Mental Health Commission of Canada

Commission de la santé mentale du Canada

Intersectional Structural Stigma in Mental Health and Substance Use Health

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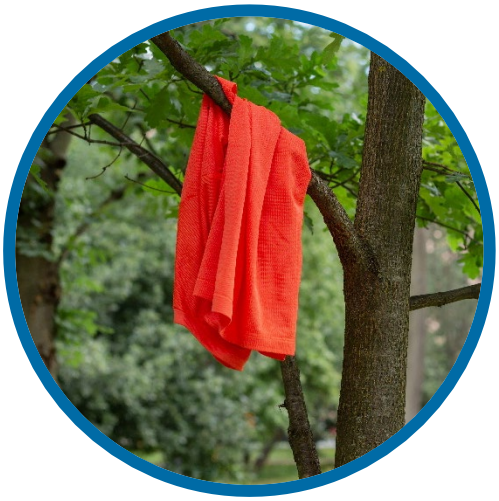
Table of contents

Land acknowledgment

The head office of the Mental Health Commission of Canada is located on the unceded traditional territory of the Algonquin Anishinaabe Nation, in what is now called Ottawa, Ontario. As a national organization, the Commission works on the traditional lands of many different nations. The Commission gives credit to their stewardship and sacrifices and is committed to recognizing and contributing to a new and equitable relationship with the First Peoples.



About the Commission

The Mental Health Commission of Canada is a not-for-profit charitable organization dedicated to better evidence, solutions and practices for better mental health. The Commission collaborates with leading experts and organizations nationally and internationally, including people with lived and living experience and First Nations, Inuit, and Métis leaders, to develop evidence-based national guidelines, standards, and strategies; promote innovation and best practices; reduce stigma; deliver training; and increase mental health literacy. We partner with and support decision makers and all levels of government to improve mental health outcomes for everyone living in Canada.

Structural stigma and intersectional structural stigma

What is structural stigma?

The Mental Health Commission of Canada describes **structural stigma** as the result of laws, policies, everyday routines, and organizational cultures creating unfair treatment for people with lived and living experience of mental health and substance use health concerns. In health care, this unfairness shows up as poorer access to services and lower quality care compared with care for physical health concerns.

Over the past several years, the Commission has led a multi-phase structural stigma initiative, including:

- a literature review on structural stigma in health-care contexts
- a framework for assessing structural stigma, focused on access and quality
- a collection of personal experience narratives and educational videos
- a free and accredited online training on mental health structural stigma in health care
- an implementation guide for dismantling structural stigma in health care
- two measurement scales to assess the scope and severity of structural stigma in any health-care setting, as experienced by patients and clients
- a national capacity-building workshop initiative, entitled *Stigma-Free & Inclusive: A Pathway to Quality Health Care,* designed to foster meaningful engagement with health-care organizations seeking to improve the quality of their services

Together, these initiatives have advanced efforts to dismantle structural stigma across diverse health-care settings by shifting the focus from individual stigma to system-level accountability, quality improvement, and sustainable change. This concept paper builds on this groundbreaking work by drawing on a critical narrative review to examine what the evidence shows about the ways in which structural stigma related to mental health and substance use health interacts with other structural forms of discrimination: intersectional structural stigma.

The Commission's structural stigma initiative focuses on two central problems in health care: inequitable access and lower quality of care for people with mental health and substance use health concerns. Intersectional structural stigma connects directly to this agenda in the following ways:

Access

People who face racism, immigration restrictions, poverty, or other forms of discrimination, including prejudice against First Nations, Inuit, and Métis people, are more likely to encounter long waits, fragmented services, eligibility rules that

exclude them, and services that do not feel safe or respectful. People experiencing homelessness face these same barriers, often with greater intensity, as housing instability disrupts continuity of care and limits access to services that may require a fixed address. Similarly, people with low health literacy or who lack the linguistic skills to access care in one of Canada's two official languages, such as some members of the country's many linguistic minority communities, face challenges that can lead to poorer health outcomes. All of these barriers need to be addressed.[1,2,3]

Quality

People who experience multiple forms of discrimination are more likely to experience misdiagnosis, diagnostic overshadowing,[i] coercive practices, and dismissive interactions.[4]

Through its work in multiple areas, the Commission has already emphasized that structural stigma operates not as a discrete phenomenon, but in dynamic relation with other structural forms of discrimination. A focus on intersectional structural stigma puts those interactions at the centre of how we analyze, measure, and address structural stigma, rather than at the periphery.

[i] Diagnostic overshadowing is the attribution of a person's symptoms to a psychiatric problem when they may actually suggest a co-existing physical health condition.

What is intersectional structural stigma?

Different forms of discrimination interact in complex ways. Individuals with mental health or substance use health concerns may experience discrimination that gets complicated by other forms of discrimination such as racism, ableism, sexism, or ageism. The concept of intersectional stigma reminds us that these types of discrimination do not simply stack on top of one another. They interact and influence one another, creating distinct experiences.

Therefore, **intersectional structural stigma** refers to the way structural stigma related to mental health and substance use health interacts with other structural forms of discrimination.

The result is

- compounded barriers to getting care
- more severe and longer term harms to health and well-being
- mutually reinforcing cycles of exclusion and mistrust.

To explore the concept of intersectional structural stigma, we conducted a critical narrative review of 28 Canadian and international research studies[ii] and found that forms of discrimination related to race and ethnicity, gender, sexual orientation, gender identity, socio-economic status, immigration status, age, and disability intersect with mental health and substance use health stigma and with each other in ways that compound and deepen inequities and worsen health outcomes.

[ii] See Appendices for a list of the research articles included in the critical narrative review.

How intersectional structural stigma shows up in everyday care

Several recurring patterns emerged from the critical narrative review findings:

First, intersectional structural stigma compounds barriers to care by shaping who can access services, how they are treated, and whether they feel safe and comfortable. These stigmas create disadvantages that marginalize entire groups and lead to deeper health inequities.[4]

Second, intersectional structural stigma produces negative health outcomes through several different pathways. One example is that stigma heightens stress, which can fuel anxiety and increase substance use. Another is that mistrust of health systems can hold people back from seeking help for their health concerns. A third is that structural discrimination such as racism might contribute to misdiagnosis, leading to inappropriate treatments that worsen health outcomes.[5,6]

Third, intersectional structural stigma is self-reinforcing. Discrimination tends to perpetuate and intensify over time, reinforcing structural inequities and leading to greater health disparities. These disadvantages can span generations and systems.[7,8]

A few hypothetical examples are illustrated below.

Case 1. Compounding barriers to care

A 24-year-old Black man comes to the emergency department after several nights without sleep and intense anxiety, and he says he is hearing voices. He has been stopped by police more times than he can count and uses cannabis occasionally to cope, but health-care staff do not slow down enough to ask about his trauma or substance use in a meaningful way. Staff quickly label him "agitated" and "non-compliant" and diagnose him with suspected schizophrenia. He is admitted involuntarily, started on antipsychotics, and given very little explanation about what is happening to him. Security is called whenever he raises his voice or asks too many questions.

When he is discharged, he receives a referral to a clinic that assumes he has access to stable housing and reliable transportation. The community clinic closer to home has a wait-list that stretches for months, and he is told they do not work with "substance users" until people are "clean". Feeling criminalized for being a member of the African, Caribbean, and Black (ACB) diaspora, experiencing distress, and using cannabis to cope, he stops looking for help. He leans on friends and whatever substances he can find just to get some sleep. His condition worsens over time.

Imagine if there was a different ending…

A health-care worker from a community-based organization reaches him through a setting outside of conventional health sector organizations. The health-care worker and the man develop a trusting relationship, and the worker connects the man to an early psychosis program that was co-designed by youth. In this program, someone recognizes the unseen weights he has been carrying and, through shared decision making, he begins to explore options that focus on his strengths and foster his recovery.

Case 2. Producing negative mental health outcomes

A First Nations transgender man in his late twenties comes to the emergency department after being assaulted by someone he knows at a party where alcohol and pills were around. At triage, staff repeatedly misgender him. They ask why he was "drinking so much if he has mental health issues" and suggest that his alcohol and drug use make his story less believable. When he shares that he has a long history of self-harm and uses cannabis and opioids to cope, the consulting psychiatrist documents "borderline traits" and "substance seeking." He leaves with a generic referral list and discharge papers that still carry the wrong name and pronouns.

In 2SLGBTQI+ spaces, he runs into subtle racism and the assumption that survivors are cisgender women. In Indigenous and other racialized spaces, he hears transphobic comments and messages that "real men do not get assaulted" and that using substances is a moral failure. Little by little, these messages sink in. He starts to believe the assault was his fault, feels unworthy and ashamed, and uses alcohol and opioids more often to numb the pain. His symptoms intensify, his thoughts of suicide grow stronger, and he pulls away from both health-care services and community supports.

Imagine if there was a different ending…

A First Nations harm reduction outreach worker finds him through a community friendship centre. They connect him to an integrated care team that includes an Elder as well as supportive counsellors and experienced peers. He feels seen and whole.

Case 3. Mutually reinforcing across systems and generations

A 16-year-old multiracial and cisgender teen girl who recently immigrated to Canada from Central America lives with her parents and younger siblings in a crowded apartment. The family does not have full documentation and survives on unstable work. At school, classmates mock her accent and appearance. Teachers see her withdrawal and slipping grades and assume she is not trying. When the school social worker suggests a mental health referral, the parents say no. They are terrified that any record of depression, panic attacks, or substance use could hurt their immigration case or draw the attention of child welfare.

At home, the teen remembers an uncle who once spoke openly about alcohol problems and was met with shame and distance. She watches her father drink heavily to cope with stress and humiliation at work, yet the family insists this is normal and "not like those addicts." She starts using cannabis, then alcohol, more often to cope with racism at school, family conflict, and constant worry about money and status. She hides this from everyone.

Across health care, education, and immigration systems, the message feels the same: having mental health or substance use health concerns makes you not worthy of care. The teen's distress and substance use grow quietly. Her younger siblings watch and learn that asking for help is dangerous. structural stigma tied to race, immigration status, and substance use is reinforced in school and clinics, creating patterns of fear and mistrust that are passed from one generation to the next.

Imagine if there was a different ending…

A trusted school counsellor and community health worker help the teen and her family understand that seeking support is confidential and will not automatically harm their immigration case. With culturally safe counselling, school support, and a nonjudgmental response to substance use, the teen's coping improves, her grades begin to recover, and her family starts to see help-seeking as a source of strength rather than shame.

Strategies to address intersectional structural stigma

The Commission's review of intersectional structural stigma and existing structural stigma resources identified the following multi-level recommendations.

1. Policy and system-level strategies

1.1 Examine laws and policies that may contribute to intersectional structural stigma and inequitable outcomes.

- Analyze the intersecting ways that laws and policies shape outcomes for individuals and communities affected by mental health and substance use health-related structural stigma, with attention to how multiple dimensions of stigma and disadvantage compound one another.
- Evaluate how specific policies, laws, and institutional practices produce disparate outcomes across diagnostic groups. For example, affordable housing eligibility criteria may systematically disadvantage people with mental health and substance use health disorders (e.g., psychosis) differently from those with complex medical and psychiatric conditions that cause physical disability. Identifying these disparities helps identify policy areas that can be reformed.
- Further explore how structural discrimination is embedded across interconnected systems such as housing, education, social services, and the criminal justice system, with the goal of generating concrete, actionable recommendations that governments, health systems, and policy makers can implement to reduce harm.

1.2 Integrate mental health, substance use health, and physical health care.

- Structural stigma is reinforced when mental health, substance use health, and physical health care are delivered in silos. Advancing integration reduces the practical barriers that fall most heavily on people navigating multiple and intersecting forms of disadvantage.
- Advance legislation and delivery models that align funding, infrastructure, and workforce planning across sectors, so that people can move more easily between primary care, mental health, hospital, and community services. In the Canadian context, this may include expanding integrated team-based care and regional models that support shared accountability, coordinated pathways, and more holistic care.
- Mental health and substance use health parity is a key enabler for creating integrated health systems that are equitable and effective. Aligning health-care coverage and funding for mental health, substance use health, and physical health helps ensure services can be delivered together in a consistent and effective way.

2. Organizational strategies in health-care settings

2.1 Name intersectional structural stigma as a quality and safety issue and link it to other organizational priorities.

- Recommend that provincial and territorial health systems, regional health authorities, hospitals, and community-based organizations look at explicitly recognizing intersectional structural stigma as a driver of inequitable access, poorer quality of care, and avoidable harm for people with mental health and substance use health concerns.
- Doing so can help position stigma reduction as a concrete system priority, not only an aspirational value, by linking it to patient and client safety, quality improvement, staff well-being, and anti-racism efforts in ways that strengthen accountability and sustain change.

For example, the Vitalité Health Network in New Brunswick demonstrates that dedicating leadership to address structural stigma is a foundational quality improvement strategy. By establishing a focused role to advance structural stigma reduction and promote recovery-oriented practice, Vitalité embeds accountability and system-level action to identify and address barriers to equitable access and care. This approach recognizes that intersecting factors, such as language, geography, and mental health status, shape care experiences, and that without intentional system-level action, these factors can perpetuate structural stigma, lead to poorer quality care, and negatively impact care experiences and outcomes.

2.2 Embed an understanding of intersectional structural stigma into measures of performance and accountability.

- Consider how disaggregating and managing data across race, ethnicity, geography, socio-economic status, and other dimensions of discrimination may improve regular reporting and regulatory standards.
- Use tools such as the Structural Stigma in Mental Health Care Scale (SSMHCS) and the Stigma Cultures in Health Care Scale (SCHCS) as key components of quality improvement, with attention to how experiences differ by race, gender, income, and other identities.

2.3 Co-design services with people who have lived and living experience of mental health and substance use health concerns.

- Ensure that advisory councils, quality teams, and governance structures include people from the communities most affected by overlapping stigmas and compensate them fairly.[iii]
- Establish compensated roles for people with lived and living experience who face multiple forms of discrimination, and ensure they influence decisions, not only share stories.
- To facilitate this process, consider using the Quality Mental Health Care Framework and Implementation Toolkit. These resources provide practical strategies and guidance for effectively involving those with lived experience in the design and delivery of services.

2.4 Align clinical, human resources, and equity strategies.

- Review hiring, promotion, training, and disciplinary processes for bias against people with mental health or substance use health concerns.
- Integrate structural stigma training into onboarding and leadership development initiatives.

[iii] For additional guidance, consider using the Commission's resource *Engaging with People with Lived and Living Experience of Mental Illness Effectively: The MHCC's Advisory Councils*.

2.5 Offer culturally affirming and culturally safe mental health and substance use health care.

- Train staff to safely name and discuss multiple identities, to avoid stereotypes, and to support autonomy, shared decision making, and recovery.
- Build anti-discrimination competencies that include intersectional perspectives.
- Practise and foster critical self-reflection on how race, gender, class, and other identities influence diagnosis and treatment.
- Create clinical spaces where patients and clients can talk about structural and identity-based harms, not just symptoms.
- Integrate peer support into care programs, offering patients and clients relatable support grounded in lived expertise and intersectional perspectives.

For example, the Fraser Health Authority's Trauma and Resiliency Informed Practice (TRIP) Program[iv] demonstrates that building provider capacity for trauma awareness and compassion is critical to dismantling structural stigma in health care. The TRIP program strengthens self-compassion and resilience among providers, enabling more empathetic, non-stigmatizing responses to people with mental health and substance use health concerns. By centring trauma and a shared humanity lens, TRIP recognizes that individuals often experience multiple, intersecting forms of marginalization, and without this understanding, health care systems risk reinforcing stigma, inequitable care, and avoidable harm.

[iv] To learn more: Knaak, S., Sandrelli, Marika, & Patten, S. (2000). How a shared humanity model can improve provider well-being and client care: An evaluation of Fraser Health's Trauma and Resiliency Informed Practice (TRIP) training program. *Healthcare Management Forum, 34*(2), 87-92. https://pmc.ncbi.nlm.nih.gov/articles/PMC7903856/

3. Community strategies

3.1 Embed peer and family leadership in the design and delivery of services.

- Create paid positions for peer workers, family navigators, and community advisors with clear job supports and resources such as honoraria.
- Ensure such roles are filled by individuals who reflect diverse identities and communities.

For example, in the Addiction Recovery and Community Health (ARCH) program,[v] peer support workers are core members of the interdisciplinary addiction medicine teams, and a community advisory group composed of people with lived experience of substance use, hospitalization, and homelessness provides direction across all areas of the program, including service delivery, research, evaluation, and education. Members meet quarterly and are compensated for their contributions.

3.2 Invest in community-based, culturally safe supports.

- Partner with trusted community organizations that are already serving groups who may experience intersecting stigmas.
- Consider and uplift models of care that recognize historical trauma, racism, colonialism, and other structural harms.
- Provide culturally appropriate services in multiple languages, including sign language.
- Offer accessible services that integrate traditional healing and spiritual practices and that respect community norms.

[v] Learn more about these examples in the Commission's *Champions and Changemakers* resource.

For example, the mental wellness program Biigajiiskaan: Indigenous Pathways to Mental Wellness[v] demonstrates that community-hospital partnership can more effectively dismantle structural stigma when the community partner holds genuine governance and financial authority. This model ensures that Indigenous community leadership is never operationally subordinate to the institution. It also includes an Indigenous governance circle that oversees the effective integration of ceremony, Elder-guided care, and traditional medicine alongside psychiatric treatment on hospital grounds.

4. Research strategies

4.1 Improve the measurement of intersectional structural stigma through stronger data, mixed-methods approaches, and participatory research.

- Measuring intersectional structural stigma requires more than adding demographic variables to existing tools. Health systems, researchers, and policy leaders could consider investing in approaches that generate more meaningful evidence about how stigma operates across structures, relationships, and lived experience, so that inequities can be identified more precisely and addressed more effectively.
- This means collecting better data, combining quantitative and qualitative methods, partnering with communities as co-researchers rather than subjects, and ensuring findings are translated into concrete plans for change rather than left at the level of description.

4.2 Collect and use disaggregated data in respectful, voluntary, and transparent ways.

- Data collection could be grounded in trust and clarity about how information will be gathered, protected, shared, and used, so that people are more willing to participate and the resulting data are more credible and actionable.

4.3 Use mixed-methods approaches to understand both patterns and mechanisms.

- Combine quantitative measures, such as structural stigma scales and administrative data, with qualitative approaches, such as interviews, focus groups, and narrative methods, so that health systems can see not only where inequities exist, but also how they are produced and sustained.

4.4 Design research in partnership with affected communities.

- Work together with people from the communities most affected by structural stigma to shape research questions, determine methods, interpret responses, and report results, so that the work reflects lived realities and is more likely to produce findings that matter in practice.

4.5 Dedicate time and resources to capacity building and training.

- Support community-engaged and participatory research through compensation, training, relationship building, and flexible timelines, so that the partnership is meaningful and sustained rather than superficial and time-limited.

4.6 Use findings to identify specific leverage points and concrete targets for change.

- Measurement should not end with description; it should help identify where structural stigma is operating and where action is most needed, so that organizations can move from awareness to targeted improvement.

4.7 Share findings and co-develop action plans.

- Results should be fed back to communities and organizational leaders in ways that support shared interpretation, accountability, and the development of practical strategies for change, so that evidence is mobilized into action rather than remaining within reports or other research outputs.

Future considerations

Considerations and priorities for future intersectional structural stigma work

Building on the Commission's multi-phase structural stigma initiative and the intersectional structural stigma review, future work could prioritize:

1. **Keeping intersectionality at the centre of all structural stigma reduction efforts**

   Ensure that all structural stigma resources (e.g., tools, trainings, implementation guides) include prompts and examples that directly address overlapping identities and systems of discrimination.

2. **Scaling structural stigma measurement with an intersectional lens**

   Use the SSMHCS and SCHCS at scale, with consistent collection of demographic information, so organizations can see where structural stigma influences outcomes and address it through implementation projects.

3. **Deepening leadership opportunities for people with lived and living experience**

   Support leadership and research roles for people who face more than one form of discrimination at the same time rather than assuming that one aspect of a person's identity represents all of who they are.

4. **Investing in comparative and longitudinal research**

   Foster studies that compare experiences across groups and over the life course, including how intersectional structural stigma shifts in different policy environments and health-care settings.

5. **Connecting structural stigma work with broader equity movements**

   Align with anti-racism, reconciliation and decolonization, disability, justice, gender, equity, and 2SLGBTQI+ rights initiatives to avoid siloed efforts and amplify impact.

6. **Supporting early adopters and communities of practice**

   Use structural stigma pilot studies as learning hubs for other organizations that want to implement structural stigma tools and intersectional approaches.

   Build communities of practice to sustain change.

Intersectional structural stigma is a persistent, systemic force that compounds health inequities by embedding discrimination within the very fabric of laws, policies, and institutions.

To dismantle self-reinforcing cycles, we recommend moving beyond individual-level considerations and prioritizing transformative systemic reform.

Our work suggests the need to re-examine discriminatory laws, enact legal protections, and implement workforce and training reforms that recognize the unique needs and vulnerabilities of individuals and communities who experience multiple forms of discrimination.

By centring the expertise of individuals with lived and living experience in research and investing in accessible, community-led support systems, we can begin to address the structural drivers of mental health disparities and foster a society where every individual has the opportunity to flourish.

Appendices

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This report was written by Javeed Sukhera MD, PhD, FRCPC, and developed by the Mental Health Commission of Canada (the Commission).

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