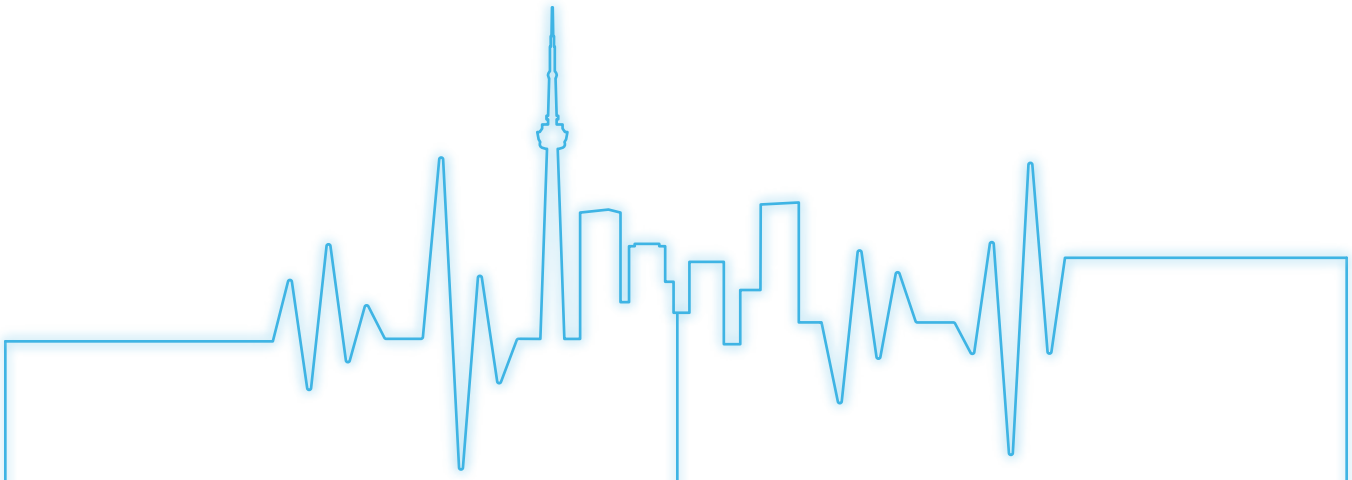
Introduction

Circumstances arising from the social environment in which we are born and live, play a major role in determining health status. These include education, employment, working conditions, and income and are known as social determinants of health. The relationship between social determinants and health outcomes is often complex with some determinants playing a direct or more proximal role than others. Recognizing these complexities, social determinants of health may simply be thought of as the root causes of health status, playing a greater role than individual choice or risk factors.

Social determinants of health are usually not distributed equally among people, making some groups healthier than others. When this distribution results from unjust social processes that are amenable to change, it is recognized as a health inequity. In Toronto and other areas, inequities have been identified for a number of health indicators resulting from the unequal distribution of income. Many of these inequities have persisted over time (see Low Income section). Health inequities related to income and other determinants, risk factors, and outcomes, represent important dimensions to consider when assessing population health status.

Toronto's unique social environment creates both opportunities and challenges, particularly around issues that include homelessness, food insecurity, access to healthcare, social inclusion, and violence. These represent key areas to address for upstream primary prevention efforts aimed at improving population health and are addressed in this chapter.



7 in **10**
have completed
post-secondary
education

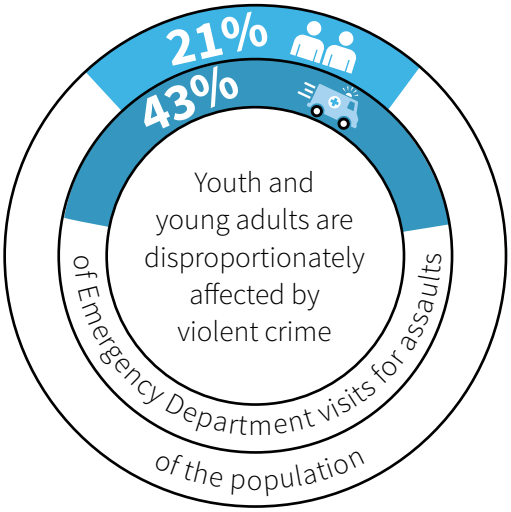
p. 21

1 in **12**
are unemployed

p. 22

Adults in
1 in **7**
households
experience food insecurity

p. 28



p. 32

1 in **5** people and more than **1** in **4** children
live in low income

p. 23

8,700+ experience
HOMELESSNESS

p. 26

Education

Education is well-documented as a prominent social determinant of health. Higher education can increase literacy and sense of control, which can help people make informed decisions about their health, including adopting healthy behaviours, and navigating the healthcare system [1] [2]. It may also have physiologic effects such as protecting against cognitive decline and dementia [3]. Higher education can also act in a more upstream manner, for example, by leading to a safe, rewarding job with a higher income and health insurance benefits. These in turn can provide the resources necessary for quality housing and food [4] [5].

Higher education also has benefits to broader society, such as lower rates of crime [6] and violence. It should be noted that contextual variables including social policies and individual or family characteristics may be involved in these outcomes. As is the case with other social determinants, an inverse relationship also exists whereby poor health can lead to lower educational outcomes [5].

Education Level[1]

People in Toronto generally had high levels of education. Among those 25 to 64 years of age, in 2016:

- 69% reported that they completed post-secondary education, an increase from 2006 (66%).
- 10% had not completed high school, a decrease from 2006 (12%).

Not all people in Toronto however, had the same high levels of education. Among those 25 to 64 years of age, in 2016:

- Lone-parents were more likely to have not completed high school (17%) compared to the overall population (10%).
- Immigrants, including recent immigrants, were more likely to have not completed high school (13% and 11% respectively) compared to Canadian-born people (6%).
- Racialized people[2] were more likely to have not completed high school (12%) compared to non-racialized people (8%). Some racialized groups were even less likely to have completed high school than other groups. For example, South East Asians were almost four times more likely (29%) to not have completed high school than non-racialized people.
- 44% of Indigenous adults[3] had not completed high school.

Employment and Working Conditions

Toronto is Canada's business and financial capital, a hub for jobs in technology, life sciences, fashion and design, food and beverage, film and television production and many more. Toronto's rich industrial diversity drives growth, innovation and cross-sectoral collaborations, making it a competitive place to seek employment [7].

Employment is generally associated with good health. It provides income, a sense of identity, access to social capital, and structure for everyday life [8].

[1] While the education concepts contained in the 2016 Census are the same as those in the 2006 Census, notable changes were made in 2016 to the wording and presentation of the education questions. As such, caution should be used comparing education data from these two Census cycles. Please see Appendix 3 for more information.

[2] Racialization refers to the social processes that construct racial categories as "real, different and unequal in ways that matter to economic, political and social life". Racialization is often based on perceived differences in anatomical, cultural, ethnic, genetic, geographical, historical, linguistic, religious, and/or social characteristics and affiliations [60]. The use of the term in this section of the report acknowledges that health inequities often exist for people as a result of racialization, based in part, on their ethno-racial identity. For the purposes of this report "racialized" and "visible minority" have the same meaning.

[3] Indigenous data in this section are based on findings from the Our Health Counts study. Other data are from the 2016 Census of Population. Caveats related to comparing results from the Our Health Counts (OHC) survey to other surveys and the 2016 Census are noted in Appendix 3.

Unemployment can lead to material deprivation including loss of income and/or employment benefits needed for food, shelter, child-care, transportation, and access to basic health services. Being unemployed is associated with poor mental and physical health, and mortality [9] [10]. Stress/anxiety, depression, low self-esteem, unhealthy behaviours (e.g. smoking, excessive drinking), and suicide are among the effects of unemployment [11].

As is the case with other social determinants, an inverse relationship also exists whereby poor health can lead to unemployment.

Unemployment Rate

The 2016 unemployment rate[4] for people 15 years of age and over in Toronto was:

- 8%. In the ten years from 2006 to 2016, the rate fluctuated between 8% and 10%.
- Slightly higher for females (9%) compared to males (8%).
- 20% for youth (15 to 24 years of age). This is almost three times higher than the rate for people 25 years of age and over (7%).
- Higher for recent immigrants (13%) but lower for longer-term immigrants (4%) compared to Canadian-born people (8%).
- Higher for racialized people (10%) compared to non-racialized people (7%). Some racialized groups had higher rates of unemployment including Arab (14%), Black (13%), and West Asian (13%).
- Slightly higher for female lone-parents (10%) compared to Toronto overall.
- Estimated at 63% for Indigenous adults.[5,6]

COMPARING TO Toronto's 2016 unemployment rate (8%) was slightly higher than the rates for the rest of Ontario (7%), Ottawa (7%) and Vancouver (6%).

Precarious (Non-Standard) Employment

Precarious or non-standard employment includes all forms of non-permanent contracts such as fixed-term, temporary, self-employment, and/or part-time work. This form of employment generally has limited protection against labour market uncertainties, poor working conditions, low wages, lack of employment benefits and pension, and limited worker control over work processes and working hours [12]. Non-standard and precarious employment[7] is associated with higher levels of employment strain which can lead to stress (due to uncertainty about the future), exhaustion, and other physical and psychological states that may lead to poorer physical and mental health [13]. While limited, some studies are beginning to show that precarious employment is also associated with poor self-rated health, coronary heart disease, poor mental health including depression and anxiety, and exposure to environmental risk [9] [12] [14] [15] [16]. It can also lead to negative effects on personal and family relationships, effective parenting, and children's behaviour [11].

[4] Unemployment data for Toronto overall and trends over time are from the Labour Force Survey. Unemployment data for specific subgroups/populations in Toronto (e.g. variables pertaining to age, sex, race, etc.) are from the 2016 Census of Population.

[5] Indigenous data in this section are based on findings from the Our Health Counts study. Other data are from the 2016 Census of Population. Caveats related to comparing results from different surveys to the 2016 Census of Population are noted in Appendix 3.

[6] The unemployment rate for Indigenous adults is the number of unemployed people as a percentage of the total population (aged 15 years and over). The denominator (the total population) used to calculate the unemployment rate in Indigenous people differs from the denominator (people in the labor force) used to calculate the unemployment rate in Toronto.

[7] The terms 'Precarious Employment' and 'Non-Standard Employment' are used synonymously in this section, however, it is important to note that they are separate concepts. As per the Government of Ontario, precarious employment can include an element of non-standard work however, not all types of non-standard work are precarious and vice versa. Precarious work is usually characterized as being unprotected from labour market uncertainties, unsecure, lacking benefits such as a pension, and having low wages, resulting in vulnerable workers.

According to the Labour Force Survey, among people 15 years of age and over who were in the labour force in Toronto in 2016:

- 17% were part-time workers. 69% of this group indicated that they were working part-time voluntarily.
- 15% were working in temporary positions.
- 6% were temporary, part-time workers, representing the most precarious employment group. This group increased by 27% from 2006 and is one of the fastest growing groups in the labour force.

Income

In Canada, income determines the quality of other social determinants such as food security, housing, and other basic prerequisites of health [11] [17], and influences health behaviours related to diet, physical activity, tobacco use, and alcohol use [17] [18]. In Toronto as elsewhere, people in lower income groups experience higher rates of premature mortality [18].

Income is a particularly challenging issue in Toronto given the increased cost of living over the last decade [19]. With some exceptions, health status in Toronto has been shown to usually improve at each income level, such that people with higher incomes have better health than people in the income group directly below them [18].

Low Income[8,9]

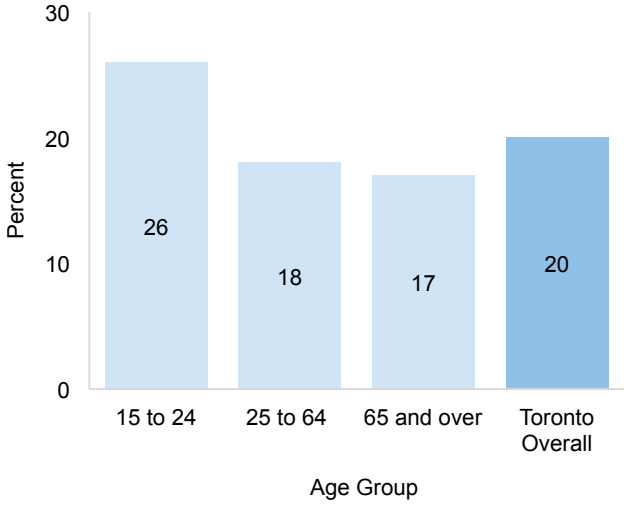
There are three national measures of low income currently used in Canada including: the Low Income Measure, before or after-tax (LIM-BT/AT), the Market Basket Measure (MBM), and the Low Income Cut-Off, before or after-tax (LICO-BT/AT) [20]. The main difference between these is how each sets the threshold at which someone is defined as having a low income [20]. Each measure has strengths and weaknesses, but all of them provide insight into the extent and nature of poverty [20]. More information on these measures is provided in Appendix 3. Despite the different approaches, they generally deliver similar results [20].

The LIM-AT is the primary measure used here, however the MBM is also included as an overall measure due to the recent decision by the Government of Canada to use this as Canada's Official Poverty Line.

In Toronto, in 2015:

- 20% of residents of all ages were living in low-income households based on the LIM-AT measure; the MBM estimate was 22%.
- 26% of youth (15 to 24 years of age) were living in low-income households, higher than the percent observed for all older age groups (Figure 2.1).

Figure 2.1: Percent of People (15 Years of Age and Over) Living in Low-Income Households by Age Group, Toronto, 2015



Note: Based on LIM-AT measure.
Data Source: Statistics Canada, Census of Population, 2016.

[8] Note that all income variables from the 2016 Census are based on the 2015 calendar year reference period, which is different than the reference period for other 2016 Census variables. See Appendix 3 for more details.

[9] See Appendix 2 for income measure (LIM-AT, LICO-BT, and MBM) definitions.

[10] The Our Health Counts study used a different low-income measure (LICO-BT) to determine low-income rates from what is used for Toronto overall and its subpopulations (LIM-AT). As such, caution should be used when comparing these estimates as they are based on different low-income concepts and thresholds.

- 87% of Indigenous adults were living in low income (based on the LICO-BT)[10] (2016).
- Racialized individuals were more likely to live in low-income households (26%) compared to non-racialized people (14%). People in some racialized groups (e.g. West Asian, Arab, Korean, and Black) were more likely to live in low income as compared to other groups (Figure 2.2).
- Recent Immigrants (38%) and non-permanent residents (48%) were more likely to live in low-income households compared to Canadian-born people (16%).
- Lone-parents were more likely (30%) to be living in low-income households compared to the general population in Toronto. Female lone-parents were more likely (32%) to live in low-income households compared to male lone-parents (23%).

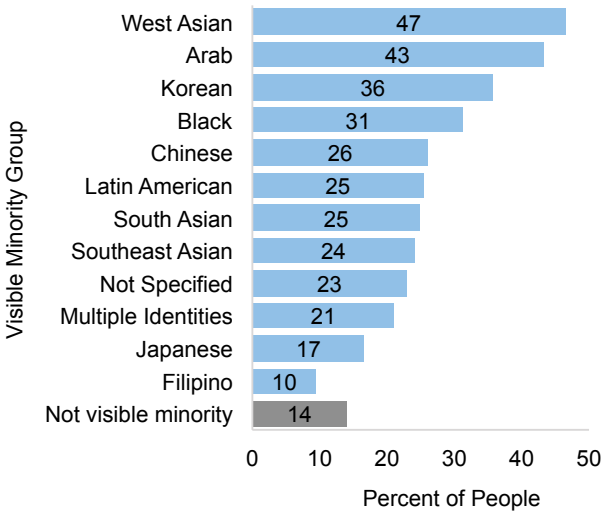
HEALTH INEQUITIES

In 2015, Toronto Public Health's Unequal City Report [18] showed that low income groups in Toronto often had worse health. To illustrate, when the lowest income group was compared to the highest income group:

- Men were 50% more likely to die before age 75.
- Women were 85% more likely to have diabetes.
- Babies were 40% more likely to be born with a low birth weight.

The report also showed that many income-related health inequities in Toronto were not improving. For 34 health status indicators analyzed over time, 21 showed that low-income groups had worse health in the first year. When trends were analyzed for a period of approximately ten years, health inequities were shown to persist for 16 indicators. Four indicators became worse over time while just one improved.

Figure 2.2: Percent of People Living in Low-Income Households by Visible Minority Group, Toronto, 2015

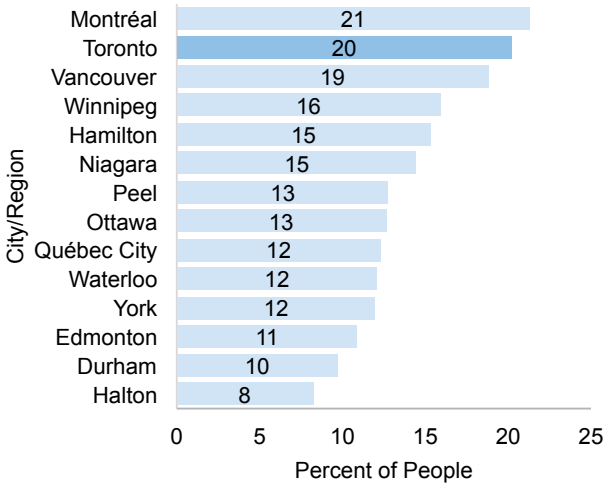


Note: Based on LIM-AT measure.
Data Source: Statistics Canada, Census of Population, 2016.

COMPARING TO

Compared to other large urban areas in Canada, Toronto had one of the highest low-income rates in 2015 (based on the LIM-AT) (Figure 2.3).

Figure 2.3: Percent of People Living in Low-Income Households by Urban Area, Canada, 2015



Note: Based on LIM-AT measure.
Data Source: Statistics Canada, Census of Population, 2016.

Children Living in Low Income

In Toronto, in 2015[11]:

- 26% of children (under 18 years of age) were living in low-income households based on the LIM-AT measure. This percent is slightly higher at 27% for younger children (14 years of age and under).

The proportion of children (under 18 years of age) living in low income varied greatly between some population groups. For example, in the Toronto Census Metropolitan Area (CMA)[12] in 2015 [21]:

- 25% of children in racialized families lived in low-income families. This is more than twice the percent for children in non-racialized families (11%). 47% of children in families of Arab and West Asian backgrounds were living in poverty, more than four times higher than the percent of children in non-racialized families.
- 36% of immigrant children lived in low-income families. This is more than twice the percent for Canadian-born children (17%). The rate for children who were recent immigrants (47%), was almost three times higher.
- 38% of children living in lone-parent families, lived in low-income families. This is two and a half times more than the percent for couple families (15%). Children in female lone-parent families (40%) were more likely to live in low-income compared to children in male lone-parent families (24%).

COMPARING TO

In 2015, Toronto had the highest rate of child poverty (26%), compared to other large cities in Canada [21] (based on the LIM-AT for children under 18 years of age).

The percent of children living in low-income families in Toronto is higher for racialized, immigrant and lone-parent families. One of the most striking inequities however, is for Toronto's Indigenous children (one to 14 years of age), 92% of whom lived in low-income households (based on the LICO-BT) in 2016[13].

Social Support

Social support from family, friends and communities has been identified as a key social determinant of health, directly impacting health outcomes and premature mortality [22]. Social support has also been identified as a determinant of positive mental health [23] likely because social support networks help people solve problems and develop coping strategies that mitigate the effects of stress [22, 24]. Social networks also provide tangible assistance with material needs such as financial help, food and housing [22, 24].

Generally, the greater the number and frequency of connections people have to others, the happier and healthier they are. A 2013 study reported that 55% of Canadians aged 15 years and older reported feeling close to at least five family members [25]. The same study showed that for younger people (less than 35 years of age), high levels of self-rated physical health were reported by 73% of those with at least five close friends and 56% with no close friends. For seniors (65 years of age and over) with many close friends, 56% rated their physical health as very good or excellent, compared to 33% with no close friends.

[11] All income variables from the 2016 Census are based on the 2015 calendar year reference period, which is different than the reference period for other 2016 Census variables. See Appendix 3 for more details.

[12] Low-income estimates for certain subpopulations (e.g. immigrant, racialized, lone-parent) are provided for children and youth under the age of 18 for the Toronto CMA as provided in the cited report. Low-income data for children aged 14 years and under from these subpopulations were unavailable for both the City of Toronto and the Toronto CMA.

[13] The Our Health Counts study used a different low-income measure (LICO-BT) to determine low-income rates from what is used for Toronto overall and its subpopulations (LIM-AT). As such, caution should be used when comparing these estimates as they are based on different low-income concepts and thresholds.

The size of Canadians' networks depends on socio-demographic characteristics, including age, sex, income, labour force participation, and education [26]. It should be noted as well, that health status can affect the likelihood of having relationships with friends and family members [26].

In Toronto, measures related to social support showed that:

- In 2016, 89% of adults (18 years of age and over) scored highly on the social provision scale, a measure of what people receive from their relationships with friends, family members, coworkers, community members, etc.
- In 2015, 82% of Toronto students in grades 7 to 12 reported that they felt comfortable talking to someone about their personal problems. Friends (62%), parents (52%) and adults at school (12%) were identified as the people they felt most comfortable talking to [27].

Community belonging is an indicator of both social support and positive mental health. **More information** on this indicator is included in Chapter 6.

Homelessness

Homelessness is associated with poor health. People experiencing homelessness are at increased risk of dying prematurely and suffer a higher incidence of chronic and acute health problems including, but not limited to, infectious disease, diabetes, cardiovascular disease and respiratory disease compared to people who are housed [28] [29]. Being homeless is associated with low levels of social support, social isolation, substance use, poverty, unsafe sexual practices, poor diet, inadequate shelter (e.g. crowding and poor ventilation), exposure to violence, and limited access to primary health care [29] [30] [31] [32] [33].

Population Estimates and Demographics

The Toronto Street Needs Assessment (SNA) is a needs assessment survey and point-in-time count of people experiencing homelessness in Toronto. The fourth survey was conducted on April 26, 2018 and included individuals experiencing absolute homelessness (outdoors and indoors in shelters and other facilities). The survey did not include the "hidden homelessness" (e.g. people who "couch surf" or stay temporarily with others and do not have the means to secure permanent housing)[14,15].

The 2018 Toronto SNA survey estimated that the homeless population included:

- 8,715 people, representing a 66% increase from the point-in-time count five years earlier in 2013 (5,253)[16]. This estimate includes both the indoor[17] and outdoor homeless populations.
- 8,182 indoor homeless people (94% of all homeless people), the majority of whom stayed in City-administered shelters (82%). The outdoor population was estimated at 533 (6% of all homeless people) (Figure 2.4).

[14] See Appendix 3 for the definition of 'homelessness' used by the 2018 SNA.

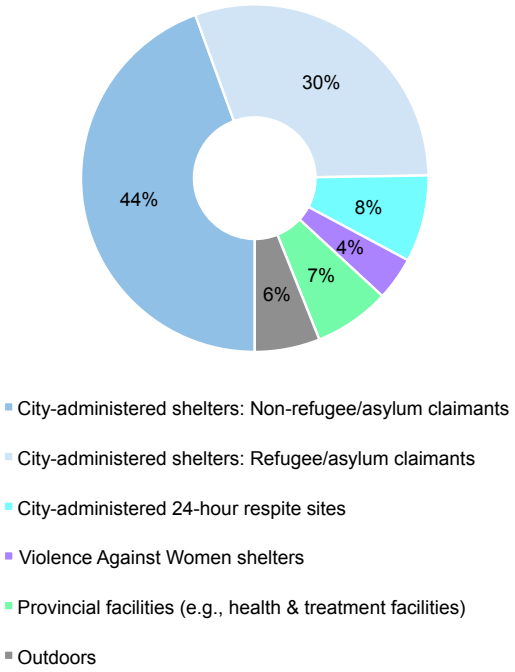
[15] Estimates are from the City of Toronto's 2018 Streets Needs Assessment (SNA) which used a point-in-time count methodology to enumerate the number of individuals experiencing homelessness. More information about the methodology and results can be found at: https://www.toronto.ca/wp-content/uploads/2018/11/99be-2018-SNA-Results-Report.pdf.

[16] The SNA employed a point-in-time methodology that is now standard for most major Canadian and U.S. urban centres. While a consistent methodology has been used over time, changes were made in 2018 in part, as a result of coordinating the count with other cities. As such, caution should be used when comparing results from previous cycles.

[17] Includes emergency and transitional shelters, 24-hour respite sites, health and treatment facilities and correctional facilities.

- People who were refugee/asylum claimants (30%).
- People between 16 and 85 years of age. The average age was 41 years. Seniors (60 years of age and over) and youth (16 to 24 years of age) represented 10% each[18].
- People who identified as male (54%), female (42%), and transgender, Two-spirit, or genderqueer/gender non-conforming (3%).
- People who were members of racialized groups (63%). Racialized groups represented the majority of the homeless population with the largest group identifying as Black (African) (31%).
- People who identified as Indigenous (approximately 16%).
- People who identified as LGBTQ2S (approximately 11%). Among youth (aged 16 to 24 years), 24% identified as LGBTQ2S.

Figure 2.4: Percent of Homeless Individuals Staying in Indoor Facilities and Outdoors, Toronto, April 26, 2018



Data Source: City of Toronto, 2018 Streets Needs Assessment

COMPARING TO In 2018, the rate of people experiencing homelessness in Toronto (about 30 homeless people per 10,000 residents) was slightly lower than in Vancouver (34 homeless people per 10,000 residents), but higher than in Calgary (21 homeless people per 10,000 residents) [35].

Morbidity and Mortality

Respondents to the 2018 Toronto SNA survey included homeless people with:

- An acute or chronic medical condition (e.g. diabetes, arthritis, heart condition) (31%).
- A mental health issue (32%).
- An addiction issue (27%).
- A physical disability (23%).

In addition:

- 28% reported having been to an emergency room in the past six months and 27% reported being hospitalized.

In 2017, Toronto Public Health began to monitor the deaths of people experiencing homelessness.

Among people experiencing homelessness in Toronto, in 2018:

- There were 91 reported deaths.
- Males (78%) represented the majority of deaths.
- The leading known causes of death were drug toxicity (33%), cardiovascular disease (12%) and suicide (4%). Other causes including cancer, infections, complications from diabetes, accidents, homicides, among other causes, made up 15% of deaths. Cause of death was unknown or pending for 25% of the cases.

[18] Estimates are based on survey respondents 16 years of age and over. Dependent children under the age of 16 years are excluded.

Disproportionate health inequities in the homeless population include higher levels of morbidity and mortality [28] [29] [30] [31] [32] [33]. Homeless people are at higher risk for substance misuse, mental illness, infectious diseases such as tuberculosis and sexually transmitted infections [28] [29] [30] [31] [32] [33] and premature death. In Toronto, the median age of death for the general population is 81 years. For homeless people who died in Toronto in 2018, the median was 54 years of age.

The 2018 Street Needs Assessment definition of homeless did not include all people experiencing homelessness. The "hidden homeless" are people living temporarily in their car or with family, friends or others, who have no guarantee of continued residence or with no immediate prospect of permanent housing [35] [36] [37]. These individuals represent the majority of people experiencing homelessness, but are difficult to enumerate as they are not visible on the street or using shelters [36]. Thus, the existing data do not reflect the broader spectrum of people who experience homelessness.

More information on conditions that contribute to being homeless are included in Chapter 3 (housing), Chapter 6 (mental illness), and Chapter 7 (addictions).

Food Insecurity

Not having regular, nutritious food can result in chronic health issues and worsen existing ailments. As such, food insecurity raises costs for the health care system [38]. Food insecurity is heavily influenced by household income [39]. As such, rental and utility costs are key drivers of food bank usage in the city.

In Toronto:

- From April 2017 to March 2018, there were 914,470 client visits to the Daily Bread Food Bank and North York Harvest Food Bank member agencies. These agencies represent the vast majority of food banks in the city. While food bank usage alone is a gross underestimation of food insecurity, it can provide some context for the issue [40].
- Food bank visits were 14% higher than they were in 2008, and more than double what they were in 1995.
- In 2013/14, adults in 15% of households were severely, moderately, or marginally food insecure[19].

Among Toronto students in grades 7 to 12 in 2014, 29% in the lowest socioeconomic access category[20] went to bed or to school hungry at least once per week. This compares to 6% in the highest socioeconomic access category.

[19] Food insecurity categories include: "marginal food insecurity": 1 item affirmed on the 10 item adult food security scale; "moderate food insecurity": 2 to 5 affirmative responses; "severe food insecurity:: 6 or more affirmative responses.

[20] "Socio-economic access" was assessed by asking students to rank their family's access to goods and services. "Low socio-economic access" represents students who ranked their families' access as five or less; "medium access" as six or seven; and "high access' as eight, nine, or ten

Access to Healthcare

People who do not have a regular healthcare provider such as a family doctor or general practitioner, medical specialist, or nurse practitioner are less likely to be screened and/or treated for medical conditions [41]. Preventive practices like screening can have a positive impact on a person's health and can reduce the burden on the health care system.

Regular Health Care Provider

In Toronto, in 2015/16, 86% of adults had a regular healthcare provider, compared to 91% in the rest of Ontario.

HEALTH INEQUITIES

Recent immigrants (69%) and non-permanent residents (59%) were significantly less likely to have a regular healthcare provider compared to the overall Toronto population.

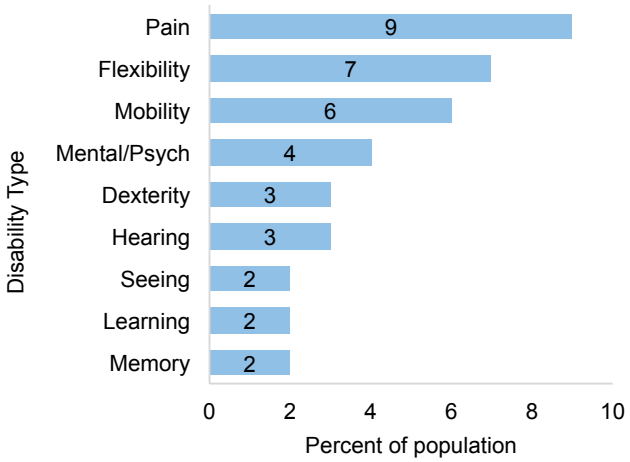
Disability

Disability is sometimes seen as a problem that exists in a person's body, or impairment that may require treatment. An alternative view based on the social model of disability, distinguishes between impairment and disability, identifying the latter as a disadvantage that stems from a lack of fit between a body and its social environment [42]. More specifically, people with disabilities experience added social barriers to education, limited employment opportunities, unemployment, low wages, poverty, social exclusion, violence, barriers to accessing housing and healthcare, and other barriers that can lead to negative health outcomes that extend beyond a person's disability [44] [45] [46] [47] [48]. Providing accessible healthcare and other support services prevents secondary conditions[21], promotes independence, and enables people with disabilities to seek education, work, and engage with their families and communities [49].

Among Toronto residents 15 years of age and over, in 2012:

- 13%[22] (15% of females, 11% of males) had a disability.
- 39% of seniors (65 years of age and over) had a disability, almost five times greater than those 15 to 64 years of age (8%).
- The most common disabilities relate to pain (9%), flexibility (7%), and mobility (6%) (Figure 2.5).

Figure 2.5: Percent of Individuals 15 Years of Age and Over with Disabilities by Disability Type, Toronto, 2012



Data Source: Canadian Survey on Disability, 2012

Violence

Exposure to violence is detrimental to the health of individuals, groups and communities, and is often connected with social and neighbourhood deprivation, and other determinants of health. People can be exposed to violence directly as a victim, or indirectly by witnessing or living in a community that has experienced violence. Beyond causing potential injury or death, evidence suggests

[21] Illnesses, injuries, or issues that are caused or aggravated by the primary disabling condition, such as medical (e.g. pressure sores, depression) and/or social (e.g. unemployment) issues.

[22] The survey excluded persons living in institutions, such as hospitals and nursing homes. As a result, the prevalence of disability in the population is underestimated.

that exposure to violence is a risk factor for chronic diseases including diabetes, heart disease, and asthma [50, 51, 52]. Potential mental health issues include depression, anxiety and post-traumatic stress disorder [53]. The stress and trauma of exposure to violence may also contribute to harmful health behaviours, including smoking and substance use [54]. Children who are exposed to violence are at increased risk of behavioural, emotional, and learning problems, which may negatively impact health and other important developmental outcomes [55]. Fear of violence in neighbourhoods or communities may also reduce physical activity and make people reluctant to visit parks or public spaces [56, 57].

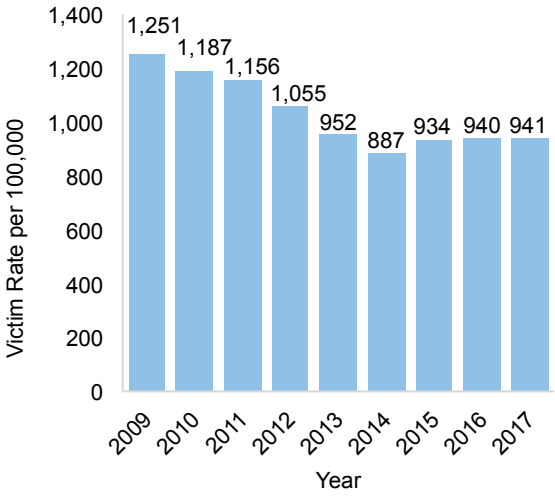
Violent Crime Overall, Homicide, and Shooting

Violent crimes involve the use or threatened use of violence against a person, including homicide, attempted murder, nonsexual assault, sexual assault, abduction and robbery. Violent crimes are counted by the number of victims.

Police-reported trends in violent crime for Toronto showed that:

- The overall violent crime rate decreased from 1,251 victims per 100,000 people in 2009 to 941 victims per 100,000 people in 2017 (Figure 2.6).
- The homicide rate fluctuated between 1.9 and 2.6 per 100,000 people between 2009 and 2017 (Figure 2.7). In that time period, the lowest rate occurred in 2011 (1.9 per 100,000 people based on 51 deaths), and the highest rate occurred in 2016 (2.6 per 100,000 people based on 75 deaths).
- Shooting was the most common method of homicide, accounting for 52% of homicide deaths between 2009 and 2017.
- The rate for shooting (as measured by victims) declined from 2009 (13.0 victims per 100,000 people) to 2014 (8.6 victims per 100,000 people). The rate increased notably however, in 2015 and again in 2016, and remained at approximately 20 victims per 100,000 for the following year (Figure 2.7).

Figure 2.6: Rate of Violent Crime (Victims), Toronto, 2009 to 2017



Data Source: Statistics Canada, Uniform Crime Reporting Survey, 2009-2017, Custom Data Request.

Figure 2.7: Rates of Homicide and Shooting (Victims), Toronto, 2009 to 2017

Data Source: Toronto Police Services Online Data Portal, Shooting Occurrences and Victims, Updated December 31 2018.

Police-reported violent crime for 2017 in Toronto showed that:

- Victims were more likely to be male (1,007 victims per 100,000) than female (879 victims per 100,000). Victims were most often victimized by a stranger (45%) or a friend or acquaintance (26%).
- Physical violence accounted for 61% of all violent crimes, other violent offences (e.g., robbery/ extortion, uttering threats) accounted for 31%, and sexual violence for 7%.
- Sexual assaults occurred at rate of 69 victims per 100,000 people. Female victims accounted for 89% of all sexual assaults. This likely under-represents the true extent of this issue as only an estimated 5% of Canadians report a sexual assault to the police (see data gap).

Emergency Department (ED) visits for Toronto residents in 2017 showed that:

- There were 7,372 visits for assault-related injuries, a rate of 2.5 per 1,000.
- Males (3.5 per 1,000) were more than twice as likely as females (1.5 per 1,000) to have an ED visit for an assault-related injury.

More information on assault as an age and sex-specific cause of death is included in Appendix 1.

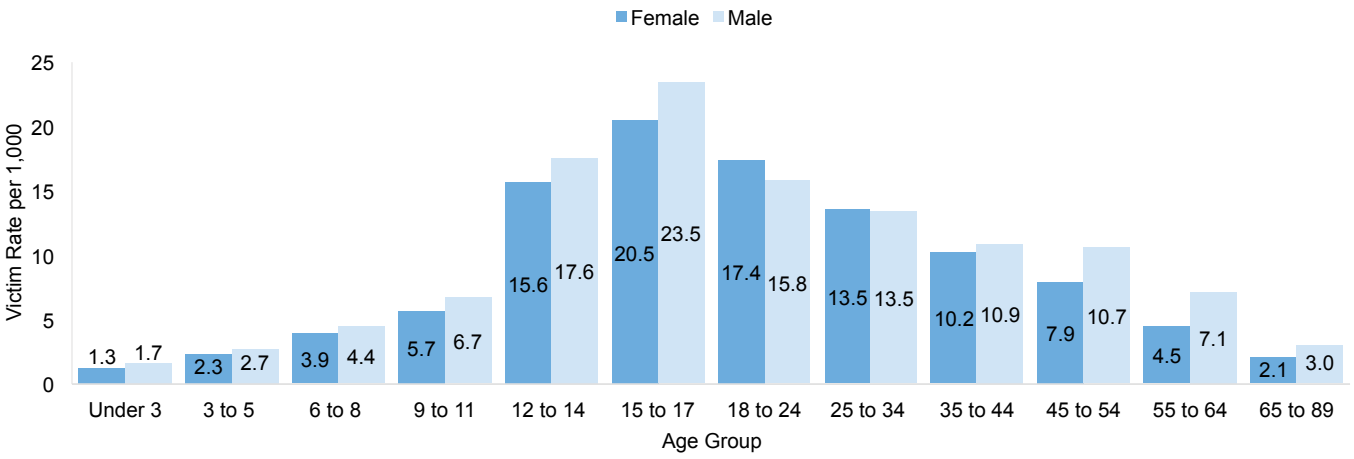
Many violence-related occurrences go unreported to police. As such, the true prevalence of violence is under-estimated when using police-reported data. Population-based survey data on victimization such as the General Social Survey, are currently only available at the provincial level. These data are needed at the Toronto level to more accurately estimate local issues related to victimization and exposure to violence. There is also a lack of population-level data on the physical and mental health impacts of both direct and indirect exposure to violence, as well as associated inequities related to racialized or Indigenous people, sexual orientation, gender identity, and ability status.

Violence against Children, Youth and Young Adults

Police-reported violent crime for 2017 in Toronto showed that:

- Youth aged 15 to 17 years of age were more likely to be victims of violence (1,774 victims or 22 per 1,000) compared to all other age groups. The rate for males in this age group was 23 per 1,000 and the rate for females was 20 per 1,000 (Figure 2.8).
- Child victims 8 years of age and under were most often victimized by a parent or another family member (58%). Older children and youth were more likely to be victimized by someone that was not related to them (63% for ages 9 to 11, 85% for ages 12 to 14, and 82% for ages 15 to 17).

Figure 2.8: Rate of Violent Crime (Victims) by Age Group, Toronto, 2017



Note: The number of ages included in the age groups varies in order to provide more detailed information for younger ages.
Data Sources: Statistics Canada, Uniform Crime Reporting Survey, 2009-2017, Custom Data Request.

Among Toronto youth and young adults (ages 15 to 29):

- The number of Emergency Department (ED) visits for assault-related injuries was higher compared to all other age groups in 2017. This age group accounted for 43% of assault-related ED visits, but only 21% of the total population.
- From 2011 to 2015, assault was the second leading cause of death in persons 15 to 24 years of age, and the third leading cause of death in adults 25 to 29 years of age.

Among Toronto students in grade 7 to 12, in 2014:

- 20% reported being bullied at least once in the past 12 months; 5% reported having been bullied once a week or more in the past 12 months.
- 10% had taken part in bullying other students at school in the last 12 months.
- 8% of male students and 4% of female students reported being threatened or injured with a weapon on school property at least once in the past 12 months.

Elder Abuse

Police-reported violent crime for 2017 in Toronto showed that:

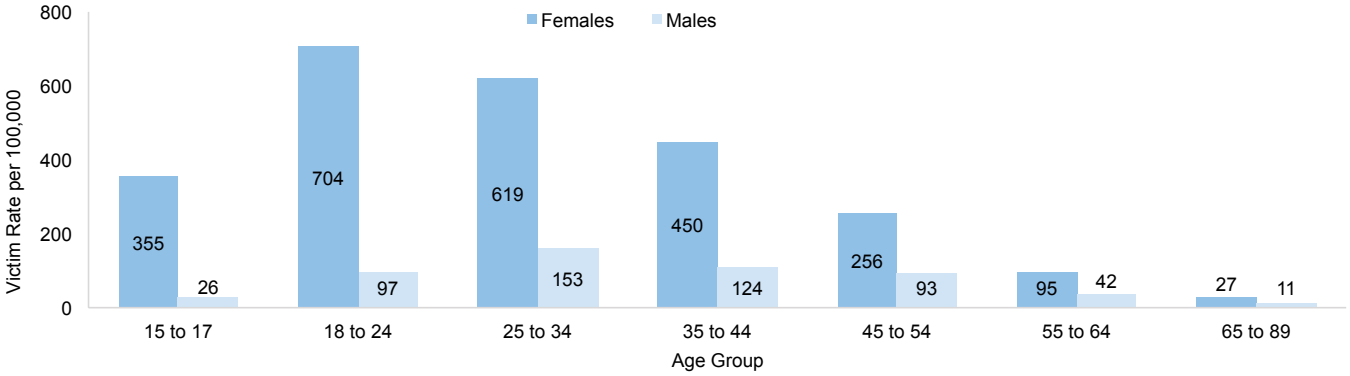
- Seniors 65 to 89 years of age were victimized at a rate of approximately 3 per 1,000 (1,042 victims).
- Seniors 65 to 89 years of age were most likely to be victimized by a stranger (40%), 10% were victimized by children and other family members, 7% were victimized by parents, and 6% were victimized by spouses.

Intimate Partner Violence

Police-reported violent crime for 2017 in Toronto showed that:

- Intimate partner violence occurred at a rate of approximately 2 per 1,000 (5,608 victims). This number is however, likely an underestimate given the nature of this type of self-reported data [58].
- Young adults 18 to 24 years of age had the highest rate of victimization. Rates declined with increasing age.
- 81% of IPV victims of all ages were female, 19% were male. Rates were higher for females in all age groups (Figure 2.9).

Figure 2.9: Rate of Intimate Partner Violence (Victims) by Age Group and Sex, Toronto, 2017



Data Source: Statistics Canada, Uniform Crime Reporting Survey, Custom Data Request.

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