Policy Analysis of Self-Directed Care Using an Equity Framework

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Introduction to Self-Directed Care

This research project emerged from the work of the Mental Health Reform and Policy research team, Centre for the Study of Gender, Social Inequities and Mental Health (CGSM), in consultation with members of the Mental Health Strategy Team, Mental Health Commission of Canada (MHCC). Together, we identified a mental health policy area of relevance for Canadians called Self- Directed Care (SDC). SDC provides people with the option of designing their mental health care plans and giving them control over money and resources to access mental health and related services, not usually available in the current system. For example, SDC can be used to access a range of services related to mental health such as, transportation, clothing for job interviews, massage therapy, a fitness pass, or psychological counseling. SDC involves person-centred planning, individual budgeting and access to supports[1]. SDC in mental health has been implemented primarily in the UK and the US[2].

Intersectional Equity Framework

In order to explore the potential of SDC in the context of Canadian mental health policy, we applied Parken and Young's[3] multi-strand approach to conduct an intersectional policy analysis. The goal of intersectional policy analysis is to identify and address "the way specific acts and policies address the inequalities experienced by various social groups"[4], taking into account that social locations such as culture, race, class, gender, ability, sexual orientation, geography and age interact to form unique meanings and complex experiences within and between groups in society. These locations are further affected by multiple systems of power and oppression that create inequities in and between groups.

Implementation of the multi-strand approach involved convening an 'Evidence Panel' (EP) consisting of individuals with experience in social equity issues, mental health, SDC, research and/or policy. Applications from the British Columbia community were invited and reviewed by the research team, and eleven panel members were chosen who represented equity groups identified by the MHCC[5].

Methodology

The panel met on four occasions to undertake the first two steps of the multi-strand methodology (mapping the evidence and visioning) for approximately 6 hours each time. The first day involved providing information and training to the EP regarding the nature of equity and SDC in mental health, and allowed for the establishment of a collaborative working group. During the second meeting, EP members presented evidence from their respective organizations and personal experience related to SDC and equity issues in mental health. During meeting three, panel members engaged in dialogue to discuss findings, including gaps in knowledge about equity as it applies to mental health. At the fourth and final meeting, members envisioned an ideal policy model of SDC that comprehensively addresses equity.

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[1] Alakeson (2007) Self-Directed Care for adults with serious mental illness: The barriers to progress. *Psychiatric Services, 59*(7), 792-794.

[2] See: Alakeson, 2007 (ibid); Bishwakarma, R., Hunt, V., & Zajicek. A. (2007). Intersectionality and Informed Policy. *Manuscript*; Brewis, K. (2007). A voice a choice: Self-directed support by people with mental health problems. A discussion paper. *In Control*; Cook, J. A., Shore, S. E., Burke-Miller, J., Jonikas, J. A., Ferrara, M., Colegrove, S. Hicks, M. E. (2010). Participatory action research to establish Self-Directed Care for mental health recovery in Texas. *Psychiatric Rehabilitation Journal, 34*(2), 137-144.

[3] Parken, A. (2010). A multi-strand approach to promoting equalities and human rights in policy making**.** *Policy & Politics*, 38(1), 79-99.

[4] Bishwakarma et al. 2007, 9 (ibid)

[5] MHCC (2009) *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada*. Calgary, AB,120

Over the course of the panel meetings the following equity evidence was explored:

- Immigration issues (lack of service access; culture and language barriers; cultural safety; stigma)
- Life stage (service gaps in adolescence and early adulthood; service access, cognitive impairment and technology challenges for older adults)
- People living in rural and remote communities (limited access to services/choices; confidentiality).
- First Nations/Métis (potential impact of the new Health Authority; on reserve/off reserve differences; the role of trauma and colonization; rural communities; traditional healers; elders; suicide prevention)
- People with lived experience of mental health issues and psychiatric hospitalization (inclusion in policy making; differing degrees of access; trauma histories; stigma)
- Women (burden of care for others; trauma informed services)
- Spiritual or religious beliefs (immigrant & ethno-cultural needs; religious leaders as resources; stigma)
- Socio-economic status (needs re: housing and food security)

Findings

Throughout the process, EP members acknowledged that applying an intersectional lens to equity issues in mental health was challenging. By their final meeting, panel members were able to engage in a nuanced discussion of how the SDC model could be applied to people living with compounding equity issues, mental health needs and life challenges.

The project affirmed the usefulness of the multi-strand method for providing a collaborative, multi-sectoral approach to policy development that surfaces issues of concern for specific equity groups. The project fell short of being able to include all relevant equity groups in its process and in the goal of fully developing intersectional knowledge.

Based on their discussions, the evidence panel cautiously endorsed the implementation of SDC in Canadian mental health policy, noting the following concerns:

- SDC programming could intensify pressure on individuals to recover in ways that fail to hold the mental health system responsible for providing services that support their goals.
- Various difficulties could arise in sustainably funding and managing SDC programs.
- Service providers/organizations might resist embracing SDC for fear of losing funding and creating a competitive environment, especially where the allocation of funding is an ongoing issue.
- Concerns that SDC could not actually stimulate the development or availability of needed services, particularly in rural and remote areas where basic mental health care services can be difficult to access.

Despite concerns, the EP identified potential benefits of SDC: increasing service user choice and control; providing individuals with opportunities to identify and use service substitutions when needed services are not available; and enhancing access to alternative approaches for addressing mental health needs.

Conclusion

Based on these preliminary findings, we conclude that how SDC is defined and implemented by policy makers will determine whether it will ameliorate or deepen existing inequities in the Canadian health care system. Addressing social inequities at a foundational level in mental health may mean implementing change at the health or social policy level, rather than at the mental health service delivery level. One option would be to combine efforts of the Ministries of Health, Social Development, and Education in developing and implementing a comprehensive SDC program.

The multi-strand method is a promising approach to policy analysis, implementation and evaluation, fostering collaborative partnerships; enhancing awareness of the complexities of mental health policy and associated health inequities; and, encouraging the reduction of social inequities in mental health. In this study, the multi-strand method surfaced tensions regarding whether SDC is a policy option suitable to the Canadian context, particularly in relation to fostering equity.