Promoting Health and Well-Being through Social Inclusion in Toronto:

Synthesis of international and local evidence and implications for future action

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Distribution

Copies of this document are available on the Toronto Public Health Web site: https://www.toronto.ca/city-government/data-research-maps/research-reports/public-health-past-significant-reports/healthy-public-policy-reports-library/, or http://www.wellesleyinstitute.com/health/.

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Statement on Acknowledgement of Traditional Land

We would like to acknowledge this sacred land on which the Wellesley Institute and Toronto Public Health operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit River. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes.

Today, the meeting place of Toronto is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory.

Revised by the Elders Circle (Council of Aboriginal Initiatives) on November 6, 2014

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Executive Summary

Social inclusion is increasingly being recognized as a social determinant of health. Though there is no singular definition of social inclusion, there is general understanding that a socially inclusive society is one in which people feel valued, their differences and rights are respected, and their basic needs are met so that they can live in dignity, and have their voices heard. An inclusive society is one in which people are able to meaningfully participate in social, economic, cultural, and political systems.

Having social connections, access to different forms of social capital, and being civically engaged all reflect dimensions of being socially included and have been associated with positive mental and physical health and well-being. These dimensions refer to the ability to participate in and contribute to the social and civic aspects of society, such as social relationships, social activities, and political engagement. Along with economic aspects of inclusion, these non-material dimensions of social inclusion are widely seen as important drivers to addressing deepening inequities in Toronto.

There is a growing evidence base to support the association between these dimensions of social inclusion and positive health outcomes. Research suggests that social inclusion impacts health by: influencing health promoting or risk-related behaviours (e.g., physical activity, dietary behaviours, and tobacco or alcohol consumption); influencing cognitive and affective states (e.g., self-esteem, coping, self-efficacy depression, anxiety or distress, emotional regulation); and directly impacting physiological responses through the biological stress response. While there is a stronger body of work connecting social inclusion with mental health, some studies have demonstrated a link between social inclusion and higher self-rated health and lower premature heart disease mortality. At the same time, greater understanding of the complex interplay between social inclusion and the other social determinants of health is needed.

We undertook a two-part exploratory project to identify how to further promote social inclusion in Toronto. In phase one, we explored the state of social inclusion in Toronto, and differences across sub-populations. We also conducted scoping reviews and a local scan to identify interventions that create the conditions for building social connectedness, social capital, and civic engagement and social participation. In phase two, we engaged a diverse group of stakeholders, including representatives from community organizations, City of Toronto divisions and agencies, and funding organizations, to discuss what we found, identify gaps and priority areas for action to advance social inclusion in the city. This document is a synthesis of findings from these different components of the study across the two phases.

Each component of the project contributed to our understanding of the construct of social inclusion and how the non-material dimensions are applied, measured, and evaluated. Our

analysis of Torontonians' experiences of social inclusion found that a sense of community belonging, social connections with family and friends, and participation in civic life are moderately high. At the same time, social inclusion is not experienced equally across the population, and social and economic factors, and disability status shape people's experiences of social inclusion. Gaps exist in our understanding of social inclusion in Toronto that require further research.

The scoping reviews demonstrate a wealth of different ways of promoting social inclusion in various international jurisdictions, in a range of contexts and with different populations. We identify common approaches being used as **peer or community-led**, **arts-based**, **built environment**, **social media & technology**, **psychosocial**, and **volunteering & civic engagement** interventions.

Studies of these interventions report favourable outcomes on different measures of social connectedness, social capital, and/or civic engagement, such as sense of belonging, social ties, social support, social networks, and collective empowerment. They also report positive effects on a range of health and well-being outcomes, such as increased self-esteem, reduced rates of depression, improved cognitive function, and increased physical activity and other health promoting behaviours. The state of the research evidence, however, does not allow us to draw conclusions about the effectiveness of any specific intervention or broad intervention approach. Due to methodological limitations and poor descriptions in the literature, the quality of the evidence could not be assessed, making it difficult to compare specific interventions or intervention approaches.

The scan of initiatives in Toronto demonstrated an equally diverse set of approaches being used locally to promote social inclusion. Some of the ways in which local initiatives are promoting social inclusion are through opportunities for skill development, recreation, leadership training, employment readiness, community development, and neighbourhood improvements. This scan also provided insight into the design of initiatives, how they were started, what has helped them flourish, and the key challenges they faced to sustain their work.

The stakeholder consultations were intended to explore the relevance of the findings from phase one to the Toronto context and identify strategic opportunities for enhancing social inclusion in the city. These conversations reinforced the notion that social inclusion is a current concern for community organizations, funders, and the municipal sector alike. They also helped us identify additional local initiatives and emerging opportunities to advance social inclusion.

When taken as a whole, the findings from these multiple inputs highlight both the strengths of current efforts to promote social inclusion in the city and areas requiring further consideration and action. Based on a synthesis of the project findings, we developed a set of actions that can be undertaken in multiple arenas and sectors to strengthen our social

infrastructure and to effect change at a broader systemic level. These action areas are as follows:

1. Improve understanding of social inclusion in Toronto
    a) Promote awareness of the non-material dimensions of social inclusion and their link to health and well-being
    b) Advocate for the regular collection of local population data
2. Promote social inclusion city-wide through programs, services, and policies
    a) Develop ways to ensure access to services for the most marginalized
    b) Increase diversity and inclusion in governance and civic engagement
    c) Promote equitable access to inclusive spaces
3. Develop best practices for promoting social inclusion at the program level
    a) Generate local evidence through evaluation
    b) Promote community-defined, participatory, peer-led, asset-based approaches
    c) Promote innovative funding models to sustain and invest in new community approaches
    d) Build connections, networks and partnerships across social inclusion work
    e) Build understanding across and among diverse groups.

We have outlined some concrete next steps that Toronto Public Health and the Wellesley Institute will take to spearhead specific activities to address these action areas.

Introduction

Social inclusion has emerged as a critical issue in mental health and social policy work nationally and internationally.[1,2,3,4] The concept of social inclusion surfaced in response to the growth of marginalized and excluded populations in the 1980s and 1990s, and has come to reflect broad ideals of engagement, social, economic, and political participation, and a sense of belonging for diverse groups across society.[5] Social inclusion is now being recognized as a social determinant of health, and as particularly integral to promoting mental health and well-being.[6,7,8,9,10,11]

Locally, there is cause for concern about increasing economic inequity, within and between neighbourhoods and social groups,[12,13,14] and its attendant negative effects on health inequities.[15] With increased recognition of the perils of inequities, there is growing appreciation of the key role social inclusion can play in promoting well-being, particularly among those experiencing greater isolation or marginalization.[16]

Across Canada, provinces, territories, and local governments are highlighting social inclusion in their health, economic, and poverty-reduction strategies for diverse populations, emphasizing the potential that social inclusion initiatives have to impact health and well-being.[17,18,19,20] Social inclusion is considered an integral component of building a resilient city that can withstand the shocks and stresses of climate change, aging infrastructure, and housing and transit issues.[21,22] There is also a rich and growing literature on community-based efforts to promote social inclusion in a range of settings and populations, and on the relationship between social inclusion and health.

The 2018 Ontario Public Health Standards, which dictate the minimum requirements for public health programs and services, outline the role of boards of health in supporting and protecting the mental health, well-being, resiliency, and social connectedness of the health unit population.[23] These standards also identify social inclusion as a key determinant of health.[24] Boards of health are required to apply multiple strategies in order to address health inequities and promote inclusion, including developing their capacity to apply anti-racist, anti-oppressive, and culturally safe approaches to public health practice, as well as carrying out community engagement and inter-sectoral action strategies.

With these issues in mind, we need to seek new ways to build social inclusion in order to address inequities in health and well-being, and to improve the overall health of the population.

Project goals

Toronto Public Health in partnership with the Wellesley Institute embarked on a two-phase exploratory project to identify how to further promote social inclusion. An advisory group,

comprised of stakeholders from various sectors with expertise in social inclusion were consulted several times over the course of the project to help shape the project's approach and activities (see Appendix 1 for membership list).

The goals of phase one were to identify the level of social inclusion in the Toronto population and to examine international and local efforts to promote social inclusion. Specifically, phase one consisted of the following activities:

1. An analysis of available population data on the state of social inclusion in Toronto and how it differs across sociodemographic groups;
2. A two-part review of a diverse body of literature to summarize the evidence on interventions[a] being used to promote social inclusion and to identify effective interventions–
    a) A scoping review of interventions focussed on enhancing health and/or through social inclusion, and
    b) A scoping review of interventions focussed on enhancing social inclusion in general; and
3. A scan of current initiatives in Toronto that promote social inclusion more broadly.

Figure 1: Focus of Scoping Reviews

The goals of phase two were to share the findings from phase one with a broad array of stakeholders, to explore their relevance to the Toronto context, and identify opportunities for enhancing social inclusion in the city.[b] Based on these consultations, we have identified a set

a "Intervention" is used broadly to include a set of actions or activities introduced to effect change such as a policy, program, service, or strategy.

b The analysis of data on the extent of social inclusion in Toronto was not completed in time to be considered in these consultations.

of action areas, along with concrete next steps to be undertaken to advance social inclusion in Toronto.

Structure of report

This report begins with the definition and dimensions of social inclusion that were the focus of this project, including a brief review of some research that explores the relationship between social inclusion and health. Next, a synthesis of our findings from each component of phase one of the project is provided.[c] The final section contains action areas for advancing social inclusion in the city, and outlines some concrete next steps that Toronto Public Health and Wellesley Institute will take to spearhead specific activities to address these action areas.

Defining social inclusion

Though there is no singular definition of social inclusion, there is a general understanding that a socially inclusive society is one in which people feel valued, their differences and rights are respected, and their basic needs are met so that they can live in dignity, and have their voices heard. An inclusive society is one in which people are able to meaningfully participate in social, economic, cultural, and political systems.[11]

As this suggests, there are many interconnected dimensions of social inclusion that can be considered at the individual and/or collective level. These can be broadly captured in two main categories:

1. **Economic dimensions**, which generally refer to having access to material resources required for living, such as education, training, income security, employment, and affordable housing, all of which are well accepted as key social determinants of health; and
2. **Non-material dimensions,** which refer to being able to participate in and contribute to the social and civic aspects of society, such as social relationships, activities, and political engagement.[25,26,27]

The critical importance of the economic dimensions of social inclusion in enabling full participation in society are well-recognized,[28,29,30,31,32] and need to be further promoted. With this project, however, we focussed on non-material dimensions of social inclusion. Social relations that promote connectedness, cohesion, and participation in the collective activities of everyday life represent important aspects of belonging, and are key for promoting healthy and socially inclusive cities as well as paving pathways to achieving economic inclusion.[33,34]

c The detailed findings from the two scoping reviews, local scan, population data analysis, and stakeholder consultations are presented in separate reports that are available at https://www.toronto.ca/city-government/data-research-maps/research-reports/public-health-past-significant-reports/healthy-public-policy-reports-library/, or http://www.wellesleyinstitute.com/health/.

Non-material dimensions of social inclusion

Non-material dimensions of social inclusion have been identified by many organizations that work to improve mental health. For this project, we employed the following definitions of these constructs, largely adapted from the Ontario Chapter of the Canadian Mental Health Association: [35]

> **Social connectedness:** This refers to connections to family, friends, and different types of community groups, clubs and organizations, and having informal relationships with people, such as family, friends, neighbours, and co-workers.
>
> **Social capital:** This refers to the resources available to people and to society that are provided through social connections, relationships, or networks. Resources could be in the form of instrumental support (e.g., financial or practical assistance), emotional support, informational resources (e.g., knowledge sharing), or psychological or cognitive resources (e.g., sense of mutual trust, shared values, sense of community belonging).[d]
>
> **Civic engagement and social participation:** Civic engagement refers to getting involved and trying to address issues the community faces, or advocating for change. Social participation means taking part in organized social, cultural, and recreational opportunities or associations, such as sports teams, cultural programs, faith-based groups, and other community groups.

These concepts overlap in the way that they are employed. For instance, civic engagement has been used as an indicator to measure both social capital and social connectedness. See Box 1 for a list of some of the ways that these dimensions have been operationalized and measured. There are also many other related concepts in the literature that overlap with these, including social cohesion, social integration, and informal social control.

Furthermore, these three concepts are interconnected and mutually reinforcing.[36] At the individual level, our social connections and relationships with individuals and groups can expand and strengthen our networks and social capital. Through our social networks and social participation, we identify common issues of interest or concern and find the material and cognitive resources that enable us to take action to address those issues. Likewise, through our civic engagement and social participation, there is opportunity to form new social ties, develop trust in others, and expand our social capital.[37,38]

These dimensions of social inclusion can be promoted at the individual level as well as at the collective level of a group, community, or society. For instance, a program aimed at

d The CMHA ON definition organizes resources in the following categories: cultural (e.g., libraries, schools, community centres), economic (e.g., jobs, community gardens), and social (e.g., informal arrangements that provide support).

building relationships between seniors within a particular neighbourhood would benefit individuals and the neighbourhood, whereas legislation directing the design of new seniors living facilities to promote social connections within and outside the facility would have the potential for broader impact on this population. Civic engagement can have an impact on a small geographic scale, but broad citizen participation is a mechanism for redistributing power to facilitate community influence in decision-making and policy setting which affects well-being and quality of life.[39]

Box 1. Some ways in which these dimensions have been operationalized and measured

Social connectedness: the number of close relationships or companionship; size of social networks; number of social gatherings and activities; satisfaction with social contacts; feelings of isolation, disconnectedness, or loneliness; and sense of belonging.

Social capital: mutual trust; civic trust; reciprocity; volunteerism; nature and density of formal and informal networks; perceived social support; informal social control; social cohesion; resources and employment linked to networks; acquisition of skills; perceived lack of fairness and helpfulness; group/organizational membership; reciprocity between citizens; social ties; and collective action.

Civic engagement: volunteering; voting; civic or political group membership; community involvement; self-help; and peer support.

How these dimensions of social inclusion contribute to health[e]

A growing body of research shows that there is an association between social inclusion and positive impacts on health, particularly mental health. [40,41] Box 2 lists several of the physical and mental aspects of health that can be influenced by a person's state of social inclusion. There is also growing interest in examining the impacts of these dimensions on broader societal outcomes, such as economic performance, resilience, and social integration and cohesion.[11,42,43,44]

The pathways by which social inclusion and each of its dimensions influences health are multiple, complex and multi-directional.[42,45] Some of these pathways are listed in Box 3. Social relationships, networks, and participation have been shown to affect health by providing

e This section summarizes some of the recent research on social inclusion and health, but is not a comprehensive review.

different forms of social support, social influence, opportunities for social engagement, meaningful social roles, access to resources, and/or intimate one-on-one contact.[45,46]

While there is extensive overlap in the definitions and measures of these three constructs in the literature, and it is difficult to describe the impacts of each independently, the following section provides a brief summary of some ways in which social capital, social connectedness, and civic engagement and social participation have been linked to health.

Box 2. Health behaviours and outcomes associated with social inclusion dimensions

- Well-being
- Body-mass index
- Self-rated health
- Physical activity/exercise
- Nutrition/eating
- Stress/distress
- Anxiety, depression, affect
- Cognitive & physical function
- Life satisfaction
- Self-esteem
- Sense of purpose, usefulness, self-efficacy

Social connectedness

Social connectedness can increase feelings of security and decrease or buffer stress, which is known to have a physiological impact on the body.[37] Some research has shown that higher levels of perceived social connectedness are associated with lower blood pressure rates, better immune responses, and lower levels of stress hormones, all of which contribute to the prevention of chronic disease.[47] A recent Canadian study found that having a larger number of close friends is linked to better self-rated health and greater life satisfaction.[48] Social relationships have also been associated with higher cognitive and physical functioning in older adults through engagement with others.[49,50] Conversely, social disconnectedness and perceived isolation in older adults are both independently associated with lower levels of self-rated physical health.[51] Low levels of emotional support and companionship have been associated with an increased probability of having a coronary condition in the elderly.[52]

Connections and relationships with others may also be linked to increased social support which can benefit individuals through assistance with everyday activities and emotional issues, and correspondingly have a positive impact on health outcomes.[53,54] Smaller social networks, fewer close relationships, and lower perceived adequacy of social support have

all been linked to depressive symptoms.[37] Some have noted that the association between disconnectedness and mental health may operate through the strong relationship between perceived isolation and mental health.[51,55]

Research also suggests that because social interaction and connections are structured around norms and values that shape behaviors, these relationships often have consequences for health. Social networks can influence initiation of, and adherence to, health-promoting behaviours (e.g., exercise or use of health screening and prevention programs), which, in turn, might lead to better health outcomes.[47,53,56] Furthermore, social connectedness may increase access to, and use of, health and social services for older adults, which has implications for the health of this group.[51,57]

Higher levels of social connectedness among adolescents has been shown to act as a protective factor against a range of risk behaviors and foster more positive mental health outcomes by decreasing feelings of anxiety, depression, and loneliness. Some research has also shown that the degree of connectedness to different social domains (i.e., family, school, friends, and community) in adolescence is not only a factor for young people's positive development, lifestyle, and general health behaviors, but also a predictor of their sense of well-being in adulthood. This work suggests that linkages to the social world are important for self-identity formation, cultivating personal interests, and feelings of belonging.[58]

Social capital

Social capital has been used to describe the benefits gained from social relationships and exchanges between members in social networks. These exchanges generate both material gains (e.g., higher wages or the ability to lobby for political changes with collective benefits) and non-material gains (e.g., improved relationships, happiness or trust) to individuals, which may in turn impact health outcomes, such as self-reported health.[59]

The exact mechanisms between social capital and health are diverse and complex. For instance, more frequent contact with friends and family can strengthen bonds, feelings of reciprocity and belonging to the group, which can enhance sense of well-being.[38] Social networks generate psychological effects by impacting social support, social and political influence, meaningful roles and engagement, resources and material goods, and intimate contact.[60]

As with social connectedness, the networks from which social capital is derived can be protective against negative health behaviours such as alcohol misuse in youth,[61] and they can improve psychological and emotional health indirectly by buffering the effects of stress, and directly by influencing levels of well-being.[60] Diverse social networks have been found to be protective against smoking relapse and hypertension.[62] Studies also find a relationship between low social capital and risky health behaviours, mental health issues, depressive

symptoms, distress, and poor emotional health.[60] Social capital has also been associated with reduced violence and homicide rates in parts of the United States.[63]

A review of North American and European studies found that living in an area with higher levels of social capital (measured by indicators such as civic trust, reciprocity, volunteering, mistrust, neighbourhood relations, density of local networks, and social cohesion) was associated with better self-rated health and lower premature heart disease mortality.[63] Other research has demonstrated that high levels of social capital at the neighbourhood level reduces or eliminates health differences due to socioeconomic status.[63] There is strong evidence that individual-level social capital (trust, social cohesion and support and sense of community) is protective against common mental disorders, through alleviation of stressors and promotion of health promoting behaviours.[64]

Social capital derived from connections between people from different backgrounds can take the form of information about jobs and other opportunities for accessing the social determinants of health.[65] Furthermore, networks that bring together individuals and groups from diverse cultures, faiths, abilities, or socioeconomic classes can have a positive impact on social cohesion.[4] In some cases social capital can be understood as a buffer to some of the negative effects of socioeconomic inequalities on health. At other times, access to social capital can depend on whether an individual or community has a certain level of economic capital.[66] For example, neighbourhoods that have poor public transit and/or social infrastructure may limit the capacity of residents in those neighbourhoods to connect with others.

Civic engagement and social participation

The impact of civic engagement and social participation on health is not as well studied compared to the other dimensions of social inclusion. Studies of civic engagement and social participation in Saskatchewan, measured by the breadth and depth of involvement in voluntary associations, found that more participation was associated with various health measures, including emotional distress, body-mass index, and self-rated health, before and after controlling for age, gender, and neighborhood of residence.[63]

There has been a greater focus on the impact of activities such as volunteering on cognitive and physical function in older adults. [67,68] Research has found that there are fairly substantial physical and psychological health benefits to be gained from volunteering in older adults.[67,69,70, 71,72,73,74] One study of older adults with mild cognitive impairment and depressive symptoms found that volunteering promoted physical activity, reduced depressive symptoms and slowed functional decline.[75]

There is some evidence to support the relationship between civic engagement and extended longevity in older adults; some study designs have found that volunteering is associated with reduction in mortality for older adults, whereas other types of studies have found no impact

on health outcomes such as well-being, depression and mortality from civic engagement activities.[72]

While most of the literature focuses on the older adult and elderly populations, some research on college students has found a relationship between involvement in civic engagement activities and a reduction in negative health behaviors such as heavy drinking. The research suggests that these kinds of activities could reduce stress levels and enhance individual's sense of control over their environment, which could have a positive impact on health.[76]

It is difficult to point to the specific type and amount of civic engagement that positively influences longevity of life or to the pathways or mechanisms by which this could occur, but some authors suggest that this type of social participation in later life instills a sense of self-worth and efficacy,[70,71] and enhances positive affect from feelings of connectedness to others.[71] Research also supports the idea that frequent participation in civic engagement activities increases brain plasticity, which supports the brain's executive function and ultimately maintains function during aging.[68]

Box 3. Some pathways linking social inclusion dimensions and health

- Physiological responses to stres
- Social support, bonds, and relationships
- Access and utilization of health and social services
- Financial support
- Access to health information, health-promoting resources, and networks
- Sense of security, control, self-esteem, empathy, and self-efficacy
- Social influence (e.g., healthy social norms)
- Collective lobbying for health-promoting policies/infrastructure
- Socioeconomic inequalities

Discussion

Based on this limited review of the literature in this growing area of research, there is evidence to suggest that social inclusion could impact health and well-being through at least three general pathways: by influencing health promoting or risk-related behaviours; by influencing affective and cognitive states such as self-efficacy, self-esteem, coping, depression, distress or emotional regulation; and by directly impacting physiological responses, largely through biological stress responses.

It is important to recognize that these pathways occur within broader social, economic, and political mechanisms (i.e. the structural and social dimensions of health) that create health inequities across income, gender, occupation, education, racialized identity, ethnicity, and dis/ability status.[42,45] These larger mechanisms will affect both material resources and the social environment at the individual level. Access to the other social determinants can also increase social ties, networks, participation, and overall engagement in society, and thus enhance social inclusion for diverse groups.[29,77,78,79,80,81,82]

Overall, there is broad consensus that social connectedness, social capital, and civic engagement and social participation serve as important sources of support, power, and agency for individuals, groups, and communities.[83] These effects have the potential to contribute to improved health outcomes and reduce health inequities for those who are vulnerable to social exclusion. At the same time, further work is required to better understand the complex relationship between social inclusion, the other social determinants and health outcomes. This is especially true since it is widely accepted that the economic and social conditions in which one lives have cumulative effects upon the probability of developing a range of chronic health conditions, such as heart disease, stroke and diabetes.[84]

State of social inclusion in Toronto

Understanding the state of social inclusion in Toronto is an important consideration in planning future social inclusion initiatives. This section describes the findings from our analyses of people's self-reported experiences of social inclusion in Toronto using indicators of social connectedness, social capital, civic engagement, social participation, and social inclusion from two local data sources (described below). It also describes trends over time, where possible, and differences in people's experiences of social inclusion by socio-demographic characteristics. The socio-demographic characteristics examined were selected based on data availability, the findings of existing research on social inclusion, and on factors that were identified as theoretically relevant based on assumptions about potential associations between these characteristics and experiences of social inclusion. The specific characteristics examined were gender, age group, immigrant status, ethno-racial group, main language spoken, sexual orientation, household composition, type of housing, disability

status, education, employment status, and household income. Together, these results provide a snapshot and preliminary findings on the state of social inclusion in Toronto.

Data sources and indicators of social inclusion

Two local data sets were used to examine people's self-reported experiences of social inclusion in Toronto. The first data source was the Neighbourhood Effects on Health and Well-being Survey (NEHW), which is a cross-sectional population-based survey of 2,412 Toronto residents between 25 and 64 years of age conducted between 2009 and 2011 by the Centre for Urban Health Solutions in Toronto.[85] The survey includes a number of relevant measures of social connectedness, social capital, civic engagement and social participation that have been used in or adapted from other Canadian and international studies. For the current analysis, we selected one to three indicators from each of the three dimensions of social inclusion.

The second data source was the Toronto sample of the Canadian Community Health Survey (CCHS), an annual population-based survey of individuals 12 years of age and older conducted by Statistics Canada.[86] The CCHS includes one general indicator of social inclusion assessing the respondents' sense of belonging to their local community. This and other similar measures of people's sense of belonging have been included in a number of surveys that measure social inclusion in Canada and internationally.[87] Data from seven cycles of the CCHS - 2001 to 2013/2014 - were included, allowing for some analysis of trends over time in this indicator. The 2013/2014 cycle was the most recent data available when the analyses were conducted. Each cycle had between 2,000 and 4,000 respondents.

Results

Table 1 below describes the overall prevalence of each measure of social inclusion that was examined. The section that follows provides a high-level summary of these findings. A detailed description of the study methods and findings can be found in the report entitled "Promoting Social Inclusion in Toronto: Analysis of Social Inclusion in the CCHS and NEHW Study."[88]

Table 1: Prevalence (95% confidence intervals; CI) of Indicators of Social Inclusion in Toronto, NEHW Study (2009-2011) and CCHS (2013-2014)

Measures of Social Inclusion	%	(95% CI)
Sense of belonging to local community[a]		
Very weak	8.8	(7.4-10.1)
Somewhat weak	23.8	(21.5-26.0)
Somewhat strong	49.4	(46.9-52.0)
Very strong	18.0	(15.9-20.1)
Weak: Somewhat weak/very weak	32.6	(30.1-35.0)
Strong: Somewhat strong/very strong	67.4	(65.0-69.9)
Social Connectedness		
Number of close friends/relatives		
0	1.7	(1.0-2.4)
0 to 4	40.8	(36.9-44.7)
5 or more	59.2	(55.3-63.1)
Not counting the people you live with, how often do you:		
See relatives/Speak to relatives on the phone?		
Less than once or twice a week	22.6	(20.2-25.1)
Once or twice a week or more	77.4	(74.9-79.8)
See friends/Speak to friends on the phone?		
Less than once or twice a week	14.5	(12.7-16.2)
Once or twice a week or more	85.5	(83.8-87.3)
Speak to neighbours		
Less than once or twice a week	28.1	(25.0-31.1)
Once or twice a week or more	71.9	(68.9-75.0)
Social Capital		
How often you received support when you needed it in the past 12 months		
Never	0.7	(0.3-1.2)
Rarely	3.9	(2.7-5.1)
Half the time	10.5	(8.6-12.3)
Frequently	25.5	(21.9-29.2)
Almost always	59.4	(55.1-63.6)
Never/rarely/half the time/frequently	40.6	(36.4-44.9)
Almost always	59.4	(55.1-63.6)

Measures of Social Inclusion	%	(95% CI)
Civic Engagement and Social Participation		
Number of citizen/political activities in which individual participated in the last 12 months[b]		
None	36.7	(32.7-40.7)
One or more	63.3	(59.3-67.3)
Number of social groups in which individual was an active member in the last 12 months[c]		
None	35.7	(33.1-38.2)
One or more	64.3	(61.8-66.9)

a Data for sense of community belonging was obtained from the 2013-2014 cycle of the CCHS.

b The citizen/political activities examined were attending a neighbourhood council meeting, public hearing, or public discussion group; meeting a politician, calling him/her, or sending him/her a letter; participating in a protest or demonstration; participating in an information or election campaign; alerting a newspaper, radio or TV to a local problem; notifying the police or court about a local problem; joining with other neighbours to address a problem or common issue.

c The social groups examined were work-related/trade union, religious group, community association/co-op, women's group, sports group, political group, ethnic/cultural group or association, neighbourhood committee.

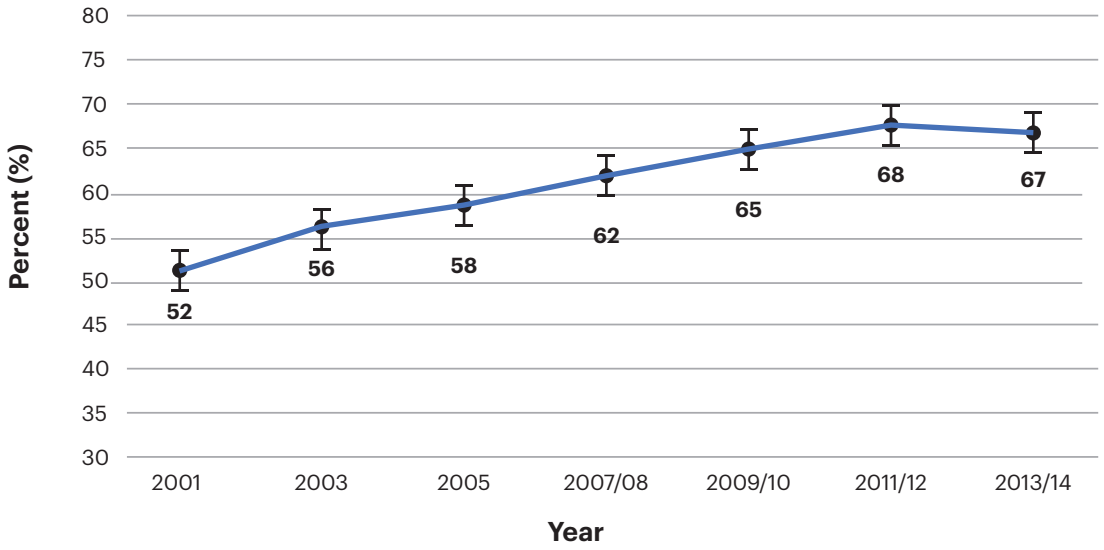
Source: 1) Canadian Community Health Survey, 2001 – 2013/2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care, 2) Neighbourhood Effects on Health and Well-being (NEHW) Study, 2009 – 2011. Centre for Urban Health Solutions (C-UHS), St. Michael's Hospital, Toronto, Ontario

Prepared by: Healthy Public Policy Directorate, Toronto Public Health

Sense of community belonging

A majority of people in Toronto reported a strong sense of belonging to their local community. In 2013/14, 67% of Torontonians 12 years of age and over reported having a strong sense of community belonging (see Table 1). Moreover, this percentage has been increasing over time, with just over half the population (52%) reporting a strong sense of community belonging in 2001 compared to 67% in 2013/14 (see Figure 2). This represents a 30% increase in the proportion of people in Toronto reporting a strong sense of community belonging over this period. Changes over time may be due to demographic changes in the population and/or to actual changes in people's perceptions of community belonging.

Figure 2: Percent of People 12 Years of Age and Over Reporting a 'Very Strong' or 'Somewhat Strong' Sense of Community Belonging, Toronto, 2001 to 2013/14



Error bars (I) denote 95% confidence intervals for the estimates

Source: Canadian Community Health Survey, 2001 – 2013/2014. Statistics Canada, Share File, Knowledge Management and Reporting Branch, Ontario Ministry of Health and Long-Term Care

Prepared by: Healthy Public Policy Directorate, Toronto Public Health

Although a majority of people reported a strong sense of community belonging, people's experiences differed based on their socio-demographic characteristics. There were differences across gender, age group, ethno-racial identity, help needed with activities of daily living, household living arrangements, education and household income. Specifically, the odds of having a strong sense of community belonging were slightly higher for females compared to males. Much larger differences were found across age groups, where the odds of having a strong sense of community belonging were higher for younger and older age groups compared to those 20 to 29 years of age. After age 20 to 29, the odds increased with each age group.

The odds were also higher for those who identified as South Asian and Filipino/Southeast Asian compared to those who identified as White, while the odds were lower for those who identified as Chinese/Japanese/Korean. Those who reported needing help with activities of daily living had a lower odds of reporting a strong sense of community belonging compared to those who reported not needing help. Couples living with children less than 25 years of age also had a higher odds of reporting a strong sense of community belonging compared to those living in most other household types, with lone parents with all children 25 years of age or older having the lowest odds. Finally, different patterns of association were found for education and household income. The odds of having a strong sense of community belonging were higher for those with lower levels of education and those living in higher income households.

Social connectedness

In Toronto, 59% of adults 25 to 64 years of age reported having five or more close friends or relatives they felt at ease with and could talk to about what was on their mind. A majority of Toronto adults also reported interactions at least once or twice a week with relatives (77%), friends (86%), and neighbours (72%).

There were differences across sociodemographic groups in people's experiences of social connectedness, which varied depending on the specific measure of social connectedness examined. For example, the odds of having five or more close friends and family varied by ethno-racial group, immigrant status, having a current or previous disability, education, employment, and household income. Specifically, the odds were lower for those who identified as Chinese/Japanese/Korean and those who identified as Other/multiple ethno-racial groups compared to those who identified as White. Both shorter and longer-term immigrants had a lower odds of reporting five or more close friends and family than those born in Canada. The odds were also lower for those who reported a current or previous disability compared to those who did not, those with lower education, lower household incomes, and those who were unemployed compared to those who were employed.

Social connectedness, as measured by the frequency of contact with relatives, friends, and neighbours, also differed across the socio-demographic groups. The odds of having contact with relatives at least once or twice a week differed by gender, age group, disability status, and household income. The odds were higher for females compared to males and those in the middle age group (35 to 44 years) compared to those in the oldest age group (55 to 64 years). However, the odds of having frequent contact with relatives were lower for those with a current or previous disability compared to those without a disability. Finally, those in the lowest household income group had a lower odds of reporting frequent contact with relatives compared to those in the highest household income group.

Relatively few socio-demographic differences were found for the measure assessing frequent contact with friends. The only difference found was among ethno-racial group. Compared to those who identified as White, those who identified as Chinese/Japanese/Korean had a lower odds of having frequent contact with friends.

Finally, frequent contact with neighbours varied by age group, ethno-racial group, type of housing, and education. Frequent contact with neighbours was lower among adults 25 to 34 years of age compared to those 35 to 44 years and those 55 to 64 years of age. Those who identified as Chinese/Japanese/ Korean also had a lower odds of frequent contact with neighbours compared to those who identified as White. A strong association was found for type of housing, where the odds of having frequent contact with neighbors were much lower for those living in high rise apartments compared to those living in other types of housing. Finally, the odds of having frequent contact with neighbours were lower among those with university level education compared to those with high school or less.

Social capital

When asked how often they received support when they needed it in the past 12 months, the majority of Torontonians 25 to 64 years of age (59%) reported 'almost always' receiving the support they needed, while 26% reported 'frequently' receiving it.

Receiving support when needed varied by age group, ethno-racial group, immigrant status, disability status, and household income. The odds of 'almost always' receiving support when needed was highest for 25 to 34 year olds compared to the oldest age group (55 to 64 year olds). Compared to those who identified as White, those who identified as Black/Caribbean, Chinese/Japanese/Korean, and as Other/multiple ethno-racial identities had a lower odds of 'almost always' receiving support when needed. However, the effects for those who identified as Black/Caribbean and Other/multiple identities were no longer lower compared to those who identified as White after taking into account the respondent's socio-economic characteristics (e.g., education, employment status, household income). This suggests that socio-economic differences between these ethno-racial groups and those who identified as White may be explaining the lower levels of social capital for these ethno-racial groups.

Longer-term immigrants had a higher odds of 'almost always' receiving support compared to those born in Canada. Those with a current or previous disability had a lower odds compared to those not reporting a disability. Finally, individuals from lower income households had a lower odds of 'almost always' receiving support than those from higher income households.

Civic engagement and social participation

We found moderately high levels of civic engagement. Two-thirds (63%) of Toronto adults 25 to 64 years of age reported having participated in at least one citizen or political activity in the past 12 months, such as attending a neighbourhood council meeting, public hearing, or public discussion group; meeting a politician, calling him or her, or sending him or her a letter; participating in a protest or demonstration; alerting the media, police, or court about a local problem; or joining with other neighbours to address a common issue.

Civic engagement varied by gender, age group, ethno-racial group, sexual orientation, and education. The odds of participating in at least one activity were higher for males compared to females and those in the middle age groups (35 to 54 years) compared to those 55 to 64 years of age. However, the odds were lower for those who identified as South Asian compared to those who identified as White. Those who reported being lesbian, gay, or bisexual had a higher odds of having participated in at least one citizen or political activity compared to those who reported being heterosexual. Finally, the odds of participating in at least one activity were lower for those with lower levels of education.

In relation to social participation, roughly two-thirds (64%) of Toronto adults 25 to 64 years of age reported being an active member of at least one social group in the past 12 months, such

as a work-related or trade union group, religious group, community association, women's group, sports group, political group, ethnic or cultural group or neighbourhood committee.

Social participation differed by age group, main language spoken, type of housing, and education. The odds of social participation were lower among adults 25 to 34 years of age compared to those 55 to 64 years of age. The odds were also lower for those who mainly spoke a non-official language or French at home compared to those who mainly spoke English. Finally, the odds were lower among those living in a high-rise apartment building compared to those living in other types of housing and for those with lower levels of education.

Discussion

In summary, the results of the CCHS and NEHW data analyses revealed moderately high levels of sense of community belonging, social connectedness, social capital, civic engagement and social participation in Toronto. The majority of Torontonians reported having a strong sense of community belonging and high levels of social connectedness in terms of having close friends or relatives they could talk to and having frequent contact with friends, relatives, and neighbours. One measure of social capital was examined, which showed that the majority of Torontonians received the support they needed. Civic engagement and social participation were also high, with most people having recently participated in a citizen or political activity or having been active in a social group. The results also revealed that the proportion reporting a strong sense of community belonging in Toronto has increased between 2001 and 2013/2014.

Despite relatively high levels of social inclusion on these indicators, there remains a substantial proportion of the population who reported lower levels of social inclusion. For example, about one in three Torontonians reported a weak sense of belonging to their local community. About 15% reported only receiving the support they needed half the time or less in the past 12 months. Roughly one third reported not being involved in any citizen or political activities or social groups.

The results also showed that social inclusion was not experienced equally across the population; people's experiences varied by social factors, economic factors, and disability status. Moreover, the nature of these differences often depended on the dimension of social inclusion examined and the specific measure examined within each dimension. For example, the odds of having a strong sense of community belonging was high for those 12 to 19 years of age and increased with age after age 30; however, it was lowest for those 20 to 29 years of age. On the other hand, those 35 to 54 years of age had a higher odds of being civically engaged (i.e., participating in at least one citizen or political activity) compared to those 55 to 64 years of age. Having a current or previous disability was one characteristic that was associated with a lower odds of social inclusion across a number of dimensions; such as having a strong sense

of community belonging, social capital, and social connectedness (i.e., having five or more close friends or relatives, having frequent contact with relatives).

The findings for the socio-economic factors such as education, employment, and household income were inconsistent, although some interesting and divergent findings were obtained. For example, those with higher education had a lower odds of reporting a strong sense of community belonging and social connectedness, as measured by frequent contact with neighbours. However, they had a higher odds of social participation and civic engagement. Higher household income was associated with a higher odds of having a strong sense of community belonging, social capital, and social connectedness (i.e., more frequently seeing relatives).

Although some ethno-racial differences were observed, some groups were found to have a higher odds for certain measures than other groups. For example, compared to those who identified as White, those who identified as Chinese/Japanese/Korean had a lower odds of reporting a strong sense of community belonging, social capital, and social connectedness (i.e., having five or more close friends or relatives, and having frequent contact with friends and neighbours). However, compared to those who identified as White, those who identified as South Asian, had a higher odds of reporting a strong sense of community belonging, but a lower odds of being civically engaged.

Our findings are consistent with recent local and national research using similar or complementary measures that also document moderately high levels of social inclusion in Toronto and Canada. A 2014 United Way survey of Toronto residents exploring the effects of growing income inequality in Toronto found that 57% of people felt that most people can be trusted, while 38% reported lower levels of trust (i.e., "you can't be too careful in dealing with people").[89] The United Way study of high-rise towers in Toronto also found relatively high levels of social inclusion, with 69.5% reporting that people in their building were willing to help their neighbours and 65.9% reporting that is was possible to build strong, trusting relationships with others living in their building.[90]

Voting is another commonly used indicator of civic engagement that we did not examine because it was not available in the two data sources that were used for the analysis. Another local study conducted by the United Way in 2014, found that moving from precarious to secure employment increased the likelihood of voting by over 20%. Low income workers were less likely to vote compared to higher income workers and both racialized and immigrant, precariously employed workers, were less likely to vote compared to non-racialized and Canadian-born precariously employed workers.[91]

National data has also found that the majority of Canadians report a strong sense of community belonging. In the 2017 Canadian Community Health Survey (CCHS), 69% of Canadians reported having either a 'somewhat strong' or 'very strong' sense of belonging to their local community.[92] In the 2013 national General Social Survey (GSS), 63% of Canadians

reported having a 'very strong' sense of belonging to Canada, 45% reported having a 'very strong' sense of belonging to their province of residence, and 32% reported a 'very strong' sense of belonging to their local community.[93] Data from the GSS also shows that youth participation in formal or informal groups, organizations or associations has increased over time.[101] For example, among youth 15 to 19 years of age, social participation increased from 68% in 2003 to 74% in 2013. In 2013, youth aged 15 to 19 were among the most socially and civically engaged (74%), while the proportion of youth aged 20 to 24 years of age who were active (64%) was similar to the proportion among those aged 45 to 54 years (65%) and those aged 65 to 74 years (62%).

Areas for future research

There have been relatively few local studies in Toronto examining people's experiences of social inclusion, limiting our ability to fully describe the nature of this issue in the city. More local research is needed, particularly research focussing on the experiences of smaller subgroups in the population (e.g., Indigenous individuals, LGBTQ groups, specific ethnocultural, and racialized groups). Recent surveys, such as the Toronto Social Capital Project of 3,000 Toronto residents, conducted by the Toronto Foundation and the Environics Institute, and the YMCA survey of 8,000 residents of the greater Toronto area will help to fill the gaps in the short-term. To our knowledge, the CCHS is the only local data source with ongoing data collection that can provide information about trends over time in people's experiences of social inclusion. More longitudinal data is needed in Toronto with measures assessing different dimensions of social inclusion. Furthermore, research that examines how the broader context (social, economic, and political factors) shapes experiences of social inclusion could shed light on some of the reasons for differences across groups.

Local research examining ecological or structural indicators of social inclusion such as voting patterns, indicators of inclusive governance and the extent of network linkages between community organizations and larger institutions and government (i.e., linking social capital) is also needed. Finally, most research on social inclusion, including the current project, has focussed on examining individual-level predictors of social inclusion. Local research examining the association between community-level factors and social inclusion outcomes, such as neighbourhood or housing conditions, and density of social, cultural, or recreational spaces or meeting places, is needed. The United Way study of high-rise towers in Toronto found that while the majority of people reported a strong sense of belonging to their neighbourhood (67.6%), poor housing conditions were associated with a weaker sense of belonging to the neighbourhood.[90] This type of research could help identify interventions at the community-level that could either directly or indirectly improve people's experiences of social inclusion in the city.

Key Messages

- **Population surveys reveal that the majority of Torontonians experience moderately high levels of social inclusion.**
- **However, social inclusion is not experienced equally across the population. Social factors, economic factors, and disability status shape people's experiences of social inclusion.**
- **There are many gaps in our understanding of the nature of social inclusion in Toronto, including the experiences of smaller population subgroups (e.g., Indigenous individuals, LGBTQ groups, specific ethno-racial groups), ecological or structural indicators of social inclusion in Toronto, and community-level factors associated with people's experiences of social inclusion.**
- **There is a need for ongoing collection of local data to monitor trends over time in social inclusion to better inform planning, including broader structural measures of social inclusion and indicators of social inclusion that are not currently available in population surveys like the CCHS and NEHW.**

How social inclusion is being promoted internationally

We conducted two scoping reviews of the peer-reviewed and grey literatures to summarize the evidence on interventions to promote social inclusion and to identify effective interventions. The first review focussed on interventions that examined both social inclusion and health outcomes, whereas the second explored interventions related to social inclusion more broadly without explicit reference to their impact on a health outcome.[f] As there was considerable diversity of studies and study methodologies in this topic area, a scoping review was deemed the most appropriate method of reviewing the evidence. A detailed methodology and a discussion of limitations are provided in the full report of each scoping review.[g]

As there was overlap in the findings of the two reviews, the integrated findings are presented here. The scoping reviews highlighted that there are many different areas of intervention that aim to promote social inclusion and improve health, as seen across jurisdictions internationally, and across diverse, urban populations.

The reviews also revealed that the quality and extent of the evidence base is quite limited. There were a wide diversity of studies and study methodologies in this topic area. There were also limited descriptions of interventions in many cases and inconsistent definitions of concepts and outcomes. As a result, we did not pursue appraising the quality of individual studies. It was also not feasible to systematically compare effectiveness across interventions. Rather, the analysis of the available evidence helped to identify common intervention

f In addition to the social inclusion constructs and health outcomes, inclusion criteria included the following: intervention-based; published between 2000 and 2015; from Canada, United States, Europe, Australia, or New Zealand; and English-language. Studies were excluded if they focussed on the social determinants of health, such as housing, and did not have a clear methodology or description of the intervention.

g The first scoping review report is: *A scoping review of literature on interventions to promote social inclusion and health*. The second scoping review report is: *A scoping review of literature reviews of interventions to promote social inclusion*.

approaches, **populations**, and **communities** served through these initiatives, and what has been reported about their **impact.**

Intervention Approaches

The scoping reviews yielded six main categories of intervention approaches described below. These categories are not mutually exclusive but are used as a way to organize the findings.

Peer and community-led interventions used social networks to enhance health and social inclusion. Some focussed on peer-mentoring within marginalized communities, while others employed peer workers to facilitate health-related lifestyle changes, increase access to healthcare services, or enhance community capacity through the creation of coalitions that address community needs. These interventions targeted various populations, including young families, racialized communities, or those with mental health diagnoses. See Box 4 for an illustration of this type of intervention.[94]

Box 4. The Podor es Salud/Power for Health project,[94] funded by the US Centers for Disease Control and Prevention, engaged a group in Portland, Oregon to improve health and reduce health inequalities in Latino and African American communities. The project used participatory research methods to define and build upon community strengths, resources, and relationships. The project engaged all partners as equal members who share decision-making power and resources, sought to cultivate cross-cultural partnerships, and foster leadership within the communities to develop social capital and improve physical and mental health.

Community Health Workers worked on improving social capital by promoting civic engagement to address community concerns, building trust between different groups, and enhancing social networks. One initiative used popular education techniques to identify specific community health problems, along with corresponding solutions. They identified a lack of health insurance and employment options as two problems that were affecting the community. To address these issues they established a cooperative that provides insurance, small-business loans, and job opportunities, and a program to connect job seekers with employers.

The authors present the following general lessons about social inclusion: cultural differences between communities shape how social capital is understood, along with health problems and solutions; definitions of social capital should integrate understanding of how resources can be built and shared between communities; and successful social inclusion interventions in disadvantaged communities will simultaneously address the social determinants of health.

Arts-based interventions used arts programming as a way to engage communities and promote social capital. They capitalized on the therapeutic and creative benefits of the arts to enhance well-being and social inclusion. Arts-based interventions have been effectively used with diverse groups, including people with disabilities, children, or unemployed men, to create or view art. In another type of intervention, healthcare providers referred individuals to community-based arts programs, such as music, singing, and dance, to promote use of non-medical services as a way of facilitating social connectedness. See Box 5 for an illustration of this type of intervention.[95]

Box 5. The Portents project[95] was an innovative use of public art to improve social inclusion and understanding between diverse citizens in Bristol, UK. A community art installation was designed to bring together diverse groups and individuals to create representations of *home*, *histories* and *hope* from the perspectives of new immigrants, asylum seekers, and refugees. The installation took the form of a nine-day outdoor exhibit and was part of a broader Sanctuary City project in Bristol. Action research methods were used to collect data in the form of open-ended responses and reflections on the exhibit from visitors. Results reflected participants' hopes with respect to themes, such as the creation of a more secure and peaceful world, love and friendship, and greater opportunity to enjoy life. These findings can be used to strengthen opportunities and support individuals in achieving non-material values, and foster social cohesion more generally. The authors posit that the concept of *hope* should garner greater attention from public health circles, given its potential to promote coping with stressful events and conditions by communities.

Built environment interventions explored the relationships between health, social inclusion, and public space. These projects had diverse goals, involving the creation of a farmers' market and the restoration of public spaces, both of which aimed to enhance well-being and social inclusion by making changes to public space with lasting structures accessible to members of the public. See Box 6 for an illustration of this type of intervention.[96]

Box 6. The urban development project[96] aimed to improve social capital and community well-being by restoring public spaces in three neighbourhoods in Portland, Oregon. The project attempted to harness social networks to build social capital through three mechanisms: bonding (relies on existing ties to social and religious groups), bridging (connects dissimilar groups), and linking (connects parties unequal in power and access to resources). Using asset-mapping techniques, low to moderate-income residents were engaged in designing workshops to cultivate bonding social capital. Multiple groups were convened to design the projects and seek authorization to implement the designs, which contributed to the bridging and linking of social capital. The construction of the design aimed at empowering community members through collective action. A survey of local residents was completed before the project began and once again after the project was completed. The findings revealed improvements in mental health, increased sense of community, and an overall expansion of social capital.

Social media and technology interventions employed social media strategies for promoting a sense of belonging in youth or a sense of connectedness and social capital for different adult groups. Social connectedness was defined to include the dimensions of social support, empowerment, engagement, participation, loneliness, and isolation. Smart technologies were used to promote social connectedness. These programs included internet support sites, computer training and entertainment systems for adults. Online educational programs were used to promote connections for people related to a specific health condition or interest (e.g. women with breast cancer, people dealing with a chronic illness, people experiencing depression, anxiety or work-related stress). See Box 7 for an illustration of this type of intervention.[97]

Box 7. The CityNet 'Ambassador' project[97] was introduced to increase social capital and improve access to information and communication technology, through a public/private community development approach in Nottingham, England. The project aimed to develop connections between members of disadvantaged communities and provide a platform for improved access to information and services. Participants included young African-Caribbean men with mental health issues, long-term unemployed men, socially isolated carers, and older people. The program involved working with local people to design web interface and content, training Ambassadors to train others to use the technology, and embedding the project in local community organizations.

The project was evaluated using qualitative interviews to capture in-depth, open-ended data from participants. The project reported the following positive findings: an increase in feelings of self-efficacy, ability to learn, and self-esteem at the community-level, and new social networks that positively impact upon health and social capital formation. At the same time, they found that social inequalities and power disparities inherent in the partnership arrangement led to the disempowerment and adverse experience of some community members. The authors assert that critical approaches that acknowledge and address the significance of power for individual, group, and community well-being are important for research on health and social capital.

Psychosocial programs included setting-based interventions, such as school-based initiatives or men's sheds, and community-based structures that provide space to engage in shared activities that can be social or task-oriented in nature. These also included capacity-building programs geared to individuals and groups. The setting-based programs used various strategies, such as task-based activities, mentoring, or education/skills-building to promote social inclusion. School interventions were geared to building school connectedness including increasing attachment, engagement, and affiliation. The individual- and group-oriented interventions that engaged people living with mental health problems to facilitate social connectedness included peer support approaches, social skills development activities, and asset-based interventions. See Box 8 for an illustration of this type of intervention.[98]

Box 8. A Building Healthy Men, Men's Shed[98] was introduced in Wollongong, NSW, Australia, in response to a needs assessment that showed high levels of depression, idleness and poor self-esteem in unemployed Portuguese-speaking men in the area. The program ran for two years and included men over 40 years of age from culturally and linguistically diverse backgrounds. The men were unemployed or retired with trade/labour work histories and wanted to use or further develop their skills. The Men's Shed is a structured program, with group-based discussion that led to the design of shared artistic and manual activities by the team. Facilitators included a community cultural arts worker, a multicultural health worker and casual trainers. Research methods to evaluate the program included participant interviews at various stages of the intervention and facilitator journals. Participants reported an increased sense of purpose, self-worth and self-confidence resulting from the program, as well as expanded social networks and increased skill levels.

Volunteering and civic engagement interventions focussed on volunteer-oriented strategies for people living with a mental health issue and/or a disability geared to increasing participants' social contacts and social participation. They also included positive youth development initiatives with a civic engagement component, which involved a broad range of activities including community leadership projects, arts-based programs, and technology and skills-based projects. See Box 9 for an illustration of this type of intervention.[99]

Box 9. A five-session civic engagement intervention[99] consisting of education, service and recognition phases was piloted in a Midwestern city in the U.S. The intervention was designed for older adults with functional limitations, receiving health and social services through an adult day program to increase the overall well-being of participants. Participants learned about the challenges and needs of veterans and homeless families, and service involved assembling care packages for the two community groups. Participants were formally recognized when they presented the care packages to representatives of these community groups.

The evaluation of this intervention involved one site receiving the intervention, and a comparison group receiving the regular services of the adult day program (arts, physical activity, and intellectual stimulation programming). The intervention was then withdrawn from the first group and delivered to the comparison group. Data were collected at three points: before the intervention began, when the intervention was switched, and at the completion of the study. Recipients of the intervention reported higher levels of purpose in life, self-esteem, and perceived physical health when compared with those in the comparison group. Self-esteem and perceived physical health decreased after the intervention was withdrawn, suggesting that the intervention positively impacted participants' well-being.

Delivery of Interventions

Consistent with elements and principles of community development work, across all intervention approaches, there was a strong emphasis on participatory design and co-production, that is, bringing together community members with front line program staff to plan and deliver programming.

While some of the programs emphasized structured formats (such as curriculums and formalized program plans), others were shaped more by participants within a specific setting or platform (for example online peer support groups or men's sheds). There was considerable variation in the activities that were used to promote social inclusion including skills building, information sharing, and engaging in meaningful activities (e.g., arts, crafts, and volunteer activities). These projects used a variety of health-related constructs (e.g., quality of life, psychiatric symptoms, and physical activity measures) as well as social connectedness, social cohesion, civic engagement and social capital as outcome measures.

Most of the interventions found could be described as a program, service, or community development initiative. Public policy is an important structural vehicle for creating conditions that foster social connectedness, social capital, and civic engagement. No policy or other form of intervention geared to systemic or structural change was identified. This could reflect either limitations of the approach (i.e., the search strategy or inclusion criteria) or a lack of published evaluations of policy interventions).

Population and Communities

A common element across these various approaches was a focus on the needs and interests of diverse populations across different contexts. While some initiatives were designed to reach broad populations, most were focussed on particular sub-groups, including people who were living on low incomes, young families, children and adolescents, young adults, older adults, people with chronic physical and mental health conditions, people with disabilities, racialized groups, newcomers, and refugees. This suggests that such interventions may have been proposed to address the challenges faced by marginalized communities, and have the potential to result in positive impacts on health and wellbeing.

It is worth noting, however, that some communities that have been historically underserved or discriminated against were not well-represented in the literature. Notably absent were interventions serving people who identify as lesbian, gay, bisexual, queer, transgender or Indigenous. This may speak to the limits of our search strategy, and a need to reflect on a wider array of initiatives that promote social inclusion and health, but employ different definitions of social inclusion (e.g., social justice or empowerment) not covered by this project. Moreover, some programs or initiatives that engage these populations may

be captured within service level reports but not necessarily written up as evidence on intervention research or program implementation in the literature.

Impact

Overall, various types of initiatives are being used to promote social inclusion. Studies of these interventions report favourable outcomes on different measures of social connectedness, social capital, and/or civic engagement, such as sense of belonging, social ties, social support, social networks, and collective empowerment. They also report positive effects on a range of health and well-being outcomes, such as increased self-esteem, reduced rates of depression, improved cognitive function, and increased physical activity and other health promoting behaviours.

Drawing firm conclusions about the effectiveness or impact of any particular intervention approach or intervention, however, is challenging. Few studies provided clear and well-documented measures of outcomes of social inclusion, and similarly, there was a lack of clear health-related measures or outcomes, limiting our interpretation of the impacts of these interventions on health. There was considerable variability in how the construct of social inclusion and the various dimensions of interest were operationalized. There was also a lack of uniformity in how programs were designed and described in the literature, and an absence of methodological and technical detail in many of the studies. Thus, the studies were not assessed for their quality, rigor and replicability, or comparative effects across interventions. More detailed evidence would be needed to promote one form of intervention over another. These limitations point to considerable potential for future research to contribute to this field of study.

The scoping reviews did help identify some factors that could affect the nature of the impact of an intervention or intervention approach. Several studies emphasize the importance of context for all interventions, where success relates to the unique needs and interests of the population of focus. For example, one review of youth-oriented volunteer interventions indicates that there must be in-depth knowledge of the needs of the specific youth targeted, and community and neighbourhood context, in order to promote an appropriate or potentially useful intervention. Another youth-focussed intervention in a school system implemented overarching frameworks for identifying needs and corresponding responses/programs as opposed to running a packaged program. These studies suggest the limitations of replicating the same intervention across different settings.

There are also signs that interventions work differently for unique populations in different contexts. For example, there may be gender differences in terms of responses to technological interventions that target social inclusion for youth. In addition, some interventions, such as one of the social media interventions, had the potential to yield unintended and negative consequences.[100] These results suggest that interventions work differently across different

populations. This is an important consideration when replicating an intervention with another group or in another context.

Key Messages

- **Studies reveal a variety of definitions and indicators of social inclusion, as well as diverse types of interventions.**
- **Common social inclusion intervention approaches include peer and community-led, arts-based, built environment, social media and technology, psychosocial, and volunteering and civic engagement.**
- **Interventions were typically designed for specific populations or communities instead of the general population.**
- **Some approaches have a long history in fields of community development and health promotion, such as peer-led interventions, assets-based approaches, and coalition building.**
- **Some newer approaches were identified, such as Men's Sheds and social media.**
- **LGBTQ and Indigenous communities were underrepresented in the reviewed literature.**
- **There are limits to evaluating the relative success of interventions due to methodological issues.**
- **While some intervention research has found positive effects on social inclusion, health and well-being, additional research is needed to better determine effectiveness and specific pathways between intervention components and social inclusion and health outcomes.**

How social inclusion is being promoted locally

The purpose of the local scan was to provide a snapshot of the range of initiatives in Toronto that focussed on promoting social connectedness, social capital, and/or civic engagement, and to collect more descriptive information about a diverse subset of these interventions. The scan (current to 2016) first identified 50 distinct initiatives that promoted social inclusion and engaged different populations, such as youth, older adults, newcomers, people living with disabilities, or who identify as LGBTQ, in various regions of the city, in different settings (e.g., neighbourhood, housing complex, community agency). The detailed methodology is provided in *Local Scan of Interventions to Promote Social Inclusion in Toronto*.

Fourteen of the 50 interventions were selected to help us better understand local experiences of promoting social inclusion. These were systematically chosen to reflect a variety of populations, interventions approaches, regions of the city, and social inclusion dimensions. Interviews were conducted with program representatives via telephone and email using an open-ended interview guide.

This scan of 14 interventions revealed an equally diverse set of approaches being used locally to promote social inclusion. It also identified different contextual factors that contribute to their success, which informs potential actions to promote social inclusion more broadly.

Findings from a review of 14 local interventions

A list of the fourteen interventions is provided in Appendix 2. This section provides a brief summary of the key findings in relation to **intervention approaches, enabling factors, challenges, program evaluation, and impacts**. A more detailed discussion of each of these initiatives can be found in *Local Scan of Interventions to Promote Social Inclusion in Toronto*.

Intervention approaches

As with initiatives identified by the scoping reviews, local programs were designed to meet specific needs identified by or for a specific sociodemographic or geographic community. Many were founded on addressing barriers to social inclusion (e.g., racism or ableism) and used empowerment, participatory, and mentorship approaches. Artists Without Barriers, for example, was specifically designed for and by aspiring artists living with disabilities who were physically and socially excluded from cultivating their passion. Likewise, Remix built a mentorship program around the needs of marginalized youth to help build their social capital in the music industry.

Many initiatives emergedn as relatively small, informal activities, and grew organically over time. Some of these became formal programs or organizations as a result of the need or demand for the program and/or strategic positioning which helped secure funding for expansion (e.g., Thorncliffe Park Women's Committee, Artists Without Barriers, Gashanti Unity). Other programs originated and were formalized within institutions (e.g., Recipe for Community initiated by the City of Toronto and Toronto Foundation, or the Youth Health Action Network initiated by Toronto Public Health) and continue to rely on this institutional infrastructure.

Many initiatives were promoting one or more dimension of social inclusion and were addressing these dimensions in varying ways. In many cases, social inclusion was positioned as a secondary or indirect outcome of the program, rather than the primary focus. For example, social connectedness occurred organically as a by-product of initiatives that linked community members to service providers and relevant organizations, facilitated social, creative, and professional networks, and promoted cross-cultural learning and access to shared resources or space. Examples of activities promoting social capital included: building professional networks and resources, workshops; educational and skill-building opportunities; social problem-solving and strategic planning; developing partnerships; and building connections between organizations, services, and resources in the city. Civic engagement opportunities included: involvement in budgeting processes; education around local and regional issues; input into the design and implementation of local projects; and the planning of health promotion programming for youth.

Most interventions could be grouped within four of the six general categories that were found through the scoping reviews of the international literature.

> **Peer & community led-interventions** focussed on community capacity building through peer mentoring, education, and skills building, career development, and promoting partnerships.
>
> **Arts-based interventions** were being used to build creative social networks and increase access to arts-related resources among artists with dis/abilities and support youth artists to build social capital and increase access to income-generating opportunities.
>
> **Built environment interventions** focussed on improving public spaces as a way of building social connections and enhancing community well-being through building social capital and civic engagement. These are largely place-based, neighbourhood initiatives.
>
> **Volunteer/Civic Engagement interventions** focussed on strengthening community connection and building the social capital of volunteers, through intergenerational social support, peer education, and programs that focus on increasing participation, advocacy, activism, and diversity in decision-making at the local level.

None of the 14 interventions directly fit within the **psychosocial intervention category** nor relied on **social media or technology** as their primary means of engagement. Several programs, however, described engaging participants in developing awareness-raising media products, including films (Gashanti Unity) and educational videos on anti-oppressive concepts (Supporting Our Youth H.E.A.T.). One approach that was present locally but not identified through our scoping reviews was **intergenerational** initiatives (e.g., Toronto Intergenerational Partnership; Youth Infrastructure Collaborative) that engaged children and/or youth and older adults in a range of activities to foster learning and connections.

Common Enablers

Program representatives identified several factors that facilitated successful implementation. A core enabler for many initiatives was having a solid, dedicated team of staff and/or volunteers. Cultivating partnerships with various other community organizations, foundations, NGOs, civic organizations, schools, and the private sector enabled continuity of programming either through securing funding or sharing of resources (e.g., space). The ability to secure funding via municipal or provincial governments because of aligned objectives, and striving to achieve mutual goals with partners were also identified as key strategies. Additional enablers identified by a smaller number of organizations included the

novelty of a project, trust and respect for the program among participants, and the use of long-term program models.

Common Challenges

Program representatives also identified a number of factors that posed challenges to implementation. Lack of adequate and/or secure funding was a central challenge to the sustainability and day-to-day operations of various programs, and hindered future planning for initiatives. Funding insecurity affected volunteers, staffing, programming and space stability, and meant that programs were not always able to meet the demand for service. In the absence of funding for core staff, several organizations relied solely on volunteers. A common thread related to sustainability was a reliance on multiple sources of funding, even among the more financially secure programs, and the demand for regular funding renewal.

Other challenges identified by a smaller number of organizations included engaging community residents when the issue was not a high priority for participants; limited accessibility of the program to some participants (e.g., travel distance); low rates of participation; time spent securing resources such as space; programming not fitting traditional funding categories; insufficient funding to evaluate program; limits on who was eligible for or accepted into the program; and the recruitment of diverse participants.

Program Evaluation

There was variation in the type and rigour of evaluation across programs resulting in a mix in how programs derived and reported information on the impact of their initiative. Some reported findings from a formal, external evaluation, while others relied on internally collected data such as program use or graduation rates. Some program organizers noted that they were in the process of doing an evaluation and others indicated that they lacked capacity to undertake an evaluation. Several program organizers explained that while sustaining an initiative is dependent to some degree on producing evidence of a positive impact, it is challenging to commit scarce resources to a formal evaluation.

Impact

All programs reported a positive impact on building social connections for participants, building individual and group/community social capital, and/or supporting civic engagement to address community-identified issues. They also identified other positive outcomes, including attainment of credentials such as high school course credits, improved confidence and well-being, reduced isolation and support to continue independent living, a sense of confidence and independence, and improved sense of community. Some program impacts were also described as facilitators of social inclusion. For example, organizational

partnerships were conveyed as both an outcome of social inclusion as well as a facilitator to achieving this result for communities.

While there were many shared effects across programs, such as increased awareness due to educational components, these also took different forms. For example, education was framed as cross-cultural learning by the Youth Infrastructure Collaborative, compared to intergenerational learning by the Toronto Intergenerational Partnership in Community, and a popular education approach to empowerment by Supporting Our Youth H.E.A.T.

Key Messages

- **Local initiatives promoting social inclusion represent a mix of grass-roots, community-based, and institution-led programs.**
- **Social inclusion is being promoted in different ways, such as through opportunities for skill development, recreation, leadership training, employment readiness, community development, and neighbourhood improvements.**
- **Most initiatives shared some common elements, including being focussed on a specific sociodemographic or geographic community and on a community-defined need; being founded on addressing barriers to social inclusion (e.g., racism or ableism); and using empowerment, participatory and mentorship approaches.**
- **Key factors facilitating the success and growth of these local initiatives were dedicated staff and volunteers, as well as cultivating a range of operational and funding partnerships with other organizations.**
- **Key challenges being faced by local initiatives were inadequate and insecure funding resulting in overreliance on volunteers, space issues, and not being able to meet the demand for programming.**
- **All programs reported a positive impact on building social connections for participants, individual, group, and community social capital, and/or supporting civic engagement to address community-identified issues.**
- **There is a need for greater allocation of funding and capacity building to support program evaluation, which plays a key role in sustainability.**

Stakeholder Consultations

In phase two of this project, we engaged a broad array of stakeholders to consider our project findings in relation to their own experiences promoting social inclusion. Our ultimate goal was to garner their expertise and diverse perspectives to identify strategic opportunities for enhancing social inclusion in the city. We held formal meetings with 45 representatives from seven community organizations profiled in our scan, thirteen municipal departments and divisions, and five local funding organizations. We also met with our community advisory group to discuss the findings.

At each consultation, we provided information about the project design, presented the key findings from the literature reviews and local scan, and posed a series of open-ended

questions to facilitate discussion about social inclusion in Toronto. Detailed notes were made for each session, and summaries of themes from each session were disseminated back to the group for input about accuracy, and to provide the opportunity for participants to add information if desired. After notes were developed for all of the consultation sessions, we conducted a thematic analysis to synthesize the content and develop overarching themes for all of the sessions. What follows is a summary of these themes. A more detailed summary of the findings from these stakeholder meetings can be found in the *Stakeholder Consultation Summary*.

Multiple understandings of social inclusion

The stakeholder discussions centred primarily on the general idea of social inclusion and the dimension of civic engagement, and less on the dimensions of social connectedness and social capital. Overall, social inclusion was discussed in four ways.

Stakeholder groups discussed social inclusion in relation to everyone having access to the social determinants of health (e.g., employment, housing, freedom from discrimination, income security), and emphasized that systemic change is required to address the historical exclusion of certain populations from access to the social determinants of health. Among City stakeholders, social inclusion was also discussed in relation to all residents having access to the City's policies, programs, and services, with emphasis on the most marginalized, along with examples of how this is being, or can be, accomplished. Participation in various City programs was referenced as a way to build social connections and provide supports by extending people's networks or contacts (i.e. social capital). All stakeholder groups also emphasized the dimension of civic engagement. Finally, social inclusion was also discussed as being subjectively defined and formed by an individual's or group's lived experiences, rather than an objective construct that can be imposed and measured. These different understandings of social inclusion are reflected in the subsequent themes that emerged from the stakeholder discussions.

Inclusion of the most marginalized

An overarching theme was the importance of prioritizing the needs and interests of Toronto's most politically, economically, and socially marginalized populations. Marginalization and exclusion occur through complex processes and across different intersecting lines such as race, gender identity, class, colonial histories, sexual orientation, disability, citizenship status, age, and culture/religion.

For the City and other stakeholder groups, social inclusion was framed as an imperative to meet the needs of the most marginalized groups by increasing access to essential and supportive services. Discussions highlighted that certain groups and individuals experience

more extreme levels of exclusion relative to others. For example, some groups might be aware of existing services and programs and only need support to navigate these; whereas, other marginalized or isolated groups are not being reached at all through the existing system which should act as a source of building social connections.

It was also noted that efforts by government and other organizations to connect with the hard-to-reach should avoid reproducing segregation or stigma, and ensure that infrastructure and services are in place so that groups do not become further marginalized by existing processes.

Equitable distribution and location of services and resources across the city

The need for more equitable distribution of services and programs across the city and across sub-populations was a second key theme. The move to decentralize services outside the city core was identified as one strategy to improve access to housing support services, for example. Libraries, which are by nature decentralized with branches in most neighbourhoods, were identified as key locations for efforts to reduce inequities. Several City divisions use libraries for community engagement in planning processes, and delivery of services such as employment-related support. Libraries were also identified as playing a role in reducing inequities in digital literacy across the city, which was described as important because web-based platforms are increasingly being used to increase social connectedness.

The co-location of services within one service site, such as a community hub, was also identified as a potential strategy to increase access to services. Community hubs are also an example of agencies working together to support communities to take ownership of local spaces. These arrangements provide opportunities to address issues such as social isolation; for example, seniors programs operating within hubs to promote social connectedness.

Stakeholders highlighted the important role of various conceptual frameworks to ensure that equity and inclusion are central principles in decision-making. Examples of frameworks currently in use include health equity impact assessments, an equity lens, and collective impact and intersectionality frameworks. Funders also identified these frameworks as useful in approaching community engagement and for understanding barriers in granting streams.

Inclusive governance and civic engagement

Inclusive governance structures and civic engagement processes were identified as important for achieving social inclusion. Stakeholders discussed the importance of involving people with lived experiences of systemic exclusion (e.g., lived experience of poverty) in decision-making processes to avoid perpetuating exclusion.

There was general consensus that traditional engagement strategies (e.g., open calls for input into processes) tend to attract input from residents who are easier to engage. Barriers to engaging hard to reach groups were identified, including the lack of compensation for participation, fragmented engagement processes that do not promote sustained involvement, and sociocultural differences between people facilitating engagement and those groups that are being engaged.

There are numerous initiatives at the City that are intentionally seeking to address limited diversity and inclusion in municipal governance and civic engagement (e.g., Toronto Poverty Reduction Strategy Lived Experiences Advisory Group, the Toronto Planning Review Panel, the Participatory Budgeting Pilot project, and Elections Toronto's Accessibility Outreach Network). Various divisions have also implemented a youth engagement strategy, and Toronto Public Health, in collaboration with Children's Services, has piloted a Child Engagement Toolkit to facilitate inclusion of young people in City building. Another strategy to increase engagement of traditionally excluded groups has been to hold meetings or activities in spaces which are already used by these groups for other purposes or gatherings. Funders also acknowledged the need to engage those with lived experiences in setting priorities and are developing new methods to do this, as described in the next section.

Striving for inclusive governance and civic engagement takes time and resources. The Toronto Planning Review Panel, for example, takes a full consultant position to organize and administer the two-year process. It was noted that City systems need to be responsive to these constraints to increase access to information, and facilitate inclusive processes.

Sustainability of social infrastructure

Stakeholder groups expressed that there is a need to develop social infrastructure (programs, services, resources) and to ensure that existing infrastructure does not become dismantled.

It was also noted that inequities exist in terms of physical infrastructure across neighbourhoods (e.g., housing disrepair, lack of park space, outdated facilities), which are immensely important for building and maintaining social inclusion. These inequities are sometimes hidden because specific neighbourhoods might receive significant investment in program funding, but are simultaneously under-resourced in terms of investment into physical infrastructure (e.g., lack of funds for social housing repairs in Neighbourhood Improvement Areas). Similarly, investment into programs is often short-term, project-based without clear plans to sustain social capital and connectedness in communities.

Representatives from community organizations highlighted that in order to promote sustainability in programs and infrastructure, there is also a need for better processes to evaluate and measure program success. Standardized models of evaluation that are typically used by funding organizations do not match the complex realities of identity and history, or

what is actually happening in communities and local organizations. Similarly, many funding models do not promote the sustained intervention that some marginalized groups require.

One suggested method for fostering the sustainability of social infrastructure was through the support of peer models. There are also funding strategies that support community-led initiatives by providing infrastructural support without controlling or mandating priorities, and allowing communities to determine what programs receive funding. These methods recognize histories of unequal power relations, such as those that were initiated through colonial governance and continue in various forms in the present day. There is a clear need to strengthen efforts to evaluate these initiatives.

Balancing community-based approaches with action to address systemic issues

Another theme that emerged is that broader systemic change is required in addition to community or neighbourhood-based initiatives to promote social inclusion. Both place-based programs and system-oriented solutions are necessary to address growing economic disparities, and lack of affordable housing, for example. As discussed above, a key aspect of systemic change is addressing inclusion in institutions and greater leadership to support social inclusion in governance.

In order to accomplish broader change, there is also a need to build better connections between programs that are small or fragmented, as well as funding for larger, sustained projects that integrate numerous areas of social experience (e.g., social networks, employment, or housing). The latter can be difficult because the provision of niche funding to support specific, discrete programming is often politically salient, largely because this approach is more likely to produce results in the short-term. Representatives from funding organizations acknowledged that while many initiatives across the city promote social inclusion, the challenge is how to support this work while encouraging systemic and structural change. Despite this challenge, there are examples of efforts to do this.

Another area of focus for fostering systemic change is through the development of partnerships at the local level, including those between neighbourhood or grassroots community organizations, funders or established organizations and government. Stakeholder discussions identified that greater effort is required to support existing connections and promote new collaborative relationships across all City divisions, agencies, and community organizations.

City of Toronto representatives described many initiatives to promote social inclusion, such as the Toronto Poverty Reduction Strategy, the Seniors Strategy, and the Toronto Strong Neighbourhoods Strategy, but also recognized a need for platforms or tools that would allow divisions to identify synergies between strategies so that there is better integration of social

inclusion work across the City. Coordinating knowledge and work across City divisions could prevent duplication of engagement work, and would ideally include platforms to bring groups together to share information and build their collective social capital.

Key Messages

- **There are different understandings of social inclusion across stakeholders.**
- **Inclusion should prioritize the most marginalized, and consider exclusion across different intersecting lines (e.g., gender identity, race, age, class, ability).**
- **Inclusive governance and civic engagement structures and processes are needed to ensure those with lived experiences of exclusion are engaged in priority setting.**
- **More equitable distribution of services and resources across the city is required to better achieve social inclusion.**
- **Work to achieve social inclusion can be optimized by creating linkages and opportunities for sharing knowledge, resources, and strategy among and between groups, communities, organizations and institutions.**
- **In addition to community-based approaches to social inclusion, continued action to address systemic issues that perpetuate exclusion is required.**

Action Areas

Based on a synthesis of this project's findings, we have identified broad action areas for advancing social inclusion in the city. These areas are intended to mobilize and guide the actions of a wide range of stakeholders across sectors, including government, community groups and organizations, funding bodies, researchers, and the private sector.

Though there are many international and local initiatives working to promote social inclusion, what became evident through our stakeholder engagement is that our efforts have to go beyond a new individual program, service, or initiative. We are, thus, not promoting any one intervention, but rather a set of actions that can strengthen our social infrastructure and have the potential to effect change at a broader systemic level. These action areas are organized under three broad and interconnected goals: 1) improving understanding of social inclusion in Toronto, 2) addressing social inclusion at the city level through programs, policies, and services, and 3) promoting best practices at the program level, which would in turn promote social inclusion across the city. Figure 3 depicts the actions arranged according to the three overarching goals.

There are many local, provincial and national initiatives that have come to our attention throughout this project that demonstrate positive action in these areas. The table in Appendix 3 provides a small sample of the numerous strategies and initiatives being developed or underway to promote social inclusion in Toronto. We have identified some concrete next

steps that we will take to spearhead specific activities to build upon work underway and address gaps in these action areas. These next steps are listed below each set of action areas.

1. Improve understanding of social inclusion in Toronto

a) Promote awareness of the non-material dimensions of social inclusion and their link to health and well-being

What surfaced through this project is that social inclusion and the dimensions of social connectedness, social capital, and civic engagement - though often discussed in many different ways - are important to enhancing citizens' capacity to participate in and contribute to social and civic aspects of society. Both locally and internationally, there is some evidence that initiatives that promote these dimensions can have positive effects on different aspects of health and well-being. Through dissemination of this project's findings, we hope to promote a greater awareness of these non-material dimensions of social inclusion and their link to health and encourage further evaluation and research to explore this relationship. Stakeholders also reinforced the notion that the material and non-material dimensions of social inclusion are inextricably linked. Better understanding of how these separate dimensions interact to influence health could be considered in future research.

b) Advocate for the regular collection of local population data

Though there is growing evidence of how health is influenced by social connectedness, social capital, and civic engagement, there is no systematic collection of data on these dimensions of social inclusion at the local level. Local surveys, such as the NEHW data, provide a snapshot, but do not inform understanding of trends over time. Regular collection of local data with a comprehensive set of social inclusion indicators would allow for monitoring progress in this area, and would also contribute to evaluating the effectiveness of interventions.

Similarly, it is important to advocate for the use of new sampling strategies or research methodologies (e.g., participatory or qualitative approaches) to document the circumstances of groups experiencing marginalization that are not captured by population surveys, such as those designed by Statistics Canada. This work could also identify additional indicators for measuring social inclusion more completely. There are new, innovative sampling methods and approaches, such as respondent driven sampling, being used on smaller scales or with particular populations which could be explored for broader use.

Next steps in addressing these action areas

Broadly disseminate the project's findings to diverse stakeholders.

Continue to advocate to Statistics Canada to collect local data on indicators of social connectedness, social capital and civic engagement and social participation as important determinants of physical and mental health.

2. Promote social inclusion city-wide through programs, services, and policies

a) Develop ways to ensure access to services for the most marginalized

Providing services that are accessible to diverse groups is a key facilitator of social inclusion and can act as an important source of social connectedness for people who are isolated. Stakeholders highlighted the need to ensure that municipal and other supportive services are equitably distributed in the city and are reaching the most marginalized populations. In the literature, peer models featured prominently as an effective way of increasing access to health and social services for hard to reach populations. Tools to guide thinking about how to reduce barriers, promote equitable access to services and programs, and assess the impact for specific population groups have also been developed (e.g., equity lens, healthy equity impact assessments, social inclusion audits). We need to increase awareness and more extensive application of these approaches and tools across the City of Toronto and other institutions and organizations. Continued collection and reporting of sociodemographic information on service utilization is also needed to identify excluded groups, and inform priorities for service improvement.

b) Increase diversity and inclusion in governance and civic engagement

Prioritizing the voices of underrepresented groups is a crucial element of participatory approaches uncovered in the literature and local scan. Local stakeholders highlighted the importance of shifting decision-making power to those who are most impacted by decisions. Inclusion in priority-setting and policy-making can be promoted by increasing diversity in leadership positions across sectors, including municipal governance and civic engagement processes. This was viewed as a key element of social inclusion, an outcome of an inclusive city, and a way of addressing systemic issues that have historically led to exclusion of certain groups.

c) Promote equitable access to inclusive spaces

This project revealed the importance of spaces and places for building social inclusion in two concrete ways. First, local stakeholders conveyed the critical role of having stable, affordable space to initiate and sustain an initiative. Second, locally and internationally, underused neighbourhood spaces are being transformed into places that foster connections between and improve the quality of life and health of residents. Strategies to increase availability of space for community use include maintaining or repurposing publicly-owned facilities, such as schools, outdoor playgrounds, and parks, and co-location of various community services and programs within the same physical site. Ensuring there is equitable access to shared spaces for diverse groups is essential.

Next steps in addressing these action areas

Explore what organizational supports TPH program areas will need to apply the City's Data for Equity Guidelines that are being developed to support collecting and using client sociodemographic data to inform planning.

In alignment with the Ontario Public Health Standards Health Equity Guideline, identify organizational supports needed to promote the use of an equity tool in budgeting, service planning, delivery, evaluation and policy development and the use of mitigation measures to address equity gaps.

Continue to provide mandatory Access and Equity training for all new incoming staff, and other relevant training (e.g., gender diversity, human trafficking), to increase staff knowledge and capacity to integrate health equity approaches into their work.

Continue to support the implementation of various City strategies focused on enhancing access to services and the health of particular communities (e.g., Indigenous Health Strategy, Anti-Black Racism Plan; Seniors Strategy 2.0; Toronto Youth Equity Strategy; Toronto Poverty Reduction).

Explore the feasibility of creating a Toronto Public Health Resident Review Panel to increase the diversity of experiences considered in priority setting activities, such as strategic planning.

Through the Child Friendly TO initiative, continue to build capacity to include children from diverse communities in civic engagement processes.

3. Develop best practices for promoting social inclusion at the program level

a) Generate local evidence through evaluation

The scoping reviews identified the need for more systematic assessment of the impact of social inclusion initiatives. There are a wealth of community initiatives taking place in our city that could contribute to evidence in this area. Community funding bodies could support this objective by integrating explicit goals related to building social connectedness, social capital, and civic engagement within community granting programs. Our project illustrates that there is a need to build evaluation capacity in local initiatives, which involves adequately resourcing evaluations so that they do not compete with operational demands. Furthermore, requirements of formal evaluations should be flexible and adapt to the context and values of local initiatives in order to capture a range of impacts and outcomes. These commitments would further support the development of local evidence on social inclusion.

b) Promote community-defined, participatory, peer-led, asset-based approaches

Both locally and internationally, there are many initiatives using many different approaches to increase social connectedness, social capital, and civic engagement for marginalized populations. A common thread running through these was the importance of community-defined responses to addressing social inclusion, and participatory approaches to developing and implementing asset-based solutions. Using peer models for building social connections and social capital was another recurring strategy. Local stakeholders agreed that these types of approaches should be prioritized as they are well-established ways of engaging and promoting the autonomy of historically marginalized communities, and pointed to certain populations that could be further supported. This includes those involved with the criminal justice system, people experiencing mental health or substance use problems, older adults, racialized groups, people living in poverty, people with disabilities, those who identify as Indigenous or LGBTQ2S, and those experiencing intersecting inequities.

c) Promote innovative funding models to sustain and invest in new community approaches

The local scan and consultations highlighted the need to assess the suitability of existing funding structures and approaches to better support the sustainability of community-driven social inclusion initiatives. It was generally acknowledged that the nature of funding is increasingly short-term and project-specific, leaving programs struggling with how to continue once the funding ends. For funders, the challenge is finding a balance between maintaining established programs or organizations and supporting new grassroots or innovative initiatives. To improve sustainability and support new investments, there is a need

for more collaborative funding models that helps communities to set funding priorities, build organizational capacity (e.g., governance, finance), and community capacity for advocacy to facilitate systemic change.

d) Build connections, networks, and partnerships across social inclusion work

This project also identified the need to go beyond the individual level to build collective social capital at the community, organizational and city levels. Better linkages and networking across multiple groups, sectors, and regions of the city can serve as mechanisms for exchanging information and resources, identifying opportunities for collaboration, and can support sustainability. Creating linkages across different neighbourhoods, grassroots initiatives, or peer networks – with aligned goals would strengthen community capacity to advocate for systemic change. Overall, these processes can help to break down silos, identify synergies, and enhance the collective impact of social inclusion work.

Raising awareness of existing networks for resource exchange, as well as developing new platforms to share tools, resources, and data that promote equity and inclusion across City divisions, community organizations, and funders can help to prioritize social inclusion in the design and administration of policy and programs. Similarly, establishing conduits such as workshops and communities of practice to share best practices, information about relevant frameworks and conceptual lenses, and information about existing projects are also valuable mechanisms for building connections. Identifying possible synergies among initiatives also offers opportunities for research that would contribute to understanding the relationships between dimensions of social inclusion and other social determinants of health (e.g., employment, income security, housing, community safety, education).

e) Build understanding across diverse groups

While Toronto is renowned for embracing diversity, local stakeholders reinforced the need to consider the divisions that exist along sociodemographic lines that contribute to inequities and weaken our collective resilience. Discrimination and 'othering' based on class, ethnicity, race, ability, and gender continue to occur. Creating opportunities to build understanding between diverse groups can break down barriers, stereotypes, and misconceptions that contribute to social isolation and alienation. Opportunities to share diverse experiences and perspectives can cultivate respect for difference, as well as instil a sense of shared responsibility for addressing social and economic issues.

We found many approaches being used locally and internationally that try to build connections between different social groups, such as intergenerational programs, neighbourhood revitalization projects, and volunteering initiatives. Continued investment in such initiatives within our workplaces, educational settings, communities, and

neighbourhoods are vital to building understanding and respect for all members of society, and valuing their contribution and active participation.

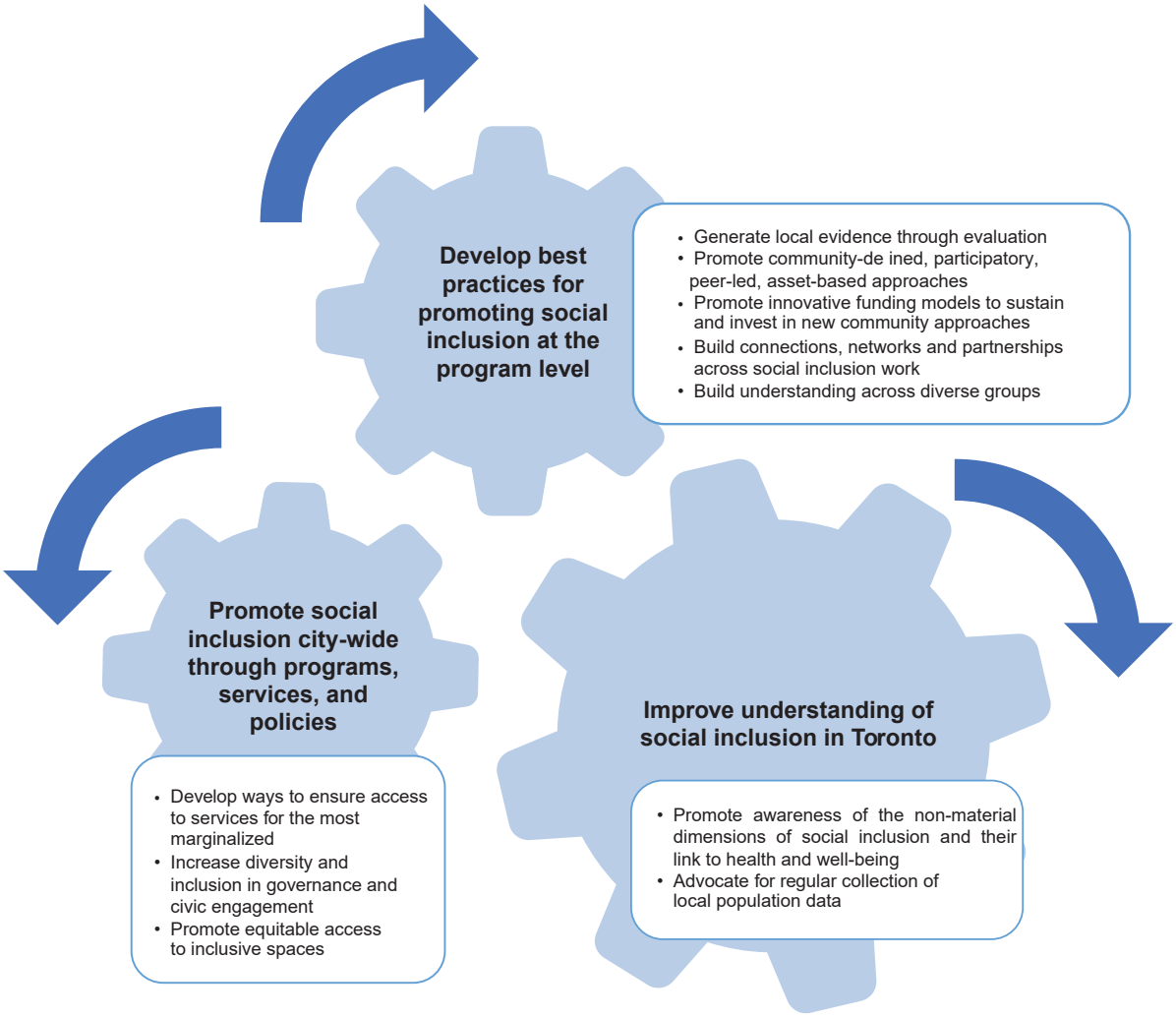
Next steps in addressing these action areas

Explore with the City of Toronto Community Funding Unit and the Toronto Urban Health Fund how to assess the collective impact of the City's investment in community initiatives on social inclusion through incorporating non-material dimensions of social inclusion into their respective theories of change and evaluation frameworks.

Meet with the Toronto Urban Health Fund and the City of Toronto Grants Coordinating Committee to explore potential opportunities for addressing action areas related to evaluation and funding.

Explore the possibility of developing a future Toronto for All campaign in collaboration with other key City of Toronto and community partners with the objective of promoting social inclusion.

Figure 3. Action areas to promote social inclusion in Toronto



Conclusion

This project has identified a wealth of initiatives that work toward developing the building blocks of social inclusion, while also reinforcing the critical importance of continued action to eliminate systemic social and economic inequities. These inequities hinder full participation in all aspects of civic life, and negatively impact health and wellbeing. We have presented the main findings from a number of different research activities aimed at increasing understanding of how to build social inclusion in Toronto.

These activities include analysis of local data to determine the extent and form of social inclusion in the city, a review of the literature on interventions to promote social inclusion and health internationally, a scan of Toronto initiatives geared toward increasing social inclusion, and consultations with representatives from community organizations, various City of Toronto divisions, and funding organizations to identify strategies for promoting social inclusion.

Following a synthesis of this work, we have identified ten action areas that require multi-sector collaboration to sustain and build upon the important work underway, and spark more innovative solutions to building an inclusive city that promotes health and well-being for all. We have outlined specific activities that we will undertake to address these areas. A next step in our process will be to reach out and actively engage interested groups in discussions of these action areas and explore how to implement these specific activities.

Appendix 1: Advisory Group Membership

Andrea Austen
Policy Development Officer
Social Policy, Analysis & Research, Social Development, Finance & Administration, City of Toronto

Renee Boi-Doku[a]
Public Health Nurse, Urban Issues
Toronto Public Health

Mihaela Dinca-Panaitescu[b]
Manager, Research, Public Policy & Evaluation
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Michael Hall
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Sarah Harris[c]
Director of Communications
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Michelle Joseph
Chief Executive Officer
Unison Health & Community Services

Dr. Patricia O'Campo
Research Scientist
Centre for Research on Inner City Health, St. Michael's Hospital

Jessica Patterson
Health Promotion Specialist, Mental Health Promotion
Toronto Public Health

a Formerly, Marlon Merraro, Manager & Hanifa Kassam, Community Health Officer, Urban Issues

b Formerly, Michelynn Lafleche, Director of Research, Public Policy & Evaluation, attended first meeting

c Formerly, Sevaun Palvetzian, CEO, attended first meeting

Dr. Barry Wellman, Retired Faculty member, Department of Sociology, University of Toronto, attended the first meeting.

Appendix 2: Description of Local Interventions Promoting Social Inclusion in Toronto Identified via Our Local Scan

Intervention Name	Population, Geography, and Intervention Description	Intervention category
Success Beyond Limits	Youth, Jane & Finch Neighbourhood Project aim is to reduce the impact of external factors that negatively affect the educational success of youth. Involves a 6-week summer program that offers credits, mentorship, youth employment, enrichment, nutrition, engagement, and relationship building, as well as permanent youth space at Westview Centennial Secondary School.	Peer and Community-led
The East Scarborough Storefront Community University Initiative	General Population, Kingston-Galloway/Orton Park Neighbourhood, Youth Partnership between University of Toronto Scarborough and KGO community working on initiatives aimed at community development.	Peer and Community-led
The Youth Infrastructure Collaborative- Youth Spirit Circles	Indigenous Youth, City-wide An intergenerational network and community of practice that co-creates supports that young people need to make good things happen in their communities.	Peer and Community-led
Gashanti Unity	Somali women, Sheppard and Birchmount Neighbourhood Group that provides leadership and mentoring programs, training, education, and community capacity building.	Peer and Community-led
Artists Without Barriers	Individuals living with a disability, City-wide Artist collective run by and for artists living with communication or mobility-related disabilities and their supports.	Arts-based
The Remix Project	Youth, City-wide Programs and services for youth from marginalized and underserved communities to help level the playing field in the creative sector by supporting them to enter into creative industries or further their formal education; provide top-notch alternative, creative, educational programs, facilitators, and facilities.	Arts-based
Recipe for Community	General population, 3 neighbourhoods (Alexandra Park, St. James Town, Westmount Dennis) Initiative to engage neighbourhood residents young and old to improve the sense of belonging and safety in their communities. The initiative brings together donors, sponsors and residents to invest in 4 key community "ingredients": food, convening, youth engagement, and neighbourhood beautification.	Built Environment

Intervention Name	Population, Geography, and Intervention Description	Intervention category
Sparking Change (Park People)	Underserved communities, high-need communities/ neighbourhoods Working with communities on the ground to transform underused outdoor space into green community hubs.	Built Environment
Thorncliffe Park Women's Committee & the Revitalization of R.V. Burgess Park	General population, Thorncliffe neighbourhood (high newcomer/ immigrant population) Thorncliffe Women's Committee self-organized to come together and completely revitalize R.V. Burgess park through meeting with government, connecting with other park groups and others. Also established a weekly bazaar in the park.	Built Environment
DiverseCity Fellows (Civic Action)	General population, City-wide Free year-long program that exposes participants to important regional issues, provides opportunities for personal leadership development and help them grow a strong network of civic minded peers across sectors.	Volunteer/Civic Engagement
Participatory Budgeting Pilot (The City of Toronto)	General population in three neighbourhoods (Rustic in Ward 12, Oak Ridge in Ward 35, Don Valley East Sheppard & Mills in Ward 33) Three-year pilot to engage city residents to propose and vote on community investment projects in their neighbourhoods, which are funded through the municipal budget.	Volunteer/Civic Engagement
Toronto Intergenerational Partnership in Community	General population (Seniors, Youth, Adults), City-wide An intergenerational program that connects and pairs individuals from different generations and facilitates programming (gardening, learning new technology, exploring Toronto, etc).	Volunteer/Civic Engagement
The Youth Health Action Network (Toronto Public Health)	Youth (age 16-24), City-wide Toronto Tobacco Control Area Network youth engagement initiative with the goal of exploring and taking action on current and emerging health issues.	Volunteer/Civic Engagement
Supporting Our Youth (SOY) H.E.A.T. (Human Rights Equity Access Team)	Queer and trans spectrum youth, City-wide Convenes emerging youth leaders with an interest in social justice and working within anti-oppressive frameworks. After participants complete an intensive 30-week training program they then have the option of joining the H.E.A.T. speakers bureau to share their own personal experiences and knowledge of homophobia and transphobia, as well as intersecting issues such as racism, ableism, and other forms of oppression and discrimination with other organizations.	Volunteer/Civic Engagement

Appendix 3: A Small Sample of Current Initiatives that Address the Action Areas

There are many local, provincial, and national initiatives that have come to our attention throughout this project that demonstrate movement in addressing action areas identified in this report. A brief description of a small sample of these initiatives is provided here. The initiatives are organized by the action area they address.

Measuring and tracking social Inclusion

Positive Mental Health Surveillance Indicator Framework
https://infobase.phac-aspc.gc.ca/positive-mental-health/

Recently published by the Public Health Agency of Canada, the Framework identifies similar social inclusion constructs as determinants of mental health. Local data for these measures would contribute to local surveillance efforts to provide a comprehensive picture of the state of mental well-being in local communities and inform service delivery planning to increase equitable access to services at the City and beyond.

Toronto Social Capital Project
https://www.environicsinstitute.org/projects/project-details/toronto-social-capital-project

This survey will contribute significantly to our understanding of current experiences of social inclusion in Toronto. Since this is intended as a cross-sectional design that provides information about social inclusion at a single point in time, the ongoing collection of data through comparable surveys would even further extend our understanding by providing comparisons over time.

Open Data Portal and the Wellbeing Toronto Dashboards
https://www.toronto.ca/city-government/data-research-maps/open-data/
https://www.toronto.ca/city-government/data-research-maps/neighbourhoods-communities/wellbeing-toronto/

These City of Toronto tools provide vehicles for making local social inclusion data publicly available, such as through the mapping of local data. Having data of this kind also enables researchers to examine in more depth the interconnectedness of various social inclusion dimensions and pathways between these dimensions and health.

Increasing equitable access to services to most marginalized

Data Standards for the Identification and Monitoring of Systemic Racism
https://www.ontario.ca/document/data-standards-identification-and-monitoring-systemic-racism

The provincial government's data standards will support evidence-based decision-making and accountability within public sector organizations in child welfare, education, and justice, by requiring the collection, analysis, and reporting of race-based information over the next five years. The City of Toronto has also begun to establish a process for implementing sociodemographic data collection across the municipal sector with the goal of delivering equitable programs and services across municipal divisions and agencies.

Community Hubs
http://www.communityhubs.ca/

These are an excellent example of the co-location of programs and services within one physical site. Community hubs are also an example of agencies working together to support communities to take ownership of spaces. There are seven community hubs across Toronto. This strategy aims to improve access to services and promote social connectedness, and features prominently in the capital infrastructure planning for the Parks, Forestry & Recreation division and the Toronto Public Library, for example.

Community Librarian Program
https://www.toronto.ca/community-people/employment-social-support/employment-support/success-story-spotlights/partnership-with-the-library/

In order to increase the accessibility of public libraries to their clients, the Toronto Public Library and the City of Toronto Employment and Social Services (TESS) are working to establish community librarian positions at TESS sites. They are also working in partnership to deliver a program that increases digital and information technology literacy to increase labour market inclusion.

Promote equitable access to inclusive spaces for community use

Community Benefits Frameworks
https://theonn.ca/wp-content/.../Community-Benefits-Policy-Framework_03-13-17.pdf.
http://www.communitybenefits.ca/
https://ccednet-rcdec.ca/en/toolbox/toronto-community-benefits-network-background-documents

There are numerous frameworks at the provincial and municipal levels that guide government work with community partners, such as the not-for-profit sector, and aim for local community benefit from projects such as infrastructure development. These frameworks could also support increased access to shared/multi-use spaces in high need neighbourhoods across the city.

Inclusive and diverse governance and civic engagement

City of Toronto Strategies

www.toronto.ca

- Toronto Poverty Reduction Strategy
  https://www.toronto.ca/city-government/accountability-operations-customer-service/long-term-vision-plans-and-strategies/poverty-reduction-strategy/
- Toronto Indigenous Health Strategy
  https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/toronto-indigenous-health-strategy/
- Anti-Black Racism Action Plan
  https://www.toronto.ca/community-people/get-involved/community/toronto-for-all/anti-black-racism/
- Seniors Strategy
  https://www.toronto.ca/community-people/get-involved/community/toronto-seniors-forum/

The Toronto Poverty Reduction Strategy is an important initiative that could inform understandings of the association between the non-material and material dimensions of social inclusion. A Lived Experiences Advisory Group has been formed to guide the development, implementation, and monitoring of the Strategy, and has the potential to contribute to other initiatives that attempt to represent the perspectives of people with lived experience of social exclusion.

New models of co-creating broad city-wide initiatives have also been demonstrated, such as the development of the *Toronto Indigenous Health Strategy*, the *Anti-Black Racism Action Plan*, and more recently the updated *Seniors Strategy*. Each of these was led by those with the greatest stake in the outcomes of these initiatives and supported by City staff, and other institutional partners.

Supporting community-defined, participatory approaches

ResilientTO (Resilient City Strategy)
https://www.toronto.ca

This City of Toronto strategy, currently being developed, has identified inclusiveness as a quality that is key to enabling cities' resilience in the face of shocks and stresses. Inclusive in this context is defined as "prioritizing broad consultation to create a sense of shared ownership in decision making." For this reason, it is another important avenue for building a greater understanding of social inclusion as both a process and outcome. The neighbourhood resilience hub component, being led by the Toronto Foundation, involves developing Resilience Hubs in ten neighbourhoods across the city using a new collaborative model of community engagement to produce new social networks. These neighbourhood groups have

received funding to develop resident-led initiatives that build new relationships and expand networks of support. Documenting and measuring the impact of the process of developing and implementing these resilience hubs on creating new social ties and social capital in communities would both inform future approaches to community engagement work as well as resilience planning in other neighbourhoods.

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