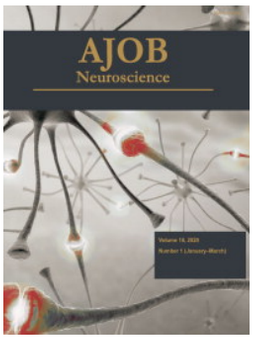

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# Rethinking Peer Support: An Intersectional Approach to Mental Health for Black, Indigenous and People of Color

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# Rethinking Peer Support: An Intersectional Approach to Mental Health for Black, Indigenous and People of Color

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In a recent article, Knopes (2025) examines how mental health peer support providers make use of the medical model and neurodiversity frameworks to better understand and express their mental health experiences. This research highlights how peer providers draw insights from both models to enhance personal meaning, improve their own recovery, and support others. However, Knopes's acknowledgment that people of color were underrepresented in the sample (attributed to lower mental health service engagement in these communities) reveals a major limitation. This lack of representation is significant, as race and systemic inequalities clearly affect people's mental health experiences and determine their access to support services. While detailed discussions are beyond the scope of this article, the following commentary builds

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on Knopes's work by briefly outlining how race and systemic inequities can impact the application of medical and neurodiversity models within mental health peer support, and in so doing, the article brings attention to ethical issues surrounding equity, diversity, inclusivity, and social justice.

Research consistently demonstrates that Black, Indigenous and People of Color (BIPOC) are disproportionately affected by mental health concerns, often worsened by structural inequalities (Kirkbride et al. 2024). For example, in the United States, BIPOC regularly encounter numerous barriers to accessing mental health support, including stigma within their communities, a deep-seated distrust of healthcare institutions, and encounters with pervasive systemic racism. Research indicates that BIPOC are less likely than their White counterparts to seek mental health treatment (Roberts et al. 2011). And when BIPOC do access treatment, they often encounter providers who lack cultural competence, which can lead to misdiagnoses and ineffective care. Research has shown that BIPOC are more frequently diagnosed with psychotic disorders, such as schizophrenia, partly due to clinician biases and cultural misunderstandings (Faber et al. 2023). Interestingly, for Black people in the criminal justice system, the systemic failures in mental health care are magnified. Evidently, Black prisoners often receive minimal or no mental health support. This neglect is exacerbated by the disproportionate placement of Black people in solitary confinement (Kaba et al. 2015). It is well known that solitary confinement is a practice that can worsen mental health issues and lead to long-term psychological harm (Strong et al. 2020). Ostensibly, these findings highlight an urgent ethical imperative. In short, healthcare providers must enhance their cultural competence and sensitivity to better serve diverse populations.

Knopes's research illustrates that many peer support providers find the medical model valuable, as it can empower people by validating mental health conditions and offering a credible basis for seeking support. However, while the medical model provides this validation, it may also unintentionally ignore the impact of structural inequalities, discrimination, and historical trauma. For example, legacies of historical injustices, such as the Tuskegee Syphilis Study and forced sterilizations of women of color (Alberstein and Davidovitch 2011), have understandably instilled deep-rooted distrust in healthcare systems within BIPOC communities. Yet, by focusing primarily on individual pathology, the medical model risks alienating those who perceive their mental health struggles to be inextricably linked to systemic injustices that affect their well-being and autonomy. Such practices may inadvertently reinforce cycles of mistrust and disengagement within BIPOC communities. That said, there is clearly a need for mental health frameworks, especially the medical model, to incorporate an understanding of systemic inequalities, historical trauma, and cultural perspectives to avoid perpetuating mistrust and alienation.

The neurodiversity model, which Knopes also discusses, reframes mental health conditions as natural variations in human neurobiology, rather than as deficits, impairments, or dysfunctions. Associated with movements such as "Mad Pride," this model promotes a more inclusive approach by challenging stigmatizing labels and celebrating differences. However, the neurodiversity model has its own limitations when applied to BIPOC, as it is invariably founded upon Western perspectives that may not fully resonate with other cultural views. For example, indigenous approaches to mental health commonly emphasize community, tradition, and spiritual well-being, and view mental health as a matter of relational harmony rather than as an individual neurological condition (Bożek, Paweł, and Mateusz 2020). Moreover, while the neurodiversity model has the potential to normalize mental health conditions, it must also recognize that neurodivergent BIPOC endure compounded challenges. BIPOC often experience "race and disability as dual factors in ongoing discrimination" (Davis, Solomon, and Belcher 2022, 306). So, rather than applying a one-size-fits-all framework, neurodiversity models must consider the varied cultural, historical, and social contexts that influence mental health and neurodivergence within BIPOC communities.

Lastly, Knopes's study points out the nonhierarchical and empathetic nature of peer support, which is valuable in mental health care. However, the study also highlights accessibility and inclusivity challenges, particularly for marginalized groups, where different cultural perspectives may not always be accommodated within standard peer support models.

Put differently, if a peer provider is trained primarily from a neurodiversity-focused perspective, they might unintentionally overlook the specific impact of racial trauma on a BIPOC's mental health, and potentially leave significant aspects of their experience unacknowledged. Similarly, a rigid medical approach to mental health can inadvertently alienate BIPOC who view their mental health challenges to be influenced more by systemic racism and

institutional barriers than by personal pathology. Thus, for peer support to be effective and inclusive, it must be flexible enough to adapt to the diverse cultural and individual experiences within the communities it serves.

In summary, while Knopes's work offers important insights into how peer providers apply medical and neurodiversity models in mental health contexts, a more equitable, diverse, and inclusive discussion is needed. Expanding on Knopes's findings, an intersectional framework that includes race, class, and systemic inequities would improve the inclusiveness of peer support models. This approach acknowledges that mental health challenges intersect with structural and sociocultural factors across different demographic groups. To put this into practice, peer provider training could emphasize developing cultural competences, awareness of systemic inequities, and the skills necessary to understand how these factors influence mental health. In other words, moving away from rigid frameworks and embracing a holistic view of mental health that respects diverse experiences may enable peer support to fulfill its ethical potential as an equitable, inclusive, and effective form of mental health support.

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