.

Hispanic and Latino are terms that are often used interchangeably though they mean two different things. Hispanic refers to people who speak Spanish or are descended from Spanish-speaking populations, while Latino refers to people who are from or descended from Latin America. In the United States, these terms are thought of as racial categories and are used to describe race in the same way as White, Black, and Asian Pacific Islander labels. However, the populations described by these terms are composed of various racial groups; thus, using them as racial categories is inaccurate.

A variety of cultures and subcultures are encompassed by each term. Make no assumptions about a person's ethnicity. Ask people direct questions with respect and dignity. Use cultural humility to be open to learning new things about the people you are working with.

Latinx and Hispanic Scenario

Alex, he/him, is a 26-year-old Latino man who has been married for eight years. Pedro, he/him, is Alex's Recovery Coach. Alex has been in recovery for five years. He lives with his wife and three young children. He is meeting with Pedro because he had his first follow-up primary care visit after receiving an HIV diagnosis last month.

Alex stated that he has not shared the information about his HIV status with his family yet, because he is afraid that they will reject him. Alex is recovering from heroin abuse and has been very successful in his current career. He expressed to Pedro that he is afraid his friends and family might think he has relapsed. He wants to talk to Pedro and make a plan about how to tell his wife about his diagnosis.

If you were Pedro:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Alex?
- What would you do if you did not have personal experience with his culture?

Suggested approach

Pedro and Alex have developed a trusting relationship and they come from similar backgrounds. Alex knows that Pedro understands how important his family is to him. Alex believes that to risk losing his family, is to risk losing everything important in life. Pedro is open and curious about what Alex is going through, and he is not critical at all. He uses open-ended questions and some of his personal recovery experience to bring hope to the interaction.

Pedro looks at pictures of Alex's family and comments on how much Alex has done for his family to support them and keep them safe. Alex agrees that safety and his love for his family is the most important thing to him. He and Pedro create a strategy to tell his wife about his diagnosis. Alex agreed to co-create a Wellness Recovery Action Plan

with Pedro before he tells his wife. This is a type of relapse prevention plan that has been useful to Alex in the past. At no time would he accuse Pedro of relapsing.

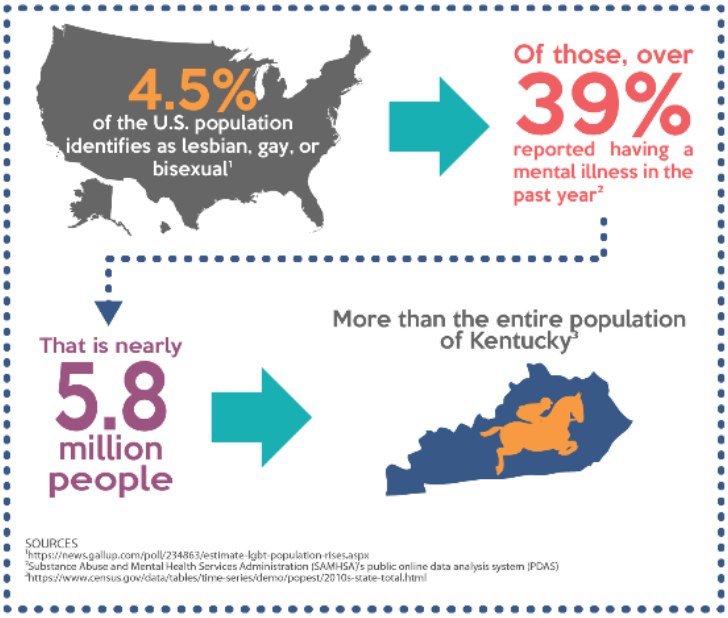
Here are some questions that can be asked to guide in this situation:

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Can I partner with you in advocacy?

GAY, LESBIAN, AND BISEXUAL CULTURAL PERSPECTIVE

People who are lesbian, gay, bisexual, or transgender (LGBT) are members of every community. We will speak in depth on the “T” portion of this acronym in the next module. People that identify as being a part of the LGBT community are diverse, come from all walks of life, and include people of all races and ethnicities, all ages, all socioeconomic statuses, and are from all parts of the country.

Lesbian, gay, bisexual, and transgender individuals still face extensive discrimination and prejudice in society. There has been a rise in violence perpetuated on people who are gay, lesbian, or transgender. Peer Support Specialist and Recovery Coaches can affirm a person’s ability to integrate their sexual identity in healthy ways into their personal recovery if that is what they choose to do. In order to best serve individuals that identify as (LGBT) you will need to learn some terms. These may or may not be familiar to you. Remember to be curious and not critical. Practice cultural humility, especially if you are from a religious background, as many religious organizations have had a history of discriminating against and stigmatizing gay, lesbian, bisexual, and transgender individuals.



Terms

Sexual Orientation

Sexual orientation is an enduring pattern of romantic or sexual attraction to persons of the opposite sex or gender, the same sex or gender, to both sexes or to more than one gender. These attractions are generally subsumed under heterosexuality, homosexuality, and bisexuality, while asexuality is sometimes identified as a fourth category.

Gender Identity

Gender is concept (rather than a tangible, physical feature like sex) that has been constructed by society. Gender identity is the personal sense of one's own gender. Gender identity can correlate with a person's assigned sex at birth or it can differ from it. Gender expression typically reflects a person's gender identity, but this is not always the case. While a person may express behaviors, attitudes, and appearances consistent with a particular gender role, such expression may not necessarily reflect their gender identity. The term gender identity was originally coined by Robert J. Stoller in 1964.

Gender Expression

Gender expression, or gender presentation, is a person's behavior, mannerisms, interests, and appearance associated with gender in a particular cultural context, specifically with the categories of femininity or masculinity. This also includes gender roles. These categories rely on stereotypes about gender.

Gay

Gay is a term that primarily refers to a homosexual person or the trait of being homosexual. The term was originally used to mean "carefree," "cheerful," or "bright and showy." The term's use as a reference to male homosexuality may date to the late 19th century, but its use gradually increased in the mid-20th century. In modern English gay has come to be used as an adjective, and as a noun, referring to the community, practices, and cultures associated with homosexuality.

Lesbian

A lesbian is a homosexual woman. The word lesbian is also used for women in relation to their sexual identity or sexual behavior, regardless of sexual orientation. It can also be used as an adjective to characterize or associate nouns with female homosexuality or same-sex attraction.

Bisexual

Bisexuality is romantic attraction, sexual attraction, or sexual behavior toward both males and females, or to more than one sex or gender. It may also be defined as romantic or sexual attraction to people of any sex or gender identity, which is also known as pansexuality.

Transgender

Transgender people have a gender identity or gender expression that differs from their sex at birth. Some transgender people who desire medical assistance to transition from one sex to another identify as transsexual. Transgender, often shortened as trans, is also an umbrella term. In addition to including people whose gender identity is the opposite of their assigned sex, it may include people who are not exclusively masculine or feminine. Other definitions of transgender also include people who belong to a third gender or conceptualize transgender as a third gender.

Cisgender

Cisgender is a term for people whose gender identity matches their sex at birth.

Statistics

- Approximately 1 in 8 lesbian women (13%), nearly half of bisexual women (46%), and 1 in 6 heterosexual women (17%) have been raped in their lifetime. This translates to an estimated 214,000 lesbian women, 1.5M bisexual women, and 19M heterosexual women.

- 4 in 10 gay men (40%), nearly half of bisexual men (47%), and 1 in 5 heterosexual men (21%) have experienced Spousal Violence (SV) other than rape in their lifetime. This translates into nearly 1.1M gay men, 903,000 bisexual men, and 21.6M heterosexual men. The “Me Too” movement is not just for women.

- 44% of lesbian women, 61% of bisexual women, and 35% of heterosexual women experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.

- LGBT Veterans are at a disproportionate risk for suicide and other poor health outcomes, due in part to barriers in accessing services and lack of social support.

- According to the FBI data of the nearly 1,200 incidents targeting people due to their sexual orientation, the majority of the incidents targeted gay men (roughly 60%), while approximately 12% targeted lesbians, 1.5% targeted bisexuals, and 1.4% targeted heterosexuals.

As a Recovery Coach or Peer Support Specialist it is statistically likely that you will work with an individual who has been a victim of a hate crime. Cultural humility and trauma-informed care are called for in this situation. For those who survive hate crimes, the lasting physical and mental health challenges are immense and can lead to ongoing health problems. Peer support is an excellent intervention for individuals who have experienced trauma. If you are comfortable, this is a place where you can share parts of your story. This is where you can bring hope to a hopeless situation. Have plenty of culturally relevant resources and referral services available for people that have been traumatized. Suicide attempts among LGBTQ youth and adults occur at a significantly higher rate than in the general population. Understanding basic components of suicide prevention are a must. Mental Health First Aid and e-CPR are two excellent training choices that will help you and the peers with whom you work.

Take a minute to examine any personal bias you may have regarding culture. Identify where you may need more education. You can join a book club specifically based on cultural humility or ask a friend to recommend some books. As a Certified Peer Counselor and/or a Recovery Coach you need to engage in continuing education as the field of behavioral heal is ever growing.

Gay, Lesbian, and Bisexual Scenario

Sheila, she/her, is a 19-year-old female. She is meeting with Rita, she/her, who is her Peer Support Specialist. Sheila has seen Rita about four times and really gets along with her and likes her. Sheila has known she was gay since she was eleven years old. She is from a strict African American, Baptist family that believes that people who are gay, lesbian, or bisexual will go to hell in the afterlife. Sheila is very worried that she will disappoint her parents if she reveals she is gay, yet she feels she must be herself. She cannot go on pretending to be someone she is not. She respects her parents' belief system but cannot believe in a God that would not accept her as she is. She asks Rita to help her write a letter to her parents. She knows what she wants to tell them: She is not going to attend church anymore and that she is gay. Sheila is scared and believes that her parents will kick her out of the house immediately, so she needs to work on finding emergency housing and on saving money so she can support herself. Rita has shared that she is a lesbian. Sheila hopes that Rita can help her make a plan and give her some resources.

If you were Rita:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Sheila?
- What would you do if you did not have personal experience with this culture?
- Do you think this is an appropriate time to bring up any of your own personal experiences if you have them?

The rainbow flag was a way of taking these various colors and turning them into a coherent symbol, reclaimed by the LGBT community. It symbolizes safety and unity to millions of people.

Suggested approach

Sheila, she/her, and Rita, she/her, have developed trust and they come from similar backgrounds. Sheila knows that Rita understands how important her family is to her. Rita will use her lived personal experience about the time she came out to her conservative and very loving family. She will not give advice or judge Sheila. Rita is Caucasian and will not pretend or (over) relate to Sheila's entire experience. She will use cultural humility, respect, and appreciative inquiry to find out what Sheila needs and how to best support her. She will tell her about Parents, Families, and Friends of Lesbians and Gays (PFLAG). PFLAG is a well-known and well-respected family resource. Rita will share statistics and health disparities with Sheila, engaging in psychosocial education from a peer perspective. Rita will discuss her own thoughts of suicide right before she came out and give Sheila the Trevor Project contact information. Rita will encourage Sheila to go at her own pace and consider all her options before she moves forward with a plan.

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that I can partner with you on?

TRANSGENDER CULTURAL PERSPECTIVE

What Does It Mean to be Transgender?

According to Webster's dictionary, the term "transgender" means, "denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex."

Dakota Steel is a member of the Cultural Coalition for Peers in Washington State. He describes being transgender as "being in the wrong package":

"It is often a dilemma of honesty and authenticity in a cold and judgmental world where people want other people to match their packaging."

Often, judgements about one's identity quickly turn into fear of the unknown and can lead to violence. Dakota has been injured by two violent attacks because of his identity, these attacks are called hate crimes. Sometimes people hate things they do not understand.

Assigning someone's sex is based on biology -- chromosomes, anatomy, and hormones. But a person's gender identity -- the inner sense of being male, female, or both -- does not always match their biology. Transgender people say they were assigned a sex that is not true to who they are inside. Many people have assumptions about what it means to be transgender, but it isn't about surgery, or sexual orientation, or even how someone dresses. It is how they feel. The Williams Institute, says there are nearly 700,000 people living publicly as transgender in the U.S. Each one is unique, and their journeys are personal.

Peer Support Specialists and Recovery Coaches should understand some terminology before we move forward in this module. There are some terms that may confuse you or you have never heard before. None of the terms are meant to insult you or fly in the face of any values or beliefs you may have. Remember to be curious and not critical - and to approach all situations with Cultural Humility.

Terms

Binary – (noun)

The idea that there are only two genders — male/female or man/woman and that a person must be strictly gendered as either/or.

Of or pertaining to someone who identifies with one of the binary genders (man or woman).

Cisgender or Cis – (adj; pronounced “siss-jendur”)

Frequently shortened to cis; a person whose gender identity and biological sex assigned at birth align (e.g., a cisman is man and male assigned at birth, a ciswoman is a woman and female assigned at birth).

Gender Expression – (noun)

The external display of one’s gender through a combination of dress, demeanor, social behavior, and other factors, generally measured on scales of masculinity and femininity. Also referred to as “gender presentation.”

Gender Identity – (noun)

The gender a person knows they are internally and how they label themselves. Common identity labels include male, female, genderqueer, non-binary, and more. Considered to be one aspect of sex. When gender identity conflicts with other sex characteristics, such as chromosomes or genitalia, a person’s internal gender identity replaces their sex assigned at birth.

Nonbinary - (noun)

Refers to any gender that is not exclusively male or female. A similar term is genderqueer.

Also is a way of thinking that sexuality, gender, and gender expression exist on a continuous spectrum as opposed to an either/or dichotomy.

Transgender or Trans – (adj)

Umbrella term covering a range of identities that transgress socially defined gender norms.

A person who lives as a member of a gender other than that assigned at birth. A trans man is a man assigned female at birth. A trans woman is a woman assigned male at birth. Trans does not indicate sexual attraction or sexual orientation.

Sex – (noun)

A vague term used to refer to a number of characteristics traditionally associated with males and females, including, but not limited to gender identity, sex chromosomes, genitalia (internal and external), endocrine system, and secondary sex characteristics. Often seen as a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics, it's more accurate to view this as a nonbinary spectrum.

Transgender Flag- Flags and symbols let people know they are in a safe zone.

Statistics

- 50% Must educate their healthcare teams,
- 65% Struggle with Substance Use Disorder,
- The average life span of a black trans woman is 35 years old,
- Depression and anxiety diagnosis 41%,
- 71% Hide their identity at work and do not feel safe to be themselves,
- Homelessness 40% (57% due to family rejection),
- 60% Do not have an ID that matches their gender identity,
- 1 in 6 Trans students leave school due to discrimination and bullying; and,
- Supported trans youth are 67% less likely to attempt suicide.

When working with a program participant who is transgender, they will likely have a few more barriers than other individuals you work with. They may not have a passport or driver's license that matches their identity. They may not have access to locker rooms or bathrooms where they feel safe. Traveling is often dangerous. They can be denied housing and lose or not get hired for jobs for which they are well-qualified. There are disproportionate rates of violence that transgender individuals may also face. When you start working with someone who is transgender, they may not have any natural supports to identify. They may have created their own family, and their biological family may have rejected them. Be aware of all these real barriers when you begin working with an individual who is transgender.

People that are marginalized or isolated from mainstream society often need more assistance than someone that isn't in a socially marginalized group. Individuals that identify with these groups are the most statistically underserved by both public and private services. Often they are chronically under or unemployed, making it less likely they can afford or obtain access to services like healthcare. These are called healthcare disparities. Healthy People 2020 defines a health disparity as, "a particular type of health difference that is closely linked with social, economic, and/or an environmental disadvantage.

What About Pronouns? Why Are They Important?

Personal pronouns are the words used in place of specific people, places, or things. Pronouns like “me, myself, and I” are how people talk about themselves, and pronouns like “you, she, he, and they” are some pronouns that people use to talk about others.

A person's pronouns are the third-person singular pronouns that they would like others to use in place of their name. Personal pronouns are used to convey a person's gender identity and do not necessarily align with the sex a person was assigned at birth. The most common third-person singular pronouns are "she/her/hers" and "he/him/his." "They/them" can also be used to refer to a single person, while some people use gender-neutral or gender-inclusive pronouns like "ze/hir" (pronounced zee/here) instead. Some people might not use pronouns at all and go only by a name.

Approach individuals who want to be called what you may think is “unique” pronouns with cultural humility. Using the pronouns that a person goes by is a way of respecting that person's gender identity -- or a person's emotional and psychological sense of their own gender and sense of self. If someone tells you that they go by the pronouns "they/them," for example, and you continue to refer to them using "he/him/his" pronouns, it can imply that you believe that transgender, non-binary or intersex people are unimportant, or shouldn't exist. It can create a lack of safety and trust in a helping relationship.

What is an Ally?

An ally (pronounced al-eye) is one that is associated with another as a helper: a person or group that provides assistance and support in an ongoing effort, activity, or struggle, like “a political ally.” Example: She has proven to be a valuable ally in the fight for better working conditions.

“Ally” is often used specifically for a person who is not a member of a marginalized or mistreated group but that expresses or gives support to that group.

Here are some simple ways to start being a more engaged and active ally:

- Be open. Talk about having lesbian, gay, bisexual, transgender, and queer (LGBTQ) friends, family members, colleagues, and acquaintances. However, when you talk about them please make sure you have their permission.

- Ask questions. If you hear acronyms, terminology, or references you are not familiar with- commit to getting the answers.

- Stay informed. Learn about the realities, challenges and issues affecting the lives of people who are Transgender through news stories, social media, websites, books, documentaries, and educational materials.

- Speak up. When you hear Transgender slurs, jokes, or misinformation, say something. Explain why you are an Ally, make your case for more welcoming and inclusive spaces.

- Teach equality. Be mindful of the day-to-day messages that your family, friends and colleagues are receiving about Transgender people in schools, from their friends and family, the web, social media platforms, and TV.

- Challenge those around you. Encourage the organizations you are a part of – including social groups, your workplace, or faith community – to consider inclusive policies that protect the Transgender community from discrimination and bias.

- Be an advocate. Call, write, email, or visit public policy makers and let them know that as an ally that votes, you support laws that extend equal rights and protections to ALL people.

- Above all, replace judgment with intrigue.

Transgender Scenario

Mark, they/them, is 36 years old and is directed to get peer support and counseling by their doctor after having decided, as a part of their personal transition, to undergo sex reassignment surgery from male to female. They will change their name to Sonia. Mark reports they have suffered for a long time trying to live as a man when they are, in fact, a woman. Mark is meeting with Dee, she/her, for the first time. All Mark knows is that Dee transitioned from male to female about five years ago and is someone their doctor wants them to talk to as a Peer Support Specialist.

Mark is currently experiencing feelings of sadness, anxiety, stress, and anger about the way they have been treated by their family and certain friends because of Mark's gender identity. Mark has started drinking alcohol on daily basis to numb their emotions and fall asleep at night.

If you were Dee:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Mark?
- What would you do if you did not have personal experience with this culture?
- Do you think this is an appropriate time to bring up any of your own personal experiences if you have them?

Suggested approach

Dee, she/her, and Mark, they/them, have not met yet so they have not been able to develop trust. When they do meet, Dee will use her story and her skills as a Peer Support Specialist to break the ice with Mark. Dee tells Mark what peer support is and what it is not and orients them to the agency policies and their rights. Dee remains conscious of cultural humility even though she has had some similar experiences. She does not assume she knows what Mark is going through. She engages in active listening and reframing to make sure she understand where Mark is coming from. Dee will take into consideration all the needs Mark identifies at this time and ask them what they want to work on first. She does this by asking, “What is happening in your life right now that is interfering with your serenity and wellbeing?” Mark will lead the conversation and discuss what priorities to work on first. The two of them will make a plan together. Mark asks Dee to go to their first counseling session. After Dee checks with her supervisor, she agrees to go. After they meet with the doctor, they will work on co-creating goals for Mark.

Some questions Dee can ask Mark to get the ball rolling are:

1. How best can I support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that I can partner with you on?

SUMMARY

Many trainings do not touch on cultural humility or identify exactly how to discuss and incorporate culture into a peer support practice. They discuss what culture is in a very general way. They rarely identify the crucial importance that culture plays in recovery. This Primer is an introduction to a few selected cultures, co-written by people from those cultures. We made it as readable as possible and gave plenty of statistics which are referenced in the appendix. This Primer is meant for people who have not been exposed to diversity in their lives and are now employed in diverse agencies and working with diverse groups of people.

We hope this information gives you a framework on which you can put your own personal touch in your practice as a Peer Support Specialist and/or Recovery Coach. The fact that you are reading this Primer means that you are seeking more information, educating yourself in an effort to be the best helper you can be.

Remember, the first step of developing a multicultural lens, is an assessment of your personal and professional cultural awareness needs. Becoming aware of culturally learned assumptions as they are both similar and different from members of other cultures is the foundation of peer support core competence. Being open, flexible, and curious are great benchmarks or places to start in developing cultural humility. You will find areas where you are racist and hold bias. It is human nature. It is the openness to accept and awareness of these attitudes- as well as the conscious effort to continually educate yourself and grow, that will make differences in the lives of people who are marginalized and face health disparities. Every human being has an equal right to healthcare regardless of their socio-economic status or culture.

APPENDICES

Appendix I – Culture Glossary

Appendix II – Behavioral Health Glossary

Appendix III – Acronyms

Appendix IV – Tools

Appendix V – White Privilege

Appendix VI – Multicultural Counseling Clinical Description

Appendix VII – Resources and References

APPENDIX I – CULTURE GLOSSARY

Culturally Competent (outdated term) – At this point in time agencies are characterized by their acceptance and respect for differences, a continuing self-assessment regarding culture, their careful attention to the dynamics of difference, a continuous expansion of cultural knowledge and resources, as well as the variety of adaptations to service models they employ in order to better meet the needs of minority populations.

Cultural Blindness – Cultural blindness is at the mid-point of the continuum; for example, “The system and its agencies provide services with the express philosophy of being unbiased. They function with the belief that color, culture, or social groups make no difference and that all people are the same."

Cultural Incapacity – This next position on the continuum is one at which the system or agencies do not intentionally seek to be culturally destructive but rather lack the capacity to help minority clients or communities. The system/agency remains racially biased, believes in the racial superiority of the dominant group, and assumes a paternal posture towards “lesser” races or social groups.

Cultural Humility – The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person].” Cultural humility is different from other culturally based training ideals because it focuses on self-humility rather than achieving a state of knowledge or awareness.

Cultural Pre-awareness – This term implies the movement of Agencies or systems on the continuum and recognize their weakness in offering services to minorities and attempt to improve some aspect of their services for specific populations.

APPENDIX II – GENERAL BEHAVIORAL HEALTH GLOSSARY

Adverse Childhood Event (ACE) – an experience during childhood that is difficult or traumatic. Experiences can include abuse, neglect, accidents, and divorce and loss.

Advocacy – promotes the cause of a person or idea.

Advocacy Groups – organizations that work in a variety of ways to create change with issues that affect society (NAMI and Youth 'n Action are examples).

Age of Consent – the age at which a person may independently consent to or deny treatment. With some legal exceptions for involuntary treatment, the age of consent varies from state to state.

Alcohol Abuse – a pattern of alcohol use leading to significant impairment or distress; see also **Substance Abuse** and **Substance Dependence**.

Appeal Process – a series of steps followed to get a decision about services reviewed and changed.

Assessment – the gathering and appraisal of information in order to identify a person's needs and strengths.

Bias – a belief a person has about a thing, person, or group of people. Biases can be conscious or unconscious, positive or negative, but are most often considered unfair.

Bilingual Staff – staff that can speak more than one language.

Boundaries – refers to the degree of closeness we have with an individual.

Case Manager – the health care professional who works directly with an individual or children and their families to coordinate various activities, services and supports, and acts as the consumer's primary contact with other members of their treatment teams; also called **Rehabilitation Specialist**, **Service Coordinator**, and **Social Worker**.

Case Management – a service that helps people arrange for appropriate services and supports. A case manager coordinates mental health, social work, educational, health, vocational, transportation, advocacy, respite care, and recreational services, as needed.

Certified Peer Counselor (CPC)/Peer Support Specialist (PSS) – a person who has completed state approved training, passed a state test, and is credentialed by an authorized agency to practice peer support in their state.

Child Abuse or Neglect – the injury, sexual abuse, or negligent treatment or maltreatment of a child by any person where a child's health, welfare, and safety are harmed.

Credential – the approval by the Department of Health to work in the counseling field. The credential may vary by level of education; however, most CPCs apply for an **Agency Affiliated Counselor credential.** A credential is required to work in a Medicaid setting, except for the first 60 days after applying to Department of Health (DOH).

Clubhouse –derived from the Fountain House model of psychiatric rehabilitation; it is a club that belongs to everyone who participates in it, providing supportive companionship with a focus on opportunities for employment.

Collaboration –where professionals and/or agencies with linked functions work effectively together on common issues, including the provision of care to an individual person.

Community – defined by the organization or person. The "Community" is identified by who is in the organization's service population. It can also be defined by geographic location/place, or by cultural group (e.g. gender, ethnicity, health diagnosis, population, e.g. Veterans, Hard of Hearing, LGBT…).

Confidentiality – the protection and proper use of patient information. Information given or received for one purpose may not be used for a different purpose or passed to anyone else without the consent of the provider of the information.

Consumer (outdated term) – a term not generally preferred to describe someone who uses or has used mental health services because of mental health challenges or a disability. The term includes parents and guardians in many situations. Also called peer or individual.

Continuum of Care – a term that implies a progression of services that an individual moves through, usually one service at a time. More recently, it has come to mean comprehensive services. Also see **system of care** and **wraparound services**.

Co-occurring Disorder – see **Dual Diagnosis**.

Coordination – means bringing people together to work efficiently.

Coordinated Services – means that several child-serving or peer-serving organizations talk with the family or individual and agree upon a plan of care that meets the child's or peer's needs. These organizations can include mental health, education, juvenile justice, adult criminal justice and child welfare. Case management is necessary to coordinate service. Also see **family centered services** and **wraparound services**.

Counseling – aims to help people develop insight into their problems and identify resources within themselves so that they can cope more effectively with their situation; see also **psychotherapy**.

Criminal Justice System – includes all agencies involved in criminal justice including the police, probation service, courts, and prisons.

Crisis – a time of extreme trouble and an opportunity for growth.

Culturally Appropriate Services – a set of values, attitudes, and practices held by an organization or individual service provider that are sensitive and responsive to cultural differences. These differences can include race and ethnicity, national origin, language, beliefs, religion, age, gender, sexual orientation, physical disability, or family values and customs.

Culture – the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

Cultural Groups – a subgroup that is from major racial or ethnic groups of African American, Hispanic, Asian American Pacific Islander, American Indian/Alaskan Native or from a recent immigrant or refugee population. Subgroups can be identified by distinct languages (e.g., Mandarin-speaking Chinese among Asian Americans), or locales of origin (e.g., Dominicans among Hispanics); or, a subgroup that is identified by the agency as requiring special attention since features of its "culture" limit the ability of its members to appropriately access or participate in mainstream service delivery systems. Such subgroups might include, but are not limited to, gay and lesbian communities, people with hearing impairments, rural and "mountain folk," migratory workers and so on.

De-escalate – to lower the intensity of a situation; often refers to a way of communicating with a person when they are upset or in crisis.

Deinstitutionalization – the process of releasing individuals from psychiatric institutions.

Dilemma – a situation where a difficult decision must be made.

Disability – a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

Discharge Plan – a care plan for people being discharged from a hospital or residential center.

Discharge Planner – the person on the hospital or residence staff who makes plans for an individual's health care outside of the hospital; this can be a nurse, doctor, resident/intern, or social worker.

Disclose – to share or make known.

Discrimination – treating a person differently, usually in a negative way, based on differences in culture, beliefs, or other characteristics.

Diverse – differing from one another.

Diversity – the practices or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc.

Diversion – the movement of an individual from the criminal justice system or hospital to health and/or social care.

Drug Dependence (Substance Use Disorder) – occurs when an individual persists in using a drug despite problems related to the use of the drug, such as legal, health, family, occupational or other problems resulting from the drug use. It can be diagnosed either with or without physical dependence, which means issues of tolerance to and withdrawal from the substance.

Dual Diagnosis – the combination of mental health challenges with other conditions, including alcohol abuse, substance abuse, compulsive gambling, a learning disability, or a physical disability. Also called **Comorbidity** or **Co-occurring Disorders**.

Duty to Warn – a mandatory reporting requirement for an employed certified peer counselor to directly warn a person who has been seriously threatened.

Early Intervention – a process used to recognize warning signs for mental health challenges and to take early action against factors that put individuals at risk.

Eligibility Criteria – guidelines used when a person seeks mental health services to determine the priority of their need and the degree of risk, in order to make decisions about the appropriate use of services. These may include age, disability, income, or type of insurance.

Emergency and Crisis Services – a group of services that is available 24 hours a day, seven days a week, to help during a mental health emergency. Examples include telephone crisis hotlines, suicide hotlines, crisis counseling, crisis residential treatment services, crisis outreach teams, and crisis respite care.

Empathize – to identify with or develop an understanding of another's situation, feelings, or motives.

Empower – to give authority, control and confidence to a previously disadvantaged group or person.

Environmental Approach – an approach to mental health treatment that attempts to influence either the physical environment (such as reducing access to lethal means) or the social environment (such as providing work or academic opportunities).

Evaluation – the systematic investigation of the value and impact of an intervention or program.

Ethics – refers to principles of right and wrong, as well as to the rules an organization or group agrees to share.

Evidence-Based Practices (EBP) – activities or programs that have been shown to be effective through scientific testing and reproduction of practices. Various organizations have lists of these practices.

Facilitation – the practice of working with several people or a group to aid in learning and discussion.

Family-Centered Services – services designed to meet the specific needs of each individual child and family; see also appropriate services, coordinated services, wraparound services, and cultural competence.

Family Focused – an approach to designing and providing services that views the child as a member of a family and recognizes that everyone in a family can be affected by how the others act, what they say, or how they feel or are doing in school or work. Decisions about services are made considering the strengths and needs of the family as a whole, as well as the individual child with a mental health challenge.

Family Support Services – services designed to keep the family together, while coping with mental health challenges that affect them. These services may include peer information workshops, in-home supports, family therapy, parenting training, crisis services, and respite care.

Frequency – the number of occurrences of a disease or injury in a given unit of time.

Goal – a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work. In behavioral health, goals are designed to increase recovery and resilience.

Gender Identity – the sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected social roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.

Health Equity – the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities (Healthy People 2020). Such goals aren't unfamiliar to public health practitioners—the field has a long and storied tradition of serving the most vulnerable and bringing life-saving care to communities that would have otherwise gone without.

(Retrieved from: http://www.apha.org/~/media/files/pdf/topics/equity/equity_stories.ashx)

Health Literacy – the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. *Organizational health literacy* is what organizations and professionals

do to help people. ~ Find ~ Process ~ Understand ~ Decide on health information and services. Organizations that remove health literacy barriers are “health literate.”

Health Promotion – education and support that enables people to increase their control over the factors that influence their health, thereby improving their health.

Holistic – considering the whole person in the treatment of their illness, i.e., the physical, emotional, psychological, spiritual, and social aspects of their life.

Homelessness – describes people living in a broad spectrum of unsatisfactory housing conditions ranging from cardboard boxes and park benches through night shelters and direct access hostels to bed and breakfast accommodation or even sleeping on a friend's floor.

Individual – defined in behavioral health state law as a person receiving or who has received services. For the purpose of services, a parent or legal guardian meets these criteria.

Immigrant – someone who chooses to resettle to another country. The United States has a legal process for an immigrant to seek legal residency and eventually citizenship. Many immigrants; however, don't have such legal status and are, thus, undocumented. As such, they are subject to "removal" or deportation from the United States. There are 11M undocumented immigrants in the United States.

Intake – the process an agency or program uses to find out about a peer or child and family for the first time and determine their eligibility for services; also called **Initial Referral**; see also **Eligibility Criteria**.

Integration – treatment that approaches multiple challenges, such as substance use and mental health, or behavioral health, and physical health.

Internalized Stigma – negative beliefs about a condition held by a person having the condition.

Interpreters – individuals with specific language skills and knowledge of health care terminology who are trained to communicate effectively with persons with limited proficiency with the English language.

Interpreter Services – methods in place to assist persons with limited English proficiency. This includes telephone interpreter services (“language lines”), interpreters obtained from a central listing maintained by the organization or other source, trained volunteers from target community with identified language skills.

Intervention – an action taken, often by a professional to assist a person.

Language Needs – special accommodation such as interpreters and translated material to ensure that the person’s civil rights are being respected and clear recognition of culture-specific meanings attributed to terms describing mental illness.

Learned Helplessness – a belief that nothing a person can do will change their circumstances.

Limited English Proficiency – a diminished level of English language skills that calls into question the person's ability to understand and respond to issues related to their treatment.

Limited Reading Skills – while difficult to measure consistently, in general textual materials must be understandable to persons reading at a 6th grade level. Other formats may make material more understandable to service users and family members not fully comfortable with the English language at that level.

Managed Care – a system of delivering of health care services. Organizations are paid a set rate to provide services and must manage costs. Under managed care, an organization may specify which service providers the insured peer or family can see and make decisions about the type and amount of services are authorized.

Managed Care Organization (MCO) – a private health organization that provides comprehensive health care. These organizations may contract with the state to provide public services.

Medicaid Services – services that the Center for Medicare and Medicaid will include in reimbursements to agencies. Services include hospital and other 24-hour services, intensive community services, outpatient services, peer support for mental health, medical management, case management, intensive psychosocial rehabilitation services, detox, and residential treatment.

Mental Health – the way a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; explore choices; handle stress; relate to other people; and make decisions.

Mental Health Advance Directives – set out a person's wishes in writing concerning their care or treatment. Directives are binding legal documents.

Mental Health Professional – a professional who meets the requirements for this designation.

Mental Health Services – health services that are specially designed for the care and treatment of people with mental health challenges, including those with co-occurring substance use disorders.

Mental Injury – non-accidental damage to intellectual, emotional or psychological functioning, which is a Mandatory Reporting requirement.

Migrant (i.e. Migrant Worker) – individual who is required to be absent from a permanent place of residence for the purpose of seeking employment in agricultural work. Migrant farmworkers are also called migratory agricultural workers. Seasonal

farmworkers are individuals who are employed in temporary farm work but do not move from their permanent residence to seek farm work; they may also have other sources of employment. There are between 1 and 2.5M hired farmworkers in the US. About a half million of those are under the age of 18. Seventy-eight percent are male, and 22 percent are female. On average, hired farmworkers are young and predominantly Latino, have limited formal education, are foreign-born, and speak limited to no English. About half have authorization to work in the United States.

(Retrieved from: http://www.migrantclinician.org/issues/migrant-info/migrant.html)

Motivational Interviewing – a collaborative conversation to strengthen a person's own motivation for and commitment to change.

Mutual Support Groups – groups where service users and/or family members share their experiences and feelings about mental health challenges and generally help each other; also called **self-help groups**.

Needs Assessment – the process of assessing and monitoring health and social care needs of a population.

Objective – a specific and measurable statement that clearly identifies what is going to be achieved, often to meet a larger goal.

Open-ended Question – a question that cannot be answered "yes" or "no" but invites a person to discuss a question more fully.

Outcomes – measurable results, such as a change in the health of an individual or group of people that is attributable to an intervention.

Parent Advocate – an individual who has been trained to help other families get the kinds of services and supports they need and want. Parent advocates are usually family members who have raised a child with a behavioral or emotional problem and have worked with the system of care and many of the agencies and providers in your community. If a parent advocate is working in a Medicaid agency, they must be certified as a peer counselor.

Partnership – working closely with others to achieve agreed-upon common goals.

Peer – one term used for an individual (youth, family member or adult) who receives or has received services.

Physical Abuse – a non-accidental serious physical injury or injuries whose effect may be permanent or temporary, which is a Mandatory Reporting requirement.

Policy – a plan of action or an agreed position adopted by an organization.

Prevention – a strategy or approach that delays or reduces the likelihood of onset of a mental health problem.

Primary Care Services – the local provider or network which provides generalized healthcare services.

Privilege – in terms of culture, refers to rights, perceptions, and advantages a group has in society.

Protective Factors – factors that make it less likely that individuals will develop a disorder; these may include biological, psychological, or social factors in the individual, family, or environment.

Provider – any organization, agency, group of people or individual who supplies a service in the community, home, or hospital in return for payment.

Psycho-education – education offered to those with psychiatric disabilities and often their families with the intent of helping them to better understand and cope with their psychiatric disability.

Public Sector – any facility maintained or controlled by a central government, local government, or other statutory body; Medicaid services are public services, while other medical treatment may be private.

Recovery – the process in which people are able to live, work, learn, and participate fully in their communities.

Recovery Story – one individual's experience leading them to improve their life and their behavioral health.

Rehabilitation – restoring skills (e.g., vocational, social, or daily living skills) through treatment or by training.

Rehabilitation Specialist – see **Case Manager**.

Resilience – the capacities within a person that promote positive outcomes, such as in areas of mental health and well-being, and provide protection from factors like difficult experiences that might otherwise place that person at risk for adverse health outcomes.

Risk Assessment – an assessment of whether a person is at risk to themselves or others.

Risk Factors – certain factors that make it more likely that individuals will develop a mental disorder. Risk factors may include biological, psychological, or social factors in the individual, family, and environment, and are especially significant for children.

Screening – the administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment; see also **Eligibility Criteria**, **Intake**.

Screening Tools – instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems; see also **Eligibility Criteria**, **Intake**.

Self-advocacy – action taken by a person to get their needs and wants met.

Self-help groups – see **Mutual Support Groups**.

Service – a type of support or clinical intervention designed to address the specific mental health needs of a peer or a child and his or her family. A service could be provided only one time or repeated over a course of time.

Service Provider – see **Provider**.

Sheltered Work – work provided for people with mental health challenges or a developmental disability in protected or well-monitored settings, outside the usual workforce; compare to supported employment.

Side Effects – the unwanted physical effects of taking medication.

Social Support – assistance that may include companionship, emotional backing, cognitive guidance, material aid and special services.

Social Worker – a graduate of a school of social work who holds either a bachelor's or master's degree and who is trained in effective ways of helping people living with mental health challenges, and other groups in need of assistance. Some case managers are referred to as 'social workers' even without the credential.

Spiritual – relates to the spirit or soul as distinct from physical matters; it includes religion but goes much wider to embrace, for example, art and music.

Stages of Change – a theory describing stages a person may consider and make life changes. Stages include pre-contemplation, contemplation, planning, action, maintenance, and termination.

Stakeholder – anyone, including organizations, groups and individuals that is affected by and contributes to decisions, consultations, and policies.

Strengths-based – the practice of focusing on strengths, not deficits, in assisting a person or family.

Statutory – related to organizations set up by law, statute or regulation (e.g. county council, local authority).

Stigma – a general term for the widespread fear and misunderstanding of behavioral health challenges, together with the stereotyping and negative attitudes toward those who suffer from them.

Street Drugs – drugs that are not prescribed by doctors for the person using them; also called **Illicit Drugs**.

Strengths – the positive characteristics of any individual, child or family, including things they do well, people they like and activities they enjoy.

Substance Abuse – the use of a substance (e.g., alcohol, prescription drugs, street drugs, solvents, etc.) to the point that it has a negative impact on one's life (e.g., leads to fights, arrests, relationship problems, etc.); compare to substance dependence.

Substance Use Disorder – an unhealthy reliance on a substance; including but not limited to alcohol, drugs, food, gambling, sex and internet. The substance is taken more frequently, in higher doses, in inappropriate situations, or in spite of the user's desire to quit. This is the preferred term for a person with addictions to harmful substances and behaviors.

Supervisor – an individual who directs another's work. A Certified Peer Counselor must be supervised by a Mental Health Professional.

Support – help provide for and encourage a person.

Supported Employment – when a person is supported (usually by an organization or program) to obtain and retain open employment in the community; compare to sheltered work.

Supported Housing – where residents have their own accommodation, but a member of staff is available to provide support when necessary.

Symptom – a reported feeling or specific observable physical sign of a person's condition.

System of Care – a coordinated network of agencies and providers that make a full range of mental health and other necessary services available to peers or children with mental health challenges and their families.

Trauma – an event, series of events, or circumstances experienced by an individual as physically or emotionally harmful or life threatening and that has lasting negative effects on the individual's functioning and mental physical, social, emotion, or spiritual well-being. Trauma is a normal response to extreme events.

Treatment – a medical or psychological therapeutic intervention.

Treatment Plan – see **Individual Service Plan**.

Treatment Team – a group of professionals, service providers, family members and/or support people who meet to develop, implement and review a comprehensive service plan for an adult individual, or child and family.

Value – a principle that is important to an individual as a standard of value.

Vulnerable Adult – someone who is physically or economically dependent on another and unable to leave a situation without assistance, or a person who has a paid aide or home service provider.

Wellness Recovery Action Plan (WRAP) – refers to training on and use of the Wellness Recovery Action Plan developed by Mary Ellen Copeland.

Wraparound Services – individualized community-based services that focus on the strengths and needs of a child and family. Wraparound services are developed through a team-planning process, where a team of individuals who are relevant to the well-being of the child (such as family members, service providers, teachers, and representatives from any involved agency) collaboratively develop and implement an individualized plan of care, known as a wraparound plan.

Youth – an individual who is between 13 and 25 years old. This definition varies in different parts of the state, nation and by organization. It may also refer to an individual under the age of 18.

Youth Culture – the norms, values, language and music that define who a young person is.

Youth in Transition – a young person between the ages of 16 and 25 generally. This term is applied to youth who are aging out of the youth systems and moving into adult systems, which includes education to higher education, and does not necessarily mean that a young person who is in the mental health system will automatically move into the adult mental health system.

Youth Partner – a person who provides peer support to youth. Individuals providing services in Medicaid agencies must be certified as peer counselors and should be of a younger age and have good rapport with youth.

APPENDIX III – ACRONYMS

AA - Alcoholics Anonymous

ACS - Access to Care Standards

ACT - Assertive Community Treatment

ADA - Americans with Disability Act

ADHD - Attention Deficit Hyperactive Disorder

ADL - Activities of Daily Living

AFH - Adult Family Home

AOT - Assisted Outpatient Treatment

APS - Adult Protective Services

CBT - Cognitive Behavioral Therapy (general talk therapy)

CFR - Code of Federal Regulations (Medicaid Rules)

CIT - Crisis Intervention Training

CMS - Centers for Medicare and Medicaid Services

CPC - Certified Peer Counselor/ Peer Support Specialist

COD - Co-Occurring Disorders

COPS - Consumer Operated Programs and Services

CPS - Child Protective Service

DBT - Dialectical Behavioral Therapy

DD - Developmental Disability

DSM-5 - Diagnostic and Statistical Manual (5th edition)

DVA - United States Department of Veterans Affairs

DVR - Division of Vocational Rehabilitation

Dx - Diagnosis (Very clinical we stay away from this)

EBP - Evidence-Based Practice

EEOC - Equal Employment Opportunity Commission

EPSDT - Early Periodic Screening, Diagnosis and Treatment

EQRO - External Quality Review Organization

ESL - English as a Second Language

FAE/FAS - Fetal Alcohol Effects/Fetal Alcohol Syndrome

FERPA - Family Educational Rights and Privacy Act

FFCMH - Federation of Families for Children's Mental Health

GA - Gamblers Anonymous

LGBTQ - Lesbian Gay Bisexual Transgender Questioning

HHS - United States Department of Health and Human Services

HMO - Health Maintenance Organization

HIPAA - Health Insurance Portability and Accountability Act

HR - Human Resources

HWD - Healthcare for Workers with Disabilities

ICCD - International Center for Clubhouse Development

IDEA - Individuals with Disabilities Education Act

IDDT - Integrated Dual Disorder Treatment

IEP - Individualized Education Plan

IMR - Illness Management and Recovery

INAPS - International Association of Peer Specialists

ISP - Individualized Service Plan

IST - Interagency Staffing Team

ITC - Individualized and Tailored Care

JAN - Job Accommodation Network

LCSW - Licensed Clinical Social Worker

LD - Learning Disability

LMFT - Licensed Marriage and Family Therapist

LOS - Length of Stay

LRA - Least/Less Restrictive Alternative

LRE – Least/Less Restrictive Environment

MCO - Managed Care Organization

MDT - Multidisciplinary Team

MHFA – Mental Health First Aid (for substance use too!)

MI – Motivational Interviewing

NA – Narcotics Anonymous

NAMI - National Alliance on Mental Illness

NIH – National Institute of Health

NIMH – National Institute of Mental Health

OEF/OIF – Operation Enduring Freedom/Operation Iraqi Freedom (veterans)

PACT – Program for Assertive Community Treatment

PASS – Plan for Achieving Self Support

PCP – Primary Care Provider OR Person-Centered Planning

QA - Quality Assurance

QI - Quality Improvement

Rx – Medical Prescription

SA – Substance Abuse OR Sexual Abuse

SAMHSA – Substance Abuse and Mental Health Services Administration

SE – Supported Employment

SGA – Substantial Gainful Activity

SSA – Social Security Administration

SSDI - Social Security Disability Insurance

SSI - Supplemental Security Income

TBI – Traumatic Brain Injury

TWP – Temporary Work Placement

Tx – Treatment (Clinical Term Peer Support Specialists do not use)

VA – United States Department of Veterans Affairs

WRAP - Wellness Recovery Action Plan

APPENDIX IV – TOOLS

Enhance your efforts in cultural humility and looking through a multi-cultural lens with these tools:

- 10 questions you can ask to be more culturally aware with the individuals you support: https://counseling.online.wfu.edu/blog/10-diversity-questions-counselors-ask/
- Disability awareness scenarios you can experience: https://www.karlencommunications.com/adobe/DisabilityAwarenessTrainingMcCall2014.pdf
- Core Competencies for peer workers: https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers
- Cultural Competency tool kit (general medical/clinical): https://med.und.edu/occupational-therapy/_files/docs/cultural-competency-tool-kit.pdf
- Cultural Humility checklist: https://www.cecsb.org/cultural-competence-staff/
- Indigenous peer support resources: https://www.ihs.gov/mspi/bppinuse/treatmentbp/
- Gay Lesbian Bisexual and Transgender call line: https://www.glbthotline.org/peer-chat.html

APPENDIX V – WHITE PRIVILEGE

White privilege refers to the collection of benefits that white people receive in societies where they top the racial hierarchy. Made famous by scholar and activist Peggy McIntosh in 1988, the concept includes everything from whiteness being equated with being "normal" to whites having more representation in the media. White privilege leads to white people being viewed as more honest and trustworthy than other groups, whether or not they have earned that trust. This form of privilege also means that white people can easily find products suitable for them—cosmetics, band-aids, hosiery for their skin tones, etc. While some of these privileges might seem trivial, it's important to recognize that no form of privilege comes without its counterpart: oppression.

Peggy McIntosh's essay about White Privilege as a concept has become a mainstay in the sociology of race and ethnicity. "White Privilege: Unpacking the Invisible Knapsack," provided real-world examples of a social fact that other scholars had acknowledged and discussed, but not in such a compelling way.

At the heart of the concept is the assertion that in a racist society white skin allows for an array of unearned privileges unavailable to people of color. Accustomed to their social status and the benefits that accompany it, white people tend not to acknowledge their white privilege. Learning about the experiences of people of color; however, may prompt whites to admit to the advantages they have in society.

There are still some people that assert the non-existence of White Privilege in our society and say that McIntosh did not research her essay. It is an essay; it is not a research study. Since then there have been thousands of peer reviewed research articles to back up her theories.

APPENDIX VI – MULTICULTURAL COUNSELING

Multicultural counseling is one of the major theoretical forces in psychology. It emerged as a necessary backlash to traditional psychological theories that assumed that Eurocentric/White and middle-class values are societal norms. Competence in multicultural counseling is crucial in societies with multiple representations of cultural groups whose social power and privilege statuses are differentiated based on visible (e.g., race, gender) and invisible (e.g., homosexual/bisexual/trans-gendered orientation, language) attributes.

Majority Group

Of equal if not more significance, multicultural counseling examines and delineates the psychosocial impact of oppression caused by people who internalized the power afforded by virtue of their cultural group membership. These people represent the majority group as the imbued sociopolitical power enables them to maintain and consolidate their privileged status at the expense of other minority groups. Sexism, racism, and heterosexism have been associated with the majority groups of men, Whites (e.g., White Americans), and heterosexual people in multicultural societies.

Cultural Knowledge

In the past, multicultural counseling has focused on knowledge of cultural characteristics (e.g., Asians are collectivistic) and culture-specific tactics purported to be preferred by minority clients (e.g., Asians prefer a directive counseling approach). Stanley Sue and Nolan Zane have argued that knowledge of this kind, however, is distal to positive treatment goals as it perpetuates cultural stereotypes and ignores the individual differences within the respective minority groups. What is more important is therapist knowledge of the within-group differences in minority clients' cultural identity development. Some minority group members aspire to or internalize majority values, some embrace their cultural roots and reject the majority culture, and some attempt to appreciate and integrate both majority culture and cultural roots toward developing a bicultural identity. Theories of racial identity development, including the work of Janet E. Helms and her colleagues, and lesbian/gay/bisexual identity development, including the work of Reynolds and Hanjorgiris, have delineated the identity confusion and conflicts between self-acceptance and self-rejection among cultural minorities during the process of developing awareness of and confronting oppression and marginalization. As such, multicultural counseling competence entails therapist empathic understanding of the catalytic impact of majority oppression on the identity development and coping of minority clients.

Recognizing that both clients and therapists are products of cultural socialization that assigns them a majority or minority status, multicultural counseling emphasizes therapist knowledge of how cultural upbringing and ascribed status shaped their own worldview. Along with micro-knowledge of cultural group characteristics and macro-knowledge of societal forces that perpetuate and exacerbate client's counseling

concerns, multicultural counseling emphasizes therapists' knowledge of their own attitudes and biases toward other cultural groups, especially therapists who are members of the majority group. Rather than developed through the lens of a single theorist, multicultural counseling is rooted in a culture-centered tradition, recognizing the therapists and the mainstream theoretical approaches they are trained to use are also culture bound. In a multicultural counseling relationship, therapist credibility is reflected by competence to discern and curb the therapist's own biases that may result in discriminatory, oppressive, or racist practice throughout the assessment, diagnostic, and intervention process.

Minority Group

Multicultural counseling is concerned with the psychological development and psychosocial (mal)adjustment of clients who are ascribed a power-disadvantaged societal status due to their cultural group membership. Regardless of their numerical representation in a given society, these cultural groups are considered minorities in sociopolitical power. Consequently, they are subjected to experiences of discrimination, racism, or oppression. Multicultural counseling literature has focused on women, non-White Americans in predominantly White societies (e.g., Asians, Blacks, Latino/as in the United States), and people with homosexual/ bisexual/transgendered orientations.

Minority Worldviews, Therapist Biases, and Relationship Dynamics

Multicultural counseling is best understood in relation to competence guidelines published and enforced by professional counseling and psychology associations in multicultural countries (e.g., United States). A tripartite model presented by Derald Wing Sue and his colleagues in 1992 provided a conceptual basis to delineate three key components of multicultural counseling competency: (1) knowledge of cultural minority groups, (2) awareness of therapist's own worldview and cultural biases, and (3) application of culturally appropriate skills to intervene with client's presenting concerns as well as therapist biases.

APPENDIX VII – RESOURCES and REFERENCES

Asian American Health Initiative Resource Library (Montgomery County Department of Health & Human Services)

Asian & Pacific Islander American Health Forum

Mental Health and Substance Abuse Resource Guide (Association of Asian Pacific Community Health Organizations)

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