SETTING THE STAGE: A PROFILE OF THE SOUTH RIVERDALE CHC COMMUNITY

September 2022

INTRODUCTION

This document is a review and an update of the environmental scans conducted periodically since 2011 which described some of the contextual issues and demographic trends impacting SRCHC's community from a social determinant of health perspective. The goal of these reports is to provide an overview and update of ongoing key trends and to highlight issues and research which will help us to better understand some of the overarching needs and concerns facing our community with a focus on income, race/ethnicity and immigration status, and drug use. This report draws from the work of research conducted by academics, community and government agencies. Social demographic and health profiles for the neighborhoods where SRCHC directs its services and for the city overall are provided in Appendix A.

Census data in this report is from both 2016 and 2021 (where available). Data from the 2021 Census, which took place in May, is still being released with final data sets expected in January 2023. Neighbourhood-level data which the City releases is not yet available for any of the 2021 Census data sets. While the Census will always be a valuable source of information about our community, it is important to keep in mind some of its shortcomings. Although the mandatory long-form census was reinstated in 2016, its elimination in 2011 leaves gaps in information. The ability to compare data with and determine trends over this window of time has been lost for much of information that the City normally provides. In addition, while neighbourhood-level gives SRCHC some valuable indications of what issues our community might be facing, it does not always give us the whole picture. SRCHC's own comparisons of our client demographics and health indicators with those provided by the City for our catchment neighbourhoods reveal much deeper poverty and more complex health and social issues then the official record would suggest. Within Toronto's diverse composition, there are health inequities within neighbourhoods and for particular groups which can sometimes be hidden by the averaging out across larger groups. Despite overall improvements in health status at the population level, health disparities based on immigration status, race/ethnicity, gender identity, income-level and other factors have been well documented within Toronto. These factors can also intersect and overlap with each other to create interdependent and worse health outcomes. Below is an overview of some of these issues.

SOUTH RIVERDALE COMMUNITY HEALTH CENTRE

South Riverdale Community Health Centre is a community-run organization, which operates from the belief that health is a state of physical, mental and social well-being. The role of the Centre is to provide quality primary health care, as well as health promotion programs and other services which address the social determinants of health. In 2021/22, SRCHC restructured its service teams to better serve our priority populations/areas of focus. Programs and services are delivered by three teams: Strategy & Systems, Integrated Planning & Delivery, and Program Delivery & Innovation. The Strategy & Systems Team is comprised of the CEO, one Vice-President (Strategy & Systems) and five Directors (Performance

& Quality, Substance Use and Mental Health, Integrated Primary Care, Community Health and Chronic Disease Programs, and Operational Health Systems). The Program Delivery & Innovation Team is made up of smaller program teams, each with a Program Manager leading and supporting their work. This includes Human Resources, IT/Information Management, Finance, Communications and Operational Health Systems which is responsible for reception, administrative support, referral management and facilities. Currently, SRCHC has a multi-disciplinary staff of 207 including 33 employees who are workers with lived/living experience. In 2021/22, there was a 35% increase in full-time positions (or equivalent) working at SRCHC and 16% of staff positions were designated for people with lived experience.

SRCHC's values and strategic directions were reviewed and updated in 2021/22 through a process that involved the board, staff, clients and partners. The values that guide SRCHC's mission of 'empowered, healthy, thriving communities where everyone belongs' are: commitment to Reconciliation & Relationship with Indigenous people, health equity and social justice, meaningful engagement of stakeholders in planning and evaluation of services, a holistic approach and evidence and values-informed practice.

CATCHMENT GEOGRAPHY

The geographic boundaries of the SRCHC's catchment were officially expanded at our June 2018 AGM and are now: Eglinton Avenue in the north to the Lake in the south, Warden Avenue to the east, and west to the Don River. Within these boundaries, there are 16 neighbourhoods (as defined by the City of Toronto): **South Riverdale, North Riverdale, Greenwood-Coxwell, Blake Jones, Playter Estates**, **Broadview North, Danforth, Danforth – East York, Old East York, O-Conner Parkview, Taylor-Massey, Oakridge, Woodbine Corridor, Woodbine-Lumsden, East End-Danforth,** and **The Beaches**. Neighbourhoods to north of the Danforth were identified as underserviced area by past environmental scans and after an extensive needs assessment conducted in 2011 by SRCHC in partnership with other community agencies. SRCHC has been working in neighbourhoods to the north and east of South Riverdale for many years through the DECNET (Diabetes Education Community Network) program, COUNTERfit harm reduction program, Toronto Community Hep C Program, Primary Care Asthma Program, services for people who are non-insured and through other projects. In 2017, SRCHC integrated with Harmony Hall Centre for Seniors which is located in the **O-Connor Parkview** neighbourhood, just above Taylor-Massey. SRCHC has also maintained an office and program space on the Danforth at Greenwood since 2011. In 2019, as part of our work within our newly formed Ontario Health Team, East Toronto Health Partners, we opened a harm reduction and health hub in the **Oakridge** Neighbourhood near St. Clair E and Warden. In 2018, SRCHC took over operation of the Moss Park Overdose Prevention Site located in the **Moss Park** neighbourhood and in 2020 became a member of the Downtown East OHT. Data for the Moss Park neighbourhood will be included in future reports when the 2021 neighbourhood profiles are released. See Appendix B for a catchment map with SRCHC's service locations.

In April 2022, the City revised the neighbourhood boundaries to reflect population shifts/growth and increased the number of officially defined neighbourhoods from 140 to 158. Sixteen neighbourhoods were split into 34 new ones (with the old ones retired), but none of these were within SRCHC

catchment. Most of the impacted neighbourhoods are in the downtown core, north/north west areas of the city or the south/west.

POPULATION

The population of SRCHC's catchment area is approximately 215,000. This represents about 8% of the population of Toronto. This rough estimate is based on 2016 Census population data from the 16 City-defined neighbourhoods mentioned above. South Riverdale is the most populated neighbourhood with almost 28,000 people (an increase of 9% since 2011). Taylor-Massey (formerly Crescent Town) is the densest with 15,528 people per sq km. By comparison the overall density of Toronto is 4,334 people/sq. km.

Between 2016 and 2021, Toronto's population increased by2.3%, less than in the previous 5-year period (when the increase was 4.5%) Toronto's highest growth neighbourhoods continue to be located in largely downtown and, more recently, in midtown, south Etobicoke and several neighborhoods in the city's north-west near Downsview. Toronto's population growth is largely driven by international migration, and this was reduced by the COVID-19 pandemic. Of the total year-over-year net change of -48,136 people, Statistics Canada has estimated that international migration represents 81% of the decline. Nine of SRCHC's catchment neighbourhoods saw population declines (all less than 4% in neighbourhoods closer to the DVP just above and below the Danforth) between 2016 and 2021. The rest of our catchment had growth during that period of up to 3.7%.[1]

Seniors

Older age is associated with increased prevalence of chronic disease and injuries due to falls. Demographic profiles of seniors in Toronto reveal that a significant proportion is faced with socioeconomic barriers that can undermine health, such as poverty and social isolation.[2]

The age structure of Toronto's population is continuing to shift towards an older population. The 2016 Census data showed that for the first time there are more people over the age of 65 in Toronto than there are people under the age of 15. In the five years since, Toronto has continued to have an increasing share of older adults - from 15.6% in 2016 to 17.1% in 2021. The proportion in SRCHC's catchment neighbourhoods ranges from 12% to 19%.

2016 Census data showed an increase in the number of seniors living on low income across Canada. At that time, most of SRCHC's neighbourhoods had a similar or higher proportion of seniors (age 65-84) who live alone compared to the City average (25%). East End-Danforth and Oakridge had the highest proportion, both at 39%.**Error! Bookmark not defined.** The social isolation of seniors affects community engagement, healthy aging, income security and care giving needs. It can also lead to depression and increased vulnerability to elder abuse. Lack of supportive networks for seniors has also been linked to

[1] City of Toronto. Backgrounder - 2021 Census: Population and Dwelling Counts. Feb 11, 2022. Available at: https://www.toronto.ca/wp-content/uploads/2022/02/92e3-City-Planning-2021-Census-Backgrounder-Population-Dwellings-Backgrounder.pdf

[2] Toronto Public Health. *Unequal City: Income and Health Inequalities in Toronto*. October 2008.

increased risk of dementia and cognitive decline.[3] In 2020/21, seniors made up 12% of Toronto food bank visitors (a proportion that has been increasing gradually for more than 10 years).[4]

It is important to note that while most government programs and policies define seniors as anyone 65 or older, many of the SRCHC's target populations do not make it to this 'old age'. For example, a Toronto study of shelter residents found that the average age of death for homeless men was 45 years.[5] In 2021, the City reported 216 deaths of people experiencing homelessness (an underestimate which doesn't include people without housing who die in hospitals). The average age of the men who died was 49 and for women was 40 years.[6] Research has also shown that individuals living in Canada's lowest income neighbourhoods had death rates that were 28% higher than those living in the wealthiest.[7] Despite their relatively young age, many of our clients live with illnesses and disability-related challenges that are typically attributed to seniors, such as diabetes, arthritis and activity limitation. The 2021 Daily Bread Food Bank survey found that overall, 51% of food bank clients report having a chronic disability or serious illness. A report that examined senior poverty from an equity lens using data from the 2016 Census found that immigrant seniors were twice as likely to live in poverty than non-immigrant seniors, and racialized seniors twice as likely to live in poverty than non-racialized seniors.[8]

Lone Parent Families and Children

Beginning in the 1980s, the number of lone parent families in Toronto started to increase at a higher rate than for couples with children. From 2016 to 2021, the number of one-parent families remained stable in Toronto with most now living in the northwest and in mid- and south Scarborough.[12] The 2016 Census data found that for Canadian children living with two parents, 11% lived in low-income households. This proportion increases to 39% in households with one parent. Additional research focused on Toronto has documented that lone parent families are likely to live in a low-income neighbourhood.[9] In 2016, the proportion of lone parent families was higher than the City average (43%) in Blake Jones, Broadview North and O-Conner-Parkview. 2021 Census data found that lone parent families in Toronto had a median income of $71,500, just over half of the median family income for couple families with children and $10,000 lower than any region in the GTHA except Hamilton.[12] The East Toronto OHT has the highest proportion of children and youth (ages 0-19 years) (23.1%) among the other sub-regions and relative to Toronto Central LHIN (17.9%). Thorncliffe Park had the highest proportion (32.8%) among all the neighbourhoods in Toronto Central LHIN.[10]

[3] Report on the Social Isolation of Seniors 2013-2014. National Seniors Council. November 2014.

[4] Daily Bread Food Bank. Who's Hungry. A Profile of Hunger in the Toronto Region 2021. Available at: https://www.dailybread.ca/wp-content/uploads/2021/11/DB-WhosHungryReport-2021-FINAL.pdf

[5] Hwang S. *Mortality Among Men Using Homeless Shelters in Toronto, Ontario*. J American Med Assoc. Vol. 283. p. 2152-57

[6] City of Toronto, Toronto Public Health. Deaths of people experiencing homelessness. Available at: https://public.tableau.com/app/profile/tphseu/viz/DeathsofPeopleExperiencingHomelessness/HomelessDeathsFinal?publish=yes

[7] Wilkins, R. (2007). Mortality by Neighbourhood Income in Urban Canada from 1971 to 2001. Ottawa: Statistics Canada, Health Analysis and Measurement Group.

[8] Social Planning Council/Well Living House. Senior poverty & inequity: the Toronto experience. August 2020. Available at: https://www.socialplanningtoronto.org/senior_poverty_report

[9] United Way of Greater Toronto and the Canadian Council of Social Development. *Poverty by Postal Code: The Geography of Neighbourhood Poverty, 1981-2001.* April 2004.

[10] Toronto Central LHIN. East Toronto Sub Region Population Profile. July 17, 2019. Accessed Sept 14, 21 from: https://drive.google.com/file/d/1z6qatcBLutONLD9Fn3p_2XjWRFj-zO93/view

SEX, GENDER AND SEXUAL ORIENTATION

Sex, gender and sexual orientation each influence individual health. These terms are sometimes used interchangeably but have different meanings. Sex refers primarily to physical and biological features, while gender is a more multidimensional concept that is influenced by additional factors, including cultural and behavioural norms and self-identity. Gender identity is how someone experiences their internal sense of gender and may be the same or different than the sex assigned to them at birth. Gender/gender-identity is not the same as sexual orientation – someone can identify as female and be sexually attracted to women, men, neither or both. Sex, gender and sexual orientation shape health behaviours, exposures and vulnerabilities, and also influence health systems/health care provider responses. Differences in healthcare utilization, unmet needs for care and health outcomes based on sex, gender or sexual orientation have been well documented.

The 2021 Census introduced the concept of gender for the first time and makes the distinction between sex at birth and gender. Canada is the first country to collect and publish data on gender diversity from a national census. In May 2021, there were 59,460 people in Canada aged 15 and older living in a private household who were transgender (0.19%) and 41,355 who were non-binary (0.14%). Together, this represents 1 in 300 people. Just over half of non-binary people aged 15 and older (52.7%) lived in one of Canada's six largest urban centres with 15.3% (the largest proportion) living in Toronto.[11] 2021 is also the first time that the Census has released data on the gender diversity of couples. In Toronto, approximately 1.5% of all couple families were same-gender, transgender or non-binary. Approximately half were married (47.8%) and half were common-law (52.2%).[12] Approximately, 11% of SRCHC's service users identify as 2SLGBTQ+ (two-spirited, lesbian, gay bisexual, trans, queer or questioning and additional sexual orientations and gender identities).[13]

INCOME & POVERTY

It has been well-established that income/poverty is a significant determinant of health and that extreme poverty in Toronto is growing. It is estimated that socio-economic circumstances account for 50% of a person's health.[2] Over the last 20 plus years, Toronto has seen an increase in the number of high poverty neighbourhoods, as well as pockets of poverty in high income neighoburhoods.[9]-[14] Poverty in Toronto is now predominantly racialized, with newcomers and visible minorities more likely to have lower incomes. A 2019 report on Toronto neighbourhood change research found that income inequality, income polarization, and ethno-cultural/racial segregation are increasing[15]. There is a long-term trend toward inequality in Toronto. Though disproportionately born by those who are low income, research has shown

[11] City of Toronto. Backgrounder. April 29, 2022. 2021 Census: age, sex, gender, dwelling type. Available at: https://www.toronto.ca/wp-content/uploads/2022/04/9654-City-Planning-2021-Census-Backgrounder-Age-Sex-Gender-DwellingType.pdf

[12] City of Toronto. Backgrounder. 2021 Census: Families, Households, Marital Status, Income. July 19, 2022. Available at: https://www.toronto.ca/wp-content/uploads/2022/07/9877-City-Planning-2021-Census-Backgrounder-Families-Hhlds-Marital-Status-Income.pdf

[13] Includes clients with at least one clinical or group encounter in the 3 years before August 2022

[14] Hulchanski D. *The Three Cities Within Toronto: Income Polarization Among Toronto's Neighbourhoods, 1970-2005.* Cities Centre & Faculty of Social Work. University of Toronto. Available at: NeighbourhoodChange.ca

[15] Hulchanski, D., Maaranen, R. (2019). How segregated is Toronto? Inequality, Polarization and Segregations Trends and Processes. Available at: https://www.ryerson.ca/content/dam/rcis/documents/Segregation_Trends_in_Toronto_Hulchanski_at_Ryerson_14_Feb_2019_w_Appendix.pdf

that social inequality negatively affects the health and well-being of the entire population by creating communities that are less cohesive, less productive, more stressful and more violent.[16]

Across Canada, the largest group of people living in poverty have a job. From 2006 to 2016, working poverty continued to grow in Toronto by 27%.[17] In a similar time period (2008 to 2018) temporary employment increased by 34% in the city, while permanent jobs increased by only 7%.[18] Immigrants and people who are racialized are disproportionately employed in these more precarious jobs.[19] When someone is unable to find work, a single person with no children is eligible to receive about $8,796 per year on social assistance (Ontario Works). The recently announced (August 2022) 5% increase to support payments for people with disabilities who are unable to work will amount to an extra $58 per month for someone currently receiving $1,169 ($14,028/year). There was no increase announced for Ontario Works recipients.

Toronto continues to rank poorly in terms of housing affordability in both national and international comparisons. The average rent for a 1-bedroom apartment in Toronto is close to $2,000 according to a recent analysis of current online apartment listings.[20] A 2015 study of rental housing across Canada ranked Toronto and the GTA as having a 'critical' lack of affordability rental options. Over 80,000 applications for affordable housing in Toronto were on the City's social housing waitlist as of June 2022.[21] The 2021 Census found that almost one in five households in Toronto were in core housing need. Core housing need refers to housing that is inadequate, unaffordability or unsuitable (i.e. not enough of bedrooms) and where income level would not allow a suitable local alternative.

Perhaps not surprisingly then, the City of Toronto's most recent (2021) Street Needs Assessment found that City's homeless population remains high at 7,347 people. This point-in-time assessment is conducted every three years in April and enumerates people with no fixed address across the city who are staying outdoors, in shelters, in hospitals, jails, out of the cold programs, or 24-hour drop-ins. In 2021, it found that Indigenous and black people are overrepresented among people experiencing homelessness, as are people who were homeless as youth or in foster care and people who are 2SLGBTQ+. The refugee shelter sector had previously been growing in Toronto but boarder restrictions due to COVID meant fewer refugee families in 2021. .[22] . In an effort to create physical distance in the City's overcrowded shelter system, the number of beds in the shelter system was reduced early the pandemic and shelter programs were offered some replacement spaces at hotels and at community centres. Many of these temporary sites are now closed. In 2021 (when the needs assessment was conducted), there were 2,978 people staying in COVID response shelters. One visible impact of the reduction in shelter capacity has been the increased visibility and size of encampments, which represented 10% of the total number of people who were homeless in

[16] Toronto Community Foundation. *Toronto's Vital Signs 2014 Report.* Available at: http://torontosvitalsigns.ca/
[17] Stapleton, J. The Working Poor in the Toronto Region: A closer look at the increasing numbers.Metcalf Foundation, 2019. Available at: https://metcalffoundation.com/wp-content/uploads/2019/11/Working-Poor-2019-NEW.pdf
[18] City of Toronto, "City Rebased - Employment Composition - City of Toronto and Other Geographies" 2019.
[19] Toronto Community Foundation. Vital Signs Report 2019/20. Available at: https://torontofoundation.ca/vitalsigns2019/
[20] GTA Rent Report. August 2022. Available at: https://liv.rent/blog/2022/08/august-2022-toronto-rent-report/

[21] City of Toronto. Social Housing Waiting List Reports. Available at: https://www.toronto.ca/city-government/data-research-maps/research-reports/housing-and-homelessness-research-and-reports/social-housing-waiting-list-reports/
[22] City of Toronto. 2021 Street Needs Assessment. Available at: https://www.toronto.ca/legdocs/mmis/2021/ec/bgrd/backgroundfile-171729.pdf

2021.The 2021 assessment found that outdoor homelessness has increased in all areas of the city. The number of people staying outdoors in 2021 was estimated to be 742, up from 533 in 2018. There are many reasons why people are choosing to live outdoors instead of in a shelter or hotel. For example, the vast majority of shelter hotels are located outside of the downtown core (only one COVID response hotel was located in SRCHC's catchment which closed in the spring of 2022 and will become a condo), far from informal and formal support networks. Additionally, shelters are often at capacity and are not safe places for people who use drugs.[23] Recent analysis by the City of Toronto found that an average of 40 people were turned away per night from the shelter system from January 2021 to June 2022 due to capacity issues. In the first six months of 2022, the average was 63, a number that doesn't include families and counts couples as a single request and in June the average was 100.[24] An estimated 216 people experiencing homelessness died in Toronto last year with 132 who were residents of shelters.[6] Fatal overdoses account for 55% of these deaths. Overdose deaths have increased in the shelter system from an average of about one per month in 2018 to four per month in 2020 to 5 per month in 2021.[25]

Research from the University of Toronto which first documented the "Three Cities" income polarization trend in Toronto in 2009 was re-analyzed and updated using 2012 tax-file data. The updated analysis showed that the trend continued: middle income earners are disappearing in Toronto (32% in 2012, down from 68% in 1990) and there is increasing poverty in the inner suburbs.[26] In 2015 Toronto Public Health updated a 2008 report which demonstrated how low-income groups in Toronto have worse health for most of the health status indicators they examined. The 2015 report found that overall inequities have not improved. Low income groups had worse health for 20 of 34 health status indicators. For example, men in the lowest income group were 50% more likely to die before age 75 and women in the lowest income group were 85% more likely to have diabetes. Health inequities persisted for 16 indicators, became worse for four and improved for only one (colorectal cancer).[27] This pattern of health inequity persisted for COVID-19. Using 2016 Census data, Toronto Public Health (TPH) looked at neighbourhood-level socio-demographics to see which communities in Toronto are being most impacted by COVID-19. Excluding long-term care facilities (where COVID-19 has been rampant and where the majority of deaths have occurred across the province), TPH found that the highest rates of COVID-19 occurred among the lowest income neighbourhoods (concentrated in the northwest corner of the City but several in SRCHC's catchment or OHT boundaries including Taylor-Massey and Thorncliffe Park), as were hospitalizations for COVID-19.

A 2018 report by the Social Planning Council of Toronto analyzed Census data and found that child poverty affects families in every single ward in Toronto. It also confirms other research which has demonstrated that the highest rates of child poverty are among Indigenous, racialized and newcomer families. For example, one third of racialized children (33.3%) live in low-income families, compared to 15% of non-racialized children. The study found that 84% of Indigenous families with children in Toronto live in

[23] Encampment Support Network. Accessed September 15, 2021 from: https://www.encampmentsupportnetwork.com/
[24] City of Toronto, Shelter Support Housing Administration. Shelter System Requests for Referrals. Available at: https://www.toronto.ca/city-government/data-research-maps/research-reports/housing-and-homelessness-research-and-reports/shelter-system-requests-for-referrals/
[25] City of Toronto. Overdoses in Homelessness Services Settings. Available at: https://www.toronto.ca/city-government/data-research-maps/research-reports/housing-and-homelessness-research-and-reports/overdoses-in-homelessness-services-settings/
[26] Hulchanksi, D. The Three Cities within Toronto. Available at: http://3cities.neighbourhoodchange.ca; Toronto Star (2015). Toronto's income gap continues to widen, finds U of T expert. Available at: http://www.thestar.com/news/city_hall/2015/01/28/torontos-income-gap-continues-to-widen-finds-u-of-t-expert.html
[27] Toronto Public Health. The Unequal City 2015: Income and Health Inequities in Toronto. April 2015.

poverty. Even among wards with the lowest rates of child poverty, areas within these wards have child poverty rates as high as 35% to 53% — 2 to 3.5 times higher than overall rates.[28] This study illustrates both the pervasiveness of child and family poverty in Toronto and the hidden pockets of poverty within seemingly affluent communities.

In 2021, Toronto had a median total household income of $85,00, continuing to be the lowest of all regions in the GTHA. The median individual income for people ages 15 and older in Toronto was $45,200 (the lowest again in the GTHA). In 2021, the poverty line threshold (i.e. the LIM-AT[29]) for a single person was $37,480 and for a four-person household was $53,005. In 2021, 13% of people in Toronto had an income that was below this poverty line.[12] **In 2015, Blake Jones**, **O'Conner-Parkview**, **Oakridge** and **Taylor-Massey** had a higher proportion of low-income residents compared to the rest of the city (when the poverty line was $44,266). Detailed neighbourhood-level data is not yet available but preliminary reports have found that low median households were scattered throughout the city in 2021 with most located in the downtown core, East York and Central Scarborough. SRCHC's 2022 client survey showed that 62% of our clients have household incomes of less than $45,000. Nearly half (49%) have social assistance (OW, ODSP or CPP) as their main source of income.

FOOD SECURITY

Those who are food insecure are more likely to suffer from chronic physical and mental health conditions according to The Public Health Agency of Canada. The Daily Bread Food Bank's (DBFB) annual survey of food bank users first noted in 2017 that people in Toronto are now coming to food banks for longer periods than they used to – the median length of time coming to a food bank then was 24 months, up from 12 months in 2008.[30] The beginning of the pandemic saw an instant and dramatic spike in food bank use. Between April 1, 2020 and March 31, 2021, food banks in Toronto saw the highest number of visits ever recorded (1.45 million). This was a 47% increase from the year prior and an unprecedented level of growth (visits rarely increase by more than 5 to 10% per year). For the first time, new clients accessing Toronto food banks outnumbered existing clients. The DBFB attributes this to the impact of the pandemic coupled with the existing ongoing stressors of financial precarity and unaffordable housing. Food prices increased by nearly 10% between April 2021 and April 2022. A recent report on the impacts of inflation from Statistics Canada found that more than two in five Canadians report being most affected by rising food prices.[31] During this period, longer-term food bank clients reported a greater degree of food insecurity than new clients. Of clients accessing food banks for

[28] Social Planning Council. 2018 Child & Family Poverty Report. Municipal Election Edition. Available at: https://www.socialplanningtoronto.org/pockets_of_poverty
[29] With the 2011 Census, Statistics Canada shifted from a measure of low income known as the LICO (low income cut-off), calculated as the line at which a household would spend 20% or more than the average on similar household essentials to the LIM (low income measure). The LIM rate is defined as the proportion of people making less than 50% of the median national after-tax income, adjusted for household size. This relative measure of poverty is becoming more commonly used than the LICO (Low-Income Cut-Off) which estimated a basket of necessities (food, shelter, clothing, etc) and then determined thresholds below which a family would likely devote a larger share of its income on these items. The LIM can be generated using tax file data (which is more reliably collected and up-to-date) and is internationally comparable. It does not, however, adjust for the cost of living in various geographies.
[30] Daily Bread Food Bank. *Who's Hungry. 2017 Profile of Hunger in Toronto*. Available at: http://www.dailybread.ca
[31] Statistics Canada. Rising prices are affecting the ability to meet day-to-day expenses for most Canadians. June 9, 2022. Available at: https://www150.statcan.gc.ca/n1/daily-quotidien/220609/dq220609a-eng.htm

more than one year, 58% did not eat for a whole day almost every month. In comparison, 44% of clients accessing food banks for one year or less did not eat for a whole day almost every month.[32]

IMMIGRATION STATUS, RACE & ETHNICITY

Although immigration to Toronto has slowed down in recent years, with more newcomers choosing to settle in the GTA[33], Toronto still remains the top city in Canada for immigrants and its population growth is due primarily to immigration.[34] Toronto receives approximately 50,000 newcomers each year.

In 2015, the overall percentage of Toronto residents born outside of Canada was about 51%. The proportion of immigrants in SRCHC's community at that time ranged greatly from neighbourhood to neighbourhood, from a low of 26% in North Riverdale to 33% in South Riverdale to 61% in Taylor Massey.[1] The total percentage of new immigrants in Toronto (less than 5 years) was 7% and most of SRCHC's neighbourhoods had a lower proportion of newcomers, except for O-Conner Parkview (7%), Oakridge (13%) and Taylor Massey (16%). 65% of SRCHC's current clients identify as being from a racialized group.[13]

More or less unchanged since 2011 is the number of Toronto residents who do not speak English or French at 5%. This rate is more than double in some SRCHC neighbourhoods, such as South Riverdale where (in 2011) 12% of newcomers do not speak English or French. The top home languages spoken in SRCHC neighbourhoods in 2011 were: Cantonese, Mandarin, Chinese (not specified), Greek, Serbian, Bulgarian, Gujarati, Urdu and Italian. For Toronto overall, in 2015 the top languages spoken at home ere: Mandarin, Cantonese, Tagalog, Tamil and Spanish. According to the 2016 Census, 44% of Toronto residents had a mother tongue other than English or French.[35] By 2021, this proportion had increased to 49%.[36] Other than English, the most commonly spoken language for SRCHC clients is Cantonese/Chinese/Mandarin (8%), followed by Bengali (3%), Tamil (2%) and Spanish (2%).[13]

Studies have shown that although immigrants are initially healthier than their Canadian born counterparts, the longer they live in Canada, the more their health declines.[37]-[38] For example, Toronto-based research documented that immigrants are at higher risk of developing diabetes, especially women.[39] A study on the conditions of Toronto's aging high-rise rental buildings found that in addition to a high prevalence of inadequate housing and risk of homelessness for the people who live in these buildings, 80% were immigrants and/or from racialized groups.[40] Both Taylor-Massey and Oakridge are

[32]Daily Bread Food Bank. Who's Hungry. 2021.Avaiable at: https://www.dailybread.ca/wp-content/uploads/2021/11/DB-WhosHungryReport-2021-FINAL.pdf
[33] Statistics Canada. Article: Migration from central to surrounding municipalities in Toronto, Montreal and Vancouver. June 8, 2010.
[34] Toronto's Vital Signs. Full Report 2010. Toronto Community Foundation.

[35] City of Toronto. Backgrounder. 2016 Census: Families, households and marital status; Language. August 3, 2017.
[36] Statistics Canada. Knowledge of Languages. Released: 2022-08-17. Available at: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/dv-vd/language-langue/index-en.html
[37] Perez CE. Health status and health behaviour among immigrants. Statistics Canada Health Reports 2002;13(Supplement):1-12.
[38] Beiser M. The health of immigrants and refugees in Canada. *Canadian Journal of Public Health*. 2005;96. Suppl 2:S30-44.
[39] Creatore, M.I., Moineddin, R., Booth, G., Manuel, D.H., DesMeules, M., McDermott, S., Glazier, R.H. (2010, May). Age- and sex-related prevalence of diabetes mellitus among immigrants to Ontario, Canada. *Canadian Medical Association Journal:* 182: 781 - 789. Available at: http://ecmaj.com/cgi/reprint/182/8/781.pdf.
[40] Paradis, E. Nine out of ten families at risk of homelessness in Toronto's aging high rise buildings. Research Update, November 2013. Neighbourhood Change Research Partnership. University of Toronto. Available at: http://www.citiescentre.utoronto.ca/Assets/Cities+Centre+2013+Digital+Assets/Cities+Centre/Cities+Centre+Digital+Assets/pdfs/publications/Homelessness+in+Toronto+Rental+Highrise+Bldgs+-+NCRP+Nov-2013.pdf

neighbourhoods with higher than average density, proportions of immigrants and low-income individuals. Both also have higher rates of many chronic illnesses and lower than average rates for most preventative health services when compared with the rest of Toronto.

By 2031, it is estimated that 63% of the population in Toronto will be from a racialized group.[34] Research has demonstrated how racialized communities experience a disproportionate level of poverty in Toronto and that this inequality often extends to health status.[41–42] A study of Ontario data from the 2011 National Household Survey found that racialized men earn 18% and racialized women earn 11% less than their non-racialized counterparts.[43] Racialized workers and recent immigrants in Ontario are also more likely to be working for minimum wage. In 2011, the share of racialized employees at minimum wage was higher than for the total population – 13% v. 9%.[44] The Daily Bread Food Bank's 2019 survey asked respondents to identify their race for the first time and found an over-representation of Black, Middle Eastern, Latin American and Indigenous people compared to the total population. The DBFB's most recent survey also found that food bank users continue to disproportionately be from these racialized communities, a trend which is also reflected in national studies on food insecurity. For example, close to 14% of food bank users identified as Black, compared to just 8% of people in the general population. The City's 2021 Street Needs Assessment also found that racialized populations, especially those who identify as Black or Indigenous were over-represented.

In late July 2020, TPH released data on the ethno-racial group and income level of people who acquired COVID-19 and found that the majority identified as belonging to a racialized group (83% compared with 51% in the general population) and half of all reported COVID-19 cases were from low-income households (compared to 30% of the population of Toronto in 2016).[45] This pattern has continued throughout the duration of the pandemic in Toronto.[46] In August 2022, Statistics Canada released data that looked at the impact of low-income and racialization combined. They found that having low-income increased the risk of COVID-19 mortality and that the Black population was at disproportionately higher risk (compared to other non-racialized and non-Indigenous groups).[47]

Systemic discrimination and racism are responsible for many of these outcomes and are issues in Toronto. This past June the Toronto Police Service released a report using its own data from 2020 which found that it used more force against Black people, more often, even accounting for types of arrest, whether a person was armed, local demographics and other factors.[48] Hate crimes overall have increased in recent years for many racialized groups in Toronto. Hate-related complaints to police were up 51% in 2020.[59] A report by

[41] City of Toronto – Social Development, Finance & Administration Division. Profile of Low Income in the City of Toronto. 2011.
[42] Colour of Poverty Campaign. Fact Sheet # 4: Understanding the Racialization of Poverty in Ontario - Health & Well-being. 2007. Available at:colourofpoverty.ca
[43] Block, S., Galabuzi, GE., Weiss, A. The Colour Coded Labour Market By the Numbers. A National Household Survey Analysis. Wellesley Institute. September 2014. Available at: http://www.wellesleyinstitute.com/wp-content/uploads/2014/09/The-Colour-Coded-Labour-Market-By-The-Numbers.pdf
[44] Block, S. Who is working for minimum wage report. Wellesley Institute 2013.
[45] City of Toronto. COVID-19: Status of Cases in Toronto. Accessed Jul 30/20 from: https://www.toronto.ca/home/covid-19/covid-19-latest-city-of-toronto-news/covid-19-status-of-cases-in-toronto/
[46] Toronto Public Health. July 1, 2020. COVID-19 and the social determinants of health: what do we know? Available at: https://www.toronto.ca/wp-content/uploads/2020/07/956b-SDOHandCOVID19_Summary_2020July1.pdf
[47] Statistics Canada. Aug 30, 2022. COVID-19 mortality among racialized populations in Canada and its association with income. Available at: https://www150.statcan.gc.ca/n1/pub/45-28-0001/2022001/article/00010-eng.htm
[48] Toronto Star. June 22, 2022. 'There is systemic discrimination in our policing': New Toronto police data confirms officers use more force against Black people. Available at: https://www.thestar.com/news/gta/2022/06/15/officers-use-more-force-against-black-people-with-no-good-explanation-why-toronto-police-data.html

Toronto Public Health which looked at racialization and health inequities confirmed that members of racialized groups often have worse access to quality health care than non-racialized groups.[49] The report also found that experiencing racial discrimination (experienced by 67%) was associated with poorer self-rated health and depressive symptoms. There have been growing calls across Canada in recent years to acknowledge and address anti-Black racism in health care.[50]

INDIGENOUS PEOPLE

While Toronto is a city of immigrants, most of us are settled on lands of the Indigenous Peoples. Toronto has the largest Indigenous population in Ontario and the 4th largest in Canada[51]. The 2021 Census data estimates that approximately 0.8% of the people in Toronto are Indigenous. The Census also found that the Indigenous population in Toronto may have decreased slightly by 0.6% since the last Census in 2016, while growing elsewhere.[52] At a national level, the Indigenous population continues to grow at a faster pace than non-Indigenous populations and accounts for 5% of the total population.[53] It is important to note that Indigenous communities have long felt that the Census was an underestimate and a 2017 study by Indigenous-led researchers in Toronto found that the population is likely two to four times the official estimates.[54] Additionally, as the City has noted: the pandemic may have affected response rates differentially across ethnoracial populations, and may have particularly affected Indigenous population response rates as they are relatively small numbers by comparison to the total population and may be subject to more fluctuation.

The ongoing, devastating impact of colonization can be observed in our social services. An analysis of the 2016 Census data found that over 90% of Indigenous peoples 55 and older in Toronto experience poverty.[55] Data from 2021 found that across Canada, 1 in 5 (20%) live in a low-income household. It also found that Indigenous children accounted for over half (53.8%) of all children in foster care.[53] Indigenous people represent approximately 15% of Toronto's homeless population and 23% of people experiencing outdoor homelessness.[22] SRCHC sees a disproportionately high number of Indigenous services users at both of our supervised consumption services (SCS). The evaluation of SCS (which includes keepSIX) found that one third of the sample identified as Indigenous and the proportion is about half at Moss Park (based on point in time staff estimates). Data from the provincial Coroner found that the rates of opioid-related deaths were two times higher among Indigenous females compared to white females.[56] A 2015 report specific to the unique health issues of Indigenous peoples in Canada found that racism against this group

[49] Toronto Public Health. *Racialization and health inequities in Toronto.* October 2013. Available at: www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-62904.pdf
[50] Dryden, O & Nnorom, O. Time to dismantle systemic anti-Black racism in medicine in Canada. CMAJ. Available at: https://www.cmaj.ca/content/193/2/E55
[51] City of Toronto website. Indigenous People of Toronto. Accessed August 23, 2019: https://www.toronto.ca/city-government/accessibility-human-rights/indigenous-affairs-office/torontos-indigenous-peoples/
[52] City of Toronto. Backgrounder. Released Sept 30, 2022. 2021 Census: Housing and Indigenous Peoples. Availabl at: https://www.toronto.ca/wp-content/uploads/2022/09/8e3a-CityPlanning-2021-Census-Backgrounder-Housing-Indigenous-Peoples.pdf
[53] Statistics Canada. The Daily. *Indigenous population continues to grow and is much younger than the non-Indigenous population, although the pace of growth has slowed.* Released Sept 21, 2022. https://www150.statcan.gc.ca/n1/daily-quotidien/220921/dq220921a-eng.htm
[54] Smyle J et al. 2017. Our Health Counts Toronto: using respondent-driven sampling to unmask census undercounts of an urban indigenous population in Toronto, Canada. BMJ Open. Available at: https://bmjopen.bmj.com/content/bmjopen/7/12/e018936.full.pdf
[55] Social Planning Council/Well Living House. Senior poverty & inequity: the Toronto experience. August 2020. Available at: https://www.socialplanningtoronto.org/senior_poverty_report
[56] Office of the Chief Coroner for Ontario. 2019 Opioid Mortality in Ontario and preliminary 2020 trends. Prepared for Ontario Harm Reduction Network meeting. July 17, 2020.

is pervasive in our health care system.[57] Approximately 2% of SRCHC's clinical and group clients identify as First Nations, Indigenous, Inuit or Metis.[13]

ENVIRONMENTAL HEALTH

SRCHC has its roots in environmental health promotion and in community mobilization to repair the area's history of environmental contamination. SRCHC's community remains vulnerable due to both global climate change and to specific industrial sources of pollution. Although some industry has left in recent years, the South Riverdale neighbourhood still contains numerous polluting facilities including a sewage plant (bulk chlorine, odors), waste transfer stations, concrete batching (more than 600 trucks/day), and a shingle manufacturer. Heavy industry zoning remains in a large area (1000 acres) south of Lakeshore Blvd. Soil clean-ups for new development are also moving hazardous material through the community. The redevelopment of main streets and industrial sites into market condos also means the continued polarizing of income and a decline affordable places to meet/congregate as coffee shops, low cost restaurants and places of worship are replaced with market housing or high rent retail. A recent report on environmental racism explores and illustrates how inequities in the built and natural environment, as well as negative health impacts, are concentrated in racialized communities. For example, the report shows that exposure to toxic pollutants is increased in areas with higher proportions of racialized communities. It also reveals how densely populated racialized communities have less transportation access.[58] Summer 2021 was marked by extreme weather events across the globe and July 2021 ended up being the hottest month ever recorded on earth.[59]

A significant upcoming environmental change for South Riverdale and surrounding neighborhoods is the development of new transit lines. Metrolinx (the project developer) plans to add additional above-ground tracks beginning just west of SRCHC's Queen St location and north/east to Gerrard St/Carlaw. Our Moss Park CTS will also be impacted by a new subway station next to its current location. Last year SRCHC commissioned a health impact assessment to better understand the health impacts that the proposed Ontario Line could have on our community and compared these to the impacts of an underground option. The report advised that the original underground "Relief Line" is a viable option that would cost the same or less and take less time to build with far fewer health impacts.[60] Community advocacy resulted in affordable housing in the Canary District, the preservation of the Red Door shelter at Logan and Queen E. and the Tower Renewal program), strong support for our supervised injection services and other inclusive initiatives and policies.

[57] Allan B & Smylie J. First Peoples, Second Class Treatment: the role of racism in the health and well-being of Indigenous peoples in Canada. Welling Living House, Centre for Research on Inner City Health, St. Michael's Hospital. Feb 2015. Available at: http://www.wellesleyinstitute.com/publications/first-peoples-second-class-treatment/

[58] Environmental Racism in Toronto. A deeper look at a systemic issue. 2020. Available at: https://storymaps.arcgis.com/stories/e0f3332504c5452a9bd94e00b667c89a

[59] Toronto Community Foundation. Vital Signs Report 2021. Available at: https://torontofoundation.ca/vitalsigns2021/

[60] Towards a Healthier Riverside and Leslieville: A Health Impact Assessment of the Ontario Line. November 2021. Available at: https://www.srchc.ca/wp-content/uploads/2021/10/A-HEALTH-IMPACT-ASSESSMENT-OF-THE-ONTARIO-LINE-Nov-2021.pdf

DRUG USE

Toronto has the highest rate of people who use drugs in Ontario. The criminalization of drug use, together with historical and ongoing structural oppressions and the neglect of people who use drugs by our health and social service system creates multiple barriers to health and well-being. Among people who inject drugs it is estimated that 11% are living with HIV and 59% either have or had hepatitis C.[61] Fatal and non-fatal overdoses have been at crisis levels in our community for years. Significant increases in overdose deaths have occurred since the COVID-19 pandemic began. Prior to COVID-19, the average number of fatal calls attended by paramedics in Toronto for suspected opioid overdoses per month was 13. During 2020, it increased to 26. In Toronto 539 people died of an opioid overdose in 2020, up from 300 in 2019. Preliminary data suggests there were at least 511 overdose fatalities in 2021. Data on the monthly numbers of emergency department visits due to opioid poisoning in Toronto in the fall of 2021 were the highest seen since 2017.[62] Rates of fatal overdose increased by 60% in Ontario during the pandemic and disproportionately impacted low-income, incarcerated and racialized populations.[63] Recently released data from the provincial coroner found that approximately 8 people died per day from overdose in the second year of the pandemic, compared to 4 before the pandemic started.[64] The pandemic disrupted an already unpredictable illicit drug market and this was coupled with COVID-19 prevention messages to self-isolate which increases overdose risk.

Recent reports from BC, Ontario, and Alberta indicate that more individuals now overdose by inhaling opioids (including fentanyl) compared to those who overdose via injection drug use.[65] Inhalation of drugs has always been common practice and many people who use drugs both inject and inhale. Inhalation was previously seen as a mode of drug use with lower overdose risk compared to injection, however, the toxic drug supply means that this is no longer true. Although safer inhalation is not currently permitted in provincially funded Consumption and Treatment services, it exists/has existed in other provinces and countries. CTS service users at both of our locations have asked for space to safely smoke their drugs and staff have responded to numerous overdoses in the vicinity related to inhalation. SRCHC is in discussions with the MOH to work through the health and safety needs that would allow us to expand CTS services for people who smoke drugs. Casey House (a specialty hospital in Toronto caring for people living with and at risk of HIV) does not receive provincial funding for their supervised consumption service and is likely to become the first in Ontario to offer safer inhalation.

SRCHC participates in the Toronto Drug Checking Service run by researchers at the Centre on Drug Policy Evaluation at St. Michael's Hospital. Their recently released 2021 annual report summarizes findings on drugs checked at CTS across the city and highlights the increasing toxicity of Toronto's unregulated drug

[61] Tarsuk J, Ogunnaike-Cooke S, Archibald CP and the I-Track Site Principle Investigators. Descriptive findings from a national enhanced HIV surveillance system, I-Track Phase 3 (2010–2012): Sex-based analysis of injecting, sexual and testing behaviours among people who inject drugs. *Canadian Journal of Infectious Diseases & Medical Microbiology.* 2013 Spring;24 (Supplement A):81A.

[62] City of Toronto. News Release, May 20,2022. Toronto Public Health releases preliminary data of confirmed opioid overdose deaths in 2021. Available at: https://www.toronto.ca/news/toronto-public-health-releases-preliminary-data-of-confirmed-opioid-overdose-deaths-in-2021/

[63] Data available from the City of Toronto's Overdose Information System and a Sept 8/21 Ontario Science Table. Science Brief. Accessed Sept 20/21 from: https://covid19-sciencetable.ca/sciencebrief/the-impact-of-the-covid-19-pandemic-on-opioid-related-harm-in-ontario/ and https://public.tableau.com/app/profile/tphseu/viz/TOISDashboard_Final/ParamedicResponse

[64] CTV Toronto News. 'It's bad': Opioids killed more Ontarians in second year of pandemic than first.' August 23, 2022. Article available at: https://toronto.ctvnews.ca/it-s-bad-opioids-killed-more-ontarians-in-second-year-of-pandemic-than-first-1.6038223

[65] Rapid Response Service. A review of supervised inhalation services in Canada. Toronto, ON: The Ontario HIV Treatment Network; July 2022.

supply. Opioids continued to be significantly more contaminated than other expected drug types. For example, expected fentanyl substances only met service users' expectations 5% of the time. In 2021, 71% of fentanyl samples also contained at least one or more respiratory and central nervous system depressant, such as benzodiazephine (v 34% in 2019). This combination of benzodiazepines and opioids can be problematic as it increases the suppression of vitals and increases prolonged sedation. [66]

In November 2017, SRCHC was able to begin offering supervised injection/consumption services at our Queen Street location. In June 2018, SRCHC took on the management of the unsanctioned and volunteer-run Moss Park Overdose Prevention Service which had been operating out of Moss Park. Today both sites operate as Consumption & Treatment Services, the provincial government's 'new' model for OPS and SCS. The teams at each site work to ensure service users have access to a range of services within the service and overall. In July 2020, SRCHC officially launched its safer supply program (a collaborative with other health and CHC partners in Toronto) which provides people who use drugs with a reliable pharmaceutical opioid as well as access to available health and social services. In April 2022, this program expanded with the addition of a mobile team to serve people who use drugs in East Toronto.

POLITICAL & POLICY CONTEXT

Many health issues that impact our community have their underlying causes in social and economic policies, which provide a foundation for health and well-being. Being aware of the social and political context in which we operate is critical if SRCHC is to support individual and community health.

While the COVID-19 pandemic brought many of us together in acts of kindness and solidarity, it has also been yet another crisis which has made clear the holes in our social safety net and reinforced the ways in which we continue to fail and make vulnerable so many in our community. The countless forms of grief and loss we have experienced collectively and individually over the last two and a half years has negatively impacted the overall mental health and wellbeing of many and damaged feelings of institutional trust and community connection.[59] Health system backlog, staffing shortages, the consequences of deferred health care, the chronic disease implications of long COVID, increased demand for mental health services, the exacerbated overdose crisis and ongoing COVID case waves are critical issues. In addition, the health care system had little capacity to adequately deal with the extra burden created by COVID after decades of under-funding and cuts at all levels of government of health care and upstream social services.

At a municipal level we have seen few initiatives in recent years that substantively address poverty and harsh responses where poverty exists. For example, in June 2022, City Council voted against regulating single room occupancy dwellings, thereby discouraging the creation of more of these affordable housing options and making those that exist less safe. And in the summer of 2021, people living in encampments were violently evicted and private companies were hired to discourage any re-establishment of these communities. This past January, Toronto Public Health submitted an exemption request to Health Canada to allow for the possession of drugs for personal use (i.e. drug decriminalization). Details (such what

[66] What's Contaminating Toronto' Drug Supply? Insights from Samples Checked by Toronto's Drug Checking Service. Centre on Drug Policy Evaluation. August 16, 2022. Available at: https://drugchecking.cdpe.org/wp-content/uploads/dlm_uploads/2022/08/Torontos-Drug-Checking-Service-Report_2021.pdf

amount constitutes 'personal use' and possible coercive diversion to social supports) are still being determined. While decriminalization is an important step in separating drug use from criminality, it does not improve or address the increasingly toxic unregulated drug supply that people who use drugs must navigate. Critics of the decriminalization model in Vancouver have pointed out that the possession threshold is too low and ignores the realities of how people buy and use drugs. A municipal election is set for October 24, 2022.

The conservative provincial government made regressive and sweeping policy changes when it was first elected in 2018, including cuts to public health, worker protections, environmental protections and rent control. The recent $10 per day child-care agreement with the Federal government was delayed and will likely only provide sufficient coverage for 43% of children. There has been a lack of transparency on exactly what their priorities and plans are for this current term, however, the province has indicated that more privatization in the health care system is coming, mainly through the use of for-profit companies who will deliver services paid for by public funds.

At the Federal level, a minority government is unlikely to be able to make any transformative policy changes without public pressure. Their willingness to decriminalize personal drug possession (when requested by smaller/regional governments) will not meaningfully address the overdose crisis. An immigration program to provide permanent residency to temporary foreign workers is being planned but will likely face opposition.