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Uplifting Our Voices: Exploring the Lived Experiences of Black Certified Peer Specialists in the Behavioral Health System and Their Recommendations for Dismantling Racism

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B.A. Sociology
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2021

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Abstract

Uplifting Our Voices: Exploring the Lived Experiences of Black Certified Peer Specialists in the Behavioral Health System and Their Recommendations for Dismantling Racism

By Lindsey Burton-Anderson

Introduction: Certified Peer Specialists (CPS) of Color are essential to the success of the Behavioral Health System (BHS) and may be in a unique position to help address racism and disparities. CPS are individuals with lived experiences of a psychiatric and/or substance use disorder who provide recovery-oriented support services to people with psychiatric conditions.

Methods: This qualitative study included 10 participants who engaged in one-time, in-depth semi-structured interviews. Our guiding theoretical frameworks were Critical Race Theory (CRT) and Intersectionality Theory (IT). The purpose of the interviews was to gain a deeper understanding of the experiences of Black CPS in the state of Georgia, with a focus on experiences with racism and discrimination. We also synthesized participants' recommendations for mental health professionals and organizations. These recommendations intended to address systemic racism and be implemented by organizations that employ peers.

Results: Our data suggests that navigating the BHS, emotional response, and self-empowerment are all strongly tied to the experiences of Black CPS. The common threads across the diverse lived experiences of Black people in a system rife with social hierarchies and unfair policies and practices were their reactions, or lack thereof, to racism and discrimination, the importance of social support, and the act of standing up for oneself. Recommendations suggested by participants include zero tolerance workplace, cultural humility training, listening to CPS, engaging in active self-reflexivity, and addressing racism in society.

Conclusions: Ultimately, our findings highlight the urgent need for anti-racist interventions and policies to address these systemic issues and support the empowerment of Black CPS in behavioral health care.

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Table of Contents

Definition of Terms

To provide the necessary context for concepts and terminology used in this study, a list of definitions will be provided.

Peer Support

Peer support is characterized by mutually beneficial support between individuals with lived experiences – past and present – of mental health or substance use struggles (Adame & Leitner, 2008). This mutual support is often emotional, instrumental, and relieving during the recovery journey.

Certified Peer Specialist

Certified Peer Specialists (CPS) are people who have personally experienced psychiatric and/or substance use disorders and who provide recovery-focused support services to people, i.e., peers, who are currently struggling with these issues (Walker et al., 2022).

Behavioral Health System (BHS)

Behavioral health refers to the comprehensive treatment of mental health disorders and substance use disorders by a variety of trained and experienced mental health practitioners (Buscemi & Hendrick, 2018). Therefore, the system is the overall avenues, persons, and organizations giving care that pertain to behavioral health.

Ethnoraciality

The concept of ethnoraciality views a person's ethnicity, race, nationality, and religion as equally significant social identifiers (Jiménez et al., 2015). This is particularly necessary since most of the CPS in this study identify with the immigrant experience.

Chapter I: Introduction and Statement of the Problem and Purpose

Introduction and Problem

Certified Peer Specialists (CPS) are essential to the success of the Behavioral Health System (BHS) and the care of individuals with psychiatric and substance use histories. Since 1999, Georgia was one of the first states to establish a certified peer specialist program that emphasizes recovery-oriented programming and peer support for people who struggle with mental health issues (Sabin & Daniels, 2003). Peer support has been seen as a less harmful alternative to traditional psychiatric interventions, particularly for those without prior meaningful experiences in the BHS (Adame & Leitner, 2008). Peer support improves patient self-efficacy and hopefulness in the recovery journey (Chinman et al., 2014). Peer support is an effective method in mental health and substance use support for various reasons. A peer worker is someone to rely on, they are empathetic and sensitive to a peer's experiences, which increases their credibility, and there is the mutual benefit of assisting one another in recovery by sharing stories (Solomon, 2004; Chinman et al., 2014; Lapidos et al., 2018).

Unfortunately, peer specialists may be met with discriminatory stereotypes by other mental health practitioners that pertain to the efficacy of their position and their ability to handle a stressful position (Davidson et al., 2012; Gates & Akabas, 2007). Identifying as a person of color – characterized as those who self-identify as Black/African American, Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, Hispanic/Latinx, or multiracial – compounds the discrimination that CPS can face. Racism has a long-standing, complicated history in the BHS, and has a negative impact on people of color who have mental health and substance use issues (Mensah et al., 2021; Suite et al., 2007; Walker et al., 2022). While there have been recommendations for dismantling racism in other sectors of the BHS such

as psychiatry, little has been done to improve the outcomes of ethnoracial disparities and inequities for organizations that employ peers (Mensah et al., 2021; Sabshin et al., 1970; Suite et al., 2007). Dialogues about racism, discrimination, and inequities are beneficial and essential to the success of the BHS and CPS, but there have been limited studies supporting these findings (Walker et al., 2022).

Based on this gap, peer workers' daily experiences will be examined to identify opportunities for eradicating racism in a system designed to stand up for those who are minoritized. A qualitative approach was used to ensure the rich stories and sentiments CPS of color have about the BHS are heard. CPS of color have a unique perspective in the BHS due to the burgeoning profession, but also the implications racism has on their experiences. Due to overlapping identities, implications of power, and significance of representation, the experiences of Black CPS are intertwined with the concepts of Critical Race Theory and Intersectionality Theory.

Theoretical Framework

Critical Race Theory

Critical Race Theory (CRT) is a race scholarship movement among activists and scholars who are dedicated to reconstructing the relationship between race, racism, and power. CRT pushes activists and scholars to iteratively question dominant ideology by utilizing six elements: Ordinariness of Race, Interest Convergence, Social Construction of Race, Consequences of Differential Racialization, Intersectionality and Antiessentialism, and Voice of Color. For this study, five of the six elements of CRT were applied to provide a deeper understanding of CPS of color's unique perspective in the BHS. The element not applied, Social Construction of Race, does not directly speak to both the experiences of Black CPS and their behavioral health history.

The first element is the Ordinariness of Race. Essentially, the dominant group fails to recognize that equality among ethnoracial groups is not being met due to adhering to colorblind ideology. As such, the dominant society insists that the rules created are fair and just for all groups. However, this is not the case (Delgado et al., 2017). Interest Convergence is the second element of CRT that states white people, both elite and working class, are solely interested in advancing their interests while simultaneously depriving minorities of the same interests (Delgado et al., 2017). The third element of CRT, Consequences of Differential Racialization, asserts that the dominant group chooses who is useful at different moments in history and recounts the narrative of minority groups by developing scripts and stereotypes about these groups (Delgado et al., 2017). Intersectionality and Antiessentialism assert that all identities of a single person intersect to shape who they are. This element notes that "no person has a single, easily stated, unitary identity" (Delgado et al., 2017). Lastly, the Voice of Color element asserts that understanding the whole story requires consideration of individuals who have experienced oppression. Being a minority immediately qualifies you to discuss racism and injustice (Delgado et al., 2017).

Applying CRT to the lived experiences of Black CPS in the Behavioral Health System can help to uncover the ways in which racism and discrimination impact people of color and can inform efforts to create more equitable and just systems of care for peers, certified peer specialists, and other mental health professionals.

Intersectionality Theory

Intersectionality Theory was created in the 1980s and practiced by Kimberlé Crenshaw to initially make sense of the simultaneous, inseparable, and intertwined identities of Black women who are often erased from theoretical and structural understandings in legal studies (Crenshaw, 1989). It has since been adapted to understand even more identities of people in various fields.

Intersectionality Theory is an exploratory term used to concentrate attention on the complex interactions of difference and the affinities of sameness in the context of anti-discrimination and social movement politics (Cho et al., 2013). Essentially, this theory conceptualizes the everyday experiences of minorities who hold multiple identities in a single-pronged world that is dominated by ruling populations, i.e., cisgender, heterosexual, Christian, and white.

Applying IT to the lived experiences of Black CPS will help to frame how racism and discrimination work in tandem to shape inequitable experiences for the multiple, complex identities of Black CPS. Analyzing through an intersectional lens can help to inform policies and practices that are more responsive to the unique needs and experiences of diverse communities.

Purpose

This project aims to elevate and center the voices of CPS of color and share their experiences with academic audiences, peer organizations, mental health and substance use organizations, and other CPS and mental health practitioners. Their expertise can help organizations and mental health providers by providing suggestions for how to support CPS of color better and incorporate anti-racist methodologies into their work. As such the research questions are:

1. What are the experiences of racism and discrimination of Black Certified Peer Specialists in the behavioral health system?
2. How do they perceive the opportunity to dismantle racism in the behavioral health system?
    a. What recommendations do Black CPS have for behavioral health organizations and professionals to better support them?

Understanding the experiences of Black CPS will help to clarify their experiences in the BHS and the ways in which behavioral health organizations, providers, and employers can incorporate anti-racist recommendations from CPS into their management. These anti-racist recommendations may also improve the experiences of peers.

Chapter II: Review of the Literature

Mental Health Movements & Peer Support

Prior to the development of peer support were four mental and behavioral health movements that sparked the need for peer support. Asylum, mental hygiene, deinstitutionalization, and the consumer and psychiatric survivor movements predate the modern BHS. The asylum movement of the 19th century, which had its roots in Europe and spread to the United States, is seen as a family-friendly alternative to cruel treatment. However, it was discovered that asylum employees in the United States were inept and brutal to patients by the middle of the 19th century (Everett, 1994; Grob, 1994, 2005). The mental hygiene movement began in the early 20th century when a former asylum resident wrote about his horrible experiences. Aside from its impacts on public opinion, the former resident failed to achieve their objectives of ameliorating the conditions of asylums and, ultimately, inadvertently propagated the institutionalization of the middle class (Everett, 1994). By the late 1940s, the federal government had entered the mental health field with the passage of the National Mental Health Act in 1946 and the subsequent founding of the National Institute of Mental Health (NIMH) in 1949 to influence the dissolution of public mental health hospitals (Grob, 1994, 2005).

Between the 1960s and 70s, the deinstitutionalization movement was underway and was characterized by the creation of a community mental health network outside of hospitals. As governor of Georgia and later President of the United States, Jimmy Carter and his wife, Rosalynn Carter, spearheaded the creation of commissions dedicated to improving services for patients with mental illness (Grob, 2005; Adame & Leitner, 2008). This movement was in response to the civil rights movement, a variety of idealistic and educated professionals from different fields waiting to make a change, the discovery of psychotropic medications, and

politicians wanting a cheaper alternative to psychiatric institutions (Everett, 1994; Fakhoury & Priebe, 2007). However, the movement was met with conflicting factors such as a lack of proper funding, disarray of institutions in the BHS, and displaced patients (Grob, 2005). The creation of the President's Commission on Mental Health (PCMH) in February of 1977 suggested a shift in discussions surrounding mental health. The 20-person commission consisted of a representative set of backgrounds accounting for gender, race, and ethnicity – twelve men, eight women, three African Americans, two Hispanics, and one Native American – with expectations of addressing mental health issues by looking at broad social problems often plaguing minorities such as poverty, racism, and discrimination (Grob, 2005). The themes of the September 1977 preliminary report covered (1) community-based mental health services, (2) issues with financing mental health services in public and private insurance plans, (3) the need to expand general knowledge of what mental health means, and (4) identifying preventative measures for mental disorders (Grob, 2005). Subsequent task panel reports emerged, complicating findings and imposing individual needs. However, the first task panel report focused on minoritized groups – women, people of color, and the disabled – because they were overrepresented in mental health statistics and under- or inappropriately served by the BHS (Grob, 2005). Minoritized groups being the focal point of the report was newfound and necessary to represent the overall behavioral health community. After an agreement among the commission's members, the Final Report, released in April 1978, focused on two main issues: (1) federal commitment to community mental health services with full citizen engagement; and (2) priority and placement for the chronically disabled (Grob, 2005). These issues intersected with the Report's mention that minoritized groups – by way of race, mental ability status, citizen privileges, and geographic location – often lacked proper care, access to necessities, and culturally and linguistically

competent care (Grob, 2005). Despite the efforts of the PCMH and the subsequent development of the Mental Health Systems and Community Mental Health Centers Acts, both were overturned under the Reagan Administration through the Omnibus Budget Reconciliation Act, thus severely limiting funding for behavioral health services (Grob, 2005). Despite the reduction in funding on a federal level, funding for community care at the state level increased from 33% in 1981 to 49% in 1993 (Rothbard & Kuno, 2000).

Although individuals from both the 1980s and 1990s consumer and psychiatric survivor movement were proponents of change, worked to expose power relations in the mental health system, and support self-help groups, both have different perspectives on the outcome. Consumers think the BHS can be changed from the inside, whereas psychiatric survivors think the system needs to be completely replaced before people can be treated with humanity (Everett, 1994; Adame & Leitner, 2008). Given this background, the peer support profession was developed, keeping in mind that peer workers have the same, unique perspective consumers and psychiatric survivors have (Adame & Leitner, 2008). Peer-led organizations are an indication of how consumers and psychiatric survivors have evolved, as well as the advocacy the latter pursued (Adame & Leitner, 2008). The integration of peer workers into various settings within the BHS speaks to the desires of consumers that change can be done from within (Adame & Leitner, 2008).

Building on the work of his predecessors, President George W. Bush formed a new commission to make lasting changes in the BHS. The New Freedom Commission on Mental Health (NFCMH) was a committee established in 2002 to address the state of mental health services in the United States. The commission was charged with evaluating the current BHS and making recommendations for improvements to ensure that individuals with mental illnesses

receive high-quality care (Hogan, 2003). The NFCMH 2003 report, "Achieving the Promise: Transforming Mental Health Care in America", has had a significant impact on mental health policy in the United States by influencing the development of several federal initiatives aimed at improving mental health services, including the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010 (Wishon Siegwarth & Blyler, 2014). A unique goal of the commission was to eliminate disparities in mental health services. This includes not only ethnoracially minoritized communities, but it also includes other, intersecting identities such as geographic location and ability status (Hogan, 2003).

Peer Support Workforce

The peer support workforce has significantly evolved over the past four decades and is an integral part of the BHS. Peer support – which has roots in self-help, 12-step, and advocacy programs – has undergone a transformation to cater to the needs of individuals with behavioral health struggles (Barton, 1999; Mowbray et al., 2021; Rogers, 2017). Peer workers intentionally assist in the recovery of individuals with similar behavioral health histories as them. As of 2016, 30,000 people are actively serving as certified peer workers in a host of settings such as recovery housing, inpatient settings, correctional facilities, community spaces, college campuses, and job sites amongst others (Gagne et al., 2018; Mental Health America, n.d.). To become certified, individuals go through a credentialing process. This process entails an application, training, and examination period. A specific curriculum is followed to ensure consistency among the different types of Georgia CPS. Elements covered include roles and responsibilities, how to effectively use personal recovery stories, active listening, creating supportive environments, professional boundaries, self-care, goal setting, and workplace conflict amongst others (Training and Certification of Peer Specialists, 01-123, 2018).

In the state of Georgia, there are four main types of CPS: (1) Mental Health (CPS-MH), (2) Addictive Disease (CPS-AD), (3) Youth (CPS-Y), and (4) Parent (CPS-P). A CPS-MH is an individual who has a lived history with a mental health condition and actively in recovery. The Georgia Mental Health Consumer Network (GMHCN) provides training and examination for this credential. A CPS-AD is an individual who has lived history with substance use and is actively in recovery; the Georgia Council on Substance Abuse provides training and examination for this credential. A CPS-Y is a young adult between the ages of 18 and 30 who has experienced a mental health condition and/or a history of substance use. Lastly, a CPS-P is a parent or legal guardian of a young individual who has lived experiences with behavioral health struggles. As of 2020, the Georgia Parent Support Network provides training and certifies the Youth and Parent credentials (Georgia Department of Behavioral Health and Developmental Disabilities, n.d.).

Peer Support Services

Peer support services are recovery-focused care directly given to a person struggling with behavioral health issues (Chinman et al., 2014). The embedded social support that peer workers offer – emotional, informational, instrumental, and affiliational assistance – makes peer recovery more successful (Center for Substance Abuse Treatment, 2009). The recovery-oriented approach that peer workers take manifests as a variety of services. Peer workers frequently facilitate recovery groups, provide educational support, provide transportation assistance, and offer one-on-one peer mentorship, outreach, or counseling, as well as programs like job readiness training, wellness seminars, and sobriety-friendly socializing opportunities (Center for Substance Abuse Treatment, 2009; Gagne et al., 2018; Salzer, 2010). When an individual experiencing behavioral health issues engages with a peer worker, quality of life, self-empowerment, self-efficacy to obtain and continue care, hopefulness in recovery, social functioning, coping, and professional

development skills increase (Chinman et al., 2014; Davidson et al., 2012; Mental Health America, 2019; Rogers, 2017; Solomon, 2004). Peer support services also provide cost-saving benefits to the BHS with a significant reduction in psychiatric hospital readmission rates and inpatient stays, and a higher return on investment (Landers & Zhou, 2014; Mental Health America, 2019; Solomon, 2004).

Peer support became Medicaid-billable under the Medicaid Rehabilitation Option in Georgia in 2001, ushering in a period of revolutionary transformation for the BHS nationwide (Landers & Zhou, 2014; Sabin & Daniels, 2003; Salzer, 2010). As of 2018, 37 of the 50 states deliver peer support services with funding from Medicaid programs (Bushfield et al., 2020; Rogers, 2017). Peer support coverage is possible due to the work of numerous task forces and commissions over the years, but there is still an issue with underfunding for these services (Grob, 2005; Salzer, 2010). A lack of funding is often attributed to non-peer mental health professionals not valuing the support peer workers give to clients' recovery (Gates et al., 2010; Silver & Nemec, 2016). Because of their troubled histories with mental illness and/or substance use, peer workers may experience stigma about their ability to carry out such crucial peer work (Gates & Akabas, 2007). Peer workers have additionally encountered negative messaging, including jokes from clinicians that refer to them as "patients," excluding them from the social aspects of workplace culture (Davidson et al., 2012; Firmin et al., 2019). These power hierarchies and workplace conflicts are detrimental to the well-being of peer workers (Gates & Akabas, 2007; Vandewalle et al., 2016).

Racism and Workplace Silencing

Racism, discrimination, and its subsets are forms of oppression that are found in various institutions, structures, and interactions (Corneau & Stergiopoulos, 2012). More specifically,

microaggressions reveal a system of everyday discrimination and oppression and can result in traumatic stress (Firmin et al., 2019; Pérez Huber & Solorzano, 2015). Racial microaggressions, a subset of racism, are "offensive mechanisms" of layered, verbal and non-verbal assaults performed in subtle ways and "delivered incessantly" which is harmful over time and accumulates as stress for people of color, especially Black people (Pierce, 1970; Pérez Huber & Solorzano, 2015). The ensuing race-based traumatic stress is characterized by abrupt, adverse, and upsetting experiences unbeknown to the receiver of the stress that causes primary symptom clusters of avoidance, arousal, and intrusion (Carter, 2007; Carter et al., 2004). The three symptom clusters expand into experiencing mild-extreme emotional distress, hypervigilance, recurring memories, and cultural mistrust – communities of color find it difficult to trust institutions that have a history of perpetuating racial discrimination (Alang, 2019; Carter et al., 2004; Suite et al., 2007; Trinh et al., 2019).

Impact of Racism on Mental Health

Racism and its subsets, discrimination and microaggression, have a profound effect on the mental health of people of color. There is a strong association between racism and poor mental health which has been shown to strongly activate processes in the brain with the dysregulation of cognitive-affective regions – these regions are where experiences of anxiety, depression, and psychosis occur (Berger & Sarnyai, 2015; Schouler-Ocak et al., 2021). Overall, experiencing ethnoracial discrimination is correlated with increased susceptibility to stress, leading to adverse mental health outcomes (Berger & Sarnyai, 2015). Individuals who experience racism in addition to discrimination due to a mental illness diagnosis report lived instances of being invalidated, feeling fearful and ashamed, enduring double discrimination, and being seen as inferior (Alang, 2019; Firmin et al., 2019; Gonzales et al., 2015).

Racism in the BHS

When examining the BHS, racism can be seen on many different levels, including personally mediated, institutional, and systemic. Personally mediated racism consists of prejudice and discrimination where prejudice refers to different presumptions about the capabilities, intents, and motives of others based on their race and discrimination refers to inequitable acts against others based on race (Ohueri et al., 2019; Dominelli, 1997). Personally mediated racism can be both intentional and unintentional and can appear as disrespect, suspicion of others based on race, devaluation of skills and aspirations, scapegoating, and dehumanization (Jones, 2000). In the BHS, personally mediated racism occurs when non-peer professionals belittle and invalidate the efficacy of peer workers of color – ethnoracial identity and mental health diagnosis overlap (Alang, 2019; Firmin et al., 2019; Gonzales et al., 2015).

As stated by Dr. Camara Jones in her revolutionary essay, "The Gardener's Tale," institutional racism, which is interchangeable with structural racism, is the "differential access to the goods, services, and opportunities of society by race" and is "codified in our institutions of custom, practice, and law, so there not need to be an identifiable perpetrator" (Jones, 2000). Institutional racism is experienced in the BHS by way of inaccessibility to care, a lack of diversity in the behavioral health workforce, the permeation of stereotyping and bias, and a lack of research centering Black identities (Murray & Ware, 2022; Sabshin et al., 1970). In particular, this lack of representation in behavioral health research can be attributed to cultural mistrust and feeling undervalued by academic audiences and funding agencies (Murray & Ware, 2022).

Lastly, systemic racism has inherent foundations in the development and subsequent establishment of what we call the United States of America. This is characterized by "(1) dominant racial hierarchy, (2) comprehensive white racial framing, (3) individual and collective discrimination, (4) social reproduction of racial-material inequalities, and (5) racist institutions

integral to white domination of Americans of color" (Feagin & Bennefield, 2014). Systemic racism is complex. It represents the culmination of centuries worth of oppressive acts of white racial dominance. The BHS as a whole has inherent foundations that, historically, do not have the best interest of ethnoracially minoritized populations, thus, the need to develop various taskforces, commissions, and acts to combat the negative effects experienced by minoritized communities (Alang, 2019; Fakhoury & Priebe, 2007; Fisher & Spiro, 2010; Grob, 1994, 2005; Hogan, 2003).

Workplace Silencing

Workplace silencing is the act of subjugating an employee to harassment, oppression, and unfair treatment, and as a result, the employee does not feel safe in expressing their thoughts, opinions, and experiences. Workplace bullying, employee silence, and psychological safety are concepts that develop into understanding workplace silencing (Liu et al., 2020). Given the aforementioned information, personally mediated and institutional racism, discrimination, and its subsets can manifest as workplace bullying, thus resulting in silencing; workplace bullying can increase employee self-stigma, decrease employee self-esteem, decrease trust in employers leading to avoidant behavior at work, and lower the likelihood of employees being treated fairly (Abiri et al., 2016; Balogun-Mwangi et al., 2022; Hielscher & Waghorn, 2017; Liu et al., 2020). Workplace discrimination for those between the ages of 18 and 55 with mental health struggles is reported at 36% (Balogun-Mwangi et al., 2022). A positive and socially inclusive work environment with senior administration and non-peer professionals that advocates for peer support workers has a positive impact on their job satisfaction and overall well-being (Davidson et al., 2012; Gagne et al., 2018; Grant et al., 2012; Ibrahim et al., 2020).

While peer specialists have been proven to be useful to the BHS, they are still discriminated against regarding concerns other mental health practitioners have raised that have since been disproved (Davidson et al., 2012; Salzer, 2010). These concerns are exacerbated by ethnoracial discrimination in the BHS. Such concerns, which can manifest as personally mediated racism and microaggressions, have been refuted including CPS being "too fragile" to handle the job due to known mental health and/or substance use histories, fear of relapse in recovery, incompetence in administrative tasks, fear of breaking the confidentiality of peers, and CPS making other mental health practitioners job harder (Davidson et al., 2012; Firmin et al., 2019; Gates & Akabas, 2007). Ethnoracial minorities are more likely to report higher levels of stress related to discriminatory workplace experiences (Balogun-Mwangi et al., 2022; Glover et al., 2010).

Addressing Racism in the BHS

Despite the numerous detriments facing Black individuals in the BHS, there are current efforts and suggestions for addressing racism in the BHS and leading an anti-racist system. Anti-racism is the deliberate and active pursuit of exposing, combatting, and eliminating all forms of systemic racism, prejudice, and discrimination. It entails acknowledging how racial inequality is woven into societal systems and actively trying to build a more fair and just society for everyone, regardless of race or ethnicity (Bonnett, 2005; Corneau & Stergiopoulos, 2012). Anti-racism can take many forms, including speaking out against racist policies and practices, advocating for diversity and inclusion, engaging in education and dialogue around race and racism, and actively promoting equity and justice. It requires ongoing self-reflection, learning, and action to address the impact of racism on individuals and communities.

Common efforts include: Anti-racist education and cultural humility training of white-led peer organizations and psychiatry residents to be more inclusive of peer workers of color (Corneau & Stergiopoulos, 2012; Hansen et al., 2018; Legha & Miranda, 2020; Neblett, 2019; Schouler-Ocak et al., 2021; Shim, 2021; Shim & Starks, 2021); white-controlled professional behavioral health organizations to actively work with and allocate more resources to Black mental health professionals (Ohueri et al., 2019; Sabshin et al., 1970); actively centering and promoting the lived experiences of Black peer workers (Alang, 2019; Corneau & Stergiopoulos, 2012; Shim & Starks, 2021); engaging in self-reflection and challenging social norms and implicit biases (Cénat, 2020; Corneau & Stergiopoulos, 2012; Legha & Miranda, 2020; Sabshin et al., 1970; Schouler-Ocak et al., 2021; Shim, 2021); addressing public policies (Shim, 2021); and updating organizational policies, documents, and workplace culture to utilize non-stigmatizing or oppressive language (Corneau & Stergiopoulos, 2012).

Theoretical Framework

Critical Race Theory and Intersectionality Theory work in tandem to inform the understanding of racism and discrimination in the BHS (see Figure 1).

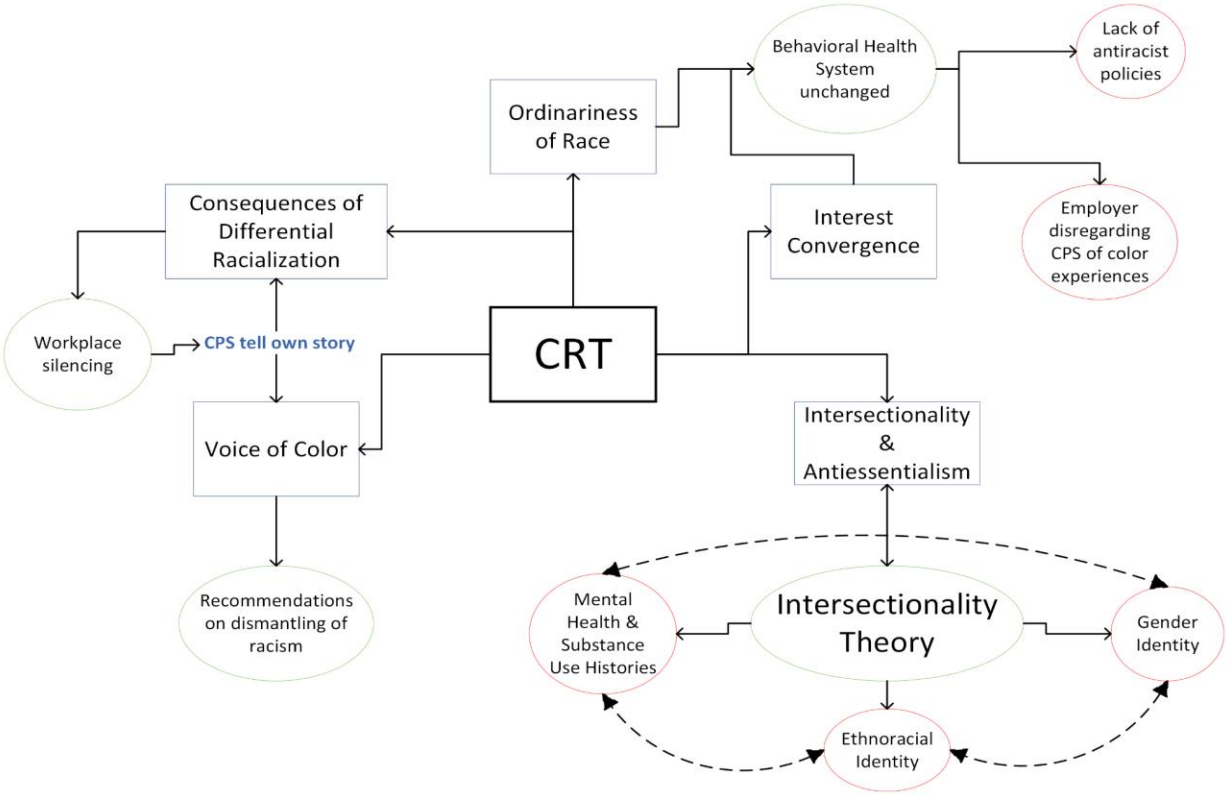

Figure 1. Critical Race Theory and Intersectionality Theory Conceptual Model

Critical Race Theory & Intersectionality Theory in the Behavioral Health System

CRT explains why the BHS serves as a microcosm of society as a whole. Ordinariness of Race refers to the way in which race is a pervasive and often subtle feature of everyday life, shaping our experiences, interactions, and perceptions in ways that are often taken for granted or normalized. It can manifest through racial biases and stereotypes, racialized social norms and expectations, and systemic racism in institutions and policies. Interest Convergence suggests that dominant groups are more likely to support social justice movements when it aligns with their own interests. It argues that historically minoritized groups are more likely to achieve their goals when they can demonstrate how it benefits those in power. The Ordinariness of Race and Interest Convergence speaks to the BHS being largely unchanged due to a lack of antiracist policies and employers disregarding CPS of color and their experiences of racism and discrimination despite

some recommendations being stated in the psychiatry sector over 50 years ago (Shim, 2021; Sabshin et al., 1970). Consequences of Differential Racialization refers to the unequal treatment of different racial groups and the resulting social, economic, and political outcomes. This can include disparities in access to resources, opportunities, and representation, as well as the perpetuation of systemic racism and discrimination. Voice of Color refers to the perspectives, experiences, and voices of people of color, who have historically been minoritized and excluded from mainstream discourse. It emphasizes the importance of amplifying and centering these voices to challenge dominant narratives and create a more inclusive and equitable society. Consequences of Differential Racialization and Voice of Color are connected when CPS tell their recovery story and personal accounts of racism, i.e., through in-depth interviews and interactions with peers. Workplace silencing leads back to CPS telling their own story. Voice of Color also helps to understand the recommendations CPS of color have on the dismantling of racism. Arrows between “Intersectionality Theory” and “Intersectionality and Antiessentialism” are bidirectional as both CRT and Intersectionality Theory inform one another. Intersectionality Theory separates into mental health and substance histories, ethnoracial identity, and gender identity of a CPS which are all interconnected.

Chapter III: Methodology

Introduction

This study utilized a qualitative design with one-time, in-depth semi-structured interviews. As this was a cross-sectional design, data collection occurred once at any stage in the CPS' journey. The one-time interview was also employed to reduce attrition rates and uncomfortable memories of substance use and mental struggles. This qualitative study was conducted at Emory University, with the approval of the Emory University Institutional Review Board (IRB). This study was informed by the six-event Race and Recovery series implemented by the Southeast Mental Health Technology Transfer Center (Walker et al., 2022). A CPS, who identifies as a Black woman, served as a consultant on the project; she provided insight into the development of the in-depth interview guide, shared contacts at mental health organizations who could share recruitment materials, informed the reflexivity of the researchers, and provided input on the interpretation of the results. The consulting CPS served as an advocate for CPS of color and ensured aspects not thought of by the researchers were covered.

For this study, CPS of color in the state of Georgia were recruited to participate in 1 hour long in-depth interviews to discuss their path to and reasons for becoming a CPS, their experiences with racism and discrimination in the BHS, and thoughts about what mental health professionals and organizations are doing and could be doing to dismantle racism in the BHS and support CPS of color. These interviews were analyzed to determine themes related to CPS of color's adverse experiences in the BHS and recommendations for mental health professionals and organizations. Semi-structured, in-depth interviews are helpful for gathering specific information, determining personal experiences, revealing sensitive issues, and helpful in establishing context for participants' life (Hennink et al., 2020). Each participant engaged in one

interview conducted via Zoom. Interviews lasted between 30 to 60 minutes. A total of 20 participants were enrolled in the study and interviewed between August 2022 and March 2023.

Recruitment and Eligibility

A combination of convenience and snowball sampling methods was employed to collect the data. Convenience sampling occurred when CPS of color in the state of Georgia responded to the recruitment flyer while snowball sampling occurred when CPS passed the information along to others who may have been interested in the study. A recruitment flyer with basic information about the study as well as a QR code was included to increase ease of access. An email with the flyer attached was sent to CPS who registered for or attended trainings conducted by the Southeast Mental Health Technology Transfer Center (Southeast MHTTC), the contact list of the Georgia Mental Health Consumer Network (GMHCN), and other behavioral health organizations such as the Georgia Department of Behavioral Health and Developmental Disabilities (GDBHDD) and Community Advanced Practice Nurses (CAPN). Inclusion criteria required people to be 18 years of age or older, currently employed as a CPS in Georgia, identifying as a person of color (e.g., Black/African American, Asian, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander, Hispanic/Latinx, or multiracial), and being fluent in English. Screening for eligibility, informed consent, and a short demographics questionnaire was collected through an online form using Qualtrics. Respondents were eligible if they are currently employed as a CPS, self-identified as a person of color, are 18 years or older, and spoke English fluently. These individuals were directed to the informed consent form. Respondents who did not meet the criteria were directed to a page that thanked them for their time.

A short demographics questionnaire was completed by eligible participants who consented to participate in the study. Gender, immigration history, education, past experience of racism and discrimination in the behavioral health system, availability for interview, contact information, and credentials were collected. Credentials included Forensic Peer Mentor (FPM), Certified Peer Specialist - Mental Health (CPS-MH), Certified Peer Specialist - Addictive Disease (CPS-AD), Certified Peer Specialist - Parent (CPS-P), Certified Peer Specialist - Youth (CPS-Y), Whole Health and Wellness Coach (WHWC), Whole Health Action Management (WHAM), Wellness Recovery Action Plan (WRAP), Trauma Informed Care, and Certified Psychiatric Rehabilitation Practitioner (CPRP).

Procedures and Privacy Measures

Informed consent was collected after respondents completed the screening questionnaire and were found to be eligible. The participants were directed to read the consent form, which included an introduction and study overview, storing and sharing information, a confidentiality statement, a statement of who would have access to participants' information, and the email address and phone number of a research team member who could answer any further questions. Individuals were guided to select if they agreed to participate in the study or not. If consent was given, individuals advanced to a short demographics questionnaire. At the beginning of the interview, participants were reminded of the study's objective, time commitment, and voluntary nature. Any inquiries the participant had concerning the study were addressed by the interviewer. Additionally, the interviewer made sure the participant was comfortable with the interview being audio-recorded. Interview notes regarding the participants were de-identified by using a unique identifier. The code did not include personal information like name, initials, date of birth, or medical record number. Files that linked to the code were secured in a different location.

Data Collection

An in-depth interview guide was used to lead the interview and obtain relevant data. Topics covered participants' journey to becoming a CPS, experiences with peers, insight into racism and discrimination as a CPS, and suggestions for dismantling racism in the behavioral health system. Data collection occurred between August 2022 and March 2023. Data was collected during 1-hour semi-structured, in-depth interviews facilitated by a member of the research team. Participants were contacted by a member of the research team to schedule an interview after the completion of the screening survey, demographic questionnaire, and informed consent form.

Data Analysis Methodology

Thematic analysis was iteratively used to understand the data, generate initial codes, search for themes, review and refine the themes, define and name the themes, and compile the themes as results (Braun & Clarke, 2006). Interviews were transcribed by a professional transcriptionist. All interviews were de-identified before the data analysis process. Transcripts were uploaded into MAXQDA, a qualitative analysis software. Original audio recordings were deleted at the end of the project.

Initial memos were written for each transcript to make note of important words, patterns, ideas, and potential codes. Next, deductive codes were developed from the in-depth interview guide and literature review such as "addressing racism in workplace". Further, inductive codes were developed from data exploration methods like "coping with racism in behavioral health system\self-advocacy". Data exploration methods included word clouds to find relevant, commonly used words, linking similar text segments between transcripts, and finding similarities between memos. A codebook was produced with detailed definitions for each code and subcode,

whether a code was inductive or deductive, relevant quoted coded segments, and a brief note on when to use and not to use a specific code. Relational thematic analysis was utilized for a clearer interpretation of the results as well as to identify the most notable patterns to determine themes, properties, and dimensions. Properties are the features that all ideas in a theme have in common, while dimensions are different forms of a property (Chun Tie et al., 2019). Interactive Quote Matrix, Code Relations Browser, and Code Map were tools utilized. The matrix allowed for ease in identifying relevant quotes for each theme, property, and dimension. The code relations browser and code map helped in the development of said themes, properties, and dimensions by illustrating relationships between selected codes by intersection and occurrence in transcripts.

Self-Reflexivity and Positionality Statement

As an Afro-Latina woman, I bring a unique perspective to the project. Growing up, mental health was not a topic that was openly discussed or acknowledged within my community. It wasn't until I experienced the effects of depression that I became interested in understanding mental health and its impact on individuals and communities. As someone with no prior knowledge of peer workers or peer support organizations, I recognize that my positionality may bring certain biases and limitations. However, I believe that my personal experiences and cultural background provide valuable insights that can contribute to the development of more inclusive and culturally competent approaches to the behavioral health system. As a member of a minoritized community, I am acutely aware of the impact that systemic inequalities can have on mental well-being. As such, I actively engage in self-reflexivity when conducting interviews and reading transcripts so as to not impose my personal understanding, but to serve as a vessel for participants in this study to voice their lived experiences and recommendations.

Chapter IV: Results

There were a total of 98 complete responses to the Qualtrics survey. Out of this, 93 respondents identified as a person of color, thus qualifying for the study. One person (n=1) identified as American Indian or Alaskan Native, none identified as Asian, ninety (n=90) identified as Black or African American, one (n=1) identified as Hispanic or Latinx, and one (n=1) identified as Native Hawaiian or other Pacific Islander. Four respondents (n=4) identified as white, thus not meeting the inclusion criteria for the study. As an overwhelming majority of respondents identified as Black or African American, the team decided to interview this demographic only.

A total of 20 Black CPS were interviewed for this study of which 10 interviews were analyzed for this thesis. Of the ten participants, six (n=6) participants identified as a cis-woman, two (n=2) participants identified as a cis-man, and two (n=2) participants identified as a trans-man. Seven of the participants identified with the immigrant experience meaning that at least one parent migrated to the United States, or the participant emigrated to the United States. Five participants were certified as a CPS-MH, four as CPS-P, one as a Forensic Peer Mentor, and one as a WHWC. One participant did not provide their credential but are employed as a CPS on a college campus. Two participants have more than one credential. The time served as a CPS ranged from 1 year to 17 years with the average being 6.3 years. Based on these interviews, three main themes emerged: Navigating the Behavioral Health System, Emotional Response, and Self-Empowerment.

Theme 1: Navigating the Behavioral Health System

Navigating the Behavioral Health System is the core theme that explores the multiple identities of a Black peer worker and how they react to discriminatory situations and negative

messaging that may result in traumatic stress (Carter, 2007; Carter et al., 2004). All participants were able to give examples of how they navigate the behavioral health system as a CPS whether that be through their job duties, work environments, sharing their story with peers, challenges experienced, coping mechanisms, or reactions to discriminatory experiences. It is important to note that despite each individual inherently having intersecting identities, discrimination against one aspect of a person can occur. In particular, a participant stated that "it wasn't racism I was experiencing, It was discrimination against me having a mental illness," when being the victim of intra-racial and -gender discrimination. The participant experienced harm from a Black non-peer worker who happened to identify as a woman. This participant expanded on their experience by saying:

> "A lot of the Black women in particular shunned me, would leave me out of conversations, would treat me like I was not relevant, would treat me like there was something wrong with me or I was weird. They really didn't talk as freely around me as they talked around each other. They joked more so with each other and had more of a laid back relationship with each other. With me, they just kept it to the point and really didn't try to get to know me as a person."

While situations such as these are rare in this study – only two participants experienced this – capturing the full picture is important when exploring how Black CPS navigate the BHS. Two main themes, five properties, and three dimensions emerge from this core theme, which are explained further below.

Theme 2: Emotional Response

Emotional Response refers to the ways in which participants react to racism, microaggressions, and discrimination on the basis of ethnoracial identity, gender identity, and

mental health and substance use histories. Common emotions included anger, sadness, fear, embarrassment, and no response. All participants mentioned how they react to racism and discrimination as a CPS. Three properties – "I felt so bad", desensitization, and feeling invalidated – and two dimensions – ignoring ignorance and workplace hierarchies – were found to cover the various possibilities in responding to adverse experiences.

"I felt so bad"

Some participants expressed deep, emotional feelings when race-based and other discriminatory harm was done to them. One participant shared:

> Just bad, because – I felt so bad, because it's bad. It's bad to exclude anyone from anything, because we are all one. We are not supposed to be divided in any way on any ground. So I felt bad, because it's not even right [inaudible 18:23] it's very bad.

Another participant noted:

> Yes, it really feels bad when someone is discriminating [against] you and not allowing you to access services just because of your color, and yet you can deliver the same.

The participant reported feeling that they were made to feel bad or judged by others due to their skin color and race, which caused them significant distress. This participant experienced double discrimination by being made to feel bad due to their skin color and race, and mental health diagnosis (Alang, 2019; Firmin et al., 2019; Gonzales et al., 2015).

Desensitization

Desensitization is the act of not being bothered or not adversely reacting to instances of racism and discrimination. Participants who were not sensitive to racism and discrimination often mentioned adapting to experiencing racist or discriminatory incidents as it relates to the

behavioral health system. Five participants made statements that insinuate being desensitized or "use to" these adverse experiences. One participant expressed:

> But like I said, as time goes on, **I began getting used to this.** I began, you know, expecting [lost signal] to come, because I'm expecting it doesn't – it doesn't take me unaware. It doesn't surprise me. It doesn't make me react in a negative way to my clients. I just play along and want to [inaudible 23:09] you know, to stay true to that, you know?

This participant has had multiple adverse experiences with clients, thus becoming used to the experiences and no longer having deep emotional reactions. It is possible that the participant's repeated exposure to adverse experiences has led to a desensitization to these events. This desensitization may have occurred gradually over time, as the participant became more familiar with the types of situations they were likely to encounter. Another example of desensitization occurred when a different participant was asked if they ever sat with their thoughts and emotions after experiencing intra-racial discrimination. The participant said:

> Not really. You know, it's like this. I got to the point in my recovery where I'm like it is what it is, you know? As long as I know I'm doing the best that I can and things like that, that's the best I can do, you know? I let God cover the rest.

Ignoring Ignorance

As a dimension of desensitization, a few participants developed a coping mechanism of simply ignoring negative comments and body language, i.e., microaggressions. One participant shared:

> Sometimes I, you know, I ignore them. I ignore, maybe I have not seen what they're doing and sometimes I pretend that I have not heard anything, what they have said.

Another participant detailed how they coped with experiences of racism, discrimination, and violence by saying,

> To accept the situation and move on, because it is apparent and it is not something which it could happen to you, so for me I just accept it the way it was and now move on.

Similarly, a participant noted how many offensive experiences have "rolled off of them" because they believe they are hard to offend. In particular, the participant stated that,

> I'm really kind of hard to offend. So if I am offended, girl, you done did too much. You done did too much. I don't look to be offended. I don't – matter of fact, when somebody's trying to be offensive, **I let them off the hook a lot of times**, because – and I've learned to do that because a lot of times they don't understand how offensive something is until you like kind of offend them back or say something really kind of like off – you know, like off key or kind of uncouth to them,

This strategy may allow the participant to avoid engaging with the negative behavior and to focus instead on their own goals or objectives as a peer worker. It may also prevent the escalation of conflict and confrontation.

Feeling Invalidated

Another property of emotional response is feeling invalidated as a peer worker and the contributions given to the BHS. A participant focused on their intra-racial and -gender discrimination experiences in a Black-owned psychosocial rehabilitation center. The participant was made to feel different and "strange" as a peer worker. This individual was perplexed by the prevalence of Black women who "take up the profession of psychology and know nothing about it. They think people with mental illness are crazy. That is something I fight against. For us to

lose that word in our definition, crazy." This example speaks to both invalidating the mental health experience of a CPS, but also stigmatizes CPS. While only three participants in this study mentioned aspects of mental health stigma, the issue is still relevant. Even when interacting with peer clientele, a participant stated:

> Yeah. Yeah, sometimes maybe they [peers] mock you, laughing at you, and that's something that I feel embarrassed, but I keep giving myself [inaudible 17:40] because I want them to know the truth. Yeah.

The experience of this participant illustrates how deep mental health stigma runs in society and the BHS in which a peer, who sought help, is not taking the assistance of a CPS seriously.

Workplace Hierarchies

Seven participants either experienced racism and discrimination in the workplace by those in higher positions than them or other non-Black CPS or knew of instances where white CPS choose not to see non-white peers. Of this, three participants explicitly experienced racism or discrimination from those in higher positions. A participant noted that they had a constant issue with their white supervisor belittling them and adding more to their plate than what was found in the job description. Without notice or desire, the supervisor updated the participant's job description and gave a raise. While receiving a raise may have been seen as thoughtful, the participant stated that "she's disrespecting me. She's doing it. She's blatantly doing it. Then she calls the human resource woman and then now they want to have a meeting with me [to discuss the raise]." The participant felt their supervisor wanted them to submit to every action asked, even if redundant or unnecessary. The participant said:

> She was calling me asking me am I going to be at this meeting and can I come to the house, can I – **all this stuff she knew I wasn't going to be able to do, and then just for**

> **her to be like, (sighs) so again, you're not able to do what you're supposed to do.** I'm like girl, just fire me, girl. Fire me, boo. But she wouldn't.

Another participant expressed that their comfort levels differ when around non-peer coworkers versus peers. The participant stated that:

> I feel more comfortable even though I'm an employee, I feel more comfortable around clients than my coworkers, particularly if my coworkers are not CPSs also and they don't have an illness. So it's my tribe. You know, these are the people I feel a little comfortable around.

The participant's reference to "my tribe" suggests that they feel a sense of belonging and shared identity with their coworkers who are CPS. This is likely because the participant themselves is also a CPS, and they feel a sense of shared experience and understanding with their peers and peer coworkers.

Theme 3: Self-Empowerment

Self-empowerment is demonstrated as a buffer to experiences of racism and discrimination and includes being empowered to advocate for oneself despite the dominant narrative trying to push you down. Six participants expressed times when they advocated for themselves. Two properties – resilience and speaking up – and one dimension – the importance of social support – were found to cover the various possibilities in buffering the experiences of racism and discrimination. One participant shared, "Okay, where I work, I – it's – I feel that my voice is heard to a greater extent, because when I speak, I speak with a lot of confidence, with a lot of courage." The participant's emphasis on staying true to oneself and speaking passionately

about issues in the workplace suggests that self-empowerment involves a sense of authenticity and a willingness to stand up for one's beliefs, even in the face of adversity.

Resilience

As a dimension of self-empowerment, resilience is the act of recovering and coping with difficult situations. There are multiple aspects of resilience, such as dealing with offensive language from others, recovering from mental health and/or substance use struggles, and self-acceptance. When relating resilience to race-based discrimination, one participant mentioned how addressing racism is encouraged at their organization.

> We have been doing it with our team and encouraging the team not to tire, even if the people are against the topic. So really being able to push forward and really kind of stand strong with your ideas about racism and discouraging it.

This demonstrates that resilience is present when individuals do not allow themselves to be discouraged or silenced, even when faced with resistance.

Importance of Social Support

All participants identified speaking with a close friend or family member, employer, or peer as having a positive impact on how they view themselves. A participant mentioned, “I feel support from my director of the program. I feel very supported from her any time when I want to talk about other issues regarding culture, diversity, and things like that.” At the same time, five participants described times when they did not feel supported by their employer. There was often an overlap between feeling invalidated and having a lack of support from an employer. When asked how their employer can better support them at work, a participant stated, “By actually not looking down on me and also allowing me to access the – access the services that any other staff is supposed to access and also giving me freedom of speech.” The statement of the participant

highlights the importance of employer support in the workplace, particularly for individuals who may feel minoritized or invalidated. The participant noted that feeling looked down upon by the employer is a significant factor that contributes to feeling unsupported. This indicates that treating all employees with respect and dignity, regardless of their position, is crucial in creating an inclusive and supportive workplace environment.

Speaking Up

As a second dimension of self-empowerment, Black peer specialists often utilized their voices to speak up and out against those causing them harm. When expected to conform and stay silent in the workplace, one participant shared:

> I just have to talk sense into her and yeah, let her know that I'm of color doesn't mean I'm stupid, doesn't mean I don't know what I'm doing or my profession, I'm not some, you know, -- I am not qualified for it. And well, I notice when I react that way, sometimes they don't expect it, you know? Yeah. They'll be like, what?

When asked about personal perceptions of self-empowerment, a participant stated:

> …but I can control now, and now you're not going to talk to me like that. Or now you're not going to talk to anyone like that. If you're going to talk to anyone like that, there's the door. **I'm very frank when it comes down to respect, because most of us, the peers I've dealt with, we have been disrespected throughout our lives.** And I'm like this, the buck stops here. You're not going to disrespect anyone. So I'm very fierce when it comes down to, you know, not tolerating racism and things like that.

This sense of agency and control is likely developed through their personal experiences of being disrespected and discriminated against, as well as their professional training as a CPS.

Recommendations

All ten participants offered suggestions that are either already in place at their respective organizations or that they think should be put into practice for eliminating racism in behavioral health organizations. The first recommendation is to support CPS of color by employing a zero-tolerance rule in the workplace for racism and discrimination. For example, one participant elaborated on the rule, which is currently practiced in their organization:

> Zero tolerance. They have zero tolerance whatsoever of any type of discrimination whatsoever. They tell peers that, look, there's zero tolerance of any type of harassment based off race, sex, culture, and things like that.

Along with having a zero tolerance policy, another participant noted that zero tolerance takes the forms of suspension:

> I can say it's usually taken very serious, so maybe if you are found with an issue of racism the organization, you are being suspended. So they usually take it as a serious thing, and really support it, yeah, because it really help to avoid this.

The second recommendation is to enforce cultural competency and humility training for all non-POC staff, conducted by a person of color. A participant refers to this training as "racial reconciliation" which is practiced in their organization.

> One, the organization, they have been doing this racial reconciliation movement like literally before COVID started. Like it was a part of their culture, this organization's culture is to do – the thing is called racial reconciliation. **I honestly don't believe Black people are supposed to be in that meeting. You know, I don't need to be in there. I need y'all to talk amongst y'all's self.**

The third recommendation is to listen to peer workers, who provide a unique perspective in understanding themselves and the consumers benefiting from the services. Amongst the participants, this looked like giving opinions that are respected by non-peer workers and participants' voice being heard in the workplace.

The fourth recommendation is active self-reflexivity, regardless of identity, to learn how one's actions may harm others. One participant in particular noted how non-Black individuals helped them to "create an awareness against discrimination." The final recommendation is to address the racism embedded in society through anti-racist practices, laws, and zero tolerance for discrimination. A participant elaborates on this recommendation by saying "we can do this by addressing from every corner of the country, addressing that which is not encourage racism such that it will be able to overcome it."

Overall, these suggestions are meant to aid CPS of color and foster an inclusive workplace environment. They emphasize how crucial it is to combat racism and prejudice, advance cultural competence, and actively listen to and learn from peers. Organizations that employ peers to support mental health services may find these recommendations helpful, which could help these organizations succeed overall.

Chapter V: Conclusions, Implications, and Recommendations

Findings from this study indicate that the experiences of Black CPS are directly related to navigating the BHS, emotional response, and self-empowerment. These themes were identified through the use of CRT and IT, by examining the common themes across the unique lived experiences of Black people in a system drenched in social hierarchies and inequitable policies and actions. Each of these themes can be linked to concepts found in CRT and IT that can explain how Black CPS experience the BHS. These themes all contribute to literature regarding the experiences of peer specialists yet fill the gap within the literature as this study centers on the experiences of Black peer workers.

Discussion of Key Results

The three main themes identified – navigating the behavioral health system, emotional response, and self-empowerment – all touch on at least one element of CRT and IT. For example, all themes are embedded in the elements of Intersectionality Theory, as an individual's identity is with them no matter where they go.

The core theme of navigating the behavioral health system has been explored through the lens of Black peer workers and their experiences with discrimination and traumatic stress. All participants were able to provide examples of their navigation strategies, including coping mechanisms and sharing their stories with peers. It is important to acknowledge that discrimination can occur within intersecting identities, as seen in the participant who experienced discrimination based on their mental illness rather than their race. This study highlights the importance of understanding workplace power hierarchies and social exclusion within organizations. The core theme of navigating the behavioral health system resulted in two main

themes, five properties, and four dimensions, providing a comprehensive understanding of the experiences of Black CPS.

The emotional response of participants to racism, microaggressions, and discrimination based on ethnoracial identity, gender identity, and mental health and substance use histories was explored in this study. All participants discussed their reactions to such experiences as CPS. The analysis identified three key properties - "I felt so bad," desensitization, and feeling invalidated - which encapsulated the range of emotional responses observed. Additionally, two dimensions - ignoring ignorance and workplace hierarchies - were identified as factors that influenced participants' responses. These findings provide valuable insights into the emotional toll that racism and discrimination can take on Black CPS and highlight the need for targeted support and interventions to address the negative impact of such experiences.

Some participants expressed deep emotional reactions, highlighting the negative impact of discrimination on mental health. The findings of this study align with prior literature that has documented the harmful effects of discrimination (Berger & Sarnyai, 2015; Schouler-Ocak et al., 2021). One participant's response emphasized the negative impact of exclusion and workplace hierarchies, while another participant discussed the experience of double discrimination based on their skin color and mental health diagnosis, illustrating the intersectionality of identity. Double discrimination touches on Intersectionality Theory and how at times, separating the two identities is not possible as a minoritized person. These findings underscore the need for interventions and support to address the mental health impacts of discrimination experienced by Black CPS, particularly in the context of workplace hierarchies and intersectionality.

Another property, desensitization, spoke of the lack of negative emotional reactions to instances of racism and discrimination. In this study, participants who were desensitized often

discussed adapting to these adverse experiences within the context of the behavioral health system. Five participants shared statements that indicated being accustomed to these experiences. One participant mentioned becoming used to adverse experiences with clients over time, leading to a lack of surprise or negative reactions. This highlights the potential impact of repeated exposure to racism and discrimination on emotional responses. As a component of desensitization, some participants reported ignoring negative comments and body language, which are often microaggressions. One participant mentioned intentionally ignoring such behaviors, either by pretending not to see or hear them. This suggests that some individuals may choose to disengage from these situations as a coping mechanism.

Feeling invalidated as a peer worker and undervalued for the contributions made to the BHS is another component of emotional response. Previous research has highlighted how invalidation is a common experience for peer workers in the BHS (Alang, 2019; Firmin et al., 2019; Gates et al., 2010; Gonzales et al., 2015). This property of emotional response can be examined through the lens of CRT, which emphasizes the intersection of race and power dynamics in society. The feeling of invalidation can be seen as a consequence of differential racialization and workplace silencing within the BHS, where peer workers – who are often from ethnoracially minoritized communities – may not have the same level of power or authority as other mental health professionals. This dynamic can lead to their contributions being undervalued and dismissed. By considering the experiences of Black CPS through the lens of CRT, we can better understand the systemic issues that contribute to their emotional responses and develop strategies to address them. Similarly, stigmatization of the efficacy of a peer worker is an experience shared by three participants in this study. Despite only a few participants in this study mentioning aspects of mental health stigma, the issue remains relevant. One participant

expressed embarrassment when mocked and laughed at yet continued to assert their value and expertise as a peer worker. Another participant stated the use of negative messaging and derogatory language regarding mental health as an issue they have experienced. Appropriate and non-oppressive language is important when imagining an anti-racist and -oppressive BHS (Corneau & Stergiopoulos, 2012). Stigmatizing the efficacy of a peer worker and of ethnoracial minorities is known to have a strong influence on negative mental health outcomes (Gates & Akabas, 2007; Schouler-Ocak et al., 2021). This experience highlights the intersection of race and mental health stigma and emphasizes the importance of addressing these issues in the BHS. This aspect of invalidation is in line with CRT, which emphasizes the intersectionality of race and other social identities and the impact of systemic oppression on minoritized communities.

As a dimension of workplace discrimination and racism, several participants in the study reported experiencing or witnessing such behavior by higher-level colleagues or non-Black CPS. Three participants explicitly recounted experiencing discrimination by their superiors, including being belittled and given additional tasks outside of their job description without proper notice or discussion. These experiences serve to invalidate the contributions and value of Black CPS in the workplace, perpetuating a power dynamic that is often present in institutions that uphold white supremacy which is seen in prior literature (Davidson et al., 2012; Firmin et al., 2019). These dynamics fall in line with the ordinariness of race and interest convergence, which recognizes that systemic racism is not only a matter of individual actions but also a matter of institutional and structural factors that perpetuate inequality.

Multiple participants expressed their level of comfort with peers being greater than with non-peers and traditional psychological professionals. Comfortability falls in line with prior literature regarding the mutual benefit of the CPS-Peer relationship and the ease in establishing

trust with an individual whom has had similar experiences (Adame & Leitner, 2008; Solomon, 2004). Participants feeling safer with peers versus their non-peer colleagues is understandable considering the stigmatization and workplace hierarchies within organizations that employ peers.

Self-empowerment was identified as a protective factor against experiences of racism and discrimination. This involves advocating for oneself and resisting the dominant narrative that aims to undermine one's voice. The findings showed that resilience, speaking up, and having social support were the three dimensions that facilitated self-empowerment among the participants. Six participants reported instances where they advocated for themselves in the workplace. All participants spoke about the importance of a social support system whether that be friends and family, peers, or employers. The five participants who noted a lack of belonging and being denied access to necessary clientele information speak to instances that have also occurred in other studies (Gates & Akabas, 2007). Further, having a support system has been found to have a disruptive effect on stress and negative health outcomes, that is, reducing the negative psychological effects (Brody et al., 2014; Neblett, 2019). One participant noted that they felt their voice was heard more because they spoke with confidence and courage. This finding is consistent with voice of color, which recognizes the importance of self-empowerment and resistance as strategies for challenging racial oppression and achieving social justice. Through self-empowerment and resilience, individuals can challenge the dominant narrative and assert their identities, thus creating space for their voices to be heard (Salzer, 2010).

Recommendations for Dismantling Racism and Discrimination in the BHS

Based on these findings and explicit suggestions from Black CPS, recommendations were formed. Future research should ideally focus on enhancing the connections between the topics that were previously discussed in this discussion section, or on revealing fresh connections.

Further, these recommendations are intended to be implemented by organizations that employ peers to support not only Black CPS but all CPS of color.

Recommendation 1: Zero Tolerance for Workplace Racism and Discrimination

One recommendation is to support all CPS by employing a zero-tolerance rule in the workplace. Any instances of racism, discrimination, and its subsets against a peer worker would be met with strict protocols and rules of action. This recommendation is a crucial step towards creating a more inclusive and supportive environment for all CPS but especially those of color. Mandatory cultural sensitivity training, suspension, and firing are all tactics suggested by CPS in this study – these suggestions are in line with findings from other studies (Schouler-Ocak et al., 2021; Walker et al., 2022). These protocols and rules of action should be clearly communicated to all employees and enforced consistently to ensure that there is a clear understanding of the consequences of engaging in such behavior (Liu et al., 2020). In addition to cultural sensitivity training, CPS in the study also suggest that suspension and firing should be considered as consequences for engaging in racism or discrimination. This underlines how crucial it is to develop a workplace culture that is opposed to this type of conduct and makes it clear that it will not be accepted.

Recommendation 2: Cultural Competency and Humility Training

Another recommendation to support peer workers is enforcing cultural competency and humility training to all non-peer and/or non-POC staff. Further, the training should be conducted by a person of color who has lived experiences with racism and discrimination versus a white person. This training should be made mandatory as the content of the training would be beneficial to not only the capacity building of the peer support organization but for the interpersonal interactions between coworkers and peers (Corneau & Stergiopoulos, 2012; Trinh

et al., 2019). Mandatory training can help to raise awareness and understanding of the experiences and perspectives of peers of color (Dominelli, 1997; Feagin & Bennefield, 2014; Neblett, 2019; Ohueri et al., 2019; Schouler-Ocak et al., 2021). This training should be designed to educate all behavioral health workers about the history of racism and discrimination, as well as the impact that it has on individuals and communities in the BHS (Alang, 2019; Bonnett, 2005; Carter, 2007; Cénat, 2020; Legha & Miranda, 2020; Shim, 2021). The training should also provide practical tools and strategies for addressing and preventing racism and discrimination in the workplace.

Recommendation 3: Listen to CPS

Next, Peer workers need to be heard because, traditionally, the BHS workplace culture and power structures have given little weight to their contributions to the workplace. Historically, peer workers have not been fully valued or integrated into the decision-making processes of behavioral health organizations. By recognizing the contributions of peer workers, organizations can benefit from their unique perspective and insights, which can help to inform policies and practices that are more responsive to the needs of consumers and peers (Alang, 2019; Ford & Airhihenbuwa, 2010; Gagne et al., 2018; Walker et al., 2022). Peer workers can also serve as advocates and role models for individuals who are seeking support and guidance in their recovery journey. Furthermore, the recognition of peer workers can help to address power imbalances in the workplace, as it can promote a more equitable distribution of decision-making authority and influence (Corneau & Stergiopoulos, 2012; Feagin & Bennefield, 2014). Peer workers can offer a valuable perspective on the experiences of individuals with lived experience of mental health challenges, which can help to promote a more collaborative and inclusive workplace culture.

Recommendation 4: Active Self-Reflexivity

All parties within the BHS can benefit from engaging in self-reflexivity. Regardless of ethnoracial identity, gender identity, mental health diagnosis, and job title, being self-reflexive and actively learning the ways in which you as an individual may intentionally or unintentionally harm another is crucial for the success of any recommendations presented in this study. Self-reflexivity is an important aspect of promoting a more inclusive and equitable workplace culture that values diversity, promotes empathy and understanding, and addresses power imbalances (Shim, 2021). Encouraging individuals to reflect on their attitudes, beliefs, and behaviors, as well as engage in continuous learning and growth, can help organizations to mitigate the risk of harm or discrimination while fostering a more inclusive, empathetic, and equitable workplace culture that values diversity (Cénat, 2020; Corneau & Stergiopoulos, 2012; Dominelli, 1997; Legha & Miranda, 2020; Sukhera et al., 2022).

Recommendation 5: Addressing Racism in Society

The last recommendation is to address the racism embedded in society. Peer workers, traditional behavioral health professionals, and patients of all races, cultures, religions, backgrounds, and lifestyles would all benefit greatly from anti-racist practices, the creation and enactment of anti-racist laws, and the adoption of a policy of zero tolerance for discriminatory behavior at any level of society. It is important to address the root causes of racism and discrimination within the larger society to create a more inclusive and equitable environment for all. Engaging in anti-racist practices, such as actively challenging discriminatory attitudes and behaviors, and advocating for structural changes that promote equity and justice, can help to break down systemic barriers and promote a more inclusive society. Additionally, the enactment of anti-racist laws, which prohibit discriminatory practices and protect the rights of minoritized

communities, can provide a framework for addressing the issue of racism and discrimination on a broader level (Feagin & Bennefield, 2014; Shim, 2021; Shim et al., 2018). It is feasible to build a society where people of various ethnoracial identities and backgrounds feel safe and valued by enforcing a zero-tolerance policy against discriminatory behavior at all levels of society. Both the general health of the community and the well-being of the individual can benefit from this. A more equitable and just society that benefits all people, regardless of their background or circumstances, can be created by eliminating the systemic barriers that support racism and prejudice.

Strengths and Limitations

One major strength of this study is its exploration of an often overlooked and minoritized group not only in the behavioral health system but in society as a whole. This study offers a unique insight into the lived experiences of Black Certified Peer Specialists within a system designed against them. Furthermore, this study's sample included perspectives from the Black diaspora, with a majority of participants identifying with the immigrant experience. Another strength of the study is its use of Critical Race Theory and Intersectionality Theory, which both center on the experiences of minoritized populations. Having the consultation of a Black peer specialist is another strength of this study. The hands-on insight and guidance from a CPS in the BHS are invaluable. In addition, four of the five members on the team identify as Black/African American. Identifying the same as the participants has benefits such as having an inherent understanding due to ethnoracial background, the participant potentially feeling more comfortable sharing their story with someone who looks like them – known as racial concordance – and the team feeling justified in conducting such research on a specific population (Shen et al., 2018).

Another strength, but also a limitation, of this study, was the range of gender identities. Cis-women were the majority of participants in this study, whereas only two trans-men were interviewed, no trans-women, and no nonbinary/genderqueer people. A more inclusive understanding of the experiences of Black CPS could have been met with analysis of more non-cisgender individuals. Another overlap is my positionality to the study. While I have the unique perspective as an Afro-Latina woman with personal experience of depression and awareness of systemic inequalities, I have potential biases and limitations due to my lack of prior knowledge of peer support organizations.

Limitations in this study were some language and accent barriers. While all participants spoke English, an amount of information was missed during transcription; these barriers were also exacerbated by technical, connectivity issues. Another limitation of the study lies in data collection methods. Due to the use of Zoom as the interview platform, it is probable that alterations in nonverbal communication and social cues may have gone unnoticed. Further, as the study's participants are certified in Georgia, the findings may not capture the experiences of individuals certified outside of Georgia. Lastly, the sample does not include the experiences Non-Black Latinx, Indigenous, and APIDA peers have with systems of oppression, so the findings from this study cannot be applied to these ethnoracial populations.

Conclusion

The experiences of Black peer workers reveal the pervasive and insidious nature of racism and discrimination in mental health care systems. By employing Critical Race Theory and Intersectionality Theory, this study was able to provide a nuanced and intersectional analysis of how the intersection of race, gender, and other identities shape the experiences of Black peer workers. These theories proved useful in illuminating the ways in which systemic oppression and

structural inequalities operate within mental health care settings and how they impact the lived experiences of Black peer workers. Ultimately, this study highlights the urgent need for anti-racist interventions and policies to address these systemic issues and support the empowerment of Black peer workers in mental health care.

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