

## **Taking Action on Stigma and Discrimination: An Intersectionality-Informed Model of Social Inclusion and Exclusion**

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### **Abstract**

Social inclusion has increasingly been positioned within research and policy as integral to addressing stigma and discrimination related to mental health and substance use. Yet there is a lack of consensus about the meaning of social inclusion and how this concept can be applied to understand the broader social contexts that influence health and inequity. In this paper, we respond to a recently developed model of social inclusion for mental health and substance use in British Columbia (BC), Canada, by proposing an alternative model: an Intersectionality-Informed Model of Social Inclusion and Exclusion. Drawing on the BC model, we demonstrate what we see as key limitations of current conceptualizations of social inclusion and highlight the ways in which the proposed model extends, improves, and complicates understandings of social inclusion. We argue that this inquiry is a necessary precursor to better addressing the complexities of stigma, discrimination, and social exclusion, and in so doing, to promoting social inclusion and equity.

*Keywords:* social inclusion, social exclusion, intersectionality, mental health, substance use

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Addressing stigma and discrimination related to mental health and substance use has become a significant area of policy concern in Canada, as well as in other jurisdictions internationally. As part of the response to address these issues, there has been a growing interest in the concept of social inclusion, which has been described as “compelling, complex and contested” (Novick, 2001, p. 1). While it is widely understood that there is a lack of consensus on exactly what constitutes social inclusion (Cobigo & Stuart, 2010; Martin & Cobigo, 2011; World Bank, 2013; Wright & Stickley, 2012), there is nevertheless a broadly held assumption that social inclusion is integral to “improve the ability, opportunity, and dignity of people disadvantaged ... to take part in society” (World Bank, 2013, p. 4). Accordingly then, there is a growing interest in understanding how conceptions of social inclusion

can guide the design and development of effective and efficient policies, programs, and services that better theorize and address inequality and exclusion (Armstrong, 2010; Carter, Satcher, & Coelho, 2013; Verdonschot, de Witte, Reichrath, Buntinx, & Curfs, 2009; World Bank, 2013).

In Canada, for example, this is evidenced by the attention to social inclusion by the Mental Health Commission of Canada (MHCC) in its development of a *Mental Health Strategy for Canada* (MHCC, 2012), as well as in the work by the province of British Columbia (BC), demonstrated in its recent policy report *Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Use in British Columbia* (Ministry of Health Services & Ministry of Children and Family Development [MHS & MCFD], 2010). This latter report aims to reduce stigma and discrimination so that “by 2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities” (MHS & MCFD, 2010, p. 18). Stemming from this, the Healthy Minds, Healthy People Directorate commissioned another report entitled *Taking Action on Stigma and Social Inclusion in British Columbia* (Zappelli & Ardiles, 2013). The *Taking Action* report offers a model that is intended to be instrumental in addressing exclusionary barriers to well-being and care—the “Circle of Belonging: Social Inclusion Model for Mental Health and Substance Use” (p. 30).

In this paper, we utilize an intersectionality framework to critically analyze the Circle of Belonging model and propose an alternative model that we refer to as an Intersectionality-Informed Model of Social Inclusion and Exclusion. We draw on the Circle of Belonging model to demonstrate what we see as key limitations in current conceptualizations of social inclusion. Such interrogation aligns with a recent observation made by Wright and Stickley (2013) that despite being a dominant concept over the last decade, very little theoretical work has attempted to unpack what social inclusion means in relation to mental health (and, arguably, substance use and addiction). We highlight that this inquiry is a necessary precursor to better addressing the multi-level factors and processes that perpetuate exclusion, and in so doing, to promoting social inclusion.

The paper begins with an introduction to intersectionality and in particular, to its operationalization via the Intersectionality-Based Policy Analysis (IBPA) Framework (Hankivsky et al., 2012, 2014). We then present a brief overview of the purpose and components of the Circle of Belonging model, followed by a description of the alternative model informed by intersectionality. In the final section of the paper we outline how the Intersectionality-Informed Model extends, improves, and complicates understandings of social inclusion. We expect that the insights offered by this intersectionality-informed alternative have potential relevance not only for the fields of mental health and addictions, but also, more broadly, for attempts to mitigate stigma, discrimination, and exclusion related to a range of other health and health-related phenomena.

## **Intersectionality**

### **What is Intersectionality?**

The tradition of intersectionality is rooted in the history of Black feminist writing as well as Indigenous feminism, queer theory, and postcolonial theory (Collins, 1990; Crenshaw, 1989, 1991; Van Herk, Smith, & Andrew, 2011). *Intersectionality* is widely used but is defined in different ways: a ground-breaking theory (McCall, 2005), an innovative method and framework (Hankivsky, 2011), an analytical lens (Wilson, 2013), a transformative research and policy paradigm (Dhamoon, 2011; Hancock, 2007), and a mechanism for social change (Murphy, Hunt, Zajicek, Norris, & Hamilton, 2009). We conceptualize intersectionality as a framework that promotes an understanding of human beings as shaped by interacting social locations and identities (e.g., race, Indigeneity, sexuality, gender expression, migration status, age, ability, religion). These interactions occur “within a context of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media)” (Hankivsky, 2014, p. 2). It is through these processes that interdependent forms of oppression and privilege shaped by colonialism, imperialism, racism, homophobia, ableism, sanism<sup>1</sup>, and patriarchy are perpetuated.

Researchers who use intersectionality in their work are concerned with bringing about a conceptual shift in how civil society, policy actors, and other researchers understand social categories and their relationships and interactions. Such analysis underscores the problem with focusing on specific groups discreetly (e.g., “men,” “women,” “Aboriginal persons,” “youth,” “the elderly”) assuming that members of such groups share similar experiences, social locations, and needs. Instead, intersectionality brings to the fore the diversity that exists within and between population groups. Intersectionality instead requires a consideration of the complex relationships among mutually constituting factors of social location and structural disadvantage so as to more accurately map and conceptualize determinants of equity and inequity in and beyond health (Grace, 2013).

### **Doing Intersectionality-Informed Analysis**

The evidence base for understanding the differential effects of policy across multiple axes of inequity is currently in its infancy (Hankivsky et al., 2012). However, intersectionality-based analyses have been leading research in this interdisciplinary field (e.g., Bose, 2012; Collins, 1990; Crenshaw, 1989, 1991; Grace, 2014; Hancock, 2007, 2011; Hankivsky, 2011; Hankivsky & Cormier, 2011; Iyer, Sen, & Östlin, 2008; Lombardo & Agustin, 2009; Lombardo & Verloo, 2009; Manuel, 2006; Mens-Verhulst & Radtke, 2009; Murphy et al., 2009; Reid, Pederson, & Dupere, 2012; Schulz & Mullings, 2006; Varcoe, Hankivsky, & Morrow, 2007). As part of the ongoing efforts to move this work forward, there is a growing interest

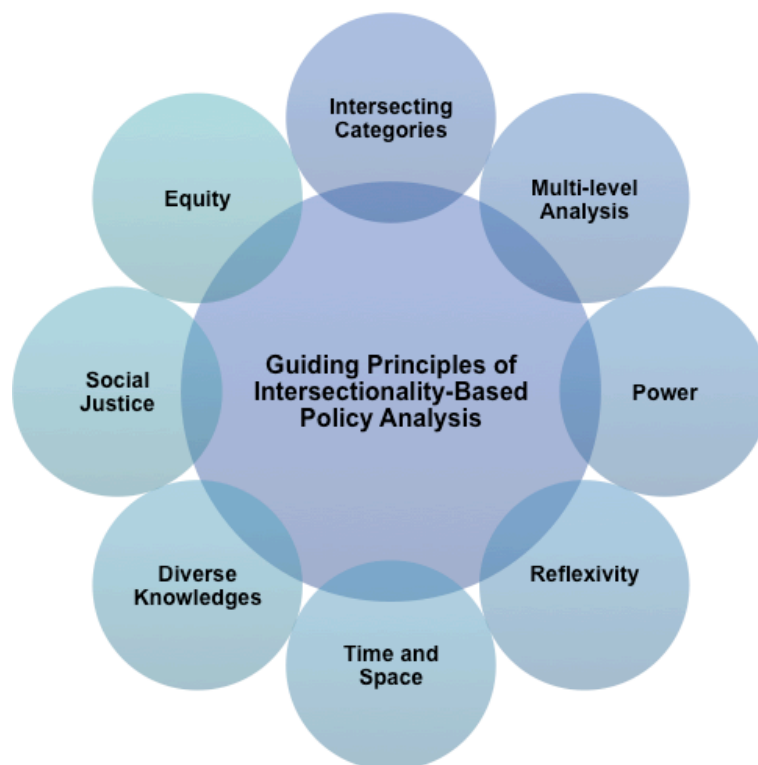
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<sup>1</sup> Sanism refers to the systemic oppression experienced by people who have been historically and contemporarily labelled “mentally disabled” or “mentally ill” and to the corresponding privilege experienced by those who are not so labeled (Perlin, 1993).

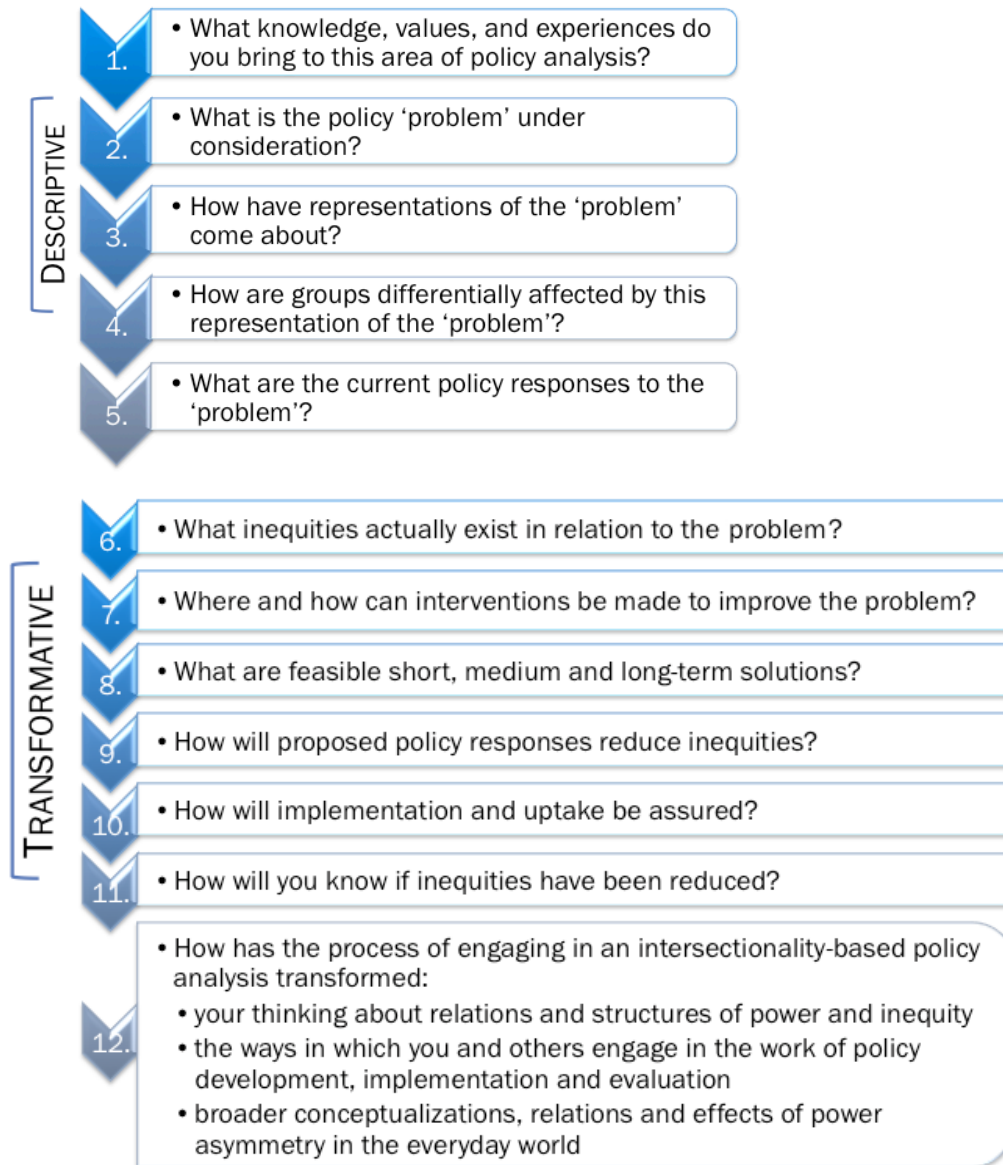
in the use of intersectionality and its potential to improve current equity-driven health policy analyses (Hankivsky, 2011; Hankivsky & Cormier, 2009; Weber & Fore, 2007). However, the potential of intersectionality has not been fully realized, largely due to the fact that few methods have been developed to apply intersectionality in the context of health policy.

In order to operationalize intersectionality in the context of health and health-related policy, Hankivsky et al. (2012) have developed an Intersectionality-Based Policy Analysis (IBPA) Framework. The IBPA Framework is a peer-reviewed, user-friendly how-to guide for policy actors that draws on the principles of intersectionality-based analysis to enable better understandings of who is benefiting from and who is excluded from policy goals, priorities, and related resource allocation. It consists of two components: (a) a set of guiding principles that reflect the central tenets of intersectionality (see Figure 1) and (b) a list of 12 overarching questions, divided into descriptive and transformative subsets (see Figure 2) to help guide policy analyses. The guiding principles are intended to ground the overarching questions to ensure that the analysis is intersectionality-informed.<sup>2</sup>

**Figure 1.** Guiding Principles of Intersectionality-Based Policy Analysis



<sup>2</sup> For a complete description of IBPA, including detailed summaries of the guiding principles and overarching questions, as well as case studies to which IBPA is applied, see Hankivsky et al. (2012, 2014).

**Figure 2.** Descriptive and Transformative Overarching Questions of IBPA\*

\*Note: Questions excerpted from Hankivsky et al., 2012, p. 39–42.

The IBPA Framework and its corresponding principles and questions are intended to capture and respond to the multi-level interacting social locations, forces, factors, and power structures that shape and influence human life and health.

### **Operationalizing Social Inclusion: The Circle of Belonging Model**

In the Canadian context, there have been a plethora of definitions of social inclusion. For example, Cobigo, Ouellette-Kuntz, Lysaght, and Martin (2012) stated that social inclusion is “the result of complex interactions between personal and environmental factors which increase an individual’s opportunities to contribute to

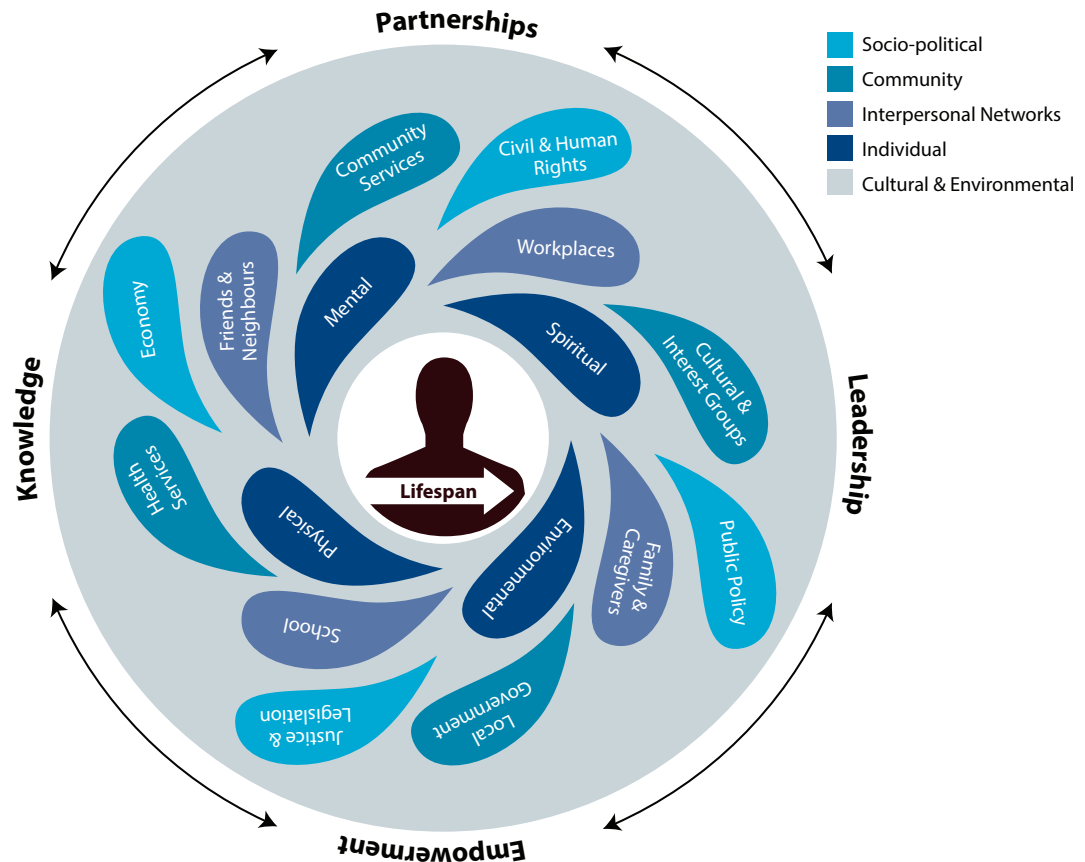
society and to experience a sense of belonging” (p. 81). According to Everett (2009), “social inclusion is the formal name given to a fairly recent set of government policies aimed at including marginalized people more meaningfully in society not only for their sake but for the sake of protecting social cohesion and lessening threats to economic progress” (p. 3). In another example, Westfall (2010) asserted that a socially inclusive society “cultivates the skills and abilities of its citizens and communities, and works towards a goal of equal opportunity and freedom from discrimination” (p. 8). Despite the differences in conceptualizations, social inclusion is typically posited in opposition to, or as a panacea for, social exclusion. There is also an explicit assumption that social inclusion is an important goal for creating more complete, vibrant, and just societies. Especially important in recent social inclusion discourses has been the focus on improving a sense of belonging among the members of a society (Cobigo et al., 2012; Crisp, 2010; Garbutt, 2009; Hall, 2010; Lambert et al., 2013).

Social inclusion has gained specific currency in the areas of mental health and substance use (Wright & Stickley, 2012). One of the most recent examples of its influence in these areas of policy can be found in the efforts of the province of BC. For example, according to the *Taking Action* report:

Researchers, collaborators and partners are starting to recognize that social inclusion is a powerful means to reduce the impact of stigma and discrimination for people living with moderate to severe mental health and substance use issues, and equally important to increase their ability to meaningfully participate in their community and seek the care and support required to reach their potential as active, engaged citizens in BC. (Zappelli & Ardiles, 2013, p. 29)

In this policy context, the *Taking Action* report proposes a “Circle of Belonging: Social Inclusion Model for Mental Health and Substance Use”—informed by an environmental scan of national and BC-specific best practices—to promote “a common understanding of social inclusion amongst key stakeholders” (Zappelli & Ardiles, 2013, p. 6; see Figure 3). Given that models of social inclusion are in nascent stages of development, this is an important new contribution to the national and international policy landscape. Further, in promoting a common understanding of social inclusion, the Circle of Belonging model is said to support the reduction of stigma and discrimination “amongst people with moderate to severe mental health and/or substance use issues” (p. 30) and in so doing, promote social inclusion.

The model identifies five multi-level domains (from the individual to socio-political level) as well as four key strategies (i.e., partnerships, leadership, empowerment, and knowledge) that can support a “cultural shift” toward social inclusion (p. 30). The model is said to focus on “partnerships and collaboration, and sharing knowledge and power across policy domains, the lifespan, and across the continuum of care—from promotion to recovery” (p. 29).

**Figure 3.** Circle of Belonging: Social Inclusion Model for Mental Health and Substance Use\*

\*Note: Model adapted from Zappelli and Ardiles (2013, p. 30)  
 “Circle of Belonging: Social Inclusion Model”

### **An Intersectionality-Informed Model of Social Inclusion and Exclusion**

The Circle of Belonging model reflects an important shift occurring within health frameworks that recognizes how multi-level factors (e.g., cultural and environmental context) can influence health across the lifespan as well as the need for a multi-sectoral approach. This shift has been critical in expanding conceptions of health beyond individual-level categories or factors toward acknowledging the role of social relations, institutions, and structures (Weber & Fore, 2007). As discussed, intersectionality can complement and further understandings as to the interrelatedness of micro- and macro-level factors and processes that shape inclusion. Presented below is an intersectionality-informed model of social inclusion and exclusion that makes explicit the role of social locations and multi-level contexts and

processes in shaping belonging, inclusion, and exclusion. It was developed out of a recently commissioned report that sought to apply the IBPA Framework (Hankivsky et al., 2012) to the *Taking Action* report (Institute for Intersectionality Research & Policy, 2013). The proposed model is intended to deepen and complicate understandings of social exclusion and to inspire innovative solutions for advancing social inclusion.

**Figure 4.** An Intersectionality-Informed Model of Social Inclusion and Exclusion



The Intersectionality-Informed Model of Social Inclusion and Exclusion (see Figure 4) is intended to transform current understandings of, and approaches to, social inclusion, paying special attention to the relationship between inclusion and exclusion and, in general, to the complexities and diversities of experience. This is accomplished by interrogating both social inclusion and exclusion in relation to eight key principles reflecting the tenets of intersectionality. These principles mirror those presented in IBPA (Hankivsky et al., 2012, pp. 35–38), with the integration of an additional principle (highlighted in yellow): “Resistance and Resilience.” The descriptive and transformative questions that inform these principles (outlined in Figure 2 above) are considered integral to this model, particularly to ensure that the model facilitates the transformation of how social inclusion is interpreted and promoted. Further, as with IBPA, this model does not subscribe to a linear or singular method of uptake and application, but rather is intended to have what Murphy et al. (2009) have referred to as the “built-in flexibility [of intersectionality-informed policy analysis that] allows movement in either direction in response to a particular policy problem and its changing environment” (p. 60).



The Intersectionality-Informed Model is predicated on the following understandings:

- (a) Social inclusion and exclusion are dynamic and simultaneously experienced by individuals;
- (b) Experiences of social inclusion and exclusion differ and change both within and across social locations and populations according to time and place; and
- (c) Social inclusion and exclusion are constituted and shaped by processes and structures of power on multiple levels.

What follows is a critical discussion of how these three understandings of the Intersectionality-Informed Model strengthen and build upon current understandings of and responses to social inclusion in ways that promote social justice and equity. We demonstrate the value-added of this proposed model using the Circle of Belonging model as the focus of our analysis. Though discussed elsewhere (IIRP, 2013), this analysis does not focus on the key strategies and interventions recommended in the Circle of Belonging model, as we believe it essential to first expand and strengthen conceptualizations of inclusion in ways that promote equity before proceeding with any policy or service reform. Further, despite the focus of this discussion on mental health and substance use, we argue that the proposed model can be applied to other health and social issues in which inclusion and exclusion figure prominently.

### **Intersectionality-Informed Social Inclusion: Discussion & Implications**

#### **Social Inclusion and Exclusion Are Dynamic and Simultaneous**

Conceptualizations and models of social inclusion and social exclusion have often constructed a false binary, as is often the case with conceptions of difference and power (e.g., dominant–subordinate; Dhamoon, 2011). This is exemplified by the Circle of Belonging model, which focuses predominantly on social inclusion to the omission of social exclusion. This false separation between social inclusion and exclusion ignores the dynamic relationship between the two: specifically, that the processes and systems of power that shape social exclusion across populations (e.g., stigma, discrimination, racism) simultaneously shape experiences of social inclusion. For instance, Caxaj and Berman (2010) argued that newcomer youths to Canada can experience positive experiences of inclusion (e.g., creating spaces for resistance and alternative worldviews) within their experiences of exclusion (e.g., racialized discrimination). This relationality is highlighted by the Intersectionality-Informed Model which recognizes inclusion as inextricable from exclusion.

The relationality of inclusion and exclusion is foregrounded by the key principle of “Power” in IBPA, which recognizes that processes and systems of power converge to shape experiences of privilege and penalty between and among groups (Hankivsky et al., 2012; Collins, 1990). This highlights how, for instance, the various sectors and groups commonly depicted as responsible for social inclusion (e.g., health services, local government, etc.) can advertently or inadvertently contribute to the exclusion often faced by people with mental health and/or substance

use issues (Bungay, Johnson, Varcoe, & Boyd, 2010; Khanlou & Gonsalves, 2011; Poole et al., 2012; Smye, Browne, Varcoe, & Josewski, 2011). Further, in recognizing the relational nature of power more generally, the Intersectionality-Informed Model problematizes constructions of entire groups (e.g., individuals experiencing mental distress and substance use or addiction) as inherently “excluded,” as it ignores how such individuals may experience varying degrees of privilege and penalty or, more specifically, forms of inclusion and exclusion.

In overlooking the relationship between inclusion and exclusion, and the forces of power that shape them, well-meaning inclusion initiatives can actually reify experiences of exclusion as they take the focus away from the dynamics and operation of exclusion turning it instead toward the individuals or groups deemed to be excluded. This is particularly concerning, given the common links between processes of exclusion (e.g., racism, colonialism, stigmatization) and experiences of poor health outcomes (Hankivsky, 2011; McGibbon, 2012; Nestel, 2012). Promoting social inclusion in this way does not necessitate addressing the power dynamics shaping inclusion and exclusion and, in turn, diverts attention from the ways in which people advertently or inadvertently participate in and benefit from the exclusion of others. As Holley, Stromwall, and Bashor (2012) argued in their discussion of mental-health-related stigma and exclusion, attention to the role of privilege in the promotion of equity and inclusion is paramount. They articulated privilege as internalized and “woven into the fabric of institutions” (p. 59), making it a necessary focus when involving institutions and stakeholders in the promotion of inclusion. Effective models of inclusion must work to understand and reflect such complexities if the goal is to interrupt and ameliorate exclusion and inequity.

Informed by the IBPA guiding questions, the Intersectionality-Informed Model prompts future inclusion models and initiatives to interrogate key questions related to power and how it shapes interpretations of and responses to social inclusion. One way that intersectionality can help one attend to various manifestations of power is through reflexivity. The IBPA highlights the importance of “Reflexivity” in its principles as well as with its first question, which asks: “What knowledge, values and experiences do you bring to this area of policy analysis?” (Hankivsky et al., 2012, p. 39).

According to Hankivsky et al. (2012), reflexivity acknowledges the importance of power at the micro level of the self and our relationships with others, as well as at the macro levels of society. Practising reflexivity requires researchers, policy actors, and stakeholders to commit to ongoing dialogue and deconstruction of “tacit, personal, professional or organizational knowledges” and their influences on policy (Parken, 2010, p. 85). The transformative potential of reflexivity is found within practices that bring critical self-awareness, role-awareness, interrogation of power and privilege, and the questioning of assumptions and “truths” in policy processes (Clark, 2012), including how various groups are labeled, stigmatized, and responded to. For instance, the tendency for policymakers to reinforce stereotypes and moral judgments in ways that silence and exclude particular groups (e.g., low-income mothers dependent on welfare) has been highlighted as central in preventing inclusive democracy as well as in silencing and dismissing the complex needs of such groups (Hancock, 2004). For these reasons, reflexivity can facilitate socially

conscious interventions where organizations and institutions are aware of their role in reinforcing the power relations that hinder access to health care (van Mens-Verhulst & Radtke, 2009).

While reflexivity is important in all policy contexts, reflexive practices are particularly relevant in the context of Indigenous experiences, as they allow for the consideration of individual connections to colonization and for the interrogation of policy and practices in the colonization of Indigenous peoples (Blackstock, 2005). Failing to make connections between the systemic oppression of Indigenous people and their disproportionate experiences of health and social inequity contributes to the individualization of particular problems and in turn, maintains or increases processes of racialization, exclusion, and stigmatization (Battiste & Henderson, 2012; Fiske & Browne, 2006; Hunting & Browne, 2012).

Similarly, as seen in Canada, overlooking the systemic and structural barriers to health care experienced by new immigrants tends to reduce the problem to address as solely one of cultural difference. This ignores the intersecting barriers to immigrant health and health care beyond perceived cultural difference (e.g., age, literacy, economic integration barriers, access to community support, stigma) and, in turn, furthers one-dimensional understandings of cultural difference (Habib, 2012; Hynie, Baldeo, & Settino, 2013; Khanlou, 2009). Being reflexive as to the assumptions one may bring to one's work about who is being excluded, and how, is necessary to avoid re-inscribing potentially oppressive processes. Further, reflecting on what current policy responses are trying to achieve (Hankivsky et al., 2012) is also paramount. If the goal is meaningful inclusion in ways that promote equity and social justice, the dynamics of power, privilege, and disadvantage must be attended to.

One way in which research and practice has moved toward understanding and addressing power inequities is the incorporation of the concept of cultural safety (e.g., Godard et al., 2012; Mental Health Commission of Canada Task Group on Diversity, 2009; Rossiter & Morrow, 2011). Cultural safety, in contrast to a sole focus on paying attention or being sensitive to cultural difference, involves reflexive analysis of how power imbalances and institutional discrimination shape health and health care (NAHO, 2008). This need for critical reflection as to how health care systems (and the social, historical, and political contexts in which they are embedded) shape and respond to the health of individuals across diverse social locations is a necessary step in ameliorating discriminatory barriers to health and wellness. Notably, the potential for intersectionality to inform the conceptualization of cultural safety in ways that more robustly reflect and attend to the complexity of culture and its intersections has been increasingly highlighted (Browne & Varcoe, 2006; Clark et al., 2009; Hunting, 2012).

### **Experiences of Social Inclusion and Exclusion Differ and Change Across Populations**

Though the goal of transcending social exclusion among individuals experiencing mental health and/or substance use issues is important, a one-size-fits-all model of social inclusion for this diverse population has limitations. First and

foremost, the Circle of Belonging model—in failing to reflect the diverse identities and social locations across populations—constructs people who experience issues related to mental health and/or substance use as sharing the same experiences, perspectives, and needs. Rather, this broadly labeled group experiences social inclusion and exclusion in varying ways across multiple social locations and identities (e.g., age, ethnicity, religious views, income, and geography) and consequently may have very different needs and perspectives. The Intersectionality-Informed Model reflects this diversity in experiences by explicitly rejecting the tendency—particularly in population-health approaches—to essentialize group identities and experiences.

Key principles from the IBPA that reflect this variation and change within and across groups and inform the proposed model are “Intersecting Categories” and “Time and Space” (Hankivsky et al., 2012, p. 35 & 37). Firstly, conceptualizing people who experience mental health and substance use issues as constituted and constructed by intersecting categories has two effects: (a) It does not assume that placing primary importance on categories such as “the mentally ill” or “the addicted” is sufficient for understanding or addressing people’s needs and experiences; and (b) it explicitly recognizes and rejects how labels and categories have served as tools of power and oppression. Secondly, the emphasis on time and space highlights that identity, social location, knowledge, and experience are dependent on and change across time and space. This principle, for instance, highlights the complex and changing nature of how categories such as *mental illness* or *addict* have been experienced, defined, and responded to. Problematizing assumedly observable categories in this way allows for a more nuanced understanding of mental health and substance use, and importantly, provides space for people to self-identify if and how their mental health and/or substance use affects their lives (Laviolette, 2011).

Recognizing the limitations of categorical approaches to populations as well as to health and social issues is essential, or the complexities of people’s identities, degrees of inclusion and exclusion, and social and historical contexts are overlooked. Arguably, the “over-inclusion” of specific groups—e.g., targeting and conceptualizing a group of people as having a single shared experience without recognizing within-group diversity—can be counterproductive to equity-oriented goals (van Mens-Verhulst & Radtke, 2009). For instance, when substance-use-related policies and discourses name and target people who experience mental health and substance use as necessarily at risk of exclusion—without acknowledging the diversity of factors producing risk—relations of inequity can be exacerbated. Specifically, a failing to acknowledge the diversity of experience across categories, time, and space within policies and related discourses can reinforce assumptions about “problem populations,” which has historically contributed to surveillance, stigmatization, and discrimination of populations experiencing mental health and/or substance use issues (de Leeuw, Greenwood, & Cameron, 2010; Hunting, 2012; Windsor, Dunlap, & Armour, 2012). At the same time, such framings can result in the under-representation or invisibility of people who do not identify or are not identified as belonging to certain categories considered high-risk. For example, Grace (2013) argued that categorizing people as “most-at-risk-populations”

(MARPs) with respect to behavioural or epidemiological categories fails to address important within- and between-group differences, identities, and social locations.

The proposed intersectional model invites future directives involving people experiencing mental health and substance-use-related issues to critically ask: “How are groups differentially affected by this representation of the ‘problem’?” and specifically “What differences, variations and similarities are considered to exist between and among relevant groups?” (IBPA Question 4, Hankivsky et al., 2012, p. 39). This inquiry could foster context-specific questions such as “How does the ‘problem’ of addiction and responses to it change if I understand those affected as a different age, or gender, or from a different location?” and “Would all citizens equally benefit from this policy response?” Such intersectional interrogation is a necessary step in moving away from a tendency to construct issues as being problems of particular categories of people toward policies and programs that more accurately reflect the complexities of subjectivity, identity, and experience.

From an intersectionality perspective, struggles for social justice, including those that seek to improve the lives of individuals experiencing issues related to mental health and/or substance use, have to confront the intertwined nature of domination rather than focus on specific identities or concerns. This reality contributes to an understanding that social justice requires collective action across different, albeit interrelated, groups. In some instances this can open the possibility of creating seemingly counterintuitive associations between groups that have been in competition with each other, missing the opportunity to work together to dismantle interacting structural systems that often create the root causes of mental distress and addiction.

Intersectionality-informed thinking in relation to partnership development may provide unique opportunities for building stronger coalitions and alliances among diverse social justice organizations at multiple levels, beyond those focused exclusively on mental health and substance use programs or interventions. In this, collaborative action can occur across groups including women’s organizations, disability and civil rights activists, labour unions, Indigenous organizations, queer organizations, human rights organizations, faith-based organizations, and immigrant advocacy groups. This coalition and alliance building is central in providing information for multi-level analysis of the cross-sectoral factors influencing mental health, substance use, and appropriate responses to them. The power of cross-sectoral dialogue and alliance building in addressing social exclusion is illustrated by a recent forum on addictions and mental health held in Vancouver entitled “Nuts and Junkies: Beyond the Stereotypes” (Reid, 2010). Centred on the perspectives of drug users and mental health consumer survivors, the forum brought together academic and community-based groups to discuss how policy reform can best occur across diverse social locations and experiences. Reflected in the title of the forum, this event also sought to reclaim discriminatory labels often perpetuated within research, policy, and practice, which was central in developing allied strategies to address the intersections of social exclusion.

### **Social Inclusion and Exclusion are Constituted and Shaped by Power**

To properly address social exclusion, the Intersectionality-Informed Model acknowledges diverse social locations and identities and how they are situated in power relations. This entails going beyond conceptualizing the individual as being constituted by physical, mental, spiritual, and emotional attributes that determine individual level beliefs, attitudes, and behaviours (as the Circle of Belonging model does). Specifically, the Intersectionality-Informed Model recognizes the complex interactions of age, geographic location, gender, race and ethnicity, socio-economic status, and ability in everyday lived experiences and over the course of the lifespan. It also necessitates examining how such interactions materialize in concrete and diverse positioning of persons on the spectrum of inclusion and exclusion, privilege and disadvantage, power and discrimination. Key IBPA questions to facilitate such a line of inquiry include: “What are the important intersecting social locations and systems [in relation to the problem]?” and further, “What are the knowledge/evidence gaps about this problem across the diversity of the population?” (IBPA Question 6, Hankivsky et al., 2012, p. 40).

In the Circle of Belonging model, the acknowledgement of interpersonal networks is important for understanding the relational quality of people’s lives, but an intersectionality-informed analysis recognizes that all relationships are shaped and informed by a socio-political context that either promotes well-being or undermines it. As Dodman (2004) has noted, although belonging is tied to feelings of pride and attachment to one’s local community, it is indivisible from larger social and environmental contexts. Though the Circle of Belonging model acknowledges socio-political aspects (namely civil and human rights, economy, justice and legislation, and public policy), it falls short of explicitly recognizing mutually constituting structures and processes of power (e.g., racism, ableism, patriarchy, capitalism, imperialism) which determine and shape these socio-political elements and, in turn, shape boundaries of belonging. Importantly, as Seebohm et al. (2013) have noted, reducing power inequities—especially because they pervade mental health and related systems—is a central element in bringing about social inclusion. To do this effectively, intersectionality insists on seeing all of these different levels of analysis as inextricably connected and consequently requiring a framework that engenders a multi-level analysis.

Attention to the multiple levels of power shaping and responding to relations of inclusion and exclusion is central to the development of policies and programs that adequately reflect the complexities of experience. As Hankivsky et al. (2012) argued:

Intersectionality is concerned with understanding the effects between and across various levels in society, including macro (global and national-level institutions and policies), meso or intermediate (provincial and regional-level institutions and policies) and micro levels (community-level, grassroots institutions and policies as well as the individual or ‘self’). Attending to this *multi-level* dimension of intersectionality also requires addressing processes of inequity and differentiation across levels of structure, identity and representation (Dhamoon & Hankivsky, 2011; Winker & Degele, 2011). The significance of and relationship between

these various levels of structure and social location are not predetermined in an IBPA, but rather reveal themselves through the process of research and discovery. (p. 35)

The importance of multi-level analysis is especially relevant in the context of substance use and mental health, where researchers and practitioners in these fields have increasingly advocated for approaches that better respond to the social and political context of people's lives. For instance, Morrow and Weisser (2012) underscored that mental health recovery approaches need to recognize the relationship between the individual and the social—specifically, that interlocking forms of oppression are directly related to experiences and perceptions of mental health.

The *Taking Action* report (Zappelli & Ardiles, 2013) provided an important insight by stating that strategies to address structural barriers to well-being need to involve addressing stigmatizing social attitudes. This is reflected in the Circle of Belonging domain of “Culture and Environment” (see Figure 3), explained as consisting of dominant beliefs and attitudes. The role of symbolic representations such as persons who are mentally ill are “nuts,” “deranged,” “crazy,” and “violent”; and that those with addictions are “junkies,” “losers,” and “trouble” figure prominently in terms of such representations perpetuating social inequality and exclusion (Winkler & Degele, 2011). The Intersectionality-Informed Model requires, however, that such dominant beliefs and attitudes be examined in the context of complex relations of inclusion and exclusion. This can reveal the shifting nature of values across social locations, time, and space according to intersections of power—problematizing seemingly homogenous and static representations of cultural or dominant beliefs. Interrogating how power relations shape and reflect dominant values and assumptions in this way is reflected in IBPA Question 3, which asks “How has the framing of the ‘problem’ [e.g., who is considered mentally ill and why] changed over time (historically) or across different places?” (Hankivsky et al., 2012, p. 39). Developing a critical awareness of values and, in particular, naming what is valued and privileged by different communities and how this relates to relations of advantage and disadvantage, is the first step to dismantling attitudes and behaviors that oppress others.

The proposed Intersectionality-Informed Model also necessitates finding out how persons “feel about their location in the social world, which is generated partly through experiences of exclusion rather than being about inclusion per se” (Anthias, 2008, p. 8). Without doubt, it is important to foreground the principle and concept of knowledge as inextricable from issues of power—specifically, that power operates at discursive and structural levels to both privilege and exclude particular knowledges and experiences (Foucault, 1977). Including the perspectives and worldviews of people who are typically marginalized or excluded in the production of knowledge that informs policy across intersecting categories is thus central in disrupting exclusion. As part of this alternative approach, it is important to capture what differently situated and excluded persons may seek, recognizing that such needs may not be phrased in the language of inclusion or belonging (Winkler & Degele, 2011). As Galabuzi (2012) has emphasized, social exclusion is mutually constituted by intersections—such as economic exclusion, the racialization and feminization of

poverty, and spatial exclusion—which generate complex inequalities requiring context-specific responses.

It would therefore follow that according to the Intersectionality-Informed Model, the idea of belonging that is dominant in social inclusion discourse would need to be critically examined. As Anthias (2008) noted, constructions of belonging have long been shaped and imposed by people and institutions in positions of power to regulate and sort populations and communities. Thus, the concept of belonging can create false boundaries, defined by people who hold power, between a perceived norm and others who fall short of that norm. These categorizations of belonging directly link to the distribution of privileges, opportunities, and penalties, reinforcing social hierarchies in society across gender, race, sexual orientation, ability, religious affiliation, citizenship status, or class, etc. It must also be recognized that constructions of belonging (and inclusion more broadly) can place undue responsibility on individuals to become included, which takes the onus off other stakeholders (e.g., governments, service providers, and the general public) to reduce stigma and promote genuine inclusion (Seebohm et al., 2013).

For instance, perceptions of inclusion and belonging among new immigrants to Canada shift and change with respect to multi-level intersecting factors (e.g., quality of social support, employment opportunities, immigration policies, systemic discrimination) and do not tend to follow an upward trajectory (Goldman, 2012; Khanlou, 2009; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). In recognizing this, the proposed model allows for more nuanced understandings of and approaches to conceptualizing inclusion and belonging across diverse groups, often overlooked with one-size-fits-all approaches. Of course, bringing such thinking into the realm of policy is difficult because it is generally perceived that manageable interventions are those that focus more on individual behaviours and even institutional arrangements rather than on structures of oppression and the large-scale societal changes that need to be realized in order to effectively mitigate inequities. However, intersectionality points to the fact that transformative social change requires not only taking into account, but finding ways to respond to, the impacts of policies and practices on different groups.

Finally, the Intersectionality-Informed Model incorporates the IBPA principle of “Resistance and Resilience.” As described elsewhere (IIRP, 2013), this principle acknowledges that

the operation of resistance and resilience can disrupt processes of power and oppression. Similarly, policies and discourses that label groups of people as inherently marginalized or vulnerable undermine the reality that there are no ‘pure victims or oppressors’ (Collins 1990; Dhmoon & Hankivsky, 2011). Thus, even from so-called ‘marginalized’ spaces and locations, oppressive values, norms and practices can be challenged. For instance, one principle [sic] mechanism of resistance from subordinated groups has been collective actions to destabilize dominant ideologies (Dhmoon, 2011). Categorical policy approaches obscure similarities between groups and their shared relationships to power. It also prevents coalitional work by reinforcing conceptions of difference based upon specific categories. (IIRP, 2013, p. 47)



Considering resistance and resilience is essential for understanding how individuals navigate multiple forms of power and oppression. This is consistent with what others have referred to as an anti-oppression paradigm in the fields of mental health and substance use, which identifies strategies that people use to promote resilience and resist oppression (e.g., Across Boundaries, 2012; BC Association, 2007; BC Society of Transition Houses, 2011; Holley et al., 2012; Poole et al., 2012; Shahsiah & Yee, 2006) rather than focusing only on the negative effects of oppression. The need to understand and promote resilience in addressing stigma and social exclusion has been punctuated within intersectionality-informed research discussing substance use and/or mental health (Barkdull et al., 2011; Benbow, Forchuck, & Ray, 2011; Earnshaw, Bogart, Dovidio, & Williams, 2013; Lane, Tribe, & Hui, 2010). Importantly, intersectional understandings of resilience move beyond narrow conceptions of individual capabilities toward situating resilience both as occurring at multiple levels (from individuals to communities) and as inextricable from multi-level structures and processes of power. Overall, accounting for resistance and resilience in this way is essential for setting the policy agenda, as well as in the implementation and evaluation of programs and services.

### **Conclusion**

The promotion of social inclusion to reduce experiences of stigma, discrimination, and other forms of exclusion is currently on policy agendas internationally (e.g., Health Scotland, 2008; Substance Abuse & Mental Health Services Administration, 2013; Queensland Alliance for Mental Health, 2010). It is thus vital that social inclusion is conceptualized within public policies and programs as directly shaped by, and intersecting with, the processes and factors that shape exclusion or, as Burman (2003) has argued, it is likely that they will “overlook critical appraisal of precisely what it is those designated ‘excluded’ are to be included into” (p. 294). In turn, well-meaning attempts to promote inclusion within public and institutional settings can inadvertently pathologize and individualize the “problem” of those deemed excluded.

If intersectionality is brought to bear on existing models, it brings us more in line with an approach that is able to capture the simultaneity of both inclusion and exclusion. As Wright and Stickley have argued, “the main benefit of the social exclusion concept may be that it has helped to draw attention to the social injustice experienced by people with mental health problems” (2012, p. 79). Any initiatives geared toward the promotion of social inclusion in and beyond the fields of mental health and substance use must acknowledge how the dynamics of exclusion shape experiences and needs. The Intersectionality-Informed Model of Social Inclusion and Exclusion, in its expansion of current paradigms of social inclusion, highlights the centrality of these multi-level processes and factors in shaping experience as well as the critical role of health stakeholders in recognizing and addressing them. Though the proposed model has been discussed in the context of policies addressing mental health and substance use, its potential application crosses many health and non-health sectors. It is hoped that the equity-focused nature of the model will inspire

others to advance social justice in their work and ultimately assist in a paradigm shift toward meaningful and inclusive policies and practices.

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