Intersectional Policy Analysis of Self-Directed Mental Health Care in Canada

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Objective: Recovery from mental illness is influenced by one's social location along multiple dimensions of identity, such as race, class, gender, age, and ability, and by how these social locations are expressed through structural and institutional barriers. This project was developed using an intersectional policy analysis framework designed to promote equity across identity locations– called the multistrand method–to examine the potential use of self-directed care financing approaches in the Canadian mental health system. ***Method:*** A panel of 16 diverse stakeholders came together 4 times at structured 6-hr meetings to examine the evidence for self-directed care and explore its application in the Canadian context. Telephone interviews with evidence panel members were conducted to assess their perceptions of the group process and outcomes. ***Results:*** Our analysis revealed ways that intersecting strand locations might differentially influence the degree of choice and recovery experienced by self-directed care participants. Individualized resource allocation, draining financial resources from ethnically specific services, unevenness in acceptance of the recovery orientation, and paucity of service options in different geographical regions were identified as contexts in which self-directed care policies could promote inequity. However, greater peer involvement in the model's implementation, use of indigenous community supports, purchase of material goods by economically disenfranchised persons, and access to services from ethnically diverse clinicians in the private sector were identified as equity-promoting model features. ***Conclusion and Implications for Practice:*** By couching their analysis at the level of unique socially-situated perspectives, the group developed detailed policy recommendations and insights into both the potential and limitations of self-directed care. The knowledge gained from our project can be used to develop uniquely Canadian self-directed care models tailored to promote recovery through empowerment and self-determination across intersecting identity strand locations.

Keywords: self-directed care, intersectional analysis, mental health policy, recovery

In 2010, the Mental Health Commission of Canada (MHCC) launched the creation of a comprehensive strategic plan to realize the vision and goals of its earlier fact-finding report, *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy for Canada* (MHCC, 2009). As part of this work, the Commission identified social and structural inequities as an area of importance for addressing the mental health of diverse populations (see MHCC, 2009, Goal 3). This set the stage for a group of scholars to work with Commission staff and members in applying a method of policy analysis designed to proactively promote equity and human rights through policy making. This article describes the results of a project conducted collaboratively by the Commission's policy staff and researchers from two universities: the Centre for the Study of Gender, Social Inequities and Mental Health (CGSM)[1] at Simon Fraser University in Vancouver, British Columbia, Canada; and the Center for Mental Health Services Research and Policy at the University of Illinois at Chicago in the United States. We engaged in an intersectional policy analysis using the multistrand method to explore the suitability of a recovery-oriented mental health approach called self-directed care for use in the Canadian context.

Background

Defining the Policy Problem

Following an extensive review of Canada's current mental health service delivery system, including travel to all provinces

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[1] The Centre was funded by the Canadian Institutes for Health Research (see www.socialinequities.ca for more information on the Centre's activities).

and territories to elicit input from a broad range of stakeholders, the Commission noted a number of problems in its 2009 report (MHCC, 2009), starting with the fact that only one of three Canadians who need help receives it, with only one of four children receiving needed services. This situation was deemed worse in northern, rural, remote, and other underserved areas of the country. Moreover, the Commission found that differences in culture and language regarding mental health and illness led to inappropriate diagnosis, treatment, and other barriers preventing people from finding services that felt safe and were effective, or from seeking help at all. Noting that public mental health spending in Canada is lower than in most developed countries,[2] the Commission found that one result was lengthy waiting lists for services, leading many people with mental health problems into homeless shelters or the justice system. Moreover, people with mental health problems were too often led to believe that they would never improve their quality of life or be able to function in society. Societal power imbalances and discrimination were seen as contributing to poorer mental health outcomes as well as reducing access to and the quality of care received. Proposed in response to these problems was a "transformed mental health system" (p. 16) designed to address the complex interaction of economic, social, psychological, and biological factors that influence mental health and mental illness across the life span. This would involve collaboration between public, private, and voluntary sectors to promote factors that strengthen mental health, including "adequate housing, vibrant communities, nurturing relationships, and resilience" (p.18), and to reduce factors that increase the risk of developing poor mental health, such as "poverty, abuse, and social isolation" (p. 18). The goal of this transformed system would be "recovery," which is a term not necessarily referring to a "cure," but is instead the notion of resuming life in the community with dignity and purpose, lived at the individual's full potential. Also affirmed was the importance of mental health promotion and prevention, which should be integrated throughout Canada's mental health policy and practice, as well as into public health and social policy more broadly. This analysis set the stage for our project, on which researchers from Canada and the United States worked with Commission staff and mental health-service-system stakeholders in British Columbia to explore the transformative potential of an alternative service delivery model called self-directed care.

Policy Analysis From an Equity Framework

Conventional approaches to addressing diversity in policy analysis often start with one identity category or equity "strand," such as race, to which others are then added. These analyses assume the existence of homogenous categories that are based on a uniform set of experiences that can be brought together simplistically to understand differences (Hancock, 2007; Hankivsky, 2005). One limitation of these approaches is the assumption of homogeneity among members of the same identity category, which disregards the complex relationships between broader societal inequalities and diversity of individual experiences of discrimination among members of the same strand (Parken & Young, 2007).

> Structural intersectionality can help to explain why a Black woman is not considered for one job because she is black since the 'norm employee' is a White woman, while other jobs are also unavailable to her since the jobs available to Black persons in that context are predominantly male jobs. (Verloo, 2006, p. 213)

Another limitation to an "additive approach" is that it leads policymakers to isolate and potentially prioritize some categories over others, without taking into account how social divisions intersect and the importance of this intersection for policy formation (Thorvaldsdóttir & Einarsdóttir, 2011). The result is the creation of policies that may benefit certain groups at the expense of others, leading to an "oppression Olympics," such that marginal groups must compete with one another for low levels of resources instead of cooperating with one another to work for systemic reform that could alter the larger logic of distribution (Hancock, 2007, p. 70). Another complication is that the origins and outcomes of inequality for different identity strands have differed historically, as have the varied remedies that have been used to promote equity for different social groups (Parken & Young, 2007). Intersectionality acknowledges that public policies affect people differently according to their cross-strand locations, and that social locations and structural barriers affect people's responses to new policies or policy changes (Manuel, 2006). The question is how to redesign policies that address inequities through creation of solutions that are heterogeneous by strand, while also ensuring that diverse members of any marginalized group are enabled to empower themselves (Hancock, 2007). Ultimately, intersectional approaches allow us to see the power relations that are operating to maintain oppression and privilege.

Intersectionality offers an alternative to an additive approach to policy making. It promotes exploration of differing social, cultural, and economic origins and outcomes of inequity by strand, while simultaneously addressing the question of how these disadvantages stem from discrimination, structural mechanisms of social and economic divisions, and their interaction (Verloo, 2006). Intersectional analysis focuses on the ways in which specific policies promote the inequities experienced by various social groups, and how these interact across strands (Bishwakarma et al., 2007). The transformative potential of intersectionality in the field of public health policy is widely recognized (Hankivsky, 2011). This perspective has the potential to change the way in which policy analysis is undertaken and how the resultant policy is developed, implemented, and evaluated (Hankivsky, 2005).

Couching the analysis at the level of unique, socially situated perspectives has the advantage of providing more precise information for use in policy formulation, while also allowing greater insights into systems of marginalization and oppression (Rummens, 2003). This kind of knowledge, in turn, allows policymakers to design more effective and efficient programs and services to better meet the needs of individuals and groups most disadvantaged by social inequities. For example, a national Canadian study of poor immigrant and refugee children found that they had better mental health than their native-born counterparts (Beiser et al., 2002). Further analysis suggested that features of immigrant and refugee families (being intact, having functional parenting) acted to mitigate the impact of poverty on their children's mental health in ways that did not

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[2] The average percentage of health-care budgets going to mental health in Canada is 5–9%, with British Columbia at approximately 8% (Auditor General, 2013).

occur in native-born families. Thus, the intersection of poverty with immigration status and ethnicity and its association with children's well-being may differ for different cultural groups, requiring policies tailored accordingly, and this is something an intersectional analysis can reveal. As Rummens (2003) noted, responsive health policy depends on understanding the complex ways that inequities interact along the intersection of particular strands, such as age and immigration status in the foregoing example, to inform program development and service delivery, and ultimately improve health outcomes.

The complexity and relative "newness" of intersectional policy analysis remains a challenge for policymakers; one promising method for such analysis is the multistrand method, developed by Parken and colleagues (Parken, 2010; Parken & Young, 2007, 2008). This method was pioneered in the UK context, where emerging legislation prompted progressive work to develop policy models that were able to address multiple grounds of inequality. Thus, it reflects the fundamental nature of intersectionality scholarship as a blend of knowledge and action (Hankivsky & Cormier, 2011; Manuel, 2006). Because the method uses meaningful engagement of people who are affected by the policies being analyzed, it also addresses the oft-noted tension between mental health policy reforms born out of concern for service recipients' well-being and care, versus those driven by cost-containment and efficiency (Morrow, 2004). In summary, our objective was to apply the multistrand method to a policy area identified in collaboration with the Mental Health Commission of Canada. In so doing, we aimed to determine the potential of intersectional policy analysis for promoting equity in the transformation of Canadian mental health service delivery.

Research Methodology

The Multistrand Method

We applied the multistrand method (Parken, 2010) to develop equity-promoting public policy both within and across social identity groups. In addition, we were interested in whether the differing perspectives of the evidence panel members occupying different intersectional spaces would promote equity in new ways and for intersecting strands that had been less well-served by the current system. In applying this method to the work of Canadian policy formulation, we recognized that several adaptations of Parken and Young's (2008) approach were needed. To accomplish this, Alison Parken and equity scholar Meike Verloo consulted with us and traveled to Vancouver for the first evidence panel meeting. The first adaptation of the method was in identification of the policy area of focus, which typically would have occurred during the initial panel meeting. In our case, however, Simon Fraser University researchers worked ahead of time with members and policy staff of the MHCC to select a policy area of mutual interest. This was done to build relationships with MHCC members that would lay the foundation for future working and to engage in knowledge exchange that would benefit the project (Battersby et al., 2012). As Commission representatives learned from researchers about intersectionality and how the multistrand method works, researchers learned about the Commission's policy-making processes and different key policy areas in its deliberations. Through this interaction-based form of knowledge transfer (Graham et al.,

2006), the decision was made to focus the project on the policy of promoting greater choice in recovery services and supports through models of self-directed care. The research study and all human subjects procedures were approved by the Simon Fraser University Research Ethics Board, and the University of Illinois at Chicago Institutional Review Board.

Policy of Focus: Mental Health Self-Directed Care

Self-directed care is a model of health care financing in which recipients have direct control over service delivery dollars, allowing them greater choice of providers, as well as the flexibility to purchase material goods and services not usually available in traditional service systems (Cook, Russell, et al., 2008). After developing person-centered recovery plans, participants create individual budgets with line items that correspond directly to their plan's goals. Self-directed care staff called "support brokers" are available to assist participants with program enrollment and orientation, development of recovery plans and budgets, choosing and hiring service providers, purchasing material goods directly relevant to attainment of goals, revision of plans and budgets as participants' circumstances change, and evaluation of how well the program is working for each participant (Cook et al., 2010). The amount of money in a person's budget is typically based on the average service cost for outpatients, so that budget neutrality can be achieved (i.e., service cost is no greater than current expenditures).

Another unique feature of the model is that participants can choose "service substitutions" to pursue their recovery goals (Spaulding-Givens et al., 2015). One example is when participants choose to replace a clinical service, such as psychotherapy, with a nonclinical service, such as working with a peer supporter. Another type of service substitution involves replacing a formal service, such as participating in a weight-loss skills-training group at their mental health center, with "natural" community activities, such as purchasing a health-club membership and working with a personal fitness trainer. Yet another example involves replacing public services with private services, as when a participant chooses to hire a psychologist from the private sector to receive trauma-informed therapy that is not readily available from public sector psychologists. Finally, service substitution can involve replacing services with goods, as when an individual purchases a cell phone and calling plan rather than using the pay phone at a mental health center to arrange social and leisure activities. In this way, the self-directed care model helps expand participants' choices in how they pursue their recovery journey. Typically, an organization with no vested interest in which services are purchased acts as the program's fiscal intermediary, enrolling and paying providers, handling payroll tax withholding and other fiscal matters, and accounting to funders for dollars spent (Alakeson, 2008). This model has been used extensively in the United States, Australia, the UK, and other parts of Europe, under various formulations and names including "individual budgets," "direct payments," "cash-for-care," and "personal budgets" (Alakeson, 2010; Kremer, 2006; Manthorpe et al., 2008; Spaulding-Givens & Lacasse, 2015; Taylor, 2008; Timonen et al., 2006). It has been applied far less frequently in Canada, where it has been used primarily with individuals who have developmental or physical disabilities (Lord & Hutchison, 2003).

Assembling the Evidence Panel

Once the policy was selected, researchers began the process of identifying and recruiting members for the project's evidence panel. In multistrand methodology, this phase of investigation is critical (Parken, 2010). Because this method involves content experts (including those directly impacted by the policy) and policy analysts in mapping the policy field, the selection of panel members with diverse locations in multiple policy-relevant sectors and on multiple identity strands was required. The goal was the creation of a group that included diverse sectors (e.g., researchers, service providers, people with lived experience of mental illness, policymakers) from relevant equity groups (e.g., race, gender and sexual orientation, age, ethnocultural background and migration history, socioeconomic status, life stage, spiritual or religious beliefs, and First Nations/Inuit/Métis identity). Funding constraints limited reimbursement for travel, and so the panel was comprised primarily of individuals from Vancouver's lower mainland and Vancouver Island, with one representative from British Columbia's interior. The intention was to hold subsequent panels in other provinces to test the generalizability of the results. A brief project description and application form was developed and circulated by direct outreach, word of mouth, and electronically. Candidates were provided with information about the policy area that would be discussed, as well as the number and length of meetings and what activities would occur at each meeting.

The panel was selected by a multistakeholder committee that reviewed applications and identified a group of 12 panel members. In some cases, members represented multiple equity groups. In other cases, equity groups had to be represented by community organizations that served them because individuals from those strands were not available. All individuals who were invited agreed to participate (although one was subsequently unable to attend because of health reasons), and the addition of five researchers, one of whom was also a Commission staff member, brought the total to 16. The evidence panel met in person four times for 6 hr each time, from April through June 2011 at Simon Fraser University's downtown campus.

Steps in the multistrand policy analysis process. The first meeting was designed to educate panel members about the project, as well as the notions of equity and intersectional mainstreaming. After an orientation to the project and its goals, Parken presented her work in Wales, and Verloo described how policy development and critique could promote equity. Another presentation by a United States researcher focused on self-directed care policies and programs in the field of mental health, and how the model has been applied in different countries, including Canada.

At the second evidence panel meeting, each panel member gave a 15-min presentation of "evidence," including both empirical findings and personal experiences relevant to self-directed care in particular, and the use of alternative financing models giving people greater control over service delivery finances in general. To the group's surprise, three small mental health self-directed care initiatives were identified in British Columbia that provide cash payments to service users for recovery-related activities such as attending school, leisure pursuits, and enhancing wellness.

During the third meeting, panel members engaged in dialogue to discuss emerging findings about self-directed care and gaps in knowledge about how well the model has worked in Canada. Also discussed were the many equity issues raised by this approach, as well as the meaning of equity in mental health more broadly.

At the fourth and final meeting, the group was asked to reflect upon a series of questions in order to a guide a process called "visioning" that comprises the multistrand method's second stage. Panel members were also asked to visualize an ideal, self-directed care program that successfully addressed the many equity issues that had surfaced throughout their discussions. Finally, the panel discussed concrete examples of how self-directed care could be applied in real-life situations, using case examples of people in recovery that had been prepared in advance.

Data collection and analysis. At each panel meeting, detailed notes were taken electronically by the project's qualitative researcher (L. Battersby) and were supplemented with information from notes taken by the project's other researchers. Notes were reviewed and compiled into summary reports for each of the four meetings and shared among the researchers for comment and feedback. Synopses of these reports were shared with panel members, who were encouraged to contribute their feedback, provide missing information, and offer corrections. At the project's conclusion, an interviewer external to the panel contacted each participant for a brief telephone interview about the process and outcomes of panel deliberations. A final report describing the entire project was prepared and shared with all participants who provided feedback and offered corrections. Analysis for this article involved reading the summary reports from each of the four meetings, extracting common themes, and then associating these with (a) critical features of self-directed care policy and practice and (b) different aspects of the multistrand methodology's process, especially its encouragement of intersectional analysis and production of new knowledge.

Results

Self-Directed Care and Equity Gaps in the Service System

Panel members articulated a number of ways in which self-directed care could address equity gaps, as well as exacerbate inequities. One gap was the relative absence of consumer-run initiatives in British Columbia. The concern here was that, without meaningful involvement of people with lived experience, self-directed care financing initiatives could devolve into efforts focused primarily on cost containment and abrogation of public responsibility for people's mental health. Along the same lines, another equity gap was tied to regional differences in the province regarding the acceptance of a recovery philosophy in mental health service systems. Panel members noted that there was wide variation in the extent to which recovery-oriented models were being practiced in different regions. Given the high degree of decentralization in the province, there was concern that some systems of care that were not recovery-focused might implement the new model in disempowering ways with negative consequences for participants.

Panel members noted that the self-directed care model often includes people with lived experience of mental illness as staff members, holding positions such as support broker and program director. It encourages the purchase of peer services and also can

involve peer organizations in serving as the administrative "host" for the program. By bringing peers into the service-delivery system, the model could serve as a corrective to the exclusion of people with lived experience. Locating the new program at a consumer-run organization would have a similar impact of legitimizing the organizational expertise of people with lived experience. Some panel members felt that the advocacy and high level of scrutiny that would undoubtedly accompany the introduction of self-directed care programs would focus attention on issues of implementation quality, helping to preserve the model's critical ingredients of consumer choice and self-determination. Along these lines, a panel member noted that, once self-directed care programs were operating successfully, it would be harder for the traditional system to remain focused on treating symptoms and maintaining current functioning versus on promoting growth and recovery.

Another equity gap the panel identified was a paucity of services in certain regions of the province and an attendant concern that economies of scale could dictate the nature and breadth of services that would be available for purchase. This was seen as a formidable barrier for self-directed care implementation in rural and remote communities with low provider density. However, others argued that self-directed care's emphasis on using "natural supports," rather than solely offering mental health specialty services, would enable people to have an even wider choice than they have now. Moreover, allowing for the purchase of material goods instead of restricting options to traditional services was seen as a chance to address service gaps in rural and remote areas of the province.

One equity gap discussed repeatedly by panel members was a lack of cultural competency in services and service providers. Most often noted was a general lack of knowledge among providers about specific immigrant/refugee groups, particularly generational and migration issues faced by these groups. Also discussed was the tension between individual versus collective solutions to problems and how, for some more collectivist ethnocultural groups, the individualistic focus of self-directed care might not be perceived as useful and might even be threatening. Other panel members felt that the flexibility of self-directed care could lend itself to being used for prevention and health promotion as long as the non-Western medical beliefs of some refugee and immigrant groups were respected. One panel member who was both a therapist and a member of a racialized ethnic group commented that her service was not publicly funded and that this is also true for many of her colleagues who speak the multiple languages of their larger culture. She noted that, by allowing people to purchase services from the private sector, self-directed care could enable participants to access linguistically and culturally competent mental health care providers who have not been included in the public health care system. There was also discussion of the impact of colonialism, racism, and social isolation/disconnection through various forms of oppression as an imperative that would need to be addressed by a culturally competent self-directed care model. Panel members noted that self-directed care approaches could allow for expenses to combat social isolation (e.g., cell phones, transportation) and stigma (e.g., peer support, books written by members of immigrant/refugee communities, and those with lived experience of mental illness).

Panel members discussed whether it might be more productive to advocate for wider coverage of people and services as a political strategy versus promoting self-directed care policies. In a context in which provinces are delisting covered services, there was the question of whether both approaches (wider coverage and self-directed care) could coexist as a political strategy. Others noted that although this might be a risk, self-directed care could be a way to help move the public system away from a primarily biomedical model paradigm (i.e., one that is diagnosis-driven and focused on medication and psychotherapeutic treatment modalities to relieve symptoms) to a more recovery-oriented paradigm promoting self-determination.

Visualization of Equity-Promoting Self-Directed Care Policy

At its final meeting, the panel was asked to visualize an ideal self-directed care program that would successfully address the many equity issues surfaced throughout their discussions. Members were encouraged to assume unlimited resources to support such a program, in order to address as many intersecting identity strands as possible. This exercise had an unexpected outcome when tensions arose within the group between those who wanted to visualize a "blue-sky"-type of self-directed care program and those who wanted to emphasize practicality by developing policy recommendations that could work within the current system. Most panel members during this exercise seemed reluctant to dream big, constrained by funding concerns. One participant pointed out that one's social location could affect one's ability to take the blue-sky perspective in this discussion, surfacing an important finding regarding this step of multistrand methodology. Specifically, some evidence-panel members with extremely financially constrained or politically/socially oppressed backgrounds may have difficulty envisioning more equitable public policies without support and encouragement.

The panel also found it difficult to design a program without knowing its operational context. For example, would the government still pay for core services and what would those be? Where would monies come from to fund the individual budgets, and which programs or individuals might be harmed by loss of funding? The group was advised that the Commission's framework embraces transformative policy solutions that necessitates thinking outside the box and engaging in risk-taking. But again, the panel fell back to discussing their fears about scarce resources and scarce dollars, noting that health authorities are used to being held accountable to the public for tying all expenditures to traditional services. Self-directed care was seen as a high-risk proposition in a political landscape where the public has been indoctrinated to expect only traditional medical model expenditures. Since different health regions in British Columbia already experience inequities due to unequal resource allocation across the province, self-directed care could negatively impact their struggle to retain their "piece of the pie." Panel members noted that if funds were to come from social service areas other than mental health, some of these concerns could be mitigated. Gradually, two camps emerged. The first wanted to design the most ambitious program possible that would be available universally. The second group preferred to

brainstorm a program that took the current political climate into consideration. The nature of the two policy visions and their illustration using case examples is described in detail in another article reporting on our study's results (Battersby et al., 2012). In what follows we present the group's final set of policy recommendations.

Self-Directed Care Policy Recommendations

The following recommendations were based on the panel's intersectional analysis of whether and how self-directed care policy could promote equity as well as constrain it.

- Given the high value placed on diversity in the Canadian health care system, care should be taken to preserve existing equity-promoting programs in areas where self-directed care is implemented, and any redistribution of service-delivery dollars should not come at the expense of such programs.

- Following from Canadian health care's tradition of self-reflexive practice, self-directed care programs should be subject to a critical lens, ongoing review, and continuous quality improvement. Oversight from advisory boards mandated to contain a significant proportion of self-directed care participants and other people with lived experience would be one way to accomplish this. Participant-directed program evaluation would be another.

- Given the importance of universal coverage in Canada's system, self-directed care should be widely available, including to people without formal diagnoses, recently arrived immigrants, and those who avoid the traditional system because of stigma or prior coercive experiences. Eligibility criteria should be carefully formulated to include people who eschew psychiatric labels and any limitations on eligibility should be based on multistakeholder consensus. The model's implementation could thus be a way to expand the number of people receiving assistance. Another way to expand the number of people helped would be allowing biological and intentional family members to benefit from use of an individual's self-directed care funds.

- Given the current system's holistic emphasis, self-directed care policies should support the purchase of health and wellness services, supports, and material goods, and not be limited to the medical model of psychiatric care. There should be no artificial separation of the individual's needs based on the demands of funding streams, enabling peoples' recovery plans to encompass diverse elements such as emotional wellness, career development, and better housing. Funding for this holistic approach would necessitate interdepartmental collaboration of provincial governments as well as at the federal level.

- To support the principle of locating Canadian health care in close proximity to people's residences, local services should continue alongside self-directed care programs. Also encouraged should be use of natural supports available outside any service-delivery program. Natural supports have the potential to combat stigma and social isolation in ways that traditional services do not, as exemplified by the MHCC's goal of enhancing mental health through "vibrant communities, nurturing relationships and resilience" (p. 20).

- Given the current system's emphasis on prevention, self-directed care-purchasing policies should encourage participants to purchase goods and services addressing primary, secondary, and tertiary prevention of both mental health and medical conditions. This too would require cooperation across government sectors.

- The newly recognized value of peer providers and mentors in the Canadian system should be enhanced by affording them a central role in developing self-directed care policies and practices. This involvement should occur at all levels, including policy planning, program implementation, staffing and management, provision of services, program evaluation, and quality assurance.

Discussion

Our application of the multistrand method to the policy of promoting recovery through self-directed care financing arrangements led to a number of important findings, along with the foregoing policy recommendations formulated by the evidence panel. While a hallmark of self-directed care is its promotion of service users' increased choices and control in health care decision-making and utilization, our analysis revealed that intersecting strand locations might differentially influence the degree of choice that participants experience. For English-speaking individuals living in urban or suburban areas with high concentrations of providers, self-directed care has the potential to increase choice of provider type (e.g., ability to access private as well as public providers) and service type (e.g., access to services not covered in a medical model service system). But for members of minority ethnocultural groups in geographically remote areas with low provider density, chances of selecting clinicians with similar backgrounds who speak participants' preferred languages might be slim to nonexistent. Thus, implementation of new financing models should not occur at the expense of initiatives using public dollars to fund start-up costs of ethnically specific service organizations, or investment in academic training that enhances cultural diversity in the mental health workforce.

Another central feature of self-directed care programs is control of individual service delivery budgets, which increases self-determination by allowing participants to tailor services and supports to their unique needs and circumstances. However, this emphasis on individualistic resource allocation has the potential to conflict with traditions and practices for people at some intersecting strand locations. For example, families in severely constrained economic circumstances from First Nations/Inuit/Metis cultures that place a high value on collective decision-making might have difficulty with the notion of one member having a budget targeted to that individual's needs and not the family's needs. Such an approach might generate resentment among relatives or lead to attempts to spend funds in ways that violate program policies. This connects to a policy recommendation that equity would be enhanced by allowing some (or all) use of funds to benefit the entire family in ways that promote the recovery of one of its members.

Another possible constraint on self-directed care's equity-promoting potential concerns the individual's position vís a vís the formal mental health system. Persons with a psychiatric diagnosis

and formally acknowledged functional limitations may be better positioned to learn about self-directed care and be deemed eligible for participation. However, this may disadvantage equally needy individuals without a diagnosis, especially if they are members of cultures or at life stages with high levels of stigma regarding mental illness and receiving treatment. A central feature of the evidence panel's deliberations was the suitability of self-directed care for this group of individuals because it uses a social model of recovery, and could serve as a conduit to culturally competent assistance for those with undiagnosed and untreated mental health difficulties.

Our analysis also revealed a number of ways in which self-directed care has a unique potential to enhance cross-strand equity. The first of these stems from the current system's exclusion of people with lived experience of mental illness from important roles such as service providers, program planners, evaluators, and quality monitors. A common problematic theme expressed throughout the panel's deliberations was the absence of the diverse voices of people with lived experience from multiple system levels. Self-directed care can address this inequity by offering ample opportunities for peers at multiple strand intersections to serve as formal and informal mentors, paid support brokers, and advocates, as well as to host self-directed care programs in peer-run organizations. To the extent that peers from local communities have full ownership of self-directed care programs, there is greater possibility that these programs can be organized and operated in ways that promote equity, both within and across strands.

Another way that self-directed care can enhance equity has to do with its potential for combating interpersonal and structural stigma and discrimination faced by people with mental illness. Perhaps the most fundamental way this occurs is through the model's emphasis on participants' innate ability to recover by having opportunities to set life goals, make wise treatment choices, and spend funds responsibly. This strengths-based approach delivers a powerful message to participants, service providers, and the larger community, which is absent in a deficit-focused treatment philosophy, and can counter internalized stigma and self-disparagement. The potential of employment in self-directed care programs also offers peers opportunities for organizational and structural change, not only by improving their economic positions, but also by locating service users in influential policy positions with input into system financing and redesign.

Our final observations concern the value and appropriateness of the multistrand method when applied in the Canadian health-policy formulation context. We found that it did provide a process by which the evidence panel created policy solutions that were heterogeneous by strand, while also preserving the potential for diverse members of marginalized groups to empower themselves (Hancock, 2007). We saw how couching the analysis at the level of unique socially-situated perspectives provided more precise findings that could then be applied in policy formation, while at the same time, allowing for greater insights into the marginalization and oppression inherent in the current service system (Rummens, 2003). Another indication of the method's value was evident after Centre faculty were invited to share and discuss the findings of our project with MHCC members and staff. Soon after that, the Commission released its final strategic plan designed to guide Canadian mental health policy for the coming decade, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada.* Included

in this plan were specific references to the self-directed care model of financing, and a recommendation that self-directed care funding initiatives be adapted to the Canadian context as part of activities designed to reorient policy and practice toward recovery and well-being (MHCC, 2012).

At the same time, it is important to keep in mind the many problematic issues that can arise when researchers work at the interface of the academy and public policy (Fonow & Cook, 2005). In an era of "cash-strapped populist politics," attempts to tighten eligibility criteria and push responsibility for health care entirely on the individual may masquerade as approaches designed to increase choice, control, and empowerment (Newman, 2011, p. 481). Whether it is possible to maintain a critical, independent stance while attempting to influence policy development is very much an open question, and it is one requiring policy researchers to engage in continual and vigilant self-reflection (Cook & Fonow, 2006).

Keeping these reservations in mind, the next step in our application of the multistrand method is a process referred to by Parken and Young (2008) as "road-testing." This involves evaluating the newly formulated policy vision by testing it among diverse groups of stakeholders. We are doing this through a new study, launched in 2015, which explores the process and outcomes of two self-directed care "bursary programs" identified in the panel's initial evidence-gathering activities. A research team comprised of people with lived experience, service providers, researchers, and advocates, including some of the original panel members, interviewed bursary recipients to learn about the nature of their purchases, their perceptions of the bursary programs' rules and policies, and the self-perceived impact on their recovery and level of community participation.

We feel that the knowledge gained from our project can be used to point the way toward development of a uniquely Canadian model or models of self-directed care that will promote recovery through empowerment and self-determination. We saw how an intersectional policy analysis could serve the Commission's goal of collaboration between public, private, and voluntary sectors to strengthen public mental health and to reduce factors that weaken it. Our hope is that continued application of intersectional policy analysis will reveal how recovery from mental illness is influenced by multiple dimensions of identity, and by how these social locations are expressed through structural and institutional barriers.

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