

9. social determinants of health



This module explores the social determinants of health and how social, economic and other factors lead to better or worse health outcomes.

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15. poverty, homelessness & food insecurity

16. creating greater equity in the mental health & substance use systems

17. social justice, advocacy & moving forward with hope

18. core values assessment

19. summary

20. next steps

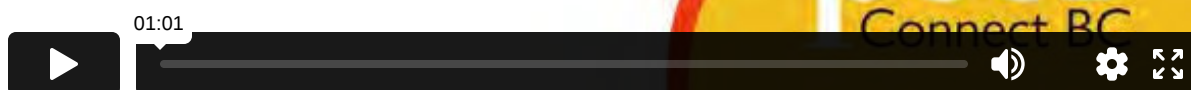
21. module references

EXIT the module

1. welcome



social determinants of health



1. welcome

welcome to
WHERE WE ARE AT
social
determinants
of health



Welcome to ***Where We Are At***, a training course for Provincial Peer Support Workers. We're glad you're here! This course is made up of 16 modules, all designed to support your training in peer support work.

The purpose of module **9. social determinants of health** is to help peer support workers better understand the different socioeconomic factors that impact health outcomes and how this fits into peer support work.

Any of the modules in this training can stand alone, but you'll notice they are very interconnected. All of the concepts and core values have many layers, and they will look a little different when you perceive them through the lens of different topics. For example, self-determination, one of the core values that is essential for peer support work, will look a little different when we look at it through the lens of learned helplessness, grief and loss, or goal planning, but the main message will always be the same.

You will get to experience all of those layers and intersections when you move through each module of the training. Feel free to navigate back and forth between modules as you move along since learning never has to be linear. There will be references to other modules intersected throughout.

Thank you for joining us on this educational journey!

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Thank you for joining us on this educational journey!

2. gratitude



**Before we begin this
new *learning* journey, we ask that you
open your mind and heart to reflect on
the following question:**

What am I grateful for today?

Download the [reflection journal](#) below and use it to record your thoughts. Please don't rush. Take all the time you need. This journal will be used for several questions throughout the module.



M09_reflection-journal.pdf
63.9 KB

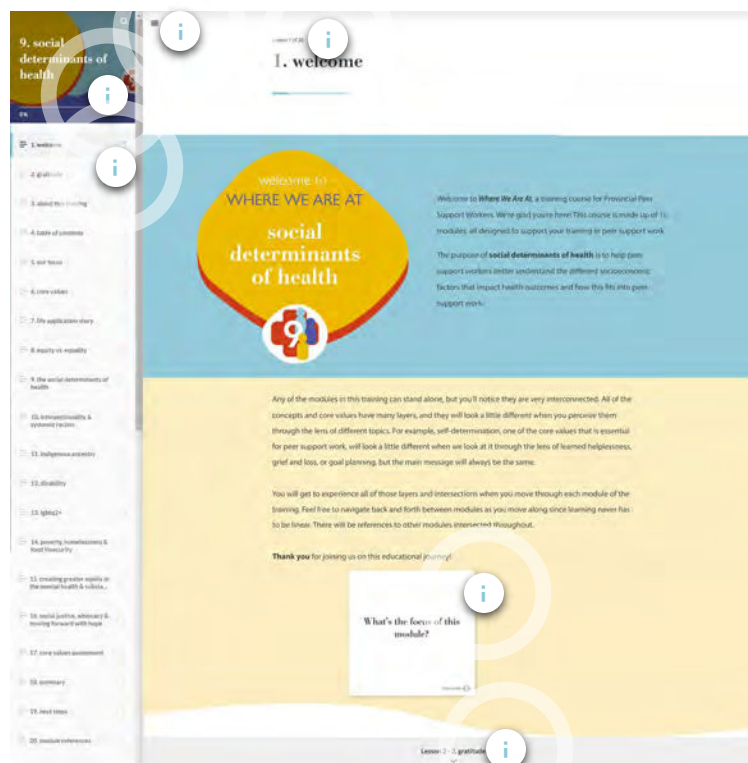


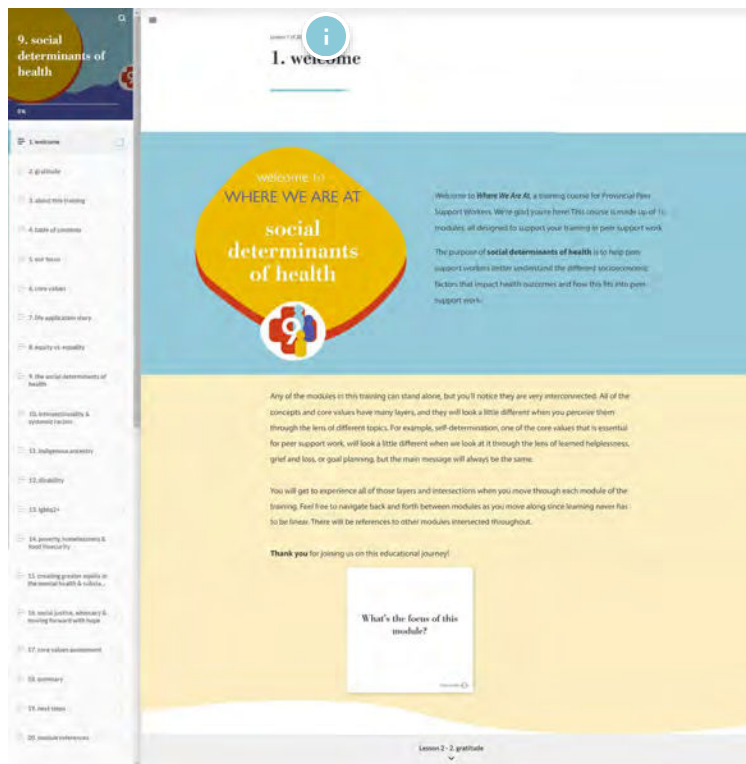
3. about this training

The course content has been guided by consultations that were held with peer support workers. It's with the utmost respect for their experience and wisdom that we share these learnings.

course navigation

You may have questions on how to use the course. We designed an interactive diagram to give you the chance to explore the different functions on the screen. Click the buttons below to learn more.





Lesson titles

Lesson 1 of 20

Above each lesson title, the lesson count is shown.

CONTINUE

reflection journal

As you discovered in the previous section, included in this training is a reflection journal. The journal is designed for you to use throughout the training. It's full of reflective questions related to the topics being explored that will get you engaging in the world around you with curiosity.

Feel free to use the journal in a way that works for you:

- 1 You can print it off and write in it or just use it to support reflective processing
- 2 You can use the fillable PDF version and complete it online
- 3 You can write in your own journal, using the questions as guides

We encourage you to find a safe, comfortable spot to engage with these questions.

CONTINUE

where we are at

provincial peer support worker training curriculum

The *Where We Are At* educational curriculum includes 16 modules. You'll find a brief description of each below.

1. the foundations —

An overview of all the practices and knowledge that will be transferable to all of the modules in this training.

2. peer support & wholeness

Provides an introduction to peer support work and explores differences between the peer support role and other roles within the mental health and substance use systems.

3. categories & containers: unpacking our biases

Help syou understand how and why we judge.

4. self-determination

Looks at self-determination, the theory of self-determination and how peer support workers can support creating an ecology where people trust their own inner wisdom.

5. cultural humility

Explores how to approach your peer support work through the lens of cultural humility and helps you understand how culture (and the destruction of culture) shapes our lives.

6. understanding boundaries & what it means to co-create them

Examines boundary creation within the context of peer support, grounded in the core value of mutuality.

7. connection & communication —

Focuses on cultivating compassion and empathy, listening deeply to understand, and asking powerful questions to increase reflection and connection.

8. healing-centred connection: principles in trauma-informed care —

Brings together all the learnings from previous modules to support the creation of environments and relationships that are safe and trauma-informed.

9. social determinants of health —

Explores the social determinants of health and how social, economic and other factors lead to better or worse health outcomes.

10. supporting someone who is grieving —

Examines how to understand grief and loss in order to support someone who is grieving, without trying to “fix” or “save” them.

11. substance use & peer support —

Explores the principles and methodologies around the harm reduction approach to substance use disorders and some of the history around the criminalization of substance use.

12. mental health & supporting those in crisis —

Explores the mindset shift necessary to support someone through a crisis.

13. goal planning —

Focuses on how peer support relationships can support the creation and meeting of goals.

14. building personal resilience —

Explores ways to build resiliency, create wellness plans and practice self-compassion.

15. family peer support —

Explores family peer support work and how, by working from a place of shared lived experience, family peer support workers can create positive change for families by building long-term relationships based on trust with those supporting loved ones.

16. working with youth & young adults —

Explores the unique application of peer support principles to working with youth and young adults.

4. table of contents

Below you'll find a short overview of the topics in this module.

As you move through these topics, please remember you can always return to this page to revisit the main ideas being explored in each lesson.

life application story —

A scenario about barriers, privilege and social determinants of health.

equity vs. equality —

Clarifies the difference between these concepts and expands on how this applies to health and other related concepts.

the social determinants of health

Outlines the Social Determinants of Health and how they connect to peer support core values.

intersectionality

Examines the meaning of intersectionality.

systemic racism

Explores what we mean by systemic racism and how we can help stop systemic racism as well as individual acts of racism.

indigenous ancestry

Examines the impacts of colonialism on Indigenous Canadians and their health outcomes as well as giving a brief overview of the TRC.

disability

Touches on the interconnected social and health impacts of disability.

lgbtq2+ —

Defines important terms related to gender, sexual orientation and other related concepts and looks at the social determinants that impact on health outcomes for LGBTQ2+ people.

poverty, homelessness & food insecurity —

Breaks down the impacts of some of these key determinants on health outcomes.

creating greater equity in the mental health & substance use systems —

Shares ways we can reduce inequities for those with mental health diagnoses and/or substance use disorders.

social justice, advocacy & moving forward with hope —

Offers a way we can look to the future as we walk alongside peers.

5. our focus

What's the focus of this module?

1 of 1

As a society we can have a simplistic view of health. However, we know that many complex social factors have a significant impact on a person's overall wellness. Many peer support workers have also been personally affected by social determinants of health. Understanding the social determinants of health equips peer support workers to understand and have empathy for others, and also serves as a guide in advocacy efforts.

The Government of Canada has listed the following 12 factors as key Social Determinants of Health:

- Income and social status
- Employment and working conditions
- Education and literacy
- Childhood experiences
- Physical environments
- Social supports and coping skills
- Healthy behaviours
- Access to health services
- Biology and genetic endowment
- Gender
- Culture
- Race/Racism

Connection and relationship remain the overarching purpose of peer support. It's not uncommon, however, for many peer support workers to find themselves sometimes in an advocacy role. This module is particularly useful for these experiences in peer support work.

after reviewing this module, you'll be able to...



Define the role of a peer supporter and the application of peer support in understanding the social determinants of health and their implications, as well as how they connect to the core peer support values.



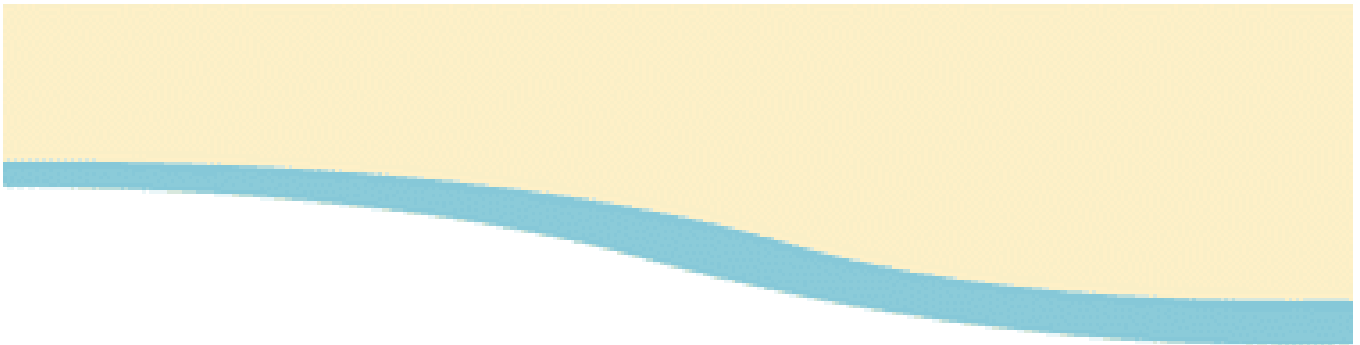
Explain how the complex social factors, including economic status, social status, culture and gender, affect health outcomes.



Demonstrate awareness of how these determinants of health create inequities in our communities.

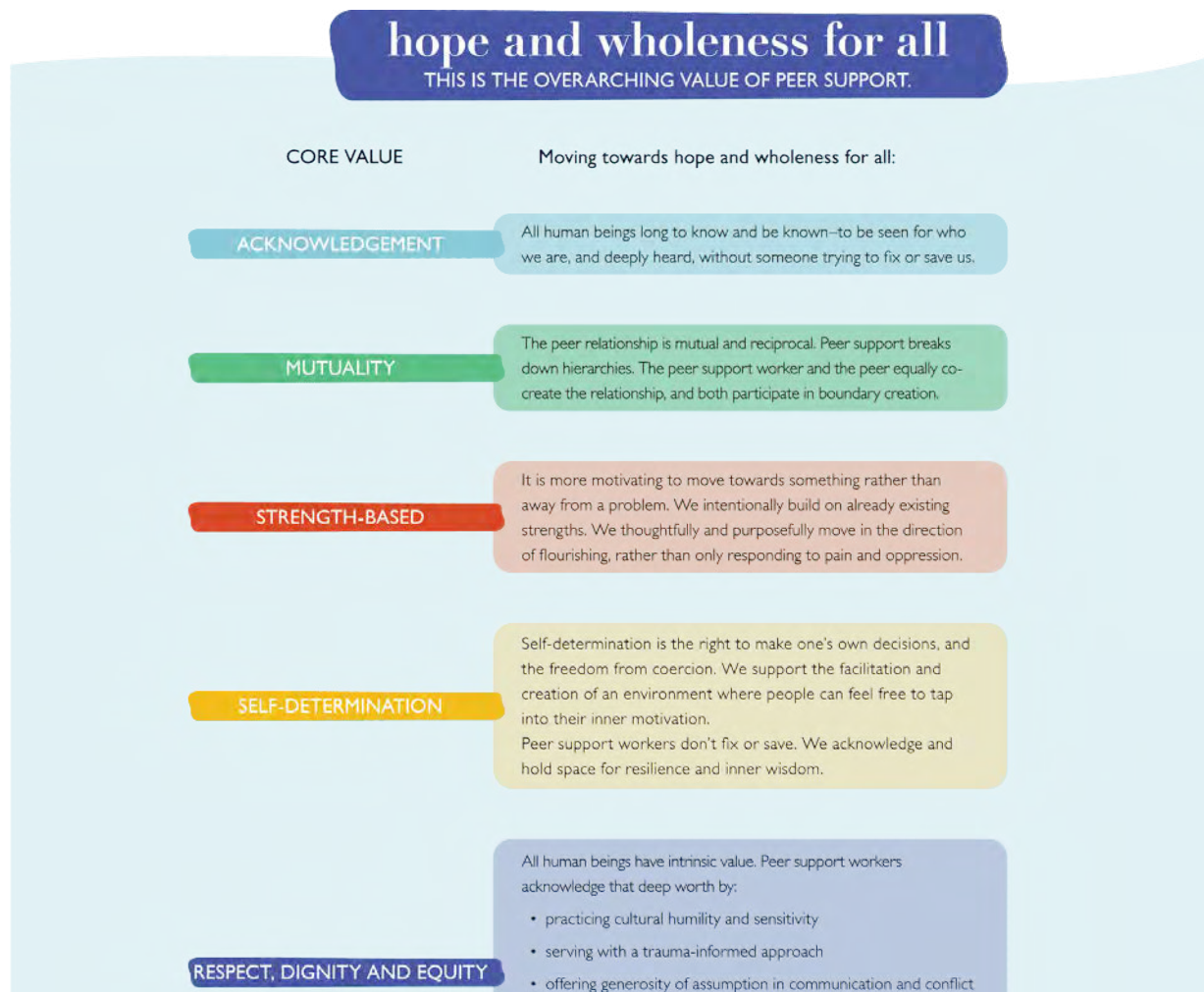


Explore ways in which peer support can help create equity and move towards better health outcomes for all.



6. core values

The following core values are essential for peer support work. At the end of this module, you'll be asked to decide which ones are key to this topic.



- mindfully addressing personal biases

Peer support is about meeting people where they are at and serving others with a knowledge of equity.

BELONGING AND COMMUNITY

Peer Support acknowledges that all human beings need to belong and be a part of a community. Peer support recognizes that many people have barriers that keep them from developing community. We actively work towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support workers serve with a social justice mindset, and intentionally practice empathy, compassion & self-compassion.

CURIOSITY

We are always intentional about how curiosity and inquiry support connection, growth, learning and engagement.

This curiosity isn't fueled by personal gain but by a genuine interest in connection. We encourage curiosity while respecting the boundaries and protecting the privacy of the people we support.

We are continually curious, but not invasive, while challenging assumptions and narratives. We ask powerful questions. We offer generosity of assumption to those who think differently than we do. We know that listening and asking questions are more important than providing answers.

***Note on the meaning of the term "generosity of assumption" from the glossary of terms:** Assumptions happen when we don't know the whole story, and allow our brains to fill in the blanks. Often we make negative assumptions about people or situations. Generosity of assumption means that we extend someone the most generous interpretation of their intent, actions, or words.

7. life application story

Check out this scenario with Melissa and Heather.

part one

Heather, a white cisgender woman, had just started working with her new peer, Melissa. Melissa is a Métis trans woman who has been living with a mental health diagnosis and using substances in a potentially harmful way. They live in a small basement suite with a couple of roommates and have been in and out of the hospital. Melissa's only income is provincial disability. They have a hard time making ends meet.

Heather and Melissa both have an interest in photography, so they decided to meet up and take photographs of the neighbourhood. Heather brought her brand new digital camera, while Melissa took photos on their outdated phone. As they walked through the neighbourhood, Melissa described their frustration about feeling like they weren't moving forward in their life.

"I understand completely what that's like," Heather said. "I felt that way when I was out of the hospital the first time. I didn't think I would ever find a career or a relationship, and it seemed like my life would never move forward in the way that I wanted."

"Yeah...That's cool you were able to move on so quickly. I feel like I should have my life together by now."

"Well, I'm sure you'll get there too. What do you feel you want to change?"

Melissa hesitated as it's a big question. They then talked about wanting to live a healthier lifestyle.

"That's a good place to start," said Heather. "I've really been enjoying learning how to cook healthy meals lately. If you want, I can give you the name of my yoga studio or some good recipe websites."

"That's okay," said Melissa. They were quiet for a while and then changed the subject.

As they continued to meet up, Melissa slowly opened up more about their circumstances. They wanted to go back to school but didn't have the money, and their parents were both passed and they had no other family who could help. They wanted to eat healthier but didn't have enough money to make the kind of meals they

wanted. They'd also experienced a lot of racism and a lack of gender aware care within the medical system and didn't always feel safe advocating for their needs.

Heather began to read more about the social determinants of health. She realized that despite having similar mental health experiences, she didn't really have any understanding of what Melissa's unique struggles were like because of her own privilege. After her mental health crisis, Heather's parents had been there to help her. Since she was white, cisgender and part of the dominant culture, she hadn't experienced racism or discrimination in the system and felt pretty comfortable advocating for what she needed. She also had the resources to make healthy lifestyle choices and do things to support her wellbeing that Melissa wasn't able to afford.

Heather realized that she needed to spend some time thinking about the barriers Melissa was facing and adjust how she was interacting with Melissa. Let's take a look at whether this made a difference.

part two

The next time they met, Heather didn't try to over-relate to Melissa's situation. She told Melissa about the respect she had for Melissa's resiliency and ability to cope in difficult circumstances. She then asked if it would feel helpful if she looked up resources and organizations that delivered fresh food to those with low incomes. Heather could tell this approach made Melissa feel more understood.

Once they'd developed greater trust, Heather asked Melissa if they'd like Heather to join them at one of their psychiatrist appointments so they'd perhaps feel safer and more comfortable advocating for their needs. Melissa agreed, realizing Heather was there to support them rather than trying to directly advocate or speak for them.

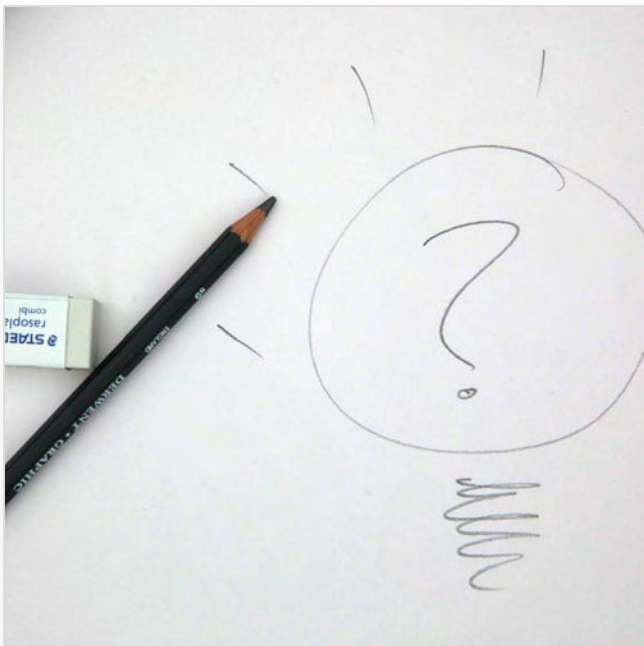
Heather realized that when she was trying to make her and Melissa's experiences the same, she was ignoring the barriers that Melissa faces on a regular basis. Heather had no personal experience with those barriers. She was finally able to see her own privilege more clearly and began to work hard on being more aware and more sensitive.

Once Heather began to realize this, her relationship with Melissa was able to grow and deepen.

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



How did Heather's privilege show up in this story?

1 of 3



Reflect on the different barriers

Melissa faced. Beyond some of the more obvious, are there others you think Melissa might have faced?

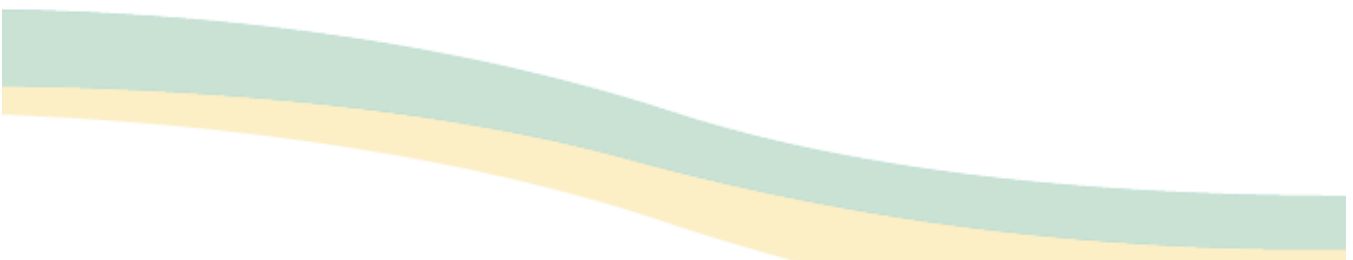
How might you ask if there are other less obvious barriers Melissa faces that they may want support in navigating?

2 of 3

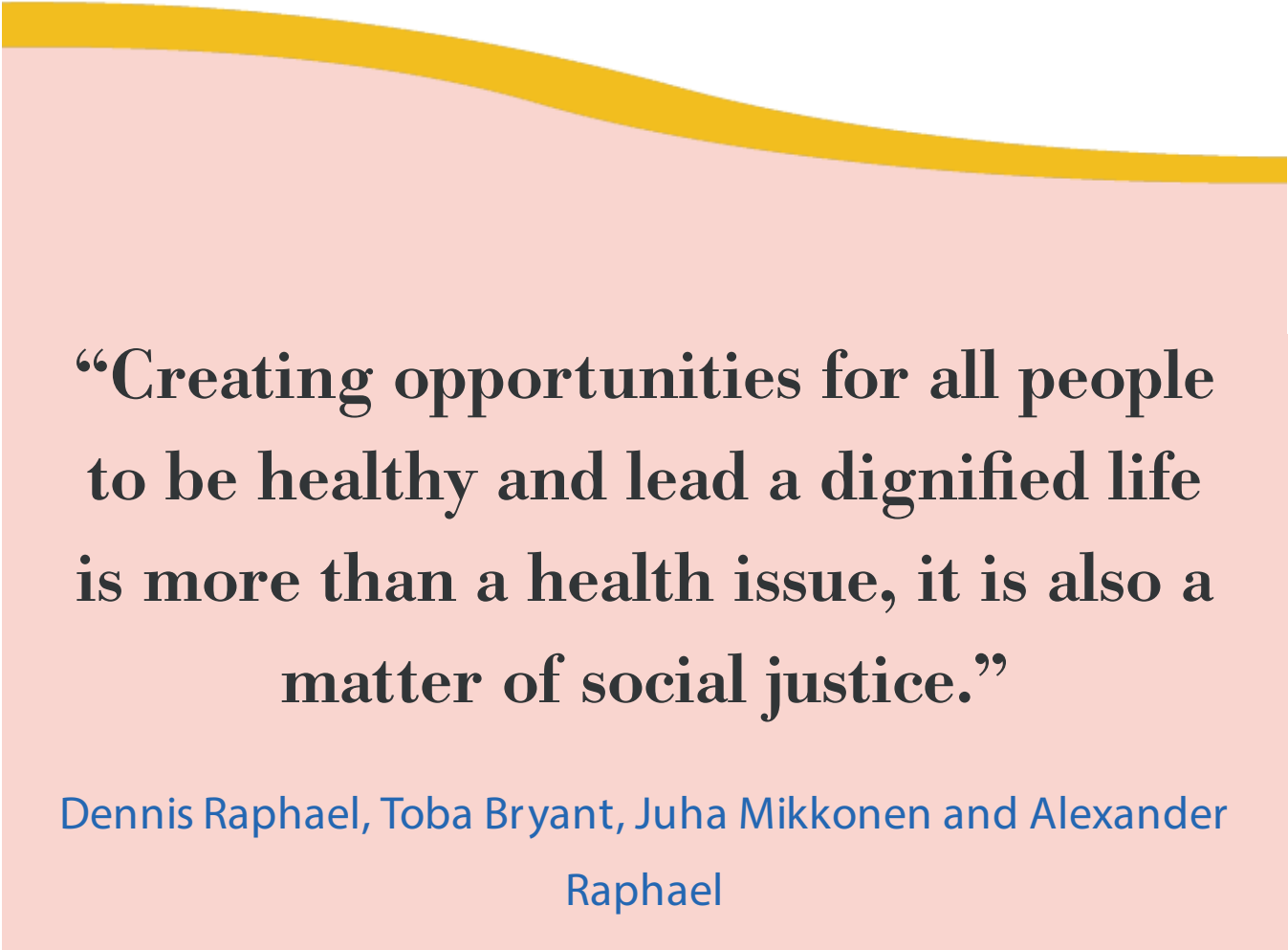


Do you think Heather's new approach was an improvement? Why or why not? Are there other changes Heather could bring to her practice to ensure a trusting and mutual relationship with Melissa?

3 of 3



8. equity vs. equality



“Creating opportunities for all people to be healthy and lead a dignified life is more than a health issue, it is also a matter of social justice.”

Dennis Raphael, Toba Bryant, Juha Mikkonen and Alexander Raphael



In our society there are many inequities that affect people, including inequities in health and wellness. One aspect of having privilege is that it's often unnoticed by those who have it, and as a result, they may be less likely to acknowledge and address inequity. In this module we'll dig into the many layers that can affect someone's access to health care and better health outcomes and how this also connects to the core values of peer support work.

CONTINUE

what is the difference between equity and equality?

Before we dive into the social determinants of health, it's really important to understand what we mean by equity and how this is different from equality.

“Equality focuses on creating the same starting line for everyone. Equity has the goal of providing everyone with the full range of opportunities and benefits – the same finish line.”

YWCA Calgary

Imagine there's a group of three children of different heights trying to pick fruit from a tree, and that tree is on a slope. Because of where the tree is positioned, this means each child probably needs some kind of help to reach the fruit.

Now imagine you have boxes that you can give the children to stand on to help them reach the tree. How would you choose to distribute those boxes to the children?

If we were to help each child equally, we would give each child a box of the same size to stand on. This, however, means only the closest and/or tallest will reach the fruit, even with the extra help. If we focus on treating each child equitably, this means we would give each child however many boxes they specifically need to reach the fruit, based on where they're positioned on the slope, their height and any other factors impacting their access to the fruit.



Treating everyone the same is wonderful in theory, but as the story of the children and the boxes shows, treating people **equally** rather than based on need means ignoring the complex barriers that many people face, including the impact their experiences, social status and background can have on their access to resources. If we ignore these barriers, then we're inadvertently reinforcing privilege and feeding into the inequities they experience.

CONTINUE

what are inequities in health?

Even in a relatively healthy country like Canada, we know that some Canadians experience better health than others because of their access to social and economic opportunities to live a healthier life. **Health equity** is concerned with the fact that these differences exist and that they're a result of the unfair distribution of social and economic resources across our society.

When we talk about social and economic opportunities, these may be in the form of social resources like the emotional support gained from family and friends or community services like peer support, or in the form of economic resources like education, employment or income.

As the National Collaborating Centre for Determinants of Health (NCCDH) explains, differences in health are **health inequities** when they're unfair and unjust, systemic and avoidable.

unfair and unjust —

Access to sufficient clean drinking water is acknowledged by the [United Nations](#) as a basic human right; however, thousands of First Nations living on reserve in Canada don't have access to the safe, clean drinking water that many non-Indigenous Canadians take for granted. This unfair, unjust difference in access to clean water is a legacy of colonization, which displaced and continues to displace Indigenous peoples onto poor quality land, created environmental discrimination and forced cultural assimilation through the residential school system. This has resulted in lower levels of human capital and expertise on reserves, among other contributing factors such as a lack of government regulation on water supply.

"The daily hardship of living under a water advisory for years means that some people become frustrated and drink it without boiling or otherwise treating it—risking exposure to contaminants. Others use tainted water for bathing or for household tasks, such as washing dishes or clothes. Some avoid the water at all costs, but do not have sufficient safe water to meet their daily needs. Many households surveyed by Human Rights Watch reported problems related to skin infections, eczema, psoriasis, or other skin problems, which they believed were associated with water conditions in their homes. Whether or not a direct causation between exposure to the water provided to their households and these conditions can be established, the water crisis does decrease the quality and quantity of water available for hygiene." – Human Rights Watch

We know that social justice calls for a society where everyone is entitled to their basic human rights, is treated fairly and receives an equitable share of society's benefits. Therefore, health inequities that cause health impacts and health differences, like the clean drinking water example, are unfair and unjust.



systemic —

Our social status represents where we're positioned within the overall social hierarchy. This status is determined by things like our access to social and economic resources as we've mentioned, as well as other experiences of privilege and oppression connected to factors like gender identity and gender expression, sexual orientation, income, race, religion and ability. Health inequities show up in a systemic and consistent pattern that demonstrate those with higher social status experience better health than those with lower social status.

According to reports by the World Health Organization and the Public Health Agency of Canada:

- In Canada, those with lower income and lower education levels consistently report higher rates of chronic diseases such as asthma and diabetes compared to higher socio-economic status groups
- Globally, the average life expectancy in low-income countries is 62 years vs. 81 years in high-income countries and children born in the poorest 20 percent of households are nearly twice as likely to die before age 5 than children born in the richest 20 percent

- Around 95 percent of deaths from tuberculosis (TB) are in the developing world, and in Canada, TB is exceptionally high among Inuit peoples, at nearly 300 times the rate among Canadian born, non-Indigenous people
- Low self-rated mental health is more common in adults who identify as bisexual, lesbian or gay than among adults who identify as heterosexual
- Canadians with less than a high school education live 11.3 fewer healthy years than university graduates

For those who are neurodivergent, systemic issues also exist. Compared to those who are neurotypical, neurodivergent people have a much higher likelihood of dying by suicide, dying if admitted to hospital, having substance use issues and living in poverty. They also have a lower life expectancy.



avoidable —

Health inequities aren't random. They're **socially determined** by circumstances largely beyond an individual's control. These circumstances disadvantage people and limit their chance to live longer, healthier lives.

For example, lower income households are more likely to experience food insecurity, but this could be reduced or avoided through strategies like increased social assistance rates, more affordable housing and reduced

taxes on low incomes. If individuals, agencies, businesses and government worked together to distribute resources and opportunities in a more equitable way, we could avoid health inequities.



Everyone deserves a chance to reach their full health potential, regardless of their social status. We can achieve health equity if we work to fairly distribute the resources, opportunities and support that people need to be healthy. Fairness is achieved by distributing these resources and opportunities according to need.



CONTINUE

stigma, discrimination & prejudice

As we move through the social determinants and dive into these topics further, it's useful to take a moment to remember the definitions of stigma, prejudice and discrimination as these are all factors that feed into the social determinants.

stigma is...

**A mark of disgrace associated
with a particular circumstance,
quality or person.**

discrimination is...

The unjust or prejudicial treatment of different categories of people.

prejudice is...

A preconceived opinion that's not based on reason or actual experience.

There are different types of stigma. We've talked about some of these in other modules, but it's worth revisiting:

PUBLIC STIGMA

SELF-STIGMA

STIGMA-BY-ASSOCIATION

The way the public perceives substance use or those living with a mental health diagnosis.

PUBLIC STIGMA	SELF-STIGMA	STIGMA-BY-ASSOCIATION
When someone internalizes the stigma of the dominant culture.		
PUBLIC STIGMA	SELF-STIGMA	STIGMA-BY-ASSOCIATION
When family members and friends feel the effects of public stigma for their loved one.		

i **Note:** A useful resource to get more familiar with many of the other terms used when referring to the social determinants of health and health equity is the [NCCDH glossary](#). Although the glossary is written for health practitioners, it provides some good definitions of key concepts along with useful examples. Another great resource as you work through the concepts in this module is the Allies for Change [Glossary of Terms](#).

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



How do you feel equity connects to your peer support work?

1 of 2



Choose one element of your identity in which you experience privilege. What are some specific actions you could pursue to ensure more equitable access to substance use/mental health services for people who don't experience that privilege?

2 of 2

9. the social determinants of health

“The social determinants of health are the interrelated social, political and economic factors that create the conditions in which people live, learn, work and play.”

NCCDH Glossary



Many factors can influence or determine our health – from our genetics to where we live. The **social determinants of health** refer to a specific group of social and economic factors that relate to where a person finds themselves placed in society, such as their income, education levels or employment status.

The more we as peer support workers learn about how circumstances beyond a person's control impacts their health and safety, the more we can be effective advocates for them.

“These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.”

Centers for Disease Control and Prevention

CONTINUE

The social determinants of health listed below come directly from the [Government of Canada's website](#):

income and social status

The higher a person's income and social status, the better their health will be.

employment and working conditions

People who are unemployed or underemployed are less likely to be healthy. Also, those who work in environments that are unsafe have extra barriers to health. These situations affect people both mentally and physically.

education and literacy

People who have a higher socioeconomic status are more likely to have post-secondary educational opportunities and be able to earn degrees and certifications, which lead to better health outcomes.

childhood experiences

Childhood development sets people on a path towards good health or poor health, and enhanced or decreased well-being. People who have adverse childhood experiences are at a greater risk for health issues in adulthood.

physical environments

Exposure to unsafe levels of contaminants through water, food and soil can negatively impact health. Housing, transportation and access to other resources

also have a huge impact on health.

social supports and coping skills

High levels of support from family, friends and communities are associated with better health outcomes. Community and belonging are recognized as being important determinants of health, and when people have communities that are stable, diverse, safe and cohesive, their overall health is enhanced.

Practices that support disease prevention and promote self-care, including coping with adversity and developing self-reliance, all support people's overall health. However, we have to recognize that personal life "choices" are hugely influenced by the socioeconomic environment; some people don't have options for engaging in these practices.

healthy behaviours

Our behaviours greatly affect our health. The resources available to us will be drastically different for everyone. Often, people who are negatively affected by many of the social determinants of health will have fewer resources available to them. This affects everything from food choices to leisure and activity options.

access to health services

It seems obvious to say, but it's proven that those who have access to healthcare services and have the funds to pay for services that are not free are healthier than those who can't access those same levels of services.

biology and genetic endowment

Genetic endowment can predispose people to particular diseases or health problems.

gender

Society tends to link different personality traits, attitudes, behaviours, values and levels of power and influence to gender. These societal norms have a big impact on health in the way the healthcare system offers treatment.

culture

People who identify with cultures outside of the dominant culture of Canada can feel marginalized. They can often face stigmatization and are not able to receive culturally appropriate services.

race/racism

“Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians.” – Canada.ca

Many people of colour face barriers due to racism embedded in our healthcare systems. Paying attention to the prevalence of racism and discrimination in our society and our systems today and doing what we can to challenge them is essential.

CONTINUE

What do you think is missing from the list of social determinants above? Take some time to think about this before clicking on this card.

Some additional factors not included here are:

- **Indigenous ancestry and the impacts of colonialism and historical trauma**
- **Disability**
- **Food insecurity**
- **Homelessness**

CONTINUE

We need to understand and acknowledge that experiences of intergenerational trauma, discrimination and other factors are important social determinants of health for certain groups more than others, and that these factors actually have a much stronger effect on people's health than the ones associated with behaviours such as diet, physical activity or tobacco and excessive alcohol use.

CONTINUE

peer support core values & social determinants of health

One of the key values of peer support work, as you have seen throughout these modules, is **mutuality**. This core value connects powerfully to all the social determinants of health in that it allows us as peer support workers to come to our work from a place of true and practical empathy, understanding the different factors that impact our service users' health and recognizing that creating relationships based on our shared humanity is the way forward.

At the end of this module, you'll have time to reflect further on how the core values connect to the social determinants of health. You can take a moment now, however, to think about which values connect most for you to these different determinants.

CONTINUE

expanding the social determinants of health

In ***Social Determinants of Health: The Canadian Facts***, the authors actually consider 17 different social determinants of health:

- | | |
|--------------------------------------|-------------------------|
| 1. income and income distribution | 10. health services |
| 2. education | 11. geography |
| 3. unemployment and job security | 12. disability |
| 4. employment and working conditions | 13. indigenous ancestry |
| 5. early child development | 14. gender |

6. food insecurity

15. immigration

7. housing

16. race

8. social exclusion

17. globalization

9. social safety net

In the rest of this module, we'll address some of the "missing" factors in more detail, as well as some related concepts that will help you in your peer support work.

10. intersectionality

Intersectionality is a way to understand the different factors that shape social inequalities and discrimination.

In 1989, lawyer and civil rights activist Kimberlé Crenshaw wrote a legal paper called *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Anti-Racist Politics*. The paper explores legal issues and how people's social identities overlap, which leads to different experiences of discrimination. Crenshaw coined the term intersectionality specifically in the context of describing how the law seemed to ignore "...the fact that black women are both black and female, and thus subject to discrimination on the basis of both race, gender, and often, a combination of the two." (Coaston, 2019).

Today the term has grown and is generally used to illustrate overlapping types of oppression and discrimination such as gender, race, age, class, socioeconomic status, physical or mental ability, gender or sexual identity, religion and ethnicity. It's a way for us to examine how a person or group's experience of various intersecting identities reflects the larger systems of power and oppression within society.



“An African American man is going to experience the world differently than an African American woman... Somebody who is LGBT is going to experience the world differently than somebody who’s straight. Somebody who’s LGBT and African American is going to experience the world differently than somebody who’s LGBT and Latina. It’s sort of this commonsense notion

that different categories of people have different kinds of experience.”

David French

CONTINUE

We know that people can experience marginalization in some areas while being privileged in others. The consequences of some intersections have effects that are different from the sum of each identity and can't always be predicted.

what does that mean in plain language & in relation to health inequities?



Here's an example:

As a white male, Gary has experienced little discrimination and a lot more privilege than most of the women and people of colour in his life. He has had higher paying job opportunities than many of his female BIPOC counterparts, for example, which for a long time meant he had excellent extended health benefits. However, Gary is also gay, and he's faced discrimination and homophobia in his personal and professional life because of this. He also recently experienced job loss due to a substance use disorder.

This has left him low income with no extended benefits as he hasn't been able to find work, facing stigmatization as well as housing insecurity. Research shows that although Gary is a white male, he is at a higher risk of poor health outcomes because of the various intersections in his life (his sexual orientation, substance use disorder, lack of income) compared to other white men who are heterosexual and low income or who are low income but who aren't using substances.

It's important to note that being marginalized in some ways, however, also doesn't "undo" the other ways in which a person has privilege. Even though Gary's circumstances have changed, he still experiences the privileges of being white and a man, even while he's also experiencing the barriers of homophobia, substance use stigma and poverty.

CONTINUE

question for reflection

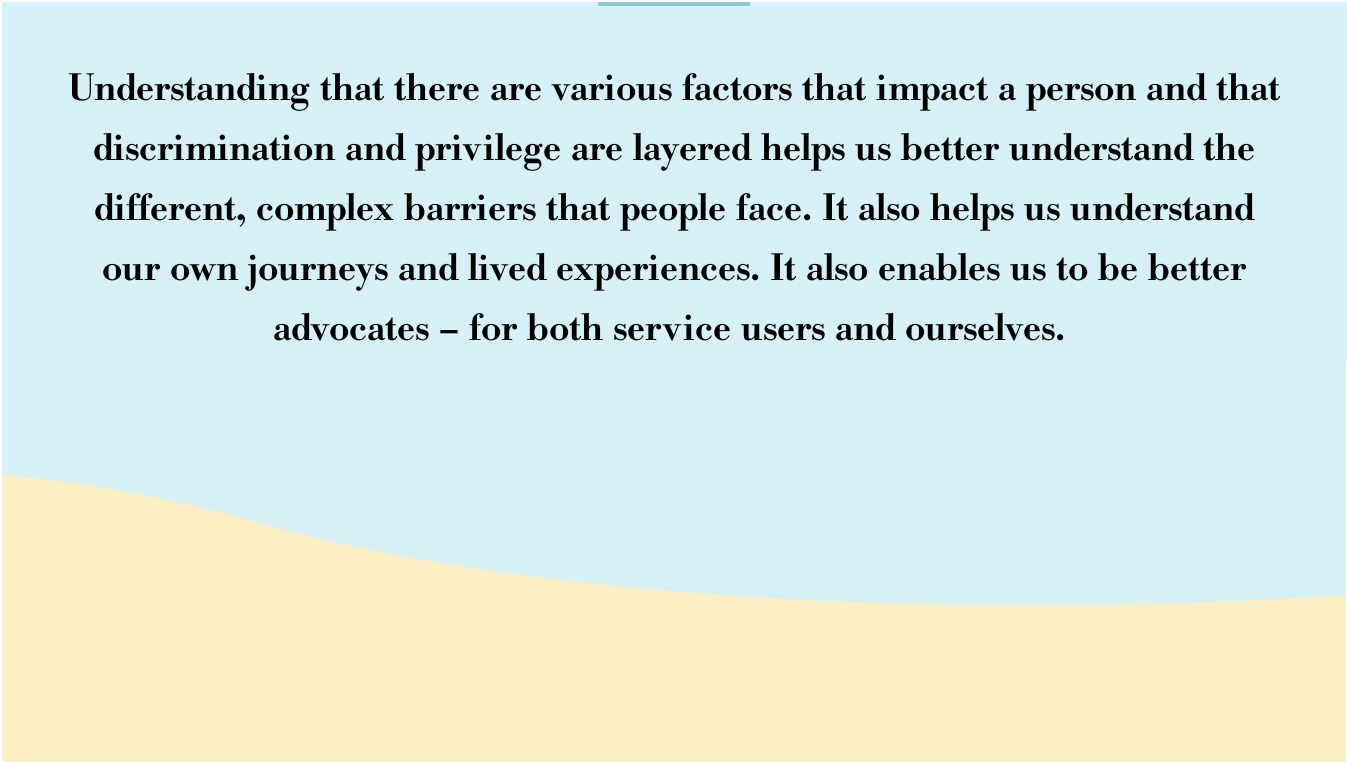
Answer this question in your reflection journal.



Why is it important as peer support workers that we understand intersectionality?

1 of 1

CONTINUE



Understanding that there are various factors that impact a person and that discrimination and privilege are layered helps us better understand the different, complex barriers that people face. It also helps us understand our own journeys and lived experiences. It also enables us to be better advocates – for both service users and ourselves.

11. systemic racism

systemic racism

Let's dive into what systemic racism is and how it's different from individual acts of racism.

“Systemic racism, also known as institutional racism, refers to the ways that white supremacy (that is, the belief that white people are superior to people of other races) is reflected and upheld in the systems in our society.”

Rebecca Gao

Systemic racism is entrenched in the various systems that make up our world and that we have to live and work within, including the criminal justice system, the education system and the healthcare system. For example, the RCMP (Canada's federal policing system) was created specifically to control Indigenous peoples in post-Confederation Canada; its origins therefore stem from racism, division and discrimination. Systemic racism still exists in the RCMP and other policing systems today.



Another example is how the COVID-19 pandemic has impacted African Americans in the U.S. A lack of access to diagnostic testing and treatment has meant that “African Americans have died from the disease at almost three times the rate of white people” (Ed Pilkington, 2020). As several commenters have pointed out, it’s not like the virus “sees” or discriminates based on race; it’s the day-to-day systems that have led to these higher rates of infection and death among non-whites.

When racism is embedded into every system, it means that people of colour are always starting from a place of inequity. It also means that racism and racist policies are legitimized. There are traumas inherent in these


systems too, which impact people; many of these in Canada are a legacy of colonization and slavery.

what can we do to help stop systemic racism & individual acts of racism?

Learning about Canada's racist history and treatment of Indigenous and non-white Canadians, opening yourself up to more diverse media, sharing your lived experiences, and learning to live with discomfort while listening openly to the experiences of others are all ways we can work to combat systemic racism. We can also learn about anti-racism activism, call on organizations and governments to change their policies and practices and try to affect systems change from the inside.

It's always important, as well, not to put the burden of explanation onto the person who is experiencing racism. Discussions about the impacts of racism and colonialism are about the other person's experiences, not about you. They aren't there to give you answers, but you can ask what you can do to support them.





“Calling out racism when you see it, challenging it within yourself and your communities, bringing conversations into your spaces and standing up for your BIPOC peers (even if it means putting yourself on the line or getting into a fight with your family) is also imperative to allyship.”

Michelle Gao

CONTINUE

It's also useful to understand a few related terms:

Our personal thoughts and feelings, both conscious or subconscious, that include an

internalized racism

acceptance of the dominant society's racist views, stereotypes and biases of our own ethnic group. It can lead to "patterns of thinking, feeling and behaving that result in discriminating, minimizing,

interpersonal racism

Acts of racism between one person and another, which the Society for Health Psychology describes as being "directly perceived discriminatory interactions between individuals whether in their institutional roles or as public and private individuals."

institutional racism

Some people use this term to mean the same as systemic racism, but others refer to institutional racism as more specifically the actual policies and practices that reinforce racist standards within an organization or workplace.

structural racism

Very similar to systemic racism (and like institutional racism, it's often used as a synonym for systemic racism), structural racism is defined as where multiple institutions collectively uphold racist policies and practices. A key difference, according to the Aspen Institute, is that “structural racism

anti-racism

Many argue that there's no such thing as 'not racist' – you're either racist or anti-racist. “If racism means both racist action and inaction in the face of racism, then antiracism means active participation in combating racism in all forms.” – Ibram X. Kendi

CONTINUE

question for reflection

Answer this question in your reflection journal.



How do you think these terms relate to, or are different from, systemic racism? Are they? Do you see any other obvious connections or differences?

1 of 1

CONTINUE

Racism and discrimination can bring with them trauma. In module 8, *healing-centred connection: principles in trauma-informed care* of this training, we look more closely at the impacts of trauma, as well as the importance of using a trauma-informed approach to care. This is a module that can greatly help you as you work to unpack the social determinants of health and understand how they relate to your peer support work.

CONTINUE

“The only way to undo racism is to consistently identify and describe it — and then dismantle it.”

Ibram X. Kendi

additional resources

To continue your work on being anti-racist and to learn more about systemic racism and related issues, we recommend checking out the following resources as a great starting point:

- *21 Things You May Not Know About the Indian Act: Helping Canadians Make Reconciliation with Indigenous Peoples a Reality* by Bob Joseph (based on [an article](#) he first wrote for the CBC)
- *How to be Antiracist* by Ibram X. Kendi
- *White Fragility* by Robin DiAngelo
- *My Grandmother's Hands: Racialized Trauma and the Pathway to Mending Our Hearts and Bodies* by Resmaa Menekem
- [Building a Foundation for Change: Canada's Anti-Racism Strategy 2019–2022](#)

12. indigenous ancestry



“As one of the richest countries in the world, Canada is well placed to right past wrongs and ensure that all Canadians, including Canada’s First Peoples, are

able to enjoy living conditions that
promote health and well-being.”

Janet Smylie and Michelle Firestone, 2016

For us to have a fuller understanding of what influences health and what causes health inequities for certain populations in Canada more than others, we need to use a historic lens. When it comes to Indigenous Canadians (First Nations, Métis and Inuit), there are various historical, political, social and economic conditions that have influenced Indigenous health. The health of Indigenous peoples in Canada is directly connected to the country's history of colonization.

We also need to acknowledge that very often we're dealing with many concepts that are defined by the dominant, Eurocentric system, including the understanding of health. In the dominant Canadian society, health is seen as an individual issue, where each of us is responsible for the health consequences of our own choices. In comparison, Indigenous societies tend to emphasize the role of the larger social system in shaping health, including the impact of family, community, nature and the Creator.

As the *Key Health Inequalities in Canada: A National Portrait* report explains, Indigenous peoples tend to see health in a balanced and holistic way, with clear connections between the spiritual, emotional, mental and physical aspects of health. Similarly, the determinants of Indigenous health are seen as closely interconnected.



Wolf Pack Musqueam dancers performing a traditional dance. Photo by James Abbott

The legacy of colonialism in Canada is one that has caused inequities in health between Indigenous and non-Indigenous peoples. Forcing the assimilation of Indigenous peoples into the dominant Euro-Canadian culture is one of the main elements responsible for destabilizing the determinants of Indigenous health. This colonial relationship between the state and Indigenous communities has continued to be enforced through policy, legislation and the dispossession of land.

“The forced displacement of First Nations into remote communities and reserves that were uninhabitable and lacking in resources; the claiming of traditional areas rich in resources by colonial powers; the oppression of First Nations created by the Indian Act; the damaging legacy of Indian Residential Schools and the Sixties Scoop; systemic discrimination against all Indigenous peoples across social, criminal justice, health care, and employment environments; and the lack of public or private economic development investments for Indigenous communities are all examples of how the colonial structure have contributed to the health inequities that exist today. In addition to this lived experience of colonialism, racism and inability to pursue self-determination, health inequalities in Métis peoples have also been particularly influenced by social exclusion and loss of Indigenous language due to cultural assimilation.”

Key Health Inequalities in Canada: A National Portrait

the truth and reconciliation commission

The Truth and Reconciliation Commission (TRC) of Canada ran from 2008 to 2015 and was established to document the history and impacts of the residential school system on residential school survivors and their families as well as to expose and record the real history of these schools. The Commission did this by setting up a process for residential school survivors, communities and other people affected by the system to tell their stories before issuing a final report documenting these experiences. The TRC concluded that the removal of children from the influence of their own culture with the intent of assimilating them into the dominant Canadian culture was a [cultural genocide](#).

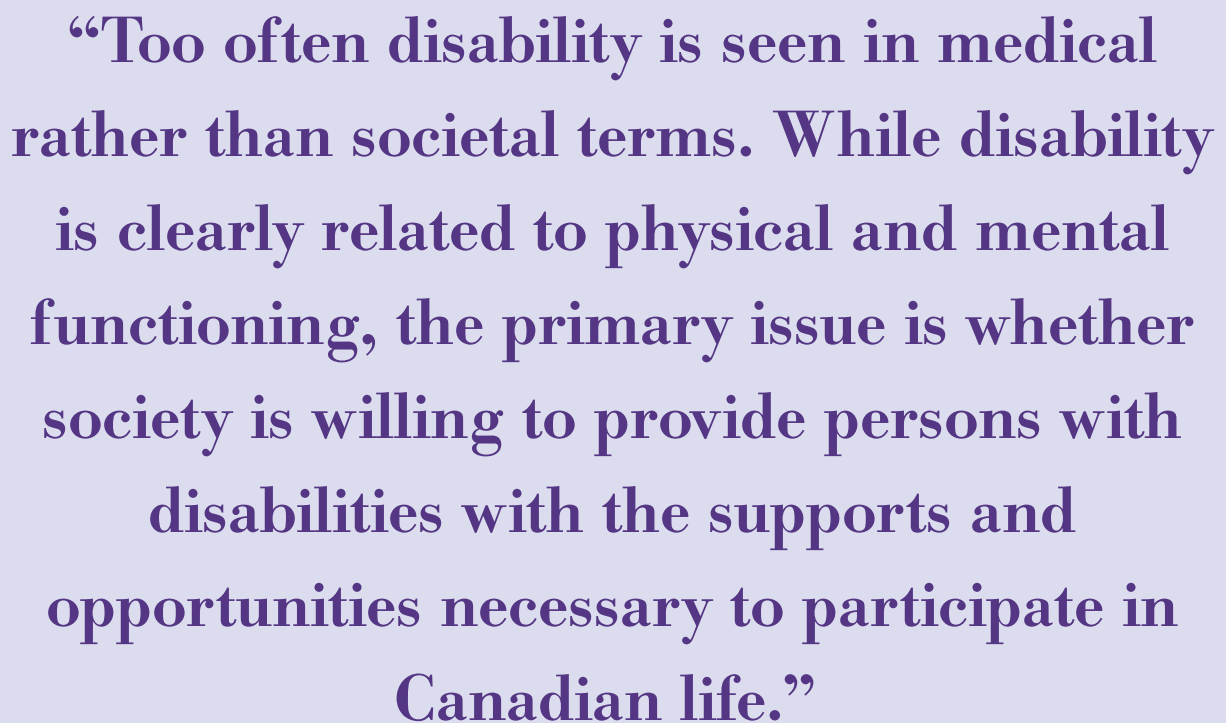
The TRC also released 94 calls to action related to health, education, language, culture and other factors that impact Indigenous peoples and to continue the reconciliation process to build and maintain respectful relationships between Indigenous and non-Indigenous peoples. As the B.C. Government website explains, these calls to action are vital:

“It’s important to recognize the historical and ongoing wrongs perpetrated against Indigenous peoples

and the legacy of colonialism still in place today. The legacy of that separation and suppression of culture has had a profoundly negative impact on Indigenous communities, families and cultural connections through the generations.”

For more information on the TRC, you can visit the [National Centre for Truth and Reconciliation](#) website.

13. disability



“Too often disability is seen in medical rather than societal terms. While disability is clearly related to physical and mental functioning, the primary issue is whether society is willing to provide persons with disabilities with the supports and opportunities necessary to participate in Canadian life.”

Raphael et al.

What is meant by ‘disability’?

“Disability refers to the interaction between individuals with a health condition (e.g. cerebral palsy, Down syndrome and depression) and personal and environmental factors (e.g. negative attitudes, inaccessible transportation and public buildings, and limited social

support)” – World Health

People with disabilities – whether physical, mental, emotional or a combination thereof – face many challenges and barriers and are often left marginalized and vulnerable. Having a disability can lead to challenges in finding housing, receiving an education, gaining skills and long-term employment, and many of the other factors that impact our overall health outcomes. If people with disabilities do find employment, they tend to get paid much less than those without disabilities and many have reported that they’ve had challenges in getting any kind of workplace accommodation for their disability; this is discouraging, disheartening and discriminatory.

by the numbers



Over 22 percent of Canadians report having a disability




Canadian women are found to have a higher rate of disability at 24 percent vs. 20 percent for men



People with disabilities are less likely to be employed and, when they’re employed, they earn less than people without disabilities



The rate of unemployment is 24 percent for those with mild disabilities and 69 percent for those with very severe disabilities



“[Article 25](#) of the UN Convention on the Rights of Persons with Disabilities (CRPD) reinforces the right of persons with disability to attain the highest standard of healthcare, without discrimination. However, the reality is that few countries provide adequate quality services for people with disability.”

– WHO

The WHO has determined that if (not when) health services for people with disabilities exist, they tend to be of poor quality and are under-resourced. Those living with disabilities are also more than twice as likely to find that their healthcare providers’ skills aren’t enough for their needs. Many health initiatives and health promotion strategies often simply ignore those with disabilities, which leaves people with disabilities at a higher risk of poor health.

Canada, outside of Korea, provides the lowest benefits to Canadians with disabilities. Canada also has some of the highest restrictions for getting those benefits. Since over 40 percent of Canadians with disabilities aren’t in the labour force, many rely on social assistance benefits but the low benefits rates don’t bring people with disabilities even close to the poverty line in most urban areas.

A positive step is that Canada ratified the UN Convention on the Rights of Persons with Disabilities and therefore is now required to report on its progress in improving circumstances for people living with disabilities in our country.



CONTINUE

Of issue for people with disabilities are the following. Expand the boxes to learn more.

ableism

Ableism refers to the systemic discrimination or prejudice against individuals with disabilities or differences, either physical or mental. It can take the form of physical barriers, such as inaccessible buildings or public transportation, or social barriers, such as discrimination in employment, education or healthcare.

Ableism can manifest in many ways, such as:

- Assumptions that people with disabilities are less capable
- Stereotypes that portray individuals with disabilities as pitiable or heroic
- The belief that people with disabilities are a burden on society

Ableism can also contribute to exclusion and marginalization of people with disabilities, limiting their opportunities and quality of life.



“double empathy problem”

The “double empathy problem” refers to the difficulty that autistic people and neurotypical individuals may have in understanding each other’s perspectives and emotions. This concept challenges the notion that autistic individuals have a “deficit” in empathy, and instead suggests that both autistic and neurotypical individuals may struggle to understand each other due to differences in communication styles, social cues and sensory processing.

In essence, the double empathy problem suggests that empathy is a two-way street that requires effort and understanding from both parties involved. Rather than seeing autism as a deficit in empathy, the double

empathy problem highlights the importance of recognizing and accommodating individual differences in communication styles and social processing, in order to promote mutual understanding and respect.



accessibility in harm reduction spaces

Harm reduction spaces, such as needle exchange programs, overdose prevention sites and drug treatment clinics, aim to provide support and resources to individuals who use drugs to reduce the negative consequences associated with drug use. However, these spaces can often be inaccessible to certain populations, creating a barrier to the very people they aim to help.

- **Physical accessibility.** Many harm reduction spaces are located in buildings that are not wheelchair accessible, which can prevent individuals with physical disabilities from accessing services. Additionally, some harm reduction spaces may not have appropriate signage or clear pathways for individuals with visual impairments, further limiting accessibility.
- **Cultural accessibility.** Harm reduction spaces may not be welcoming or accommodating to individuals from diverse cultural backgrounds. This can include a lack of culturally appropriate services, language barriers or a failure to acknowledge and address the unique needs of certain communities.
- **Structural barriers.** Barriers to accessing harm reduction services can include long wait times, limited hours of operation or a lack of transportation options. These barriers can prevent individuals from accessing the support they need and may result in missed opportunities for harm reduction.

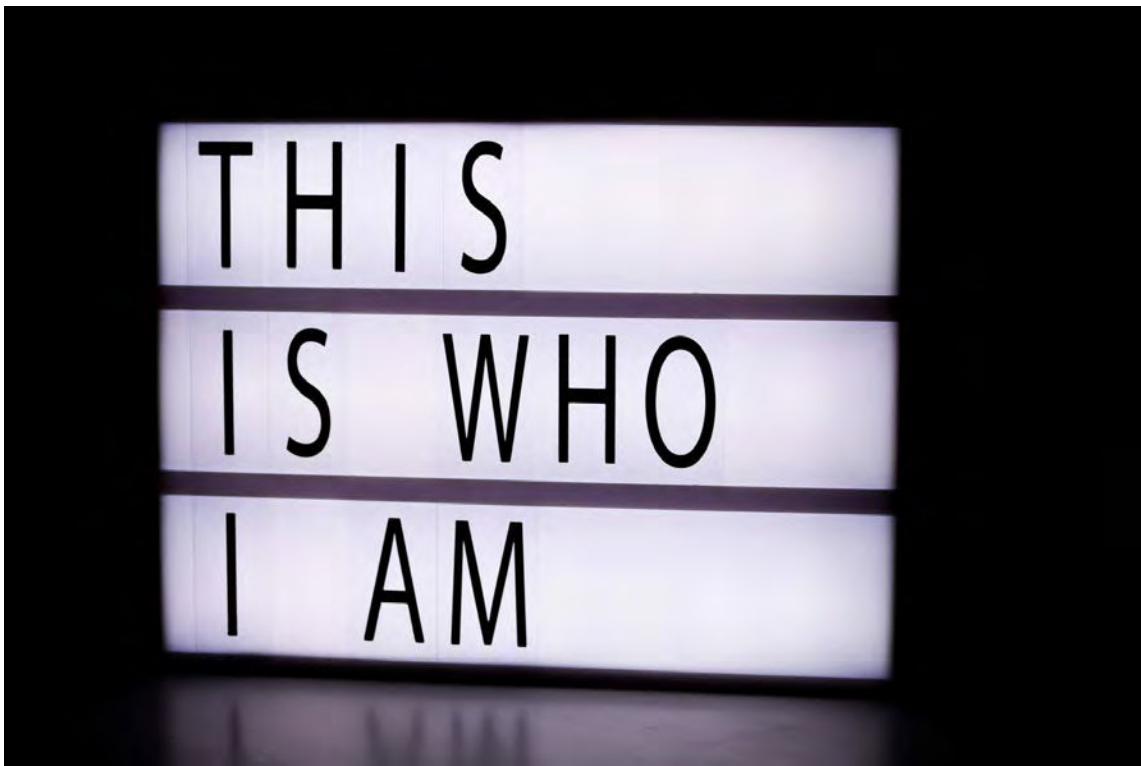
Addressing these accessibility issues is essential to ensuring that harm reduction services are effective and inclusive for all individuals who need them.



disability as an identity

Identity-first language is often used by people with disabilities and their allies as a way of reclaiming and embracing their identities. It acknowledges that their disability or difference is a fundamental part of who they are, rather than something to be ashamed of or hidden away.

However, it's important to note that not everyone with a disability prefers identity-first language. Some people may prefer person-first language, as it emphasizes the individual first and foremost. Ultimately, the best way to approach language is to ask the person how they prefer to be referred to and respect their preferences.



CONTINUE

what does this mean for us as peer support workers?

As stated earlier, this group includes nearly one-quarter of the population of Canada, so it's a segment of the community we will likely encounter regularly. We can assist people with disabilities in many ways, including:

- **Emotional support** – by listening, validating feelings and being present.
- **Experiences** – by sharing our own experiences with disability.
- **Goal-setting** – by helping people set realistic goals and strive to achieve them.
- **Advocate** – by standing up for the rights of people with disabilities.
- **Practical knowledge** – by sharing knowledge of services available.

Finally, we can acknowledge the many barriers in place that may be affecting them.

CONTINUE

questions for reflection

Answer these questions in your reflection journal.



Knowing that disability is a social determinant of health for many people, in what ways can you change your daily approach to peer support work?

1 of 4



How do you think the principle of person-first language connects here, when we talk about people with disabilities?

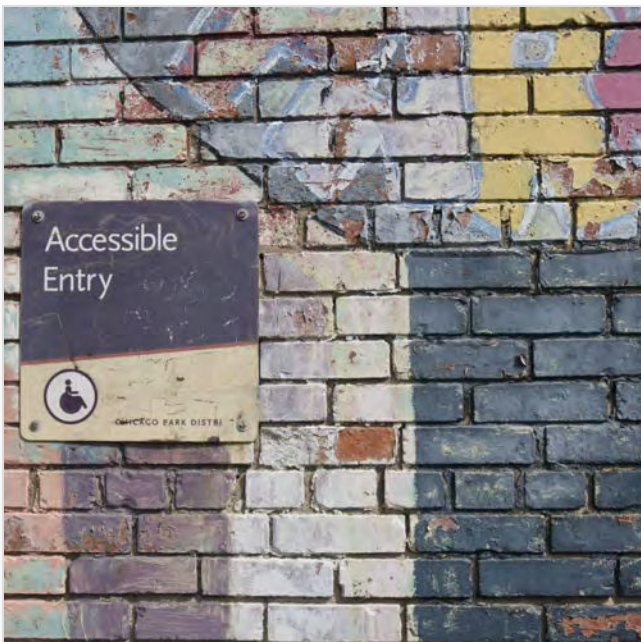


2 of 4



What are some other systemic barriers that may impact people with disabilities? How do these connect to the social determinants of health?

3 of 4



Are there concrete ways that you, as a peer support worker, can better support clients with disabilities?

4 of 4

13. lgbtq2+



Many people who are LGBTQ2+ experience discrimination and stigma. Policies and governance are slowly changing, but many big policy changes have only begun in the last few decades. As a result, many people experience an intersectionality of discrimination that affects their health and wellness. Some still have to fight to have their basic rights met.

Before we examine some of the challenges that LGBTQ2+ face in relation to health outcomes, it's helpful to have some terms defined. Click on the image below to learn more.





assigned sex

Assigned sex refers to the biological characteristics used to classify people into the categories of male, female or intersex. It refers to the physical elements of our bodies, including features like genetics, hormones and internal and external sexual anatomy and is often assigned at birth. Being intersex means that someone has natural variations in their physical sex development, which is different from being trans, which is related to gender identity.



two-spirit

Pre-contact, many Indigenous communities acknowledged more than two genders. Through the residential school system and other colonial practices and institutions (e.g., medicine, language, law, economics, religion, government) there was an attempted erasure of these genders and of the language that described them, and an enforcement of a Western European patriarchal gender binary. Today, Two-Spirit is a term used by some Indigenous people and communities that can encompass cultural, spiritual, sexual and gender identities. Often, being Two-Spirit is connected to specific roles and responsibilities within a community. While some Indigenous people who hold diverse sexual and gender identities consider themselves Two-Spirit, others may have terms in their own traditional languages or identify themselves as LGBTQ+ and Indigenous, Indigiqueer or use multiple terms.



sexual orientation

Who someone is attracted to sexually, romantically and/or emotionally. Examples of sexual orientations are queer, asexual, bisexual, pansexual, lesbian, gay, and heterosexual/straight, among others.



gender identity

Gender identity is a person's internal and individual sense of being a woman, a man, both, neither, or something entirely different (as described below). A person's gender identity may also be affected by social, emotional, cultural and spiritual elements of their life.

Examples of gender identities include:

transgender or trans: when someone's gender identity differs from their assigned sex at birth

non-binary: when someone's gender identity exists beyond, between or outside of "man or woman." Some people may use terms like gender non-conforming, genderfluid, genderqueer, agender, bigender, pangender, and many other terms.

Remember, there is no one way to "look trans" or "look non-binary" – trans and non-binary people can express their gender in a wide variety of ways and may or may not seek gender-affirming medical or surgical care.

cisgender or cis: when someone's gender identity aligns with their assigned sex; not trans. Cis people also express their gender in a wide variety of ways.



gender expression

Gender expression is the way someone expresses their gender to the outside world. This shows up in behaviour, clothing style, hairstyle and sometimes through pronouns and name, etc.

Remember that some people choose not to label themselves at all, and it's important that we respect that.

CONTINUE

pronouns

We want to be respectful of each individual's identity, and part of that means creating invitations (but not obligations) for them to share their pronouns (e.g., she/her, they/them, he/him, etc.). Using pronouns we aren't

used to using can require intentionality and practice, but just like learning a new language, when you put in the time and energy, it becomes second nature and will begin to flow more naturally for you.

NOTE: Using the term “preferred pronoun” (for example, asking someone “what is your preferred pronoun?”) implies that pronouns other than the ones specified by the person are acceptable or that using their pronouns is optional rather than fact. Pronouns are either correct or incorrect for someone’s identity.



When you mess up someone’s pronoun, simply correct yourself and move on. If you make a big deal of the mix-up by over-apologizing, it centres you. When you centre yourself in situations like these, you could be unintentionally asking for emotional support from the person to whom you’re speaking.

CONTINUE

lgbtq2+, social determinants & health outcomes

Many healthcare processes and policies can be inherently discriminatory to LGBTQ2+ folks – even if unintentionally. For example, many medical forms don't include space for a full range of gender identity questions or sexual orientation questions, which impacts not just the level of care a person may receive but also the types of services made available to them.



Healthcare providers are also commonly not trained in gender affirming care or the specific health issues faced by LGBTQ2+ people, and this can be more of an issue in remote or rural communities. The majority of providers are also often unaware of issues faced by LGBTQ2+ populations beyond health issues; for example, someone


who is trans may be unable to obtain identity documents that list their correct gender and name (and instead only list sex assigned at birth and legal name). Over and over, this places the burden on the service user rather than the care provider as they have to explain their gender identity, sexual orientation, name differences, pronouns and more.

“41% of LGBTQ people and 75% of transgender people report needing to educate their health care providers on LGBTQ-specific health needs.”

McAfee, 2019

CONTINUE

As we discussed earlier, intersectionality also impacts LGBTQ2+ people. As the National LGBT Health Education Center explains:



“Black LGBTQ people often face multiple intersecting structural adversities linked to their sexual orientations, gender identities, and racial identities. As racially marginalized people, they already face biased policies and systems as they try to gain access to housing, jobs, places of leisure, and health care. As LGBTQ people, they may have an even greater likelihood of receiving unfair treatment linked to their sexual, gender, and racial identities.”

being neurodivergent & lgbtq2+

Research has shown that a higher percentage of autistic people identify as lesbian, gay, bisexual, transgender or queer (LGBTQ) than the general population. When individuals are both neurodivergent and LGBTQ2+, they may experience unique health impacts related to the intersection of their identities. To learn more, expand the boxes below:

increased risk of discrimination and stigma

Individuals who are both neurodivergent and LGBTQ+ may face increased discrimination and stigma due to the intersection of their identities. This can lead to negative impacts on mental health, including increased rates of depression, anxiety and trauma.

difficulty accessing appropriate healthcare

Both neurodivergent and LGBTQ+ individuals may face challenges accessing appropriate healthcare due to discrimination and lack of understanding.

higher rates of social isolation

Individuals who are both neurodivergent and LGBTQ+ may be at an increased risk for social isolation due to discrimination and stigma. This can lead to negative impacts on mental health and well-being, including increased rates of depression and anxiety.

increased risk of violence

Individuals who are both neurodivergent and LGBTQ+ may be at an increased risk for violence due to discrimination and lack of understanding. This can lead to negative impacts on physical and mental health, including increased rates of post-traumatic stress disorder (PTSD).

unique challenges related to identity

Individuals who are both neurodivergent and LGBTQ+ may face unique challenges related to their identity, including difficulty finding community and support. These challenges can impact mental health and well-being, leading to increased rates of depression, anxiety and other mental health challenges.

It is important to note that every individual is unique and may not experience all of these health impacts.

CONTINUE

what does this mean for us as peer support workers?

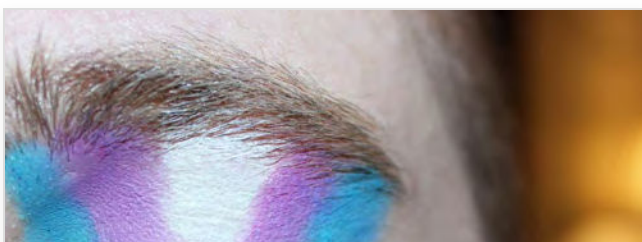
While it's not our role to provide healthcare services, we can offer our emotional support, encouragement and empathy, and we can challenge discrimination against LGBTQ2+ folks whenever we encounter it. Our peer support work also offers a vital way to reduce the common feelings of isolation and rejection amongst LGBTQ2+ service users and support them on their journey.

We can also share our lived experiences and what has helped or hasn't helped us in similar circumstances. We can use their pronouns and apologize when we get it wrong. And we can acknowledge the many barriers in place that may be affecting them.

CONTINUE

question for reflection

Answer this question in your reflection journal.



Imagine you're supporting an LGBTQ2+ person in accessing



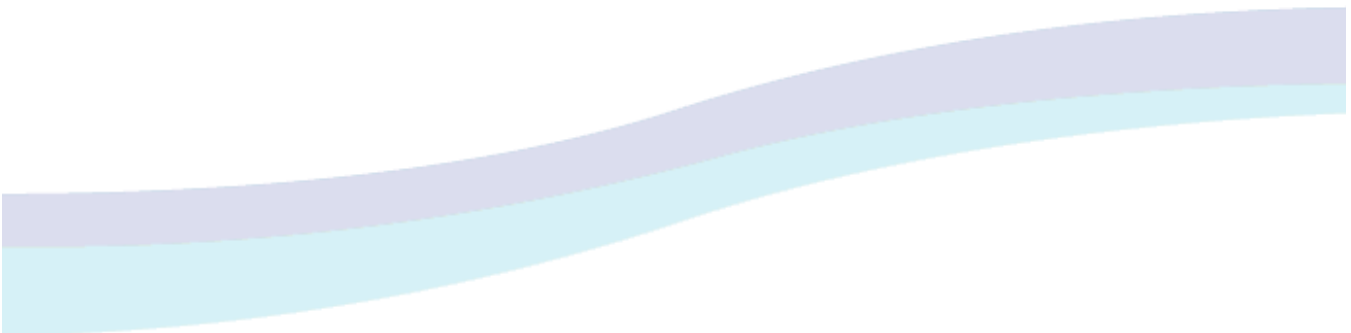
mental health services. What are five barriers that may exist in the organization itself or in their interactions with service providers? If you can't name five barriers, take a few minutes to research what other barriers

1 of 2



Now imagine you're supporting an LGBTQ2+ person in accessing substance use services. What are five barriers that may exist in the organization itself or in their interactions with service providers? If you can't name five, take a few minutes to research what other barriers

2 of 2



15. poverty, homelessness & food insecurity

We know that a socioeconomic issue like poverty can affect many things in our lives, including access to:

- ☐ Housing and housing stability
- ☐ Food (including healthy food options)
- ☐ Work and educational opportunities
- ☐ Certain health care (e.g., dental care and medications)
- ☐ Childcare

These all tie into our health outcomes.

a brief scenario

andy's story

Andy's family is low income, living in a poor neighbourhood in an old, damp one-bedroom apartment. Andy and their parents share the space with several extended family members. Their mom works multiple jobs and long hours and their dad has several health issues that mean he's receiving social assistance. Andy is currently connected to a safe supply program to manage their substance use but has been missing appointments due to having to support family.

Recently, Andy's been having difficulty breathing and experiencing coughing fits that last most of the night, disrupting their sleep and leaving them tired and distracted at school and unable to work at their part-time job. Once their mom is able to go with Andy to the walk-in clinic, they have to wait hours to see a doctor and then gets referred to a different clinic for tests. It takes another couple of months for them to get a proper diagnosis of moderate to severe asthma. One of the several doctors they sees tells Andy they need to avoid mould as this can trigger asthma; the doctor also recommends they change their diet.

It's easy to see how several factors, including their housing situation, have impacted Andy's health.

questions for reflection

Answer these questions in your reflection journal.



Imagine Andy's family lived in a large house in a middle-class neighbourhood and both their parents worked. How might their health outcomes be different?

1 of 3



How might a peer support worker be a valuable support for Andy as well as their family?

2 of 3



Take some time to reflect on the various barriers Andy faces. What are three specific barriers Andy will



are three specific barriers Andy will likely face as they interact with various service providers, particularly as they deal with a health issue?

3 of 3

CONTINUE

Many studies show that poor quality or unsafe housing, homelessness and food insecurity all have direct impacts on our health. We know that some Canadian homes, especially on Indigenous reserves, lack clean water and basic sanitation – and many are overcrowded. Overcrowding and a lack of clean water or sanitation can lead to the spread of illness and disease.

Living in inadequate housing can also increase stress as well as impact people's ways of coping, for example through substance use. We also know that those who are experiencing homelessness have a much greater rate of a wide range of physical health problems and mental health diagnoses than the general population.

“Poor housing conditions, including issues such as mould, overcrowding, and lack of affordability, have been associated with a wide range of health

conditions, such as respiratory and other infectious diseases, chronic diseases (e.g. asthma), injuries, inadequate nutrition, adverse childhood development, and poor mental health outcomes”

Key Health Inequalities Report

CONTINUE

More and more, studies show that children who grow up in food insecure households are more likely to experience behavioural, emotional and academic problems than those who live in food secure homes. A poor diet (which is usually more common when people lack income and are food insecure) is linked to higher rates of chronic diseases and challenges in managing these diseases as well. Very often, mothers try to protect their children from the nutritional impact of food insecurity by cutting back their own food intake, which in turn impacts the mothers' health.



We are also living with a housing crisis in B.C., driven by a lack of affordable accommodation, a high cost of living, low social assistance income, an increase in part-time and insecure employment and other factors that relate to government policy.

CONTINUE

offering peer support in this context

Often people get stuck in a cycle because of poverty and related factors. How can you get a job if you don't have secure housing? How can you find housing if you don't have a job and can't pass a credit check? How can you afford food (not even healthy food but just the very basics) if you don't have an income? A lack of understanding of these social determinants, as well as the intersections that can impact people, often lead to further discrimination and bias.

Like in our life application story earlier in this module, Melissa faced these types of barriers that prevented them from being able to live a healthier lifestyle or further their education. At first, Heather was unaware of how her own privilege meant it was hard for her to even see these barriers in the first place. As peer support workers, we need to be aware of the many different social, economic, material and even political factors at play for those we work alongside and how intersectionality plays a role as well.



16. creating greater equity in the mental health & substance use systems



check your knowledge

Based on what we discussed about equity versus equality earlier in this module, which of the following do you think best explains **equity**?

- ☐ People get the support that they can afford
- ☐ People get support that's in proportion to their needs
- ☐ People all get the same amount of support



People get the support they deserve

SUBMIT

CONTINUE

inequities in mental health

Major mental health inequities exist both in Canada and globally, and we know that mental health is a big part of our health that's directly impacted by social determinants. The Public Health Agency of Canada (PHAC) has reported that low self-rated mental health (meaning how people view or rate their own mental health versus an official mental health diagnosis) is more common among those with the lowest income, those with lower levels of education and those with unskilled or semi-skilled occupations.

Low self-rated mental health is also reported by people who identify as bisexual or gay/lesbian compared with those who identify as heterosexual. Non-heterosexuality is also associated with higher rates of suicidal thoughts and acts, as well as self-harm. This is directly linked to stigma and discrimination.

There is extensive evidence of greater rates of depression and anxiety occurring with autism, dyspraxia and ADHD. Autism has also been associated with higher rates of anxiety, eating disorders, mood disorders, obsessive compulsive disorder and schizophrenia.

“Factors associated with elevated rates of LGBT youth suicidality risk include homophobic and transphobic abuse, social isolation, early identification of sexual or gender diversity, conflict with family or peers about sexual or gender identity, inability to disclose sexual or gender identity, in addition to common mental health problems.”

McDermott, Hughes and Rawlings

Rates of hospitalization for those who are living with a mental health diagnosis are also directly linked to the social determinants of health. Mental health-related hospitalization rates go up with each ‘step down’ in a neighbourhood’s income, education levels and other material and social deprivations.

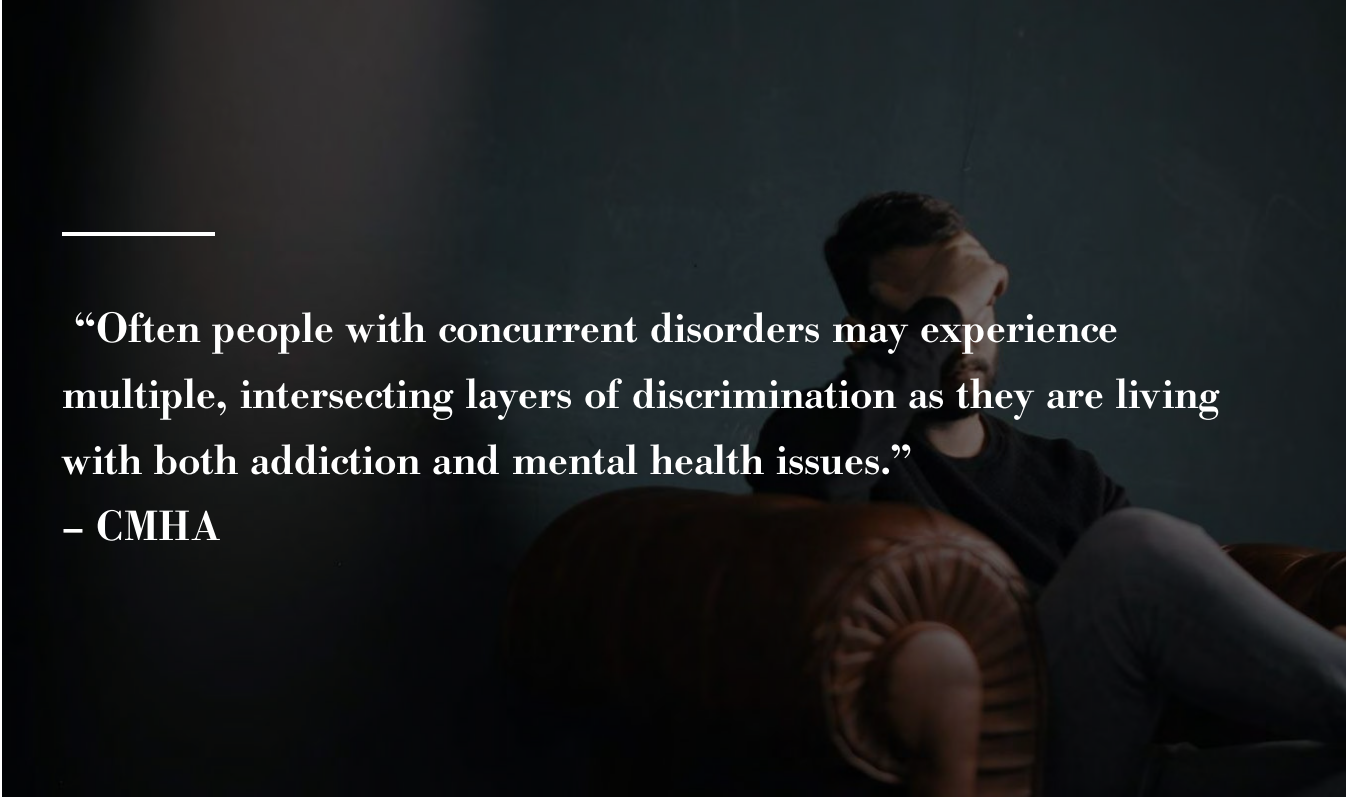
PHAC says that in places “with a high concentration of people identifying as Métis, Inuit, or First Nations, mental illness hospitalization rates were two to three times the rate among people who live in areas with a low concentration of people identifying as Indigenous.” This can be directly linked to the impacts of colonialism, trauma and systemic racism that we’ve discussed elsewhere in the module.

CONTINUE

substance use inequities

There's no one set of factors that realistically reflects the complex reason someone develops a substance use disorder; it's usually a combination of biological, psychological and social factors. As the CMHA explains, substance use disorders can be determined by a "person's genes, the way a person's brain functions, previous experiences of trauma, cultural influences, or social issues such as poverty and other barriers to accessing the social determinants of health."

More than half of those who seek help for an addiction also have a concurrent mental health diagnosis. This adds to the experiences of stigma and discrimination already experienced by those who have a substance use disorder, which can lead to further loss of self-esteem, a fear of getting treatment or feelings of isolation.

A man with a beard and short hair is sitting on a brown leather couch, looking off to the side with a thoughtful expression. The background is dark and out of focus.

“Often people with concurrent disorders may experience multiple, intersecting layers of discrimination as they are living with both addiction and mental health issues.”

– CMHA

CONTINUE

**how do we encourage greater equity in
mental health & substance use systems?**



Simply having an understanding of the complicated layers of the social determinants of health and the health inequities that exist allows us to understand our own lived experience as well as that of service users better, and deepens our awareness of the various, complex barriers that can stand in the way of better health outcomes.

Maintaining this awareness of how we all experience the social determinants of health differently and acknowledging we all have different barriers, privileges, intersections and worldview (something we've discussed before in this training) is also important. Remember, when we talk about acknowledging our own privilege, it doesn't mean that our path has been easy or that we haven't experienced discrimination and stigma ourselves. But it does often mean that we can be less aware of the barriers that we haven't personally experienced. This can sometimes impact how we relate to others in this work.

As Allies for Change explains, the more a person is privileged by the system, the more invisible its effects on others are to them, so it can be hard to spot our own privilege. As we offer connection and empathy to service users, keeping this in mind will help us be more effective peer support workers.

There are also concrete actions we can take.

CONTINUE

naming the compromise

What do we mean by 'naming the compromise'? This is a way we can hold organizations accountable to their own policies, visions and missions.

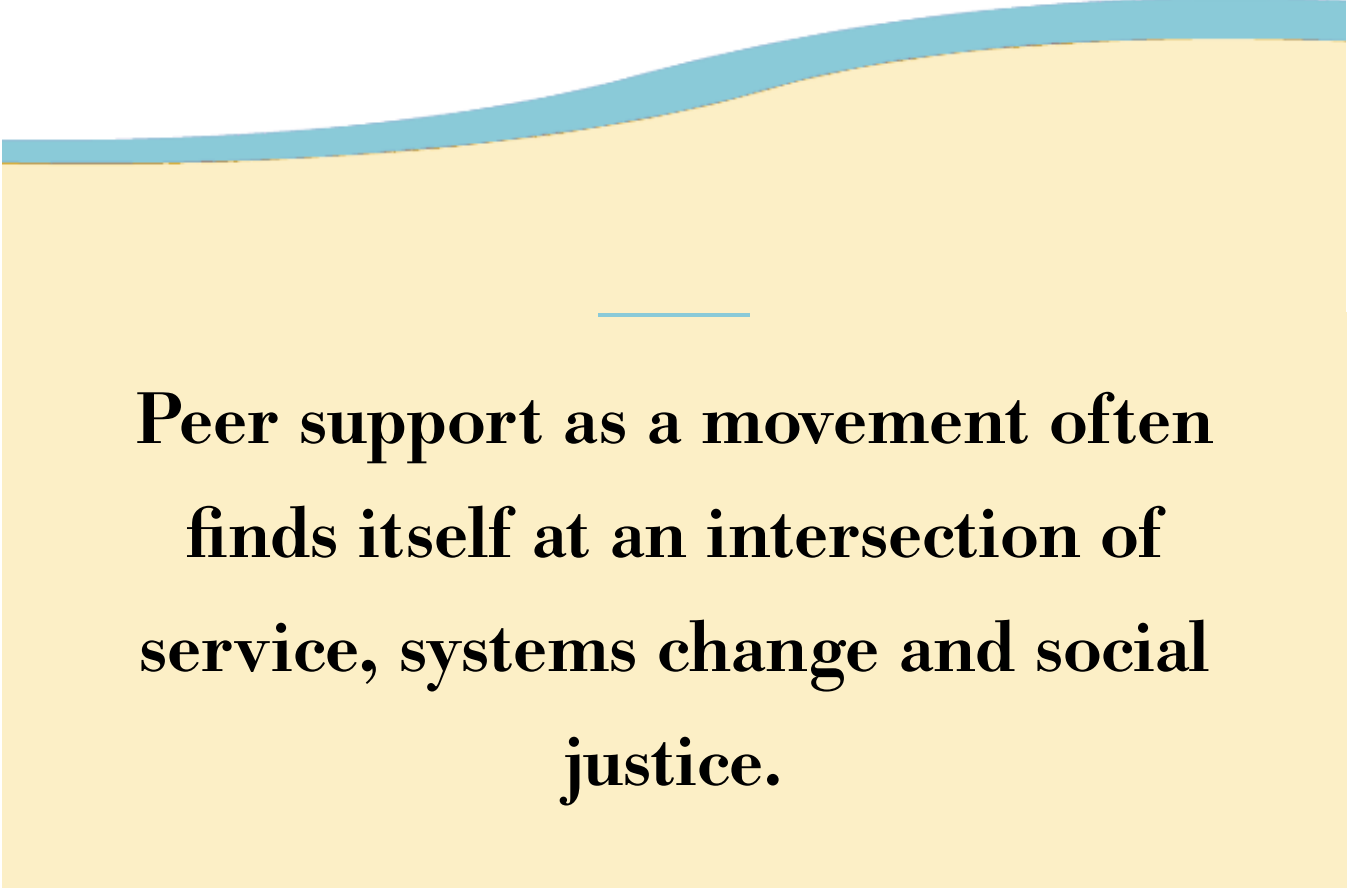
As peers, we can often find ourselves in a position where we're attending a meeting and an organization outlines some great commitments to support peers and service users in specific ways, but then after that initial meeting, things stall or barriers come up because of budgets or human resources issues. 'Naming the compromise' is about mindfully speaking up when this kind of stall happens. For example, we can send a follow-up email to the organization that explains how the failure to follow through/provide the agreed resources or whatever was planned that hasn't happened is in direct contradiction to the organization's mission and policies.



The idea is to keep the conversation going and to keep working towards concrete action. It also ensures there's a written record when this happens. When we name the particular compromise that's happening, we're also giving voice to the inequities that may have arisen and how this directly impacts both peers and service users. This is also a useful space in which to raise how difficult it can be for both peers and service users to be able to talk about these issues and to remind the organization that when they don't follow through on their promises, they're actually rejecting equity.

This type of advocacy also gives peers a space to tell the people they're working with that they're working to hold organizations accountable.

17. social justice, advocacy & moving forward with hope



**Peer support as a movement often
finds itself at an intersection of
service, systems change and social
justice.**



CONTINUE

“Reducing health inequities is... an ethical imperative. Social injustice is killing people on a grand scale.”

WHO

As you do this work, you have the opportunity to examine and challenge any biases you have about any of the social determinants of health and the inequities that we’ve discussed in this module. You also have the

opportunity, in partnership with the agency you work for, to advocate on a higher level for overall systems change. That may be within the mental health and substance use systems or perhaps pursuing change on a provincial or federal level.

We know that the role of peer support workers is to also build connection and relationship with the people we support. Often that includes greater community connections and inclusion. In these settings, you may find yourself advocating for the peer you're supporting. You're also often in a position to assist those you're walking alongside in advocating for the services they need. The goal is always to encourage those we support to self-advocate, while acknowledging that self-advocacy is a skill that must often be learned.

There's a lot we can do to change the systems that we live and work within when we learn how to use our voices and speak up with and for those who are marginalized. It's also important to acknowledge our resiliency and the capacity that we can all have to heal from the impacts of prejudice as we work towards wholeness.

There is hope and a path forward.

A close-up portrait of Martin Luther King Jr. looking slightly upwards and to the right with a thoughtful expression. The background is a solid olive green.

“We must accept finite disappointment, but never lose infinite hope.”
– Martin Luther King Jr.

18. core values assessment

question for reflection

Answer this question in your reflection journal.



We mentioned how mutuality connects to the social determinants of health earlier in this module. Now, choose three other core values (see list below), and reflect on the ways the social determinants of health may be connected to each of these.

1 of 1

CONTINUE

core peer support values



acknowledgement —

All human beings deserve to be seen for who they are.

IN ACTION: Peer support strives to acknowledge – and deeply hear – people where they are in their journey.

PSWs SUGGEST: Asking open-ended questions and actively listening to the PSW to see if they feel comfortable sharing their experience. Ask: “What do you think about that situation?” “Is there a coping strategy that you have used in a previous similar experience that worked for you?”

mutuality —

All healthy relationships are mutual and reciprocal.

IN ACTION: Peer support relationships are co-created, with all parties participating in boundary creation.

PSWs SUGGEST: Having a conversation about what is and isn’t okay to discuss with the PSW.

“...Even though I am a PSW, it’s painful for me to make eye contact with people. Hopefully, clients will see that if I’m looking away that it actually means that I am deeply listening to them. Being vulnerable and open seems to allow the other person to do their version of the same, building trust and respect and co-creating the relationship.”

strength-based —

Every human being has strengths.

IN ACTION: Peer support intentionally builds on existing strengths. It thoughtfully and purposefully moves in the direction of flourishing, rather than only responding to pain and oppression.

PSWs SUGGEST: Finding things that the PSW feels really confident about and expanding on those areas or delving into those areas and supporting their choices.

self-determination —

Motivation works best when it's driven from within.

IN ACTION: Peer support encourages self-determination and acknowledges and holds space for resilience and inner wisdom.

PSWs SUGGEST: Support the PSW in making decisions and doing things on their own – based on their wants, needs and goals.

respect, dignity & equity —

All human beings have intrinsic value.

IN ACTION: Peer support honours human value by

- Practicing cultural humility and sensitivity
- Serving with a trauma-informed approach
- Offering generosity of assumption
- Addressing personal biases mindfully
- Meeting people where they are
- Serving with a knowledge of equity

PSWs SUGGEST: Treat PSWs as you would like to be treated and expect to be treated. Learn about them on a personal level and treat them as equals.

belonging & community —

All human beings need to belong and be a part of a community.

IN ACTION: Peer support recognizes that many people have barriers that keep them from developing community and it actively works towards deconstructing those social blockades that prevent inclusion and acceptance. Peer support encourages a social justice mindset, and intentionally promotes empathy, compassion and self-compassion.

PSWs SUGGEST: Help PSWs feel wanted and cared about. Help them find resources that foster a sense of community and belonging.

“My quality of life improves immensely when I am surrounded by one or a community of people who understand me. I don’t feel alone. I can be myself among people who I know understand me on a deeper level. When I feel like I can be myself, I feel more confident and able to take positive risks, thus improving the quality of my life. The root of this is connection and being able to be seen for who I truly am. Peers can help people be seen in a real way.”

curiosity —

Curiosity and inquiry support connection, growth, learning and engagement.

IN ACTION: Peer support

- Is continually curious
- Challenges assumptions and narratives
- Asks powerful questions
- Offers generosity of assumption to those who think differently
- Knows that listening and asking questions is more important than providing answers

PSWs SUGGEST: Ask questions and be engaged in learning about your PSWs. Find out about their culture and explore with them.



19. summary

Let's review some of the key concepts covered in this module.

☐

Equity and equality are not the same thing; treating people equally rather than equitably means ignoring the complex barriers that many people face, including the impact their experiences, social status and background can have on their access to resources.

☐

Some Canadians experience better health than others because of their level of access to the social and economic opportunities to live a healthier life.

☐

The social determinants of health are the specific group of social and economic factors that relate to where a person finds themselves placed in society, such as their income, education levels or employment status.

☐

The Government of Canada lists twelve social determinants of health:

- Income and social status
- Employment and working conditions
- Education and literacy
- Childhood experiences
- Physical environments
- Social supports and coping skills
- Healthy behaviours
- Access to health services

- Biology and genetic endowment
- Gender
- Culture
- Race/Racism



People can experience marginalization or discrimination in some areas while being privileged in others; intersectionality is a way to understand the overlapping systems of discrimination or disadvantage that certain people face over others.



Systemic racism exists, but we can actively work to change it as well as to combat individual acts of racism as we work to be anti-racist.



The legacy of colonialism in Canada is one of inequity for those of Indigenous ancestry; this legacy, as well as our dominant European notions of health, has direct impacts on health outcomes for Indigenous Canadians.



Healthcare processes and policies can be inherently discriminatory to those who are LGBTQ2+ or those living with a disability.



Those who experience poverty, homelessness or housing insecurity and food insecurity are more vulnerable to experiencing poor health outcomes.



Beyond awareness of the social determinants of health and an acknowledgement of our own privilege, there are concrete actions we can take to support our peers.



20. next steps

We want to thank you for taking the time to walk alongside peer support workers on a shared path of learning from lived experience.

You are now ready to visit another module of the Peer Support Worker training curriculum!

Please head home to <https://peerconnectbc.ca> where you will find the individual training modules and facilitation guides. You will also find a [resource page](#) at that site to continue your learning about peer support work and the issues surrounding it.

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