Ontario Mental Health and Addictions Strategy
Creating Healthy Communities

"Fostering supportive communities is a shared responsibility that requires the commitment of all segments of society and coordination on the part of all government ministries."

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Common Preface for Theme Papers

The Challenge

Every year one in five Ontarians will develop a mental illness or addiction, and one in ten will have a serious problem with gambling.

Most will have relatively mild symptoms that pass with time, a change in their situation or treatment. However, two to three of every 100 Ontarians will cope with a serious or complex mental illness or addiction throughout their lives (Kessler, 2001; Ruggeri *et al*, 2000).

> Mental illnesses and addictions are serious health problems that cause great hardship for too many Ontarians and their families and friends.

Although many dedicated people work hard to provide mental health and addiction service, the current system is fragmented. People with a mental illness and/or addiction often struggle to find the services they need when they need them.

Ontario's Response

There is no health without mental health.

In 2008, the Government of Ontario made a commitment to strengthen mental health and addiction services – and to develop a comprehensive 10-year mental health and addiction strategy that would lead to better services for Ontarians. To fulfill that commitment, the Government established an Advisory Group of people with lived experience with mental illness and addictions, family members, service providers and researchers.

The Advisory Group identified five priorities or themes that would help make a real difference in the lives of people with mental illnesses and addictions:

1. Early identification and intervention
2. Consumer partnerships
3. System design
4. Strengthening the workforce
5. Healthy communities

The Advisory Group organized working groups to review the literature and discuss each theme. The working groups developed draft theme papers that explored the key issues and challenges as well as strategic priorities and opportunities. Theme group members looked for best practices, and for ideas to transform mental health and addiction services to meet needs.

The draft theme papers were used to develop a consultation paper -- *Every Door is the Right Door* – which set out a proposed vision, mission, goals, and principles to guide for Ontario's mental health and addiction strategy (see next page). The consultation paper was released at the provincial Summit on Mental Health and Addictions in July 2009, and individuals and organizations were

invited to respond. The ministry received 47 written submissions from organizations, and another 15 from individuals.

Between September and December 2009, 65 roundtable consultation sessions were held with key groups across the province. The theme working groups used the feedback from the consultation paper and the roundtables to refine their reports.

This paper is one in a series of five theme group papers. It focuses on healthy communities.

Overarching Vision, Goals and Principles for Ontario's 10-Year Mental Health and Addiction Strategy

Vision

Every Ontarian enjoys good health and well-being, and Ontarians with mild to complex mental illness and/or addiction live and participate in welcoming, supportive communities

Goals

- Improve health and well-being for all Ontarians.
- Reduce incidence of mental illnesses and addictions.
- Identify mental illnesses and addictions early and intervene appropriately.
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex symptoms of mental illnesses and/or addictions and their families.

Mission

Every door can be the right door for Ontarians with mental illnesses and addictions.

All doors in the mental health and addiction system and the broader health, children and youth, education, social services, housing, seniors services, settlement services and justice systems lead to integrated, accessible, person-directed services and supports.

Services focus on the hopes and needs of people with mental illness and/or addictions, and engage them in their own health

Principles

Respect. People with lived experience of a mental illness and/or addiction are valued and respected members of their communities. They are treated with dignity and have access to the information they need to make informed decisions about their own treatment and services. They are active members of their treatment and support team. Health and social services are provided in the environment the individual considers to be the least restrictive, intrusive and stigmatizing. Communities and services are proactively engaged in activities designed to eliminate stigma and discrimination.

Diversity. Individuals are offered culturally competent services that meet the needs of a diverse population at all ages and stages of life.

Partnership and Collaboration. People with lived experience are essential partners in system design, policy development, and program and service

provision. People with lived experience, families, family organizations, service providers, governments, and the community collaborate to raise awareness about mental health and addiction services and improve knowledge about mental illnesses and addictions. All levels of government and services collaborate to provide seamless, integrated, equitably funded care – and make every door the right door.

Healthy Development, Hope and Recovery. Individuals using mental health and addiction services feel hope and optimism about the future. They have real choice in the services they use, and a variety of options close to where they live. They receive the least intrusive services possible in the least intrusive setting, as well as flexible, individualized supports that involve their families, significant others, and communities when desired. They have opportunities for healthy development and recovery.

Harm Reduction. Individuals are supported regardless of where they are in their journey to reduce the health, economic, and social harms associated with mental illnesses, problematic substance use and harmful gambling.

Excellence and Innovation. The mental health and addiction system strives for excellence and encourages best practices and innovation. It provides an effective, efficient continuum of high quality care that is evidence- based and results-oriented.

Determinants of Health and Well-being. Mental and physical health and wellbeing is more than just the state of one's health. In addition to caring for mind and body, the system works to reduce or eliminate the underlying individual and social factors that contribute to mental illness and addiction.

Acknowledgements

This paper is a consensus document based upon the work of the Healthy Communities Theme Group for the 10-Year Mental Health and Addictions Strategy. The views expressed are the views of the individual Theme Group members and do not necessarily reflect the views of their affiliated organizations or the Government of Ontario.

The Ministry of Health and Long-Term Care would like to acknowledge the following people for their time and expertise in developing this paper.

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The members of the Healthy Communities Theme Group would like to acknowledge the work of Carol Gold, Nancy Lum Wilson, and Rahul Mediratta, in researching, developing and writing the paper. Without your support, the work of this group would not have been possible. In addition, the group would like to acknowledge the Wellesley Institute and the Canadian Mental Health Association, Ontario for carrying out a comprehensive Literature Review on Promoting Mental Health and Well-Being; the Planning Unit, Health System Planning & Research Branch, Ministry of Health and Long-Term Care, for carrying out a Rapid Literature Review on the Social Determinants of Health and Mental Health and Addictions; and Syntegrity Group for facilitating the theme group meetings.

Executive Summary

Addressing the task of creating healthy communities will necessitate taking into account the impact of the social determinants of health with respect to all aspects of health and well-being. This theme paper, therefore, takes a social determinants of health approach in its exploration of the issues and challenges related to accomplishing this task, and in its identification of opportunities for action.

The paper identifies four high level goals of creating healthy communities: advancing equity and social justice; improving health outcomes for all; fostering a holistic approach to promoting positive mental health and well-being; and addressing social, political and economic structures that can contribute to good health among individuals and their communities. Within the context of these goals, some of the key issues that have been identified include: the existence of stigma and discrimination against people with mental illness and addictions, both in the general public and among service providers; gender disparities; unequal access to mental health and addictions services; a lack of service providers who are able to provide culturally competent mental health and addiction services; the need for affordable, safe, good quality housing for people with mental illness and addictions; and the impact of adverse events in early life on an individual's psychosocial development.

Theme group members were in agreement that in order to create a healthy community it is necessary for all members of a community to share responsibility for its overall well-being and to promote health and social development, including developing initiatives that are inclusive of Ontarians living with mental illness and/or addictions. Opportunities for accomplishing this will include strengthening health and wellness promotion; recognizing and addressing gender issues; emphasizing the importance of early childhood development and promoting general access to education; ensuring equitable access to mental health and addictions services; ensuring the existence of culturally competent service providers; supporting development of social ties among individuals and social inclusion within communities; enabling communities to address the needs of populations at risk; and increasing mental health literacy among children and youth in schools to reduce stigma and discrimination.

Through the process of developing the paper, several strategic opportunities were identified with respect to creating healthy communities within the context of the Mental Health and Addiction Strategy. Given that access to economic resources such as housing, employment, and education is strongly correlated with improved health status, many of the opportunities address these factors.

They include:

- Continuing to support programs that promote and develop affordable, accessible, safe and high quality housing, including transition housing

- Promoting general access to education, given its importance with respect to health and social development. Education and training programs for people with lived experience need to take into account the fact that some individuals may need to exit and re-enter during times of treatment, rehabilitation and recovery.
- Developing an employment strategy to help persons with lived experience find and keep meaningful employment through training programs, mentoring, employer support, and paid opportunities for peer support workers.
- Adopting place-based approaches that enable communities to develop strategies to best meet the needs of populations at-risk for mental illnesses and addictions, and to take action on them
- Taking a holistic life cycle approach toward delivery of general health and mental health promotion programs
- Addressing early childhood development, since the impact of parents' availability, parenting style, and the way in which families function are important factors with respect to individuals' capacity to develop resiliency.

1.1 A Note on Language

Debate continues surrounding the use of language with respect to mental illness and addictions, as there are currently no universally accepted terminologies. It is recognized that terms are interpreted differently and as such, the usage of the terms within this document serve the purpose of providing meaning to the paper itself and are intended for use only within the context of the paper. They are not intended as recommendations for broader application outside the context of this document. Please refer to the Glossary (Appendix 1) for working definitions of terms as they are used in this document.

1.2 High Level Goals

The high level goals of creating healthy communities are to:

1) Advance equity and social justice
2) Improve health outcomes for all, striving for parity for those with the greatest health disparities
3) Foster a holistic approach across the lifespan to promoting positive mental health and well-being
4) Address social, political and economic structures that can contribute to good health among individuals and their communities

In addition to the overarching principles listed in the preface, the Healthy Communities theme group takes the view that mental health is as important as physical health in leading a productive and meaningful life and is the foundation of well-being for individuals and communities. Positive health is created through

fostering dynamic interactions between individuals, groups and the environment that takes into consideration personal dignity, culture, equity and social justice.

2.0 Key Issues and Challenges

Context

In 1948, the World Health Organization (WHO) broadly defined health as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO**,** 1948). In 2004, the WHO further defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community," and the fundamental conditions that contribute to this well-being are the social determinants of health (Commission on Social Determinants of Health, 2008). The social determinants of health are the conditions in which people are born, grow, live, work and age. The Public Health Agency of Canada has identified twelve key determinants of health: income and social status, employment, education, social environments, physical environments, healthy child development, personal health practices and coping skills, health services, social support networks, biology and genetic endowment, gender and culture (PHAC, 2006).

One of the literature reviews that informed this paper was a *Jurisdictional Scan of Mental Health & Addictions Systems* carried out by the Research and Planning Branch of the Ontario Ministry of Health and Long-Term Care (MOHLTC, 2009). The report gives an overview of the mental health and addiction systems of Australia, England, Ireland, New Zealand, and Scotland. Overall observations related to the mental health and addictions strategies and frameworks of those jurisdictions are:

- There have been significant initiatives to reform mental health care in the past decade.
- Mental health is generally prioritized over addictions. The two are either treated separately, with addictions as a lower priority or with lesser visibility than mental health; or addictions is subsumed by mental health, occasionally mentioned within the greater context of mental health, but apparently a service arena of secondary significance. New Zealand and Canadian jurisdictions have explicitly combined mental health and addictions systems, however in both the focus remains stronger on mental health.
- Of the international jurisdictions discussed, problem gambling is included in the scope of addictions only in New Zealand.
- There is a trend away from institutionalized mental health care and toward community-based service.

- ‘Patients’ are becoming ‘consumers:’ there are stated intentions to move toward client-centred services.
- There may be a greater emphasis on measurability of strategies, which increasingly include specific criteria for the fulfillment of standards and desired outcomes.
- Australia, Ireland, New Zealand and Scotland frequently reference a ‘recovery’ approach in mental health services, which maintains that those experiencing mental illness are often able to recover rather than simply cope.

In the context of this discussion of healthy communities, New Zealand, Australia, and Scotland acknowledge the social and economic causes of mental illness in their mental health strategies (see Appendix 2).

2.1 Health disparities and inequities that result in negative health outcomes extend far beyond healthcare and are woven into our social, political and economic structures. Health inequities are systematically related to social inequality and disadvantage.

Health disparities are differences or variations in health between population groups. A related and important matter is health equity, which focuses on health disparities between populations that are attributable to systematic disparities due to differing levels of underlying social disadvantage (Braveman & Gruskin, 2003). This is referred to as the social gradient.

The relationship between these disparities and health is complex and interactive. For example, lack of control over one’s life is a major mediating factor between social status and psychological distress. Lack of control can impact psychological health by frustrating the need for autonomy and by inducing a state of perceived powerlessness, which over time may lead to anxiety and depression, as well as other aspects of poor health. Social and economic inequities, such as poor housing, low level of educational attainment and poverty have a negative impact on health, and there is a clear association wherein health outcomes worsen the lower down one is on the social hierarchy. For example, a City of Vancouver report found that at least two thirds of people who are homeless and living on the street in that city have severe addictions to alcohol and other drugs and at least one third of people who lack shelter show symptoms of mental illness (City of Vancouver, 2004).

There is increasing awareness that the social determinants of health bear a greater contribution to well-being than medicine or healthcare services (WHO, 2008). Social determinants of health are affected by structural factors within our society that contribute either positively or negatively to a population’s health. Structural factors are systemic and can therefore be responsive to policy interventions. Elimination of social and institutional barriers to health will not only

enhance well-being, but also contribute to overall social cohesion, fairness, productivity, and community resilience.

Access to economic resources such as housing, education, and employment is strongly correlated with improved health status, given its impact on socio-economic status, social connectedness and personal sense of competence and control. These factors are known to both protect and promote mental health (Mulvihill, *et al,* 2001). It is not simply that lack of material resources are harmful to health but that the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatized also matters (WHO, 2003). In contrast, a sense of community belonging and social inclusion has been shown to reduce the risk of suicidal ideation and attempts across all groups (Clarke *et al,* 2008). The City of Toronto's Social Development Strategy defines supportive communities as places that exhibit belonging and pride; are inclusive environments; provide opportunities for community and civic engagement; and have the capacity to provide services and support. Further, a socially inclusive society is one where all people feel valued, their differences are respected, and they are able to participate to meet their needs (City of Toronto, 2001).

There is a clear need to shift our understanding of human health to focus on the social, political and economic structures that result in health disparities along the social gradient. There is also a need to educate Ontarians on the impact that social and economic conditions have on health. It is vital to engage all sectors of our province, including government, municipalities, the health sector, social service providers, schools, employers, community organizations, religious groups, and ethnic groups as partners to successfully build healthy communities.

2.2 The importance of a life-cycle approach to addressing the social determinants of health.

A life-cycle or developmental approach acknowledges common risk and protective factors for mental illness and addictions that occur at key transition points throughout the life cycle. Many researchers have emphasized the importance of a life-course approach to analyzing the impact of the social determinants of health over peoples' lifetimes (Graham, 2007).

Considerable research highlights the importance of early childhood development for subsequent health, especially mental health. Disadvantages in early life, including the experience of trauma, are a predisposing risk-factor for poor mental health in adulthood (Eaton *et al,* 1999; Herrman, *et al,* 2005). While these situations early on in an individuals' life can negatively impact their ability to cope and flourish across their life span, strategies that enable and promote protective factors for health and well-being can play a role in preventing the occurrence and consequences of adverse events in early childhood. Interventions that emphasize acquisition of parenting and child

development skills, along with treatment for addictions and/or mental health provide parents with an opportunity to change their behaviour in a way that will positively impact their own and their children's health.

Low income is associated with poor mental health in children (Lemstra *et al,* 2008; Beiser *et al,* 2002). Families living in poverty often live in crowded, unhealthy or unstable housing, experience more accidents and have greater exposure to violence. Specifically, family dysfunction, characterized by poor communication, problems with affective involvement, behaviour control and problem-solving within the family is greater in low income families. This is associated with stressful home environments for children, resulting in higher levels of anxiety, lower levels of pro-social behaviour and higher levels of aggressive behaviour in children (Statistics Canada on National Longitudinal Survey of Children and Youth).

Disadvantaged neighbourhoods typically have weaker social ties, less trust and lower levels of support. These types of conditions are linked to increased psychological distress, thereby affecting a child's well-being, both emotional and behavioural (Sobolewski *et al,* 2005). Poverty also reduces opportunities to foster children's social competence and educational attainment, which are predisposing factors for employability and subsequent earned income (Evans, 2004). Children living in low-income households, particularly single-parent households, are especially impacted (WHO, 2003).

While adolescence is well acknowledged as a time of transition, youth between the ages of 16 and 24 can also experience high levels of psychological distress. Within this age range young people are typically coping with the completion of secondary education, and the transition to post-secondary education, the workplace and/or other means towards independence. They may also struggle with issues of identity. For example, many gay and lesbian youth come out during this age span and frequently experience a difficult transition marked by stigma directed to them by others, bullying and/or self-stigma, which in turn may trigger, anxiety, depression, and even suicide.

At the other end of the life span continuum, seniors may be vulnerable to poor mental health and/or addictions. Today, Canadians have a life expectancy of close to 80 years (Statistics Canada, 2005). Seniors aged 65 and over now represent a large and growing proportion of our population (MacCourt, 2005). The experience of growing older is influenced by multiple factors, including genetics, roles, functional abilities, health status, and access to socio-economic resources such as income, housing and social support. "Ageism" refers to negative attitudes concerning older people and their abilities. Older adults may experience prejudice, stereotyping and discrimination simply because they are perceived or defined as "old" (American Psychological Association, 2004). Stigma is also a concern because it can present a barrier to seniors seeking help, especially when they perceive that it is coming from their service providers.

2.3 Stigma and discrimination are significant barriers to providing supports and services to people living with mental illness and /or addictions; and reduce opportunities for self-identification and management.

Stigma is "a social process, experienced or anticipated, characterized by exclusion, rejection, blame, or devaluation" (Weiss, *et al,* 2004). Stigma is a reality for people with mental illness, and they report that how others judge them is one of their greatest barriers to a complete and satisfying life (CMHA Ontario, 2009). Individuals and their families who live with mental illness, cognitive limitations, and/or addictions often say that the stigma associated with their diagnosis was more difficult to bear than the actual illness or addiction. Stigma affects individuals of all ages, across all cultures and socioeconomic status. Self-stigma refers to internalized feelings of guilt, shame or inferiority. Self-stigma may result in denial, failure to seek help, failure to recognize the signs of mental illness or addiction, and failure in following treatment plans or taking medications.

Although related, stigma differs from discrimination. Discrimination is unfair treatment due to a person's identity, such as race, ancestry, place of origin, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability (OHRC, 2006). Discrimination may be structural/systemic or socially motivated. Overt discrimination often takes the form of individual acts of differential treatment of one person by another. Covert or structural/systemic discrimination is often invisible and embedded into institutions and society at large, and serves to exclude or impose restrictions upon groups of individuals. For example, addiction, which is a chronic and disabling disorder, is also often thought of as a moral deficiency or lack of willpower, and there is often an attitude that people can just decide to stop drinking or using drugs if they want to. Stigma prevents some individuals from seeking help, and from being offered help. In a recent US survey more than 40 percent of family doctors admitted that they found the topic of substance use too difficult to discuss with patients, feeling more than double the discomfort they felt in discussing depression with a patient (BC Partners, 2009).

Stigma and discrimination can be part of a larger social belief system of *ableism*, where negative values and negative stereotypes are imposed upon individuals with physical and mental disabilities (OHRC, 2009). Ableism underpins acts of discrimination against individuals and perpetuates stigma and self-stigma.

Marginalized populations are also vulnerable to discrimination due to an aspect of their identity. Racialized individuals often face discrimination due to racism, and individuals in lesbian, gay, bisexual, transgender, queer (LGBTQ) communities often face discrimination due to homophobia or transphobia. A racialized person with a mental illness may face discrimination due to racism *and* due to their mental illness. An LGBTQ individual also may face discrimination

due to their sexual orientation or gender identity as well as their mental illness. Anxiety, depression, self-harm and suicidal feelings are more common among LGBTQ people and rates of drug and alcohol misuse are also higher than among heterosexual people as a result of the lived experience of homophobia and transphobia (Botswick, 2007).

Women are at greater risk for interpersonal victimization, including childhood abuse, sexual abuse and intimate partner violence. Mental illness and addictions frequently co-occur among women, who are survivors of violence, trauma, and abuse, often in complex, indirect, mutually reinforcing ways. *Hearing Women's Voices* (Morrow & Chappell, 1999) argues that women's mental health cannot be understood in isolation from the social conditions of women's lives, characterized by social inequities (e.g., sexism, racism, ageism, heterosexism, ableism) which influence the type of mental health problems women develop and impact on how those problems are understood and treated by health professionals and by society.

People have multiple and intersecting identities and these identities shape their experience of discrimination (OHRC, 2001). "Intersectionality" is the term used to describe these multiple forms of discrimination that occur simultaneously (OHRC, 1999). Recognizing intersectionality and addressing multiple forms of discrimination is necessary to provide equitable treatment supports and services for individuals with mental illness and addictions. Stigma and discrimination often exclude this population from activities that are open to other people, they often become internalized, and they contribute to people keeping their problems a secret. Eliminating discrimination is critical to combating stigma, self-stigma, and the social exclusion of individuals with mental illness and addictions (OHRC, 2009).

Supporting and enforcing existing anti-discrimination legislation is one path to eliminating stigma directed toward people with mental illness and addictions. Freedom from discrimination is enshrined under Ontario's *Human Rights Code*, which states that every person has the right to equal treatment with respect to services, goods and facilities, regardless of their identity (Scheffer, 2003). The grounds of discrimination under the *Human Rights Code* includes race, ancestry, place of origin, colour, ethnic origin, citizenship, religion, sex, sexual orientation, disability, and family status. The *Code* strives to "recognize the dignity and worth of every person and to provide for equal rights and opportunities", creating "a climate of understanding and mutual respect for the dignity and worth of each person so that each person feels a part of the community and able to contribute fully to the development and well-being of the community and the Province" (R.S.O., 1990). The Code recognizes that attitudinal barriers need to be addressed, as does Ontario's disability legislation.

Currently there are two separate pieces of provincial legislation aiming to promote equal opportunity in the workplace or equal access to housing,

community supports, public places like restaurants and movie theatres, and services like public transportation. These pieces of legislation are: *The Ontarians with Disabilities Act,* 2001 (ODA), and the *Accessibility for Ontarians with Disabilities Act*, 2005 (AODA). The ODA requires the Ontario government and broader public sector, which includes municipalities, public transportation organization, colleges and universities, hospitals and school boards, to develop annual accessibility plans. These obligations under the ODA remain in effect as accessibility standards are developed under the AODA.

The AODA establishes January 1st, 2025, as the target date by which all goods, services, facilities, accommodation, employment, buildings, structures and premises in the province of Ontario will become accessible to individuals with disabilities, including individuals with a mental illness and/or cognitive limitations. The AODA applies to persons, businesses and other organizations in Ontario in the public and private sectors, including the Legislative Assembly of Ontario. The AODA also established the requirement for five standards to be developed (with the consultation of individuals with disabilities). These standards encompass five different areas: customer service, transportation, the built environment, information and communications, and employment. Each standard sets out the dates for when businesses and other organizations covered by a standard must meet the requirements of the standard. Provincial ministries and other designated public sector organizations must be in compliance with the customer service standard by January 1, 2010, and all other obligated organizations will have to be in compliance by January 1, 2012. Compliance dates by which the other four standards must be met have yet to be determined.

2.4 Community structures need to be put in place to enable social inclusion in a socially and culturally diverse population.

A society that is socially inclusive is one in which members are valued, regardless of their differences, and their basic needs are met so they can live in dignity. In an inclusive society, people are not shut out from the resources that help them integrate into the community (WHO, 2003). Social capital is a related term that describes the way in which interactions within communities or groups provide access to information, resources and supports, i.e., the social networks within a community. There is a growing body of evidence that social capital correlates positively with mental health and happiness (Pevalin, *et al,* 2002) whereas low levels of social capital have been correlated with poorer mental health. However, social capital does not protect against structural economic factors that impact health or common mental illness (Victoria Health Promotion Foundation, 2005).

Building healthy, supportive and accepting communities is an important strategy for Ontario. Engaging communities at the local level provides people with a sense of ownership and control of their own destinies. Strengthening community action has the two-fold benefit of identifying needs and capacities from a local

perspective to inform priority setting and decision making, while also empowering communities to contribute to solutions that draw on their existing human and material resources.

Social exclusion has been defined as resulting from material deprivation and lack of participation in social activities, and exclusion from decision-making and community participation (Raphael, 2003).

Many Ontarians with mental health and addictions issues require income support for the long term or episodically to ensure an adequate quality of life that does not result in or that mitigates social exclusion.

Ontario has a program which provides financial and employment support: the Ontario Disability Support Program (ODSP). The ODSP is a good start in addressing issues of social exclusion, but there is much more work to do. In order to fully develop ODSP into a tool that promotes inclusion several areas must be addressed: recipients do not receive adequate funds to ensure a decent quality of life; administration of the program is not consistent across regions; some of the ODSP policies conflict with other forms of income support; and the process for people returning to work is structured in such a way that it sometimes acts as a disincentive to seeking and maintaining employment.

As previously discussed, experiences of discrimination and social exclusion can lead to poor mental health and problematic substance use. For example, people who identify as LGBTQ face significant risks to their mental health due to experiences of homophobia and transphobia from their families, peers, classmates, co-workers, and society at large (Botswick, 2007; Gonsiorek & Rudolph, 1991; Troiden, 1989). Racial discrimination may lead to low self-esteem and sense of control, psychological distress, major depression, mental disorders and associated productivity reductions (WHO, 2006). As was previously mentioned, ageism, affecting seniors, often results in social isolation, which can lead to depression and to late onset addiction. Conversely, social inclusion enables coping and resiliency and refers to the degree to which persons and/or groups are socially engaged and feel a sense of belonging.

Place-based approaches[1] are one approach to improve the social and economic opportunities, physical environment and access to treatment supports and services in order to improve opportunities for positive health, and reduce health disparities of the people living within that community (Victoria Health Promotion Foundation, 2008). This approach is asset-based in that it emphasizes identifying and promoting local strengths and it encourages capacity and community-building because a community's solutions should be tailored to its specific needs.

[1] A place-based approach focuses resources and attention on geographic areas where there are concentrations of issues to be addressed and may be used to complement the universal government programs that are the more usual way of addressing public needs (Cowan, 2008).

2.5 Community treatment services and supports must reflect the diversity of all Ontarians.

Ontario is a province of diverse communities. More than one quarter of Ontario residents are born outside of Canada and almost one-quarter of people in the province self-identify as a member of the "visible minority." Diversity encompasses sexual orientation as well as ethno-cultural differences.

Every year one in five Ontarians will have experience with mental illness and/or addictions. The ways in which people with mental illness and addictions view themselves shape their experience and perceptions of their illness or addiction, how health care providers respond to them, and how they use services. Some ethno-culturally diverse populations, due to economic and social disadvantages, isolation, racism, discrimination and cultural pressures, are particularly vulnerable to mental illness and addictions. Ethno-cultural groups are not homogenous; members of different groups experience mental illness and addiction problems in different ways and have different norms around seeking or not seeking help. Some populations are also less likely than the general population to take part in health promotion and prevention programs (CAMH, 2007).

Immigrants and refugees often experience migration stressors, and may experience post-traumatic stress as a result of adverse conditions in their country of origin. Settlement agencies are often unable to address mental illness and addictions, because staff are unaware of such conditions, and lack comprehensive approaches and the expertise to identify problems, provide services and/or refer individuals to mental health and/or addiction services that are linguistically and culturally competent to meet individuals' unique needs (CURA, 2009).

3.0 Strategic Priorities

The discussion paper, *Every Door is the Right Door* (July 2009) identified three strategic directions arising from the discussion about healthy communities: *create healthy communities, stop discrimination, and build community resilience*. The strategic priorities listed under each strategic direction are required elements to ensure the development of healthy communities under Ontario's 10 Year Mental Health and Addictions Strategy.

For this paper, Ontario has adapted three categories of primary prevention from the public health model of disease prevention (WHO, 2002) under which to organize strategic opportunities for each strategic priority. We are using this model because public health approaches take a broad view of health that includes both sickness and well-being. However, the adaptation goes beyond primary prevention to address people who already have a mental illness or addiction. The categories include:

- *Universal interventions* - interventions targeting the general public or a whole population group that are designed to promote mental health and to protect against mental illness and addiction. A population approach focuses on improving overall population health status, with the aim of reducing health disparities by addressing the social determinants of health.

- *Selective interventions* – interventions targeting individuals or subgroups of the population whose risk of developing a mental illness or an addiction is significantly higher than the rest of the population, based on biological, psychological or social risk factors (WHO, 2004).

- *Indicated interventions* – interventions targeting individuals who are at high-risk for or who are experiencing mental illness and/or addictions.

Universal interventions are oftentimes taken up by more advantaged populations, with the unintended consequence of widening health disparities. This highlights the importance of also taking action on selective and indicated strategies in order to reach and address the specific needs and situations of at-risk populations.

3.1 Create Healthy Communities

Strategic Priority 1: Provide opportunities for secure and adequate income

Poverty is a reality in Ontario for many, including single parent families, immigrants, Ontarians with disabilities, Aboriginal populations and people working for low wages (Ontario Association of Food Banks, 2008). Individuals with work-limiting disabilities are nearly three times as likely to be poor and four times as likely to be in receipt of social assistance as individuals without a disability (Berinstein and Gellatly, 2005). Further, although income support programs exist in Ontario, many are not indexed to inflation, with the result that people who use them do not have an adequate income. Low income can lead to poverty in other essential resources, such as housing, education, and employment. Evidence indicates that poverty - and the material and social deprivation associated with it - is a primary cause of poor mental and physical health among Canadians (Lightman *et al*, 2008).

Strategic Opportunities*	**Population**		
	Universal	**Selective**	**Indicated**
1. Legislate **pay equity**, since economic security is an essential determinant of health	x		
2. Increase **minimum wage rates**	x	x	

3. Align work on Mental Health and Addiction Strategy with **the Ontario Poverty Reduction Strategy**	x		
4. Index **ODSP and OW** to inflation to close the health gap		x	x
5. Ensure that **people are not penalized** while they are transitioning back to work and still accessing income supports such as ODSP & CPP	x		
6. Foster availability of **flexible employment opportunities** for people who may need to exit and re-enter the workforce during times of treatment, rehabilitation, and recovery		x	x
7. Expand and deliver **employment supports** for People With Lived Experience		x	x
8. Provide supports such as licensed childcare to people with mental illness and/or addictions who are in **care giving roles** so that they can become or stay employed		x	x

Examples

Employment Ontario Employment Service

- Resource & Information Component
- Job Search Component

Ontario Deprivation Index (component of the Ontario Poverty Reduction Strategy)

- a list of items or activities considered necessary in order to have an adequate standard of living, many of which people who are poor are unlikely to be able to afford, such as:
  - Eating fresh fruit and vegetables every day
  - Ability to get dental care if needed
  - Eating meat, fish or a vegetarian equivalent at least every other day
  - Ability to replace or repair broken or damaged appliances such as a vacuum or a toaster
  - Having appropriate clothes for job interviews
  - Ability to get around one's community, either by having a car or by taking the bus or an equivalent mode of transportation
  - Ability to have friends or family over for a meal at least once a month
  - House or apartment is free of pests, such as cockroaches
  - Ability to buy some small gifts for family or friends at least once a year
  - Having a hobby or leisure activity

*Note: The examples provided in this and subsequent charts may not all be evidence based, nor the result of a comprehensive literature review.

Strategic Priority 2: Promote employment in safe, supportive, inclusive workplaces

People with mental illness are affected, like others, by the larger economic context (Cook, 2006; Kilian & Becker, 2007). Evidence accumulated over decades in both North America and Europe suggests that economic downturns which result in higher rates of unemployment are associated with increased needs for mental health care. Higher rates of psychological distress have been found in low-income households (Orpana et. al., 2009). Unemployment is

associated with an increase in admissions for psychiatric care (Kilian & Becker, 2009; Leff & Warner, 2006). In addition the link between poor mental health and precarious employment is becoming increasingly evident (WHO, 2008).

Extensive research has demonstrated the specific benefits of employment for people with mental illnesses (Corbière & Lecomte, 2009). With education and employment, individuals often experience reductions in their symptoms and hospitalization, as well as improved quality of life (Bond et al., 2001; Waghorn & Lloyd, 2005) and a reduction in social exclusion (Dewa, 2007). These factors support people's ability to live independently and have a decent income.

Quality of work is also important. One response to low-wage work is providing increased access to education and training opportunities. Labour market success for people with mental illness and addictions is linked to higher levels of education, especially post-secondary education (Liebert, 2003). Research also shows that local actions can make a difference.

In contrast, employment insecurity has been shown to increase stress and anxiety. Stress associated with precarious employment has been linked to diminished health status (WHO, 2009). Unemployment rates for people with mental illness are higher than for people with most other disabilities and health conditions, and substantially higher than for the general population. For people with the most severe and enduring disorders, unemployment ranges from 70 to 90 percent (Harnois & Gabriel, 2009; Latimer, et al., 2005; Waghorn & Lloyd, 2005).

Having access to work is essential for the well-being of people with mental illness and addictions and for society as a whole. Once work is attained, employers have a responsibility to support and accommodate all their employees, and a duty to ensure physically safe work environments and working conditions, and freedom from violence and discrimination within the workplace.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Develop and implement **AODA Standards** (see page 18 for description).	x		
2. Make adjustments to **AODA Standards** to include people with mental illness and addictions.		x	x
3. Create and implement **high quality training** for employers and landlords specific to customer service and accommodations for people with mental illness and addictions.	x		
4. Provide incentives to employers to **champion healthy**	x		

workplaces and to develop healthy workplace policies.			
5. Develop policies to foster a more **secure workforce** (e.g. full-time, permanent, benefits) **versus a precarious workforce** (e.g. part-time, contract, no benefits)	x	x	x
6. Develop programs to train people who are in **volunteer peer-support roles** to become **paid employees**.		x	x
7. Engage **and work with unions** to promote wide implementation of supported employment programs		x	x
8. Establish a wide range of **pre-employment and employment support programs** for people with mental illness and addictions, including youth, which take into account the fact that different levels of support are required.		x	x
9. Establish and support **employment re-entry programs**, including but not limited to, Consumer/Survivor initiatives (CSIs), social enterprises, and alternative and affirmative businesses		x	x
10. Ensure that income support programs make employment feasible by providing **employment supports** and at the same time including **incentives and continued income supports.**		x	x
11. Ensure that **recipients of ODSP and CPP** are properly informed about policies regarding pension and benefit programs and that the policies are followed through on.		x	x

Examples

Employee Assistance Programs (EAPs)

- company sponsored services designed to provide confidential off-site mental health counselling to employees free of charge on a short term basis

Mental Health Works, CMHA Ontario

- helps organizations to manage their duty to accommodate employees experiencing mental disabilities such as depression or anxiety in the workplace

Individual Placement and Support (IPS) model

- goal is to support people to move into competitive employment (vs. sheltered workshops or volunteering) as soon as possible and to assist people to find jobs they are interested in
- most effective when vocational and mental health services integrate their work, including the provision of ongoing support
- also helps people navigate receiving income support benefits while working

Strategic Priority 3: Ensure safe and secure housing

The daily conditions in which people live have a strong influence on health equity. Access to quality housing is a human right, and sets the foundation for attaining other basic things such as employment, education, and health care.

It is estimated that between one fourth and one third of the people who are

homeless have a serious mental illness (Stergiopoulos, 2008). Research also suggests that a large proportion of persons who are homeless have addictions. There is also a high correlation between an individual having 'no fixed address' and that individual engaging in multiple treatment episodes for addictions. Supportive housing addresses the needs of people who need additional supports in order to successfully live in affordable housing. Supportive housing is designed to stop people from falling through the cracks and can generate positive outcomes, including enhanced life skills, improved health status, an increased sense of empowerment and involvement in the community (Canadian Mental Health Association, 2008).

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Ensure the availability **of high quality housing** that is secure, accessible and affordable and safe (this should be supported by the Ontario Municipal Board)	x		
2. Require **municipalities to address mental health and addictions issues** in their official plans by offering a range of full-scale housing (this should be supported by the Ontario Municipal Board)	x		
3. Enforce legislation requiring **landlords not to discriminate**, including against people with mental illness and/or cognitive limitations and addictions and reiterate their **duty to accommodate** people with mental illness and addictions.	x		
4. Redress **inequities within economic support** programs to improve real incomes for the poor and working poor (e.g., basic needs and shelter allowances, claw-backs, portable housing allowances, rent banks)	x		
5. Increase **affordable and safe social housing**	x		
6. Continue efforts to confront **men's violence against women** including domestic violence.	x		
7. Integrate work being done with respect to the **Mental Health and Addiction, the Municipal Affairs and Long-Term Affordable Housing, and the Poverty Reduction**	x		

Strategies			
8. Incorporate **peer support workers** into housing programs in recognition of the important role they play linking staff and clients		x	x
9. Simplify mechanisms that support **housing for people with mental illness and addictions** by: o developing linkages between housing programs and mental health and addiction services to ensure people do not lose their housing while accessing treatment, e.g., eviction prevention, trusteeship (Robins trustee model) o Expanding case management services with a specialty in addictions (that includes a harm reduction perspective) to support people in maintaining their housing in the private rental market as well as the public		x	x
10. Provide more **supportive housing for people who are frequent users of the addiction treatment system** (particularly withdrawal management services)		x	x
11. Require licensing of **retirement homes and boarding homes**		x	x
12. Implement an **Integrated Human Services model** - integrated service delivery that takes into account the social determinants of health	x		

Examples
Supportive housing for people with problematic substance use initiative, based on the 'Housing First' model for supported housing • to be implemented in 2009/10, targeted to people with problematic substance use who are homeless or at risk of homelessness and who may have one or more of the following characteristics: high users of addictions system; complex addiction problems; a concurrent disorder.
The Long-Term Affordable Housing Strategy (MMAH) • will provide a framework for affordable housing in Ontario over the next 10 years
Association of Municipalities of Ontario • partnership between governments of Canada and Ontario and municipalities to improve and revitalize public infrastructure
Peel Region Integrated Human Services Department (to be implemented 2009-2011)

Strategic Priority 4: Provide opportunities for effective, flexible, relevant education

Education increases job and income opportunities, the ability to understand health information, and control over life – all of which are linked to better mental health. Conversely, people with low levels of education or outdated job skills often end up trapped in low-income jobs, stuck in the cycle of poverty and at risk of developing a mental health or substance use issue. Many people at risk of or with mental health and/or addiction issues have had their education interrupted. Flexible, relevant, age-appropriate education programs can help people meet their education goals, build life skills, foster citizenship and develop job readiness.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Promote **access to education and facilitate students staying in school**	x		
2. Ensure that at every level the **curriculum** embeds activities that promote mental health and awareness of its importance	x		
3. Implement **positive psychology programs** in the school system that address resilience, and a strength based approach to solving problems	x		
4. Ensure that **mandatory, evidence-based education** on mental health and substance use be provided in all grades in high school and integrated throughout the curriculum, and the school environment (currently, drug prevention is only mandatory to grade 9)	x		
5. Allow funds for **teacher training and dedicated staff time** to ensure that early intervention, counselling and other supports are in place to assist students with mental health and/or substance use issues	x		
6. Advance a **comprehensive approach** to school-based health promotion, one that incorporates health and health messaging into all aspects of school activities and engages the community at large.	x		
7. Accommodate people with mental health and addictions enrolled in **education and training programs** by taking into account that some individuals may need to exit and re-enter during times of treatment, rehabilitation, and recovery		x	x
Examples			
Mental Health First Aid • Program trains educators to acquire skills and knowledge of how to			

support students showing signs of mental illness and/or addictions
Comprehensive approach to schools • looks at developmental stages, life course, clusters of behaviours and conditions (e.g. mental health, crime, tobacco, sexual risk-taking, dropouts), community and systems context analysis, synergistic combinations of strategies and initiatives (e.g. police officers, safe schools, character education, early childhood programs), multi-level, intersectoral strategies, programs and policies
Canadian Consensus Statement on Comprehensive School Health (revised 2007) • prepared and endorsed by a number of national organizations to promote a comprehensive approach to school-based and school-linked health promotion • integrates responses to several health and social problems and promotes the overall health and learning of children and youth, as well as adults who work in and with schools, parents/caregivers and surrounding communities • seeks to coordinate multiple interventions in the form of policies, programs and services delivered by various professionals, agencies, and government ministries
Supported Education • Provides specialized support within the classroom to people with mental illness, within mainstream campuses • Accommodations range from educational counseling and academic skill building to test methods that can accommodate different learning styles and disabilities • Students receive credits for the program
Augmented Education • Accommodates people with specific needs (e.g., allows them to complete programs over a longer period of time, etc.) and permits them to graduate with an industry recognized certificate • Students can also access job placement and employments supports after they graduate

Strategic Priority 5: Promote quality of life and healthy lifestyles

Mental health promotion can enhance overall mental health and well being and also contribute to reducing the burden of mental illnesses on individual, social and economic levels (Mental Health Commission of Canada, 2009). Strategies and initiatives that support positive mental health take a population approach that is holistic and includes efforts across the lifespan.

The Ottawa Charter for Health Promotion identifies personal skills, community action, supportive communities and healthy public policy as key actions to promote health. In addition to the impact of social and material conditions on determinants of health, lifestyle choices can promote health. Active living and healthy eating contribute to good physical as well as mental health. However, many people with mental health and/or addictions issues are not able to access healthy and affordable food. This issue is further complicated for people with mental health and/or addiction issues who also have compromised immune systems from conditions such as HIV/AIDS and Hepatitis C.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Ensure **food security** for the general population	x		
2. Include **special diet allowances** in the Ontario Disability Support Program for people with mental health and/or addiction issues			x
3. Strengthen **regulatory legislation and policy regarding access to alcohol**, and maintain a strong regulatory framework.	x		
4. Implement **stronger enforcement of the *Liquor Licence Act*** to reduce the illegal distribution of alcohol, and to prevent underage drinking and service to people who are intoxicated	x		
5. The **Alcohol and Gaming Commission** to limit the density of licenced establishments within any given area or neighbourhood	x		
6. Continue to **prevent children and youth from starting to smoke**; help Ontarians **quit smoking;** and protect Ontarians from involuntary **exposure to second-hand smoke** through the Smoke-Free Ontario Strategy	x		
7. Ensure there are **school-based health promotion**, **prevention, early intervention and treatment programs** that address children with mental illness and build **protective programs** that promote resiliency, healthy growth and development through childhood and support transition through critical life stages such as adolescence	x		
8. Embed requirements for **inclusive recreation and arts programs** (e.g. wheelchair athletes, equipment that makes noise, etc.) in the funding that is provided	x		
9. Accompany health promotion initiatives with **tools to enhance**		x	x

detection, help-seeking, and referral to effective interventions for children and youth who develop mental illness and addictions			
10. Ensure that the **built environment** contributes to positive quality of life	x		

Examples

Deprivation Index (Ontario Poverty Reduction Strategy) - see 3.1, Priority #1)

Mental Health Impact Assessment Tools use a four factor framework for identifying and assessing protective factors for mental well-being:

- enhancing control
- increasing resilience and community assets
- facilitating participation
- promoting inclusion

Age-Friendly Communities Model (Ontario Seniors Secretariat) includes policies, programs, services, and environments that support and enable citizens to age actively by:

- Recognizing the wide range of capacities and resources among older persons,
- Anticipating and responding flexibly to aging-related needs and preferences of seniors,
- Respecting the decisions and lifestyle choices of older adults,
- Supporting older adults who are most vulnerable, and
- Promoting the participation of older adults, and encouraging their contributions to all aspects of community life

Canadian Consensus Statement on Comprehensive School Health (see 3.1, Priority #4);

Standards (Ministry of Health & Long-Term Care/Ministry of Health Promotion):

- Ontario Public Health Standards, 2008
  - Chronic Disease Prevention Program Standards
  - Prevention of Injury and Substance Misuse Standards
  - Reproductive Health Standards
  - Child Health Standards
- Sexual Health, Sexually Transmitted Infections and Blood- Borne Infections Standards - promote healthy sexuality across age groups and targets specific groups that may engage in high risk sexual activities and behaviours
- Foundational Standard - outlines the importance of addressing determinants of health and reducing health inequities when assessing populations

Healthy Babies Healthy Children Program (Ministry of Children and Youth Services)

- supports program interventions to promote healthy family dynamics and growth and development of children

Guidance Documents (Ministry of Health Promotion)

- support the development of specific public practices that consider the determinants of health, resiliency/asset building and mental health promotion activities when implementing public health programs

3.2 Stop Stigma and Discrimination

Strategic Priorities 1& 2: Make our communities free from discrimination; Fight self-stigma.

Stigma and discrimination have very real impacts on the course and treatment of a person's mental illness or addiction. The results of the most recent Canadian Community Health Survey indicated that less than a third of people (over eighteen million Canadians) who have symptoms of mental disorders or substance dependencies sought professional assistance. Among the top three reasons given why people do not seek help are that they are too afraid to ask, or are afraid of what others would think. Prejudice and discrimination have also been shown to influence help-seeking behaviour, from attendance at self-help or therapy groups to compliance with medication.

Self-stigma relates to internalized negative stereotypes that lead people with mental illness and/or addictions and their families to adopt attitudes of self loathing and self blame leading to a sense of helplessness and hopelessness (Mood Disorders Society, 2006).

Discrimination has a negative impact on individuals and the community, reducing the ability of both to reach their full societal and economic potentials. In order to reduce discrimination and ensure equity of access in the mental health and addictions systems, issues of diversity and principles of equity, including gender equity, and strategies for social inclusion must be taken into account at all stages of mental health service delivery and planning (CMHA Ontario & Wellesley Institute, 2009).

Research by the Mental Health Commission of Canada (MHCC) has found that successful anti-stigma initiatives: are carefully targeted to specific audiences; are sustained over a substantial period of time; educate people about the reality of mental illness and engage them at an emotional level; involve people living with mental illness as spokespeople; focus on the potential for recovery and highlight the positive contributions made to local communities by people living with mental illness; deploy national resources that can be adapted to regional and local circumstances. Based on the evidence and consultations with stakeholders, the MHCC has determined that their anti-stigma initiative *Opening Minds* will: require a multi-pronged approach focused on specific target groups with the power and influence to effect change; have repeated, direct, peer-based contact with people who have experienced negative stereotypes; provide evidence-based education about the impact of discrimination; adopt the best approach to reach the target groups; and engage the target communities in program development and delivery to ensure the greatest impact (Mental Health Commission of Canada, 2006).

Strategic Opportunities	Population

	Universal	Selective	Indicated
1. Carry out **education and/or media campaigns** to support mental health literacy, self awareness, self-identification and self-management , as one element of a comprehensive strategy	x		
2. Integrate comprehensive **evidence-based knowledge and skills development** about mental illness and addictions into the curricula of relevant college and university disciplines	x		
3. Support **networks for caregivers**, including families who provide informal care		x	x
4. Assess all **public policies** to ensure they are not discriminatory against people with mental illness and addictions	x		
5. Provide **diversity, and cultural competency training** for mental health and addiction providers	x		
6. Ensure providers understand and apply the principles underlying **recovery and harm reduction, and what it means to be trauma informed** and who have the skills, knowledge and the **cultural competence** to provide appropriate supports		x	x
7. Establish **clear standards of care/clinical pathways** that include regular goal setting for the client and assessment of progress against the established goal(s).*		x	x
8. Provide **evidence-based training about mental health and substance use** issues to current health, social service, educational, correctional, etc., service providers to help increase access to existing services by people with mental health and/or addictions		x	
9. Incorporate **peer support groups** in mental health and addictions services and programs.		x	x
10. Facilitate planning and implementation of culturally competent services for mental health and addictions through **knowledge transfer and exchange strategies**		x	x
Examples			
Recovery model • fosters self-esteem and rejection of internalized negative stereotypes and discriminatory behaviours			
Anti-discrimination legislation such as the *Ontario Human Rights Code* and the *Accessibility for Ontarians with Disabilities Act.*			
Mental Health Impact Assessment Tools (see 3.1, Priority #5)			

***** Note: a key finding from the POWER study (Bierman, 2009) was that income is not identified as a factor in the treatment of cancer or with respect to stroke. This differs significantly from the treatment of many other kinds of illness, which do not reflect best practice. The implication from the finding is that people's health will generally improve, regardless of their income level or socioeconomic status, when they have access to care which reflects an organized delivery system that promotes and monitors best practices.

Strategic Priority 3: Champion respect for people with mental illness and/or addiction issues

Respect for culture, equity, social justice, interconnections and personal dignity is essential for promoting mental health for everyone. A mental health promotion approach works to challenge discrimination against people with mental illness and fosters personal resilience through empowering individuals to strengthen their coping skills, self-esteem and personal efficacy and to effectively utilize the resources available within a supportive environment (Public Health Agency of Canada, 2009).

Developing culturally competent services is necessary in order to address the needs of individuals with mental illness and/or addictions. There must be a focus on reducing the barriers to equitable access to services. It is also important to offer programs for women of childbearing age that focus on mental health, specifically trauma and domestic violence, as well as addictions and parenting skills, to provide women with opportunities for raising healthy children and for improving their own health.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Develop a **health human resources plan** that outlines strategies to support organizations in the recruitment and retention of health care providers to work with people who have mental health and/or substance use issues. Providers to include family physicians, nurses, nurse practitioners, Family Health Teams, and alternative practitioners.		x	x
2. Support **specialized programs** where evidence exists that they are needed to support equity of access and outcome e.g., women and addictions		x	
Examples			
Breaking the Cycle Toronto; Pregnant Women with Addictions Programs (Early Childhood Development) • Both programs provide addiction treatment and other services such as			

child care, life skills and parenting skill development to pregnant and parenting women across the province of Ontario.

3.3 Build Community Resilience

Strategic Priority 1: Strengthen health and wellness promotion in communities

Mental health promotion empowers people and communities to interact with their environments in ways that enhance emotional and spiritual strength by working to increase self-esteem, coping skills, social support and well-being in all individuals and communities. It is an approach that fosters individual resilience and promotes socially supportive environments. Mental health promotion includes, but is not limited to, preventing mental illness and addictions. Strategies and initiatives that support positive mental health work from a population health approach, which is holistic and includes efforts across the life cycle.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Expand awareness of mental illness and addictions through **public education campaigns** as one element of a comprehensive strategy	x		
2. Build on **existing initiatives** such as the Healthy Communities Fund, Ministry of Health Promotion (one example)	x		
3. Support existing **community hubs** as a place to provide services, social interaction, and education and establish new ones where appropriate	x	x	
4. Include **social services in health-based services** to support the most marginalized clients	x		
5. Establish **"wrap around" agencies** that provide access to multiple treatment supports and services		x	x
6. Direct health promotion efforts to **populations at risk for addictions**, including those living in poverty and experiencing health disparities		x	x
7. Educate parents in methods of **positive parenting,** with a social determinants of health focus	x	x	
8. Expand **networks** of Community Health Centres, Family Health Teams and Aboriginal Health Access Centres specifically to support people with mental illness and addictions		x	x

Examples
Short Term Assessment and Treatment (STAT) Unit for Youth • youth treatment home in Sioux Lookout for youth with serious mental illness, addictions and behavioural problems
Pregnant Women with Addictions Program (see 3.2, Priority #3)

Strategic Priority 2: Support social ties among individuals and social inclusion in communities

Strong social networks and social ties are a source of information and knowledge as well as providing support, which in turn enhance health and wellbeing. They provide individuals with a feeling of belonging, thereby contributing to community resilience to mental health and addiction problems. At an individual level social connectedness has a powerful protective effect on health, can encourage healthier behaviour, and provide support in navigating health care system. A strong socially inclusive community contributes to social cohesion and has a positive impact on the economy and the contribution of individuals within society.

Strategic Opportunities	Population		
	Universal	Selective	Indicated
1. Integrate work of the **Mental Health and Addiction Strategy with the Ontario Poverty Reduction Strategy**	x		
2. Implement and support **place-based approaches** that will enable communities to develop and take action on strategies to best meet the needs of populations at-risk for mental illness and addictions		x	x
3. Incorporate **peer support programs** into communities to help to improve mental health literacy and build capacity for provision of support within communities	x		
4. Develop initiatives to combat **isolation of rural and remote women**		x	
5. Invest in **recreation and arts programs** for low-income families and ensure they have access to them	x	x	
6. Implement schools as **community hubs**	x		
Examples			
Age-Friendly Communities (see 3.1, Priority #5)			
Ontario Healthy Communities Coalition • Promotes safe environments, public transportation, preservation of natural surroundings, easy access to services, creation of spaces for social gatherings			

Centre for Child, Family and Adolescent Advancement (www.cfcaa.com)

- A successful home based pilot of 40 Aboriginal & Caribbean families with mental health, cognitive and/or addictions experience/risk; social determinants of health model of poverty coping (budgeting, nutrition, home cleanliness/ organization, medical/health liaison), daily routine, positive discipline skills; teach parental homework support; social support development; school linkage, parent educational/ vocational development; model easily integrated within Community Health Clinics/Family Health Teams; modified model being adapted by Native Family and Child Services

Strategic Priority 3: Enable communities to address populations at risk

Social and economic inequalities are risk factors for poor mental health and the development of substance use issues. Risk factors are associated with an increased probability of onset, severity and/or duration of poor health. There is considerable evidence on the risk factors for poor mental health and addiction (WHO, 2004).

These risk factors include:

- poverty and low income
- unemployment and under-employment
- homelessness and insecure housing
- material deprivation
- unsafe living environments
- living in urban/rural/remote areas
- inadequate settlement support for immigrants and refugees
- low levels of educational attainment
- language barriers
- social exclusion
- violence and discrimination
- gender inequity

Health equity strategies seek to reduce or eliminate health disparities that are systemic and avoidable. Effective tools have been developed to address inequalities. These tools include equity lenses, which include simple questions to consider potential differential effects of programs on disadvantaged populations and overall health disparities, and can be applied to potential programs and issues to assess their equity implications (VicHealth, 2008).

Another important strategy involves directing a proportion of investments into reducing barriers to equitable access for services and investing in programs and services that are targeted to populations at-risk and those experiencing health inequalities. Jurisdictions with comprehensive health equity strategies combine overall broad policy directions with specific programs and services targeted to the

most health disadvantaged communities (Gardner, 2009). One essential element of effectively targeting investments and initiatives is to analyze where equity impact will be greatest, using these equity planning tools.

Strategic Opportunities	**Population**		
	Universal	**Selective**	**Indicated**
1. Ensure **universal strategies** are well-articulated and systematically implemented to provide a service base that can be adjusted or augmented for disadvantaged groups	x		
2. Implement and evaluate **health equity strategies** on an ongoing basis	x		
3. Pilot **health impact and mental health impact assessment tools** to identify risk factors for mental illness and addictions in all policy formulation and program implementation being contemplated in Ontario	x		
4. Use **health equity lenses** when deciding priorities for program and service planning, delivery and evaluation	x		
5. Collect and review **relevant data** that will enable communities to identify and monitor progress in addressing 'at-risk' populations	x		
6. Enhance the capability of capturing Ontario's diversity to support **program design**	x		
7. Utilize an **equity lens assessment** in all stages of planning for mental health and addictions treatment supports and service		x	x
Examples			
The POWER Study (**P**roject for an **O**ntario **W**omen's Health **E**vidence-Based **R**eport) • multi-year project funded by Echo: Improving Women's Health in Ontario that that will produce a comprehensive provincial report on women's health which will outline findings on the health differences associated with age, income, education, ethnicity, language and where the person lives in the province between men and women and between various groups of women			
CFCAA (www.cfcaa.com) see 3.3, Priority 2			
Equity lens			

- simple questions to consider potential differential effect of programs on disadvantaged populations and overall health disparities, which can be applied to potential programs and issues to assess their equity implications

Appendix 1 – Glossary

Addictions:
The term addiction is most commonly used to refer to the problematic use of alcohol and other drugs. Individuals also engage in other potentially addictive behaviours such as gambling, internet gaming and shopping, etc. For the purposes of this report, addiction is defined as chronic dependence, which is use (or behaviour) that has become habitual and compulsive despite negative health and social impacts (BC Ministry of Health Services, 2004).

The behaviours of primary focus are the use of psychoactive substances (alcohol and other drugs), and gambling. It is important to note that these behaviours occur along a continuum and do not always result in addiction. The spectrum of psychoactive substance use, as outlined below, also applies to other behaviours such as gambling:

- Beneficial use, which has positive health or social impacts (e.g., medical psycho- pharmaceuticals, coffee to increase alertness, etc.)
- Casual/non-problematic use, which is recreational or other use that has negligible health or social impacts
- Problematic use, which is use that begins to have negative consequences for individuals, friends/family, or society (e.g., impaired driving; binge consumption; harmful ways in which drugs are taken)
- Chronic dependence, which is use that has become habitual and compulsive despite negative health and social impacts. (BC Ministry of Health Services, 2004)

Concurrent disorders: applies to people who have been diagnosed with both a mental illness and an addiction.

Consumer, Consumer/Survivor, and Person with Lived Experience:
The term “consumer” or “consumer/survivor” has been used to self-identify by some service users, particularly in the mental health field, in place of terms such as “patient” or “client” which some deem problematic. The term “persons with lived experience” or “people with lived experience” will be used throughout this report to describe those who have previously or currently live with mental illness, problematic substance use or gambling, in addition to the term “consumer”, with the acknowledgement that there are a range of terms people use to self-identify, and alternate terms may be preferred to describe one’s self or experiences.

Discrimination: treatment or consideration of, or making a distinction in favour of or against, a person or thing based on the group, class, or category to which that person or thing belongs rather than on individual merit. The Ontario Human Rights Commission defines discrimination as “unfair treatment due to a person’s identity, such as race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability (OHRC, 2006). “

Dual diagnosis: applies to people diagnosed with a developmental disability and a serious mental illness.

Family:
The term “family” is used in this document to describe any person who is identified as such by a person with lived experience of mental illness, problematic substance use or gambling. In the case of children, parents or legal guardians are included in the definition of “family”; however, others such as friends may also be included in the definition of family.

Harm Reduction:
“Harm reduction” is both a philosophy and a set of practices that are pragmatic, evidence-based, and rooted in the intention to reduce harm. Harm reduction strategies embrace a long-term view of intervention and change, and place an emphasis on immediate, achievable and protective approaches to positive change.

Health Promotion: the process of enabling people to increase control over and to improve their health (WHO, 1986).

Mental Health: according to the WHO there is no “official” definition of mental health. However, most experts agree that mental health and the absence of mental illness is not the same thing; the absence of a recognized mental disorder is not the only indicator for mental health. Therefore, mental health can be understood as a resource that:

- enables individuals and communities to control their subjective well-being and to cope with adversity and change
- supports meaningful and inclusive participation in social environments.

Mental Health and Addictions Systems:
The term “mental health and addictions systems” is used throughout this report to refer to specialized health treatment, services and supports for people with mental illness, problematic substance use and gambling. However, people with However, people with mental health or addiction issues may also interact with many other general health, social and community based services, including primary care, long-term care, home care, income support, police, justice and corrections, housing, and schools.

Peer-Support: a process of providing emotional support, practical support or information exchange between people who share a common experience or identity. In the context of mental health and addictions, “peer support” includes peer counselling, peer outreach and education, or participation in peer support groups. Some peer support roles are voluntary, while others are paid positions in organizations.

Person-Directed:
This approach values and supports active participation in decision making on the part of persons with lived experience, wherever possible, while recognizing the need to consider a person's ability to make specific decisions and desire for involvement at any given time. It is an approach that is mutually respectful and collaborative between providers and people with lived experience.

Recovery:
There is significant divergence around the word recovery and its interpretation differs among many groups. In this paper, we endorse a broad vision of recovery that involves a process of restoring or developing a positive and meaningful sense of identity apart from one's condition, and a meaningful sense of belonging while rebuilding a life despite or within the limitations imposed by that condition.

A recovery oriented system of care identifies and builds upon each individual's assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful and constructive sense of membership in the broader community.

Serious Mental Illness: The three categories used to identify people with serious mental illness are: disability, anticipated duration and/or current duration, and diagnoses. The critical dimension is the extent of disability and serious risk of harm to themselves or others, related to a diagnosable disorder.

- Disability: Refers to the fact that some individuals lack the ability to perform basic living skills such as eating, bathing, or dressing; maintaining a household, managing money, getting around the community and appropriate use of medication; and functioning in social, family and vocational-educational contexts.
- Anticipated Duration/Current Duration: Evidence may indicate that a person's problem may be ongoing in nature. This does not mean that the problems are continuous; there may be intermittent periods of full recovery or enduring long-term recovery, and some can fully recover.
- Diagnoses: For example, schizophrenia, mood disorders, organic brain syndrome, and paranoid and other psychoses. Other diagnosable disorders such as severe personality disorder, concurrent disorder and dual diagnosis are also included. (Making It Happen Implementation Plan for Mental Health Reform (MOHLTC 1999).

Stigma: is attached to people or groups who are viewed as different from society's norms, mainstream behaviours or identities. In effect, stigma is often used as a way of discrediting, isolating and ultimately attempting to control people who fall within a stigmatized group (Canale, 2001). It is a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation. (Weiss and Ramakrishan, 2004).

Trauma-informed Services: take into account the impact of trauma and integrate this knowledge into the services being provided. A trauma informed perspective views the behaviours as a response or coping mechanism of past or current abusive/traumatic experiences. Trauma informed services do not require that the issue be disclosed; rather, it is the understanding that trauma may have an impact in an individual's life and be prepared to work in ways that will support the individual across the continuum of services. In trauma-informed services, all staff are trauma trained and understand the impact of trauma on the lives of those who are seeking help (*Bradley, Jean Tweed Centre*).

Appendix 2 – Findings from New Zealand, Australia, Scotland

New Zealand

Mental Health Priorities	Addictions Priorities
Ten Leading Challenges 1) Promotion and Prevention; 2) Building Mental Health Services; 3) Responsiveness: Build responsive services; 4) Build a mental health and addiction workforce that supports recovery, is person centered, is culturally capable and delivers an ongoing commitment to assure and improve the quality of services for people; 5) Continue to broaden the range, quality and choice of mental health and addiction services for Mäori; 6) Primary Health Care; 7) Improve the availability of and access to addiction services and strengthen he alignment with mental illness services; 8) Funding Mechanisms for Recovery; 9) Transparency and Trust; 10) Strengthen agencies working together.	Six Objectives 1) To prevent or delay the uptake of tobacco, alcohol, illegal and other drug use, particularly in Maori, Pacific peoples and young people; 2) To reduce the harm caused by tobacco by reducing the prevalence of tobacco smoking, consumption of tobacco products and exposure to second-hand smoke; 3) To reduce harm to individuals, families and communities from the risky consumption of alcohol; 4)To prevent or reduce the supply and use of illegal drugs and other harmful drug use; 5) To make families and communities safer by reducing the irresponsible and unlawful use of drugs; 6) To reduce the cost of drug misuse to individuals, society and government
In New Zealand there is recognition that social and economic factors impact on mental health, wellbeing and recovery and an understanding of how all parts of the State sector, and wider community services must work together (NZMOH 2005).	

Australia

Mental Health Priorities	Addictions Priorities
Ten policy directions 1) The rights and responsibilities of people with mental health problems and mental illness; 2) Mental health promotion; 3) Preventing mental health problems and mental illness, and reducing suicide risk; 4) Early intervention; 5) Access to the right care at the right time; 6) Participation and inclusion;	Eight Priorities 1) Prevention; 2) Reduction of supply; 3) Reduction of drug use and related harms 4) Improved access to quality treatment; 5) Development of the workforce, organizations and systems; 6) Strengthened partnerships; 7) Implementation of the National Drug Strategy Aboriginal and Torres Strait

7) Caregivers; 8) Workforce; 9) Quality and outcomes; 10) Building and using the evidence base.	Islander Peoples Complementary Action Plan 2003–2006 8) Identification and response to emerging trends.
Australia has been world-leading in the development of population-based mental health policy and in innovative initiatives and projects, complemented by other national strategies and action plans (Parham 2005, Townsend et al. 2006, Hickie et al. 2005)	

Scotland

Strategic Mental Health Priorities	**Addiction Priorities**
Six Priorities: 1) Mentally Healthy Infants, Children and Young People; 2) Mentally Healthy Later Life; 3) Mentally Healthy Communities 4) Mentally Healthy Employment and Working Life; 5) Reducing the Prevalence of Suicide, Self-harm and Common Mental Health Problems; 6) Improving the Quality of Life of those experiencing Mental Health Problems and Mental Illness. .	Six Key Priorities for prevention of drug use: 1)Prevention of drug problems, with improved life chances for children and young people, especially those at particular risk of developing a drug problem; 2) To see more people recover from problem drug use so that they can live longer, healthier lives 3) Having communities that are safer and stronger places to live and work because crime, disorder and danger related to drug use have been reduced; 4) Ensuring that children affected by a parental drug problem are safer and more able to achieve their potential; 5) Supporting families affected by drug use; 6) Improving the effectiveness of delivery at a national and local level. There are also four areas needing sustained action with respect to alcohol use: 1) Reduced alcohol consumption; 2) Supporting families and communities; 3) Positive public attitudes and positive choices; 4) Improved treatment and support
Scotland is known by the WHO and the European Union as an exemplar of policy development and implementation in public mental health and has influenced policies in other countries (NHS Scotland 2008).	

Appendix 3 – Ministry of Community and Social Services Ontario Disability Support Program (ODSP)

ODSP is a provincial social assistance program that provides income and employment support to eligible Ontario residents who have disabilities.

ODSP does recognize that some people with disabilities are able and can work. Employment supports are provided to recipients if they meet the specified criteria: they are 16 years of age or older, live in Ontario, are legally allowed to work in Canada, and are either receiving ODSP income support, or have a physical or mental disability that is expected to last a year or more and, as a result, makes it hard for them to find or keep a job.

Many people with disabilities, including ODSP recipients, face barriers to employment. ODSP recipients are provided with supports to address some of these barriers. ODSP supports include: job placement assistance and job retention supports to help people with disabilities prepare for, find and keep jobs and advance their careers; support for people with disabilities who are starting their own business.

ODSP also supports initiatives to inform employers about this untapped talent pool and encourages them to diversify their workplace by looking beyond traditional labour sources by providing supports to hire and retain employees with disabilities. These have included:

- The “Business Takes Action” project in partnership with the Canadian Manufacturers and Exporters (CME), which challenges employers to make 10 per cent of all new hires people with disabilities, and provides tools and advice to CME members to support that goal
- The Job Opportunities Information Network (JOIN) which represents the combined effort of local service providers in Toronto to help people with disabilities find jobs and help employers recruit qualified candidates
- In November 2007 a Symposium on Disability and Employment was held and provided nearly 200 participants with an opportunity to enhance their capacities to recruit and retain people with disabilities, and to share best practices. The subsequent employer symposiums were held on November 10, 2008 and November 5, 2009, which built on that foundation.

ODSP Employment Supports serves a diverse group of people with a range of disabilities. Clients select a community-based service provider to support them in finding and keeping employment. The service provider will work with the client to determine what employment services and supports are required, and tailor its approach to meet these individual needs. For example, one client may require help with job preparation activities to build skills and disability-related job supports, while another simply needs an advocate to make a connection to employers.

Eligibility for ODSP is based on an applicant's individual circumstances, including his or her financial situation and disability status.

Initial eligibility

To be eligible for ODSP, an applicant must live in Ontario, be 18 years of age or older, be in financial need, and have assets no greater than the limits set out in the program. The ministry takes into account a variety of factors related to an applicant's circumstances, including assets and income from all sources, family size and make up, and type of accommodation.

An applicant who qualifies financially for ODSP also needs to go through a disability determination process to determine if he or she is a person with a disability, as defined under the *ODSP Act*, unless he or she is a member of a prescribed class, such as someone receiving Canada Pension Plan Disability benefits, or a resident of certain institutions.

Ongoing eligibility

Eligibility for social assistance must be established on a monthly basis. Recipients must report income and changes in circumstance to ensure that they are receiving the correct amount of social assistance.

In addition, some ODSP recipients have medical review dates assigned when they are first found eligible for the program. Medical review dates are set only where someone's condition may improve. Recipients are informed at the time they are granted ODSP if a medical review has been assigned, and if so, when. Medical reviews help us confirm whether a recipient continues to qualify for ODSP.

For more information about eligibility for ODSP income support you may access the following link on the ministry's website at: http://www.mcss.gov.on.ca/en/mcss/programs/social/odsp/income_support/eligibility.aspx.

ODSP income support payments involve a basic needs component and shelter allowance.

- The basic needs component helps with the cost of food, clothing and other necessary personal items. The amount for basic needs is based on family size and composition.

- A shelter allowance helps with utilities, mortgage or rent, property taxes, and home insurance premiums. The amount ODSP pays is based on actual costs up to a maximum set according to family size.

Basic Needs

The maximum monthly amount provided for basic needs is determined by using the Table in Regulation section 30(1), paragraph 1, as shown below.

No. of Dependants Other than a Spouse	Dependants 18 Years or older	Dependants 13 -17 Years	Dependants 0 - 12 Years	Recipient	Recipient and Spouse	Recipient and Spouse
				See Note 1 below	See Note 2 below	See Note 3 below
0	0	0	0	$578	$855	$1,153
1	0	0	1	721	855	1,153
	0	1	0	739	873	1,171
	1	0	0	921	1,030	1,328
2	0	0	2	721	855	1,153
	0	1	1	739	873	1,171
	0	2	0	757	891	1,189
	1	0	1	921	1,030	1,328
	1	1	0	939	1,048	1,346
	2	0	0	1,097	1,225	1,523
For each additional dependant, add $196 if the dependant is 18 years of age or older, or $18 if the dependant is 13 - 17 years of age, or $0 if the dependant is 0 - 12 years of age.						
Note 1.	A recipient if there is no spouse included in the benefit unit.					
Note 2.	A recipient with a spouse included in the benefit unit if Note 3 does not apply.					
Note 3.	A recipient with a spouse included in the benefit unit if each of the recipient and the spouse is a person with a disability or a person referred to in subparagraph 1 i of subsection 4 (1) or paragraph 6 of subsection 4 (1).					

Note: The calculation of income support for a recipient with a spouse included in the benefit unit, where each is a person with a disability, is subject to a maximum of $1,707 per month. Where there are dependants included in the benefit unit, additional allowances and benefits are added to the maximum amount.

Additional assistance may be provided through Ontario Child Benefit (OCB) and National Child Benefit Supplement (NCBS). A Transitional Child Benefit (TCB) is also available for families with children under 18 years of age who are receiving social assistance and not receiving the OCB, or receiving less than the maximum amount of the OCB. This benefit covers the difference, for eligible clients, between the former ODSP Income Support rate structure and the ODSP rates that began in July 2008.

Shelter Amount

Benefit Unit Size	Maximum Monthly Shelter Allowance
1	$464
2	729
3	791
4	859
5	926
6 or more	960

Example:

The maximum monthly amount of income support a single person may receive if they do not have any dependants and if they rent or own their home is $1,042.

Basic Needs	$578
Shelter Allowance	464
Total	**$1,042**

However, ODSP is intended to supplement other income. When a person's needs are being met through other sources, such as income from employment, the need for assistance is reduced.

For more information about you may access the following income support directives on the ministry's website at http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ODSP_incomesupport.aspx:

- 6.1 - Basic Needs Calculation
- 6.2 - Shelter Calculation.

The maximum monthly employment earnings that a person may receive and continue to remain eligible for ODSP income support, is different for each person.

A person is ineligible for ODSP when their income from other sources exceeds the amount they would otherwise receive from ODSP, after all exemptions and deductions have been taken into consideration.

Generally, 50% of a recipient's or spouse's net earnings from employment is deducted from their ODSP income support payment. Net earnings are the amount remaining after mandatory deductions have been deducted from the Gross Earned Income. Mandatory deductions are the amounts which are paid from wages, salaries, casual earnings or a training allowance for income tax, Canada Pension Plan contributions, Employment Insurance, union dues, and mandatory pension contributions.

The amount deducted from ODSP income support may be further reduced if the person with earnings has eligible child care expenses or disability related employment expenses. In addition, each family member who reports employment income and who is not in full-time post-secondary education will receive a Work-Related Benefit of $100 a month to help with employment costs, such as transportation or work clothing.

For people who are attending post-secondary school full-time (defined as at least 60% of a full course load, or at least 40% of a full course load for persons with disabilities under ODSP), all of their employment earnings are exempt under ODSP, which means their earnings do not affect their ODSP payments. Since their earnings are completely exempt, they do not qualify for the Work-Related Benefit.

Scenario:

Jane is a single person without dependents. She rents the apartment she is living in and is eligible to receive the maximum shelter allowance. Jane does not qualify for any additional benefits. Jane earns $100 a week (after the mandatory deductions e.g. taxes, pension contributions) from employment and does not have any disability-related employment expenses. Jane is not attending post-secondary school. She does not have any other income and does not have any assets.

Jane's budgetary requirements are $1,042:

Basic Needs Amount	$578
Shelter Allowance Amount	+ 464
Budgetary Requirements Total	**$1,042**

Jane's chargeable employment income is $200:

Net income	$400
Apply 50% Rate Exemption for employment income ($200)	- 200
Chargeable Earnings Total	**$200**

Since Jane's income ($200) is less than the amount she would otherwise receive ($1,042) she would continue to be eligible for ODSP income support.

Jane is also eligible for the $100 Work-Related Benefit, because she works.

Her monthly income support amount would be $942:

Budgetary Requirements	$1,042
Chargeable Earnings	- 200
Sub-total	**$842**
Work-related Benefit (WRB)	+ 100
Total income support	**$942**

Jane's total income is = earnings ($400) + income support ($942) = $1342.

For more information about the treatment of employment earnings you may access the following ODSP income support directives on the ministry's website at http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ODSP_incomesupport.aspx:

- 5.3 - Deductions from Employment and Training Income
- 5.18 - Exemption of earnings of post-secondary students.

Rapid Reinstatement

There is a rapid reinstatement provision available under ODSP to help former recipients who have left the program return to ODSP quickly in some cases. This is a streamlined reapplication process for granting income support to a former ODSP recipient without reviewing his or her disability. It is available to recipients who exit ODSP for employment.

For more information you may access ODSP income support Directive 1.3 - Rapid Reinstatement on the ministry's website at http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ODSP_incomesupport.aspx.

Supplemental Health Care Benefits

ODSP provides supplemental health care benefits such as drug and dental coverage, and assistance with the costs of vision care, medical transportation, diabetic supplies, assistive devices and mobility device repairs and batteries.

A person must continue to be eligible for ODSP income support to receive these benefits. However, recipients leaving ODSP may qualify for either the Transitional Health Benefit or the Extended Health Benefit.

The Transitional Health Benefit provides an extension of drug, dental and vision care benefits to recipients exiting ODSP for employment until comparable coverage is available from their employer.

Recipients leaving ODSP who have high health care costs may be eligible for the Extended Health Benefit. Depending on the person's health care needs and

amount of income received, the Extended Health Benefit may help with the cost of:

- Prescription drugs
- Basic dental care
- Vision care
- Medical supplies, such as diabetic and incontinence supplies
- Transportation to and from medical appointments
- Assistive devices, including hearing aids.

For more information, you may access the ministry's website: http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ODSP_incomesupport.aspx:

Directive 9.10 - Extended Health Benefit

- Directive 9.19 - Transitional Health Benefit

To be eligible for ODSP Employment Supports, a person must:

- live in Ontario
- be 16 years of age or older
- be legally allowed to work in Canada, and
- EITHER be receiving ODSP income support, OR have a physical or mental disability that is expected to last a year or more and, as a result, makes it hard for them to find or keep a job.

ODSP income support family members who do not have a disability (spouses and dependent adults) are not eligible to receive ODSP Employment Supports.

- Ontario Works provides employment assistance to ODSP adult family members without disabilities.

Ontario Works participants are not eligible for ODSP Employment Supports as Ontario Works provides a comprehensive range of job placement and retention services.

A person who is receiving, or eligible to receive, disability or rehabilitation benefits from other public or private sources (i.e. Canada Pension Plan, Employment Insurance, Workers Safety Insurance Board, etc.) may not be eligible for ODSP Employment Supports.

For more information you may access ODSP Employment Supports Directive 2.1 – Program Eligibility on the ministry's website at http://www.mcss.gov.on.ca/en/mcss/programs/social/directives/ODSP_employmentsupports.aspx.

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