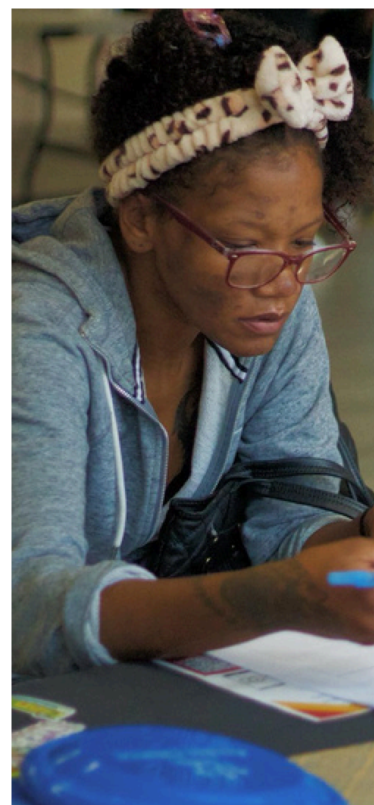
Access Alliance
Multicultural Health and Community Services

New Beginnings for Newcomers.

COMMUNITY HEALTH NEEDS ASSESSMENT:

Rockcliffe-Smythe & Mount Dennis



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March 2026

Disclosure & Citation

Access Alliance Multicultural Health and Community Services (Access Alliance) prepared this report for internal and stakeholder use as a tool for community engagement and development. Gamsa Lee, an MHE Student at the University of Waterloo, compiled this report as part of her learning plan during her practicum placement at Access Alliance and was supervised by Courtney Kupka, Research and Evaluation Coordinator. The contents of this report can be used for non-commercial purposes with the citation:

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Community Partners & Advisory Committee

We greatly appreciate and thank our partner organizations in the Rockcliffe-Smythe and Mount Dennis neighbourhoods who supported this project throughout the data collection process.

Community Partners and Advisory Committee members included representatives from:

- 8 80 Cities
- City of Toronto
- CultureLink
- FoodShare Toronto
- Jane Alliance Neighbourhood Services
- Mount Dennis Community Association
- Progress Place
- Syme 55+ Centre
- Syme-Woolner Neighbourhood & Family Centre
- The Learning Enrichment Foundation
- Toronto Community Housing Corporation
- Unison Health & Community Services
- United Way Greater Toronto
- York West Active Living Centre

Many community members and organizations have greatly assisted in making this Community Health Needs Assessment as inclusive as possible. We appreciate the support of community members, organizations, and all others who have contributed to Access Alliance's initiative towards health with dignity for all.

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Executive Summary

Background

Rockcliffe-Smythe and Mount Dennis (RS-MD) are vibrant, diverse neighbourhoods located at the west end of Toronto along the Humber River. Both areas contain large immigrant populations with various housing and employment opportunities. However, as identified by the City of Toronto, **these neighbourhoods face heightened barriers** and are designated as Neighbourhood Improvement Areas (NIA). Access Alliance Multicultural Health and Community Services (Access Alliance) provides services in these neighbourhoods with the goal of improving health outcomes for immigrants, refugees, and their communities.

Objectives

This community health needs assessment (CHNA) aimed to identify **key service needs, concerns, and assets** of the RS-MD community to design evidence-informed services and programs. Findings from this CHNA will be distributed among community members and partner organizations to assist in the development of informed resources to holistically support these neighbourhoods and improve overall health and well-being in RS-MD. Therefore, this CHNA report is primarily intended to be used by organizations and institutions that provide resources, services, and programs that influence or support health outcomes in RS-MD.

Methods

A mixed-methods sequential approach was used to collect quantitative and qualitative data from the RS-MD community (i.e., community members and service providers). An Advisory Committee and community organizations located in RS-MD were engaged to support the CHNA activities and implementation. For the initial quantitative phase, a field team was trained on ethical data collection to distribute surveys and collect data. The survey consisted of standard, validated tools in seven different languages. A total of 404 surveys that fit the inclusion criteria were gathered for initial data analysis. This was followed by a qualitative phase with focus group discussions and interviews with community members and service providers. These discussions assisted in triangulating initial quantitative findings as participants were consulted about identified community concerns and service needs.

Key Findings

Assets

Community members of RS-MD have identified accessibility to amenities, like shops and services, as the greatest asset of RS-MD. More specifically, proximity to schools, grocery stores, and a general feeling of convenience was primarily emphasized. Another strong community asset was a sense of closeness, friendliness, and respect among community members (i.e., social capital). These assets, along with appreciation for the natural environment, sense of security, and public transportation accessibility, contribute to positive well-being and perceptions in the community.

Community Concerns and Priority Service Needs

- **Cost of housing** was consistently identified as a key concern across both neighbourhoods and all demographic groups (e.g., age, gender, racial-ethnicity). **Housing quality** and **housing support** were also found as major themes contributing to housing struggles in RS-MD.
- **Finding a good job** was commonly expressed as a worry among every age group except seniors. This theme was found to be closely intertwined with **cost of living** in RS-MD.
- **Safety**, including crime and policing, was revealed as another top concern across a majority of demographic groups.
- **Healthcare services** in RS-MD were found to be majorly lacking by residents, where **free or low-cost dental services** were reported as the greatest service need by all demographic groups, followed by a high need for **primary healthcare services** and **mental health services**.
- **Getting healthy food** and having access to **free or low-cost food programs** was also identified as a top concern and service need. Approximately half of all survey respondents reported eating less due to not having enough money or food supply.

Conclusion

While the CHNA has highlighted vital community assets perceived by RS-MD community members and service providers, it has equally unveiled a wealth of concerns and constraints faced by residents. Housing, employment, community safety, health service accessibility, and food security are top concerns and needs that must be recognized and addressed to allow for positive change and development. It is recommended that relevant community members, organizations, and governmental bodies use the findings and conclusions from this needs assessment to improve upon future planning and adapt upon current challenges identified in the RS-MD neighbourhoods.

Introduction

Access Alliance Multicultural Health and Community Services (Access Alliance) is a Community Health Centre that serves vulnerable populations (i.e., immigrant and refugee communities) living in Toronto through a variety of programs and services related to health and well-being. These programs and services are designed to develop an individual's ability to achieve health with dignity, and encourage them to make autonomous decisions with their health. Access Alliance aims to improve community health outcomes by uplifting assets, enhancing capacity and promoting knowledge-sharing among individuals and organizations.

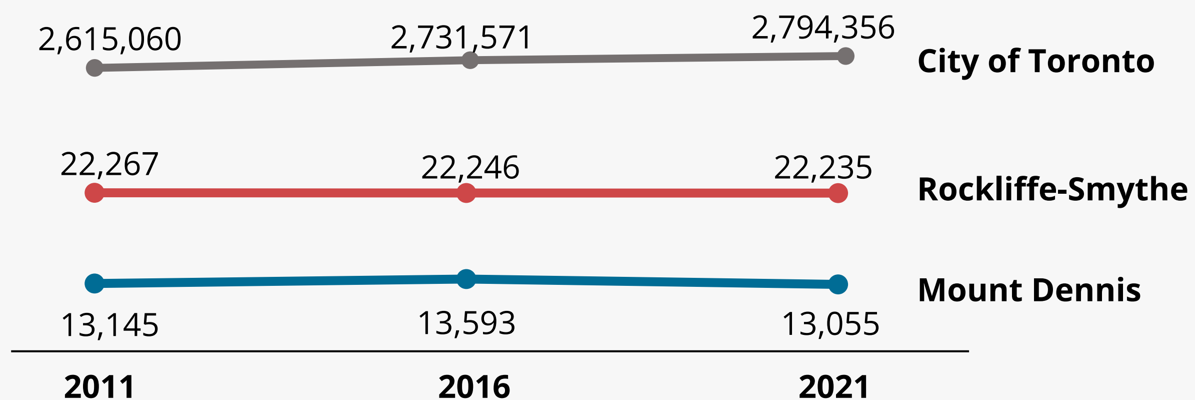
The Community Health Needs Assessment (CHNA) is a tool used by Access Alliance to gather evidence and inform programs and services on how to adequately address population or community-level needs. A needs assessment is regularly used by health organizations to understand the unique contextual barriers surrounding an issue or population by identifying key aspects and correlations. This information is then used to create contextualized recommendations for improvement (Rabarison et al., 2015; Ravaghi et al., 2023). Therefore, our goal when conducting a CHNA is to disseminate findings that highlight paths towards improvement for Access Alliance, local community organizations and community members that wish to achieve positive health and well-being outcomes

In addition, within this process of evidence-gathering, Access Alliance also strives to engage in **community-based research** and include community stakeholders in evaluation design and implementation. Including perspectives of community members and service providers creates a holistic approach that is culturally-sensitive, builds community capacity, and strengthens partnerships (Agency for Toxic Substances and Disease Registry [ATSDR], 2025; Bhawra et al., 2022).

Rockcliffe-Smythe and Mount Dennis

Rockcliffe-Smythe and Mount Dennis (RS-MD) are adjacent neighbourhoods in the City of Toronto that border the Humber River. Per the 2021 Census, Rockcliffe-Smythe had a population of 22,235 and Mount Dennis had a population of 13,055 (City of Toronto, n.d.). Rockcliffe-Smythe is mainly a residential neighbourhood (City of Toronto, 2024b) with a diverse range of shops, restaurants, and community hubs. In contrast, Mount Dennis' history of industrial and community-driven developments has contributed to gradual residential and business growth in the area (City of Toronto, 2024a; Perkins&Will, 2021). Both neighbourhoods largely consist of immigrant communities with similar demographic and socioeconomic characteristics which shape their local identity and culture.

Figure 1
RS-MD Population Growth Compared to the City of Toronto



The RS-MD neighbourhoods are designated as Neighbourhood Improvement Areas by the City of Toronto per their *Toronto Strong Neighbourhood Strategy 2020* (Social Policy, Analysis and Research, 2014). Among the 140 neighbourhoods initially reviewed in the strategy, Rockcliffe-Smythe (Neighbourhood #111) and Mount Dennis (Neighbourhood #115) ranked 12th (33.86) and 3rd (26.39) for worst Neighbourhood Equity Index score, respectively (Social Policy, Analysis and Research, 2014). While these scores and rankings were first determined in 2014, their implication remains true today, as low-income and resource insecurity indicators remain a concern in the RS-MD community. For an in-depth demographic and socioeconomic profile of RS-MD, please refer to our RS-MD Neighbourhood Profile (HERE).

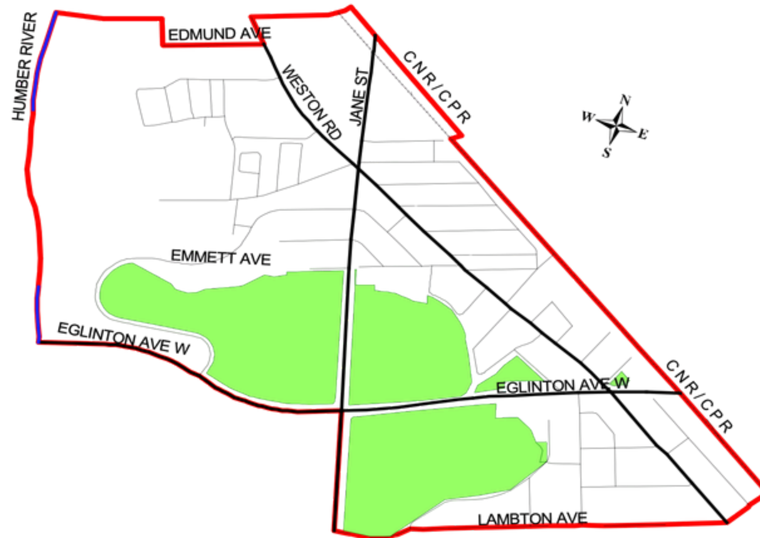


Figure 2

Map of Mount Dennis

Location: Edmund Avenue to the north, the CPR railway to the east, Eglinton Avenue West to the south, and Humber River to the west.

Figure 3

Map of Rockcliffe-Smythe

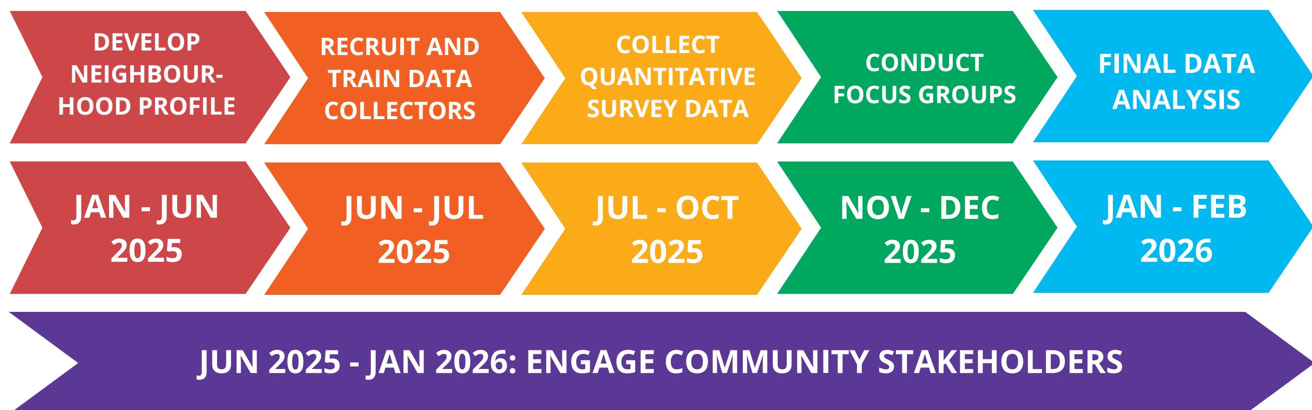
Location: Eglinton Avenue West to the north, Weston Road to the east, St. Clair Avenue West and the CPR railway to the south, and Scarlett Road to the west.

Methodology

This CHNA was conducted in the RS-MD neighbourhood from January 2025 to 2026. As shown in the project timeline in Figure 4, a sequential mixed methods approach (done in stages with both quantitative and qualitative methods) was employed to best capture data detailing the community's assets, social capital, concerns, and service needs. All evaluation and implementation activities were done while engaging community members, peers, and organizations in an effort to identify representative findings. The gathered data was then triangulated to allow for enhanced validity and accuracy of interpretations. A detailed overview of the methodology can be found in Appendix A.

Figure 4

CHNA Timeline and Methods



Summary of Methodology Activity

1

The CHNA began with the development of a Neighbourhood Profile. Creating a profile is vital for gaining insight into neighbourhood context and culture alongside previously recorded barriers, assets, and health and well-being status (Jack & Holt, 2008). This foundational step assisted with informing aspects of the CHNA, such as survey translations and contacting relevant community peers.

2

Quantitative data collection started with the construction of a survey with standardized tools (i.e., Be Well Survey of Ontario and PHQ-9). Including these validated tools in the survey allows for reliable indications of well-being and mental health status.

3

A field research team of peer researchers, community peers, placement students, volunteers, and partner organization staff, was trained on ethical data collection.

4

Based on initial findings from the survey data, qualitative focus group guides were developed and used to engage with RS-MD youth, working adults, and older adults. To generate a comprehensive perspective of community concerns and service needs, a focus group was also held with service providers from Access Alliance and partner community organizations.

5

After both quantitative survey data and qualitative focus group data was collected and cleaned, a final analysis was conducted. A mixture of descriptive and thematic analysis was used to identify key data and themes.

6

Throughout the entire evaluation, community stakeholders (e.g., RS-MD community organizations, members, service providers) were engaged to support contextual findings and data collection.

Findings

Demographic Profile of Survey Respondents

The demographic profile of respondents generally correlated with the Neighbourhood Profile. Age distribution in the profile and survey are not directly comparable due to the division for children (0-15) not being present in the CHNA, but other data points remain relatively proportional. Youth (13-25) composed 11.1% of CHNA survey respondents, compared to 10.9-12.5% of residents in the profile, while older adults (65+) represented 15.7% of respondents compared to 13.4-18.4% in the profile. However, one key difference was the overrepresentation (73.2%) of working-age adults (25-64) compared to the Neighbourhood Profile (55.7-57.6%).

Furthermore, while the profile reported a somewhat even distribution of females and males, almost three-quarters (73.2%) of CHNA participants were female and 24.1% identified as male. The top five racial-ethnic backgrounds of respondents also slightly differed, as ‘Black’ was dichotomized into African and Caribbean, and Filipino was added into South East Asian in the CHNA. Southeast Asian and Filipino were two of the top five groups in the profile, but not in the CHNA, where White European (e.g. Portuguese) was in the top five groups instead. The representation of Black and Latin American identifying individuals was similar between the survey and profile data. For a more detailed demographic profile of survey respondents, please see Appendix B.

Table 1

Demographic Profile of RS-MD CHNA Survey Respondents

Demographic Indicator	Categories	Frequency	Percentage (%)
Age (*n* = 395)* * n = 9 removed due to invalid response or suppressed due to low response category (n < 5)	13-24	44	11.1%
	25-44	178	45.1%
	45-64	111	28.1%
	65+	62	15.7%
Gender (*n* = 395)* * n = 9 removed due to invalid response or suppressed due to low response category (n < 5)	Female	289	73.2%
	Male	95	24.1%
	Prefer not to answer	11	2.8%

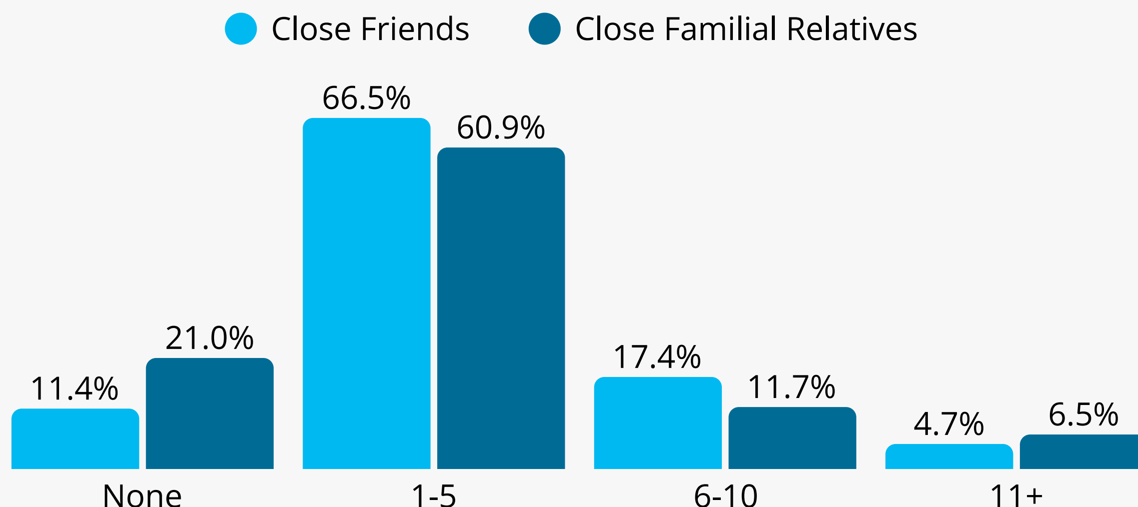
Demographic Indicator	Categories	Frequency	Percentage (%)
Racial-Ethnic Identity (*n* = 389)* * n = 15 removed due to invalid response or suppressed due to low response category (n < 5)	Latin American	110	28.3%
	Black – African	85	21.9%
	Black – Caribbean	48	12.3%
	White – European	32	8.2%
	Asian – South	30	7.7%
Born in Canada? (*n* = 402)* * n = 2 removed due to invalid response	Yes	48	11.9%
	No	341	84.8%
	Prefer not to answer	13	3.2%
Household Composition (*n* = 391)* * n = 13 removed due to invalid response or suppressed due to low response category ** Child refers to both youth and adult children (e.g., adult daughter living with father)	Couple with children	68	17.9%
	Alone	64	16.9%
	Couple	62	16.4%
	Adult in shared accommodation	62	16.4%
	Single parent or guardian household	56	14.8%
	Child living with family**	54	14.3%
Housing Situation (*n* = 357)* * n = 47 removed due to invalid response or suppressed due to low response category (n < 5)	Rental home	249	69.7%
	Owned home	46	12.9%
	Social housing, subsidized housing, or RGI	41	11.5%
	Someone else's home	16	4.5%
	Supportive housing or Group Home	5	1.4%

Social Factors Influencing Community Health and Well-Being

Social determinants are well-evidenced to impact health and well-being in a significant manner (ATSDR, 2025). Thus, it is important to examine current social indicators within the RS-MD community to better understand contexts that surround their health and well-being status.

A majority of survey respondents reported having 1-5 close friends (60.9%) or familial relatives (66.5%). The concept of 'closeness' was described to survey respondents as being able to call upon the individual for help or to openly talk to them with ease. Notably, fewer respondents indicated having zero close relatives, while more reported having zero close friends. In conjunction, the length of stay (LOS) in the RS-MD community (i.e. time since they moved to RS-MD) was slightly more varied, with the most common response (38.5%) being 1-5 years. However, while just under three-quarters of respondents (72.5%) felt a strong sense of belonging, characteristics impacting feelings of comfort were identified. Survey respondents reported feeling out of place or uncomfortable due to their culture (49.7%), ethnicity (48.5%), skin colour (46.4%), physical appearance (44%), and religion (41.3%). Most individuals (50.2%) also felt that "you cannot be too careful in dealing with people" in comparison to 35.6% of respondents indicating that "most people can be trusted."

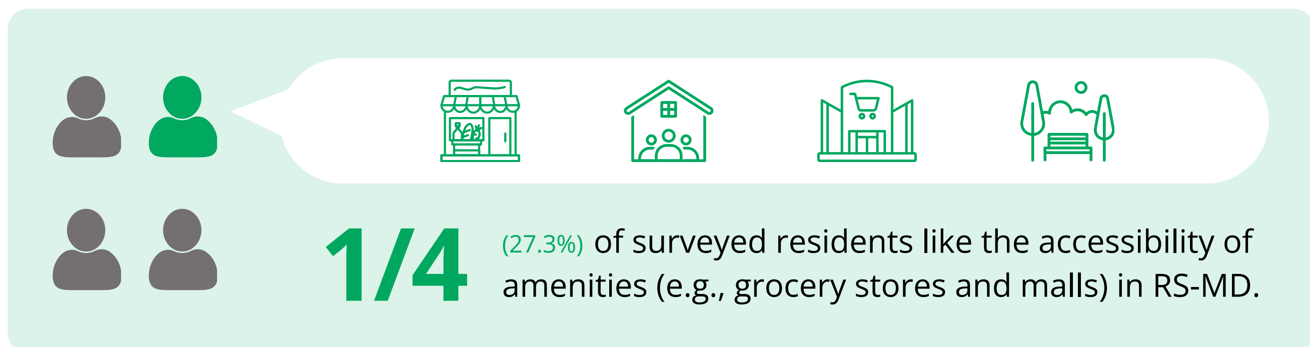
Figure 5
*Reported Number of Close Friends and Familial Relatives (n = 385; n = 386)**



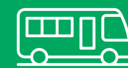
*19 responses removed from close friends and 18 responses removed from close relatives due to invalidity

Community Strengths and Assets

Survey respondents were asked to provide up to three things they liked most about the RS-MD community in an open response question. The resultant data was analyzed by identifying the most common topics out of all valid answers (e.g. was not blank). Common topics were then organized into themes and the frequency of each theme was calculated into percentages out of all valid answers. The most mentioned asset was the **accessibility of amenities in the community**. Over a quarter (27.3%) of overall responses endorsed some form of accessibility to grocery stores, community centers, and more. Positive responses about accessible public transportation was also divided out from amenity accessibility as a significant enough portion (9.2%) mentioned TTC and UP train proximity specifically.



1 in 10 like the accessibility of the TTC and UP train system.



In line with the community's sense of belonging, in which individuals feel accepted and valued, approximately a quarter (26.8%) of survey open responses mentioned positive social capital or belonging. Social capital, for this CHNA, refers to social ties, cultural dynamics of behaviours, social articulations (e.g., norms, trust, expectation of reciprocity), and support or cooperation in the community (ATSDR, 2025; Martínez-Martínez & Rodríguez-Brito, 2020). Therefore, thematically coded responses for social capital included keywords or phrases like respect, friendliness, and "good people." These responses indicated an overall theme of felt human connection between residents. However, there were also notable responses indicating negative social capital (e.g., feeling unsafe), which will be expanded upon in later sections.

3 in 4

(72.5%) surveyed community members feel a strong sense of belonging.

Focus group discussion participants would recite similar themes originally found through survey responses. Participants tended to speak positively about known services and programs, such as Access Alliance's senior exercise program or Community Place Hub's meal program. Accessibility to programs and services was deemed a primary theme throughout conversations with participants, with mention of nearby public transportation stations and walkability to amenities.

PARTICIPANT

Yeah, it's kind of like, it's... everything is in a walking distance, so we don't commute long hours, you know?

Networking and social capital were similarly mentioned by focus group participants as a positive asset of the RS-MD community. Friendliness and respect (i.e., social capital) shown by community members and service providers in community areas (e.g., church, community hubs, etc.) added to a sense of belonging. More specifically, a **welcoming or respectful manner** was key for inducing feelings of acceptance and positive social capital.

Cultural diversity of community members was another asset discussed in focus group discussions and interviews. Residents would relay appreciation for learning new things and the opportunity to expand their perspectives about the world. For other individuals, they expressed an added sense of belonging when connecting to those in a similar age range or culture. Communicating with others in a shared context was perceived as a factor adding to confidence and comfort in social situations.

PARTICIPANT

And we have our community. We feel included. And we gather, and we have fun. We exhibit our culture. We speak our language, and feel at home.

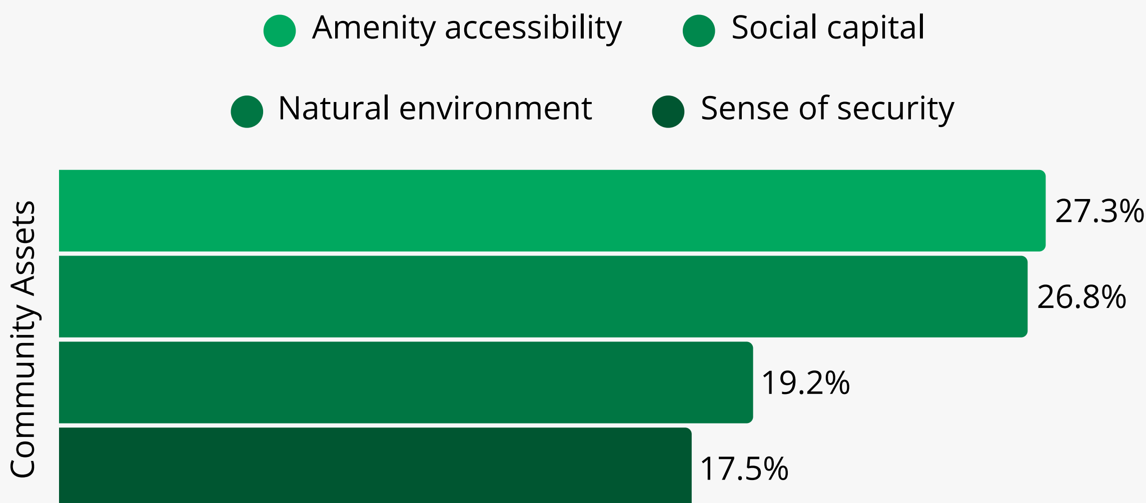
A major topic discussed in conjunction to positive social capital was the impact of social networking on information dissemination. Individuals with greater perceived social capital were more likely to have larger social networks, which aided them in finding various services, programs, and resources through word of mouth. This theme would reappear in every discussion conducted with community members, highlighting a broader theme of knowledge dissemination in RS-MD. The opposite end of the spectrum, wherein individuals struggle to connect to others and resources, will be discussed in the 'Healthcare Accessibility' and 'Discussion' sections.

SERVICE PROVIDER

So it's really good that they refer one another. When they see someone, they're like, "Oh, I go to this community center on this day, they have this program." So, it's good that they're utilizing services in the neighborhood. They're not going to [just] one agency and they also bring a friend.

Figure 6

Top Four Reported Community Assets and Strengths in RS-MD (N = 404)

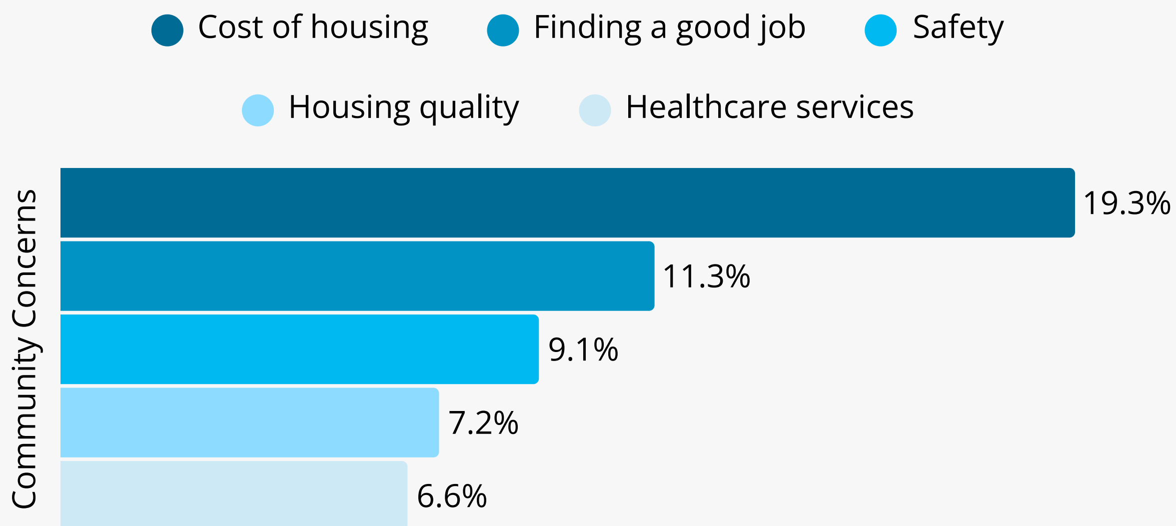


The final significant community asset mentioned by respondents was RS-MD's natural environment. This included access to parks, view of greenery and waterscapes in the area, and an appreciation of the land. In addition, a portion of responses (17.5%) indicated that respondents felt a sense of security in the area, using keywords like peaceful, safe, and quiet.

Community Concern: Housing

Housing was the dominant concern and service need expressed by all survey respondents. Per the WHO, housing is defined as a secure shelter that supports physical, mental, and social well-being (WHO, 2018). Out of the 16 neighbourhood concerns, **cost of housing ranked as #1**, with housing quality and support following closely behind. Concerns regarding housing remain unchanged in ranking across every demographic group, signifying its importance for a majority of community members. Differences only appear in the extremity of concern between groups. For example, RS residents put slightly more importance on housing, as 19.3% of RS responses indicated worries compared to 16.8% of MD responses. Furthermore, female respondents were slightly more concerned about housing costs (19.5%) than male respondents (18.7%). In terms of age group differences, the 45-64 age group had the highest proportion of responses (22.1%) concerned about housing costs, while those aged 65 and older had the lowest proportion (15.3%). Those aged 13-24 and 25-44 had similar responses (18.2%; 18.8%).

Figure 7
*Top Five Community Concerns (n = 396)**



*8 responses removed due to invalidity

Respondents primarily reported living in a rented home (68.0%), an amount more than five times that of home owners (12.6%). In relation, household composition varied widely, with the top five compositions being a couple with children (17.9%); alone (16.9%); an adult in a shared accommodation (16.4%); couple (16.4%); and single guardian household (14.8%).

There was no one predominant household type in RS-MD, with reported intergenerational households, and families in shared accommodations being fewest in number. In addition, among 21 identified service needs, **housing support services ranked #2** in terms of proportion with 60.8% of participants indicating a high or very high need. Respondents aged 45-64 once again indicated housing support services as the highest need among all other age groups.

Concerns and opinions regarding housing reappeared in open-ended survey questions as respondents would write about topics such as the use and maintenance of nearby housing units, rental costs, and barriers to finding housing for newcomers. These points reappeared in focus group discussions, but different age groups would emphasize different aspects about housing concerns. While the youth focus group would voice worries for individuals wanting to move out or attend post-secondary education, the older adult focus group mainly discussed government involvement in housing and safety and maintenance within apartment buildings.

PARTICIPANT

Now, let me give a scenario. One bedroom is almost $2000. My regular pay is, like, at most is, like, $1,500, which means I need to [save] 3 weeks [to pay rent].

SERVICE PROVIDER

Housing is a big issue in this area. Like I said earlier, most of our clients... for most of our clients, they're homeless.

Participants additionally shared observations of homelessness in the RS-MD community. While not discussed in detail, participants implied a higher prevalence of individuals experiencing homelessness or newcomers living in shelters. Service providers would also share concerns regarding housing services and clients experiencing homelessness. Extensive shelter waitlists, lack of transitional housing, and sporadic shelter timeslots were shared to adversely impact client health and wellness.

Community Concern: Employment

RS-MD community members also highlighted concerns surrounding employment, such as finding a good job, receiving enough income for daily expenses, and requirements for employment. As previously mentioned, **'finding a job' was ranked #2** (11.3%) among 16 community concerns in the CHNA survey. Employment concerns appeared as a primary concern across all demographic groups but the 65+ age group. Consistent with employment need, employment support services was ranked the 5th most needed service across 21 service needs. Employment support was indicated as a significant need for respondents aged 13-24 and 25-44, with both groups ranking this as #2.

14.2% **of male-identifying respondents** **expressed concerns about employment compared to 10.7% of female-identifying respondents**

58.2% **of participants felt that employment services were a high need in RS-MD**

Employment worries from community members also continually appear throughout related survey questions and open responses, as respondents express financial and employment difficulties. Job banks, finding a job, and employment advisory services are repeating terms found in survey open responses. More specifically, employment was repeatedly identified in community improvement open responses as part of the 'Cost of Living' theme and within 14% of service need open responses.

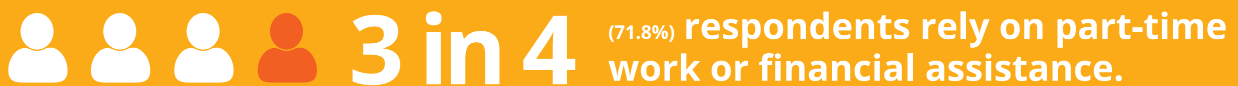
PARTICIPANT

It's like they are tying us. We have chains. Because for me, I sacrificed my sleep... But if I don't work, I'm not going to live. For sure. Because the rent is high. The groceries [are] high.

A majority of respondents who have taken a course in the past year have also stated that they attended a class to supplement employment activities. Of 157 respondents, 40.7% took a course to learn or improve their job skills, 3.2% to qualify for their current job, and 24.8% to prepare themselves for future employment.

In conjunction, approximately a third (31.5%) of respondents reported some form of difficulty (i.e., a little difficult to very difficult) filling out a job application. These reported educational or cultural aspects impede RS-MD residents from pursuing employment and earning funds required for daily living. Furthermore, while not explicitly linked to employment concerns or barriers by participants, data on travel time and income sources showcase other aspects of employment context in RS-MD.

Approximately half of all respondents wrote that they travel no more than 30 minutes to get to their workplace, whether through public transportation or personal vehicle. In comparison, 22.5% take 30 minutes to one hour, 21.6% take one to two hours, and 3.6% take more than two hours to get to work. This finding illustrates the availability of employment opportunities in or nearby RS-MD. Among reported income sources, the greatest proportion of respondents (22%) earn wages for full-time work, but the rest indicate no primary source of income (15.6%), wages for part-time work (14.7%), and some form of assistance, such as PNA, Ontario Works, or ODSP (14.2%).



SERVICE PROVIDER

I also hear a lot from clients, like, getting... transportation's really expensive... so prioritizing where they go, they can't always go to all these different [places]... especially if they're far. They... they can't afford it.

Focus group discussions with community members expanded upon findings from the CHNA survey as topics about employment were contextualized. The youth focus group discussion highlighted difficulties finding jobs for younger individuals and an increase in required qualifications. In comparison, interviews with the working adult age group would reveal similar experiences regarding employment availability, but also include additional barriers for newcomers navigating the Canadian job field and different cultural expectations regarding recruitment. Both groups generally perceived a lack of stable employment opportunities and difficulty finding viable career options.

PARTICIPANT

It's very difficult. You have to pay for [an equivalency], or you have to start school again in order to get a... a job or something.

Discussions would also reveal themes of prioritization of 'survival' related activities, which would often be linked back to employment. Participants would regularly voice personal experiences or observations of preferring work over other health and wellness programs, services, and activities (e.g., nutrition or exercise class, counselling, arts programs, preventive care, etc.). Common reasoning behind this behaviour was the prioritized need to pay essential expenses (e.g. rent, groceries, etc.). Secondary reasoning was the lack of quality employment. Not working a proper full-time job or a job with insufficient vacation and sick day policies was equated with not being able to prioritize personal aspects such as health and leisure. Implications of this emerging theme is further expanded upon in the Discussion section.

PARTICIPANT

Yeah, I think the only problem, for example, is, like, work... if they don't have [enough] vacations, or, like, a rest day. They cannot [go] because they are gonna prefer to have their money for their expenses than maybe their mental health...

SERVICE PROVIDER

However, it's the income, because they need to be able to get money, and they can't take time off work.

SERVICE PROVIDER

So most times, I feel like it's just survival. As you said, it's just toughing it out. We're here in these streets, and we're just trying to make it.

Community Concern: Community Safety

Interestingly, while a sense of security was identified as a community asset, community safety was also identified as a top concern. **Safety (including physical safety, sense of security, and crime and policing) was ranked #3** (9.1%) across the 16 outlined community concerns and #10 in terms of needs proportion (51.5%) across the 21 community service needs. While a rank of #10 may seem relatively lower, for perspective, this indicates that approximately half of RS-MD survey respondents felt a high or very high need for safety improvements. This felt need was also reflected in open responses of the survey, where 10.6% of recommendations for service needs mentioned community safety.

Negative social capital was additionally identified as a linked theme in various survey responses. Responses indicating that they felt unsafe, untrusting of others, or that RS-MD was a bad community to live in counted towards negative social capital. Responses of this type would often state perceptions of danger in the community and that it is unfit to live in.

SURVEY PARTICIPANT

I would like to mention the safety issues in Woolner Park (Parking lot). Always there is grown ups fighting, drinking alcohol, smoking. It is not safe for kids, we are tired.

SURVEY PARTICIPANT

Another point worth highlighting is the drug trafficking in the region and the number of homeless people on the streets, which sometimes causes a feeling of insecurity.

Concern regarding community safety mainly differed by neighbourhood and racial-ethnic group. For example, Mount Dennis residents ranked safety at #2 (11.4%), while Rockcliffe-Smythe residents ranked it at #3 (7.9%), and more Latin American identifying respondents reported a concern (11.5%) compared to Black-African identifying respondents (5.2%). A majority of racial-ethnic groups similarly ranked safety as a top four concern. However, there was little to no difference in reported concern between age and gender groups. Safety consistently ranked third or fourth among age and gender groups. When asked about community safety and crime prevention as service needs, youth and older adults had community safety or crime prevention programs in their top three service needs. Where working adults reported it as an average need (#11, #13).

Safety was a main discussion topic in the older adult focus group, but was scarcely mentioned in other focus groups and interviews. Older adults would commonly bring up concerns of violence and negative experiences that contributed to feelings of fear or discomfort. However, similar opinions were not brought up by other age groups. Instead, it was more common for individuals from the working adult and youth age groups to briefly comment on potential background contributors to violence rather than actual perceptions of danger. Service providers had a more middle-ground perspective as they would comment about overall safety and contributors, but only briefly discussed the topic. The overall prevalence of safety as a topic in discussions mismatched surveyed concern, but seemed to more closely match reported service and program need with the exception of the youth focus group.

PARTICIPANT

These individuals have problems, which we all feel for, but they're also very dangerous at times. You know, and go on fits of psychosis and so forth

PARTICIPANT

I don't... I never feel safe in the area. I [do not] dare to come out at night.

Table 2

Perception of Community Safety or Crime Prevention Program Need by Age Group

Age Group	Don't Know	No Need	Little and Some Need	High and Very High Need
Youth (13-24)	9.1%	13.6%	29.5%	47.7%
Working Adult (24-44)	14.6%	6.7%	29.8%	48.9%
Working Adult (45-64)	12.6%	4.5%	31.5%	51.4%
Older Adult (65+)	8.1%	9.7%	24.2%	58.1%

Community Concern: Healthcare Service Accessibility

Healthcare accessibility in RS-MD is another concern more commonly expressed by community members. Accessibility, in this instance, refers to affordability, geographic proximity, and prevalence. As a generalized community concern that includes all forms of healthcare, **healthcare services ranked #5** (6.6%) out of the 16 concerns. Perceived concern tended to vary by neighbourhood and ethnic-racial group. Between the neighbourhoods, RS residents were less likely to be concerned (5.3%) about healthcare service accessibility in comparison to MD residents (8.4%). Additionally, Black-African respondents were the least likely to show concern (3.8%), while White-North American (8.3%) and Latin American (7.8%) respondents showed the most concern.

Figure 8

Ranked Health Service Needs

Health service needs expressed in the survey ranged anywhere from a very low need to a very high need due to the variety of health service options provided in the survey questions.

The #1 service need expressed by respondents among all services, not just among other healthcare services, was **free or low-cost dental services** (69.3%). Accessible dental services had the highest proportion of community members reporting a high or very high need compared to all other services in the survey. The next greatest perceived need was for primary healthcare services (59.8%), which ranked #4 out of all 21 service needs. Mental health services were also found to be a great need, sitting at #6 as 57% of respondents indicated that it was a high or very high need.

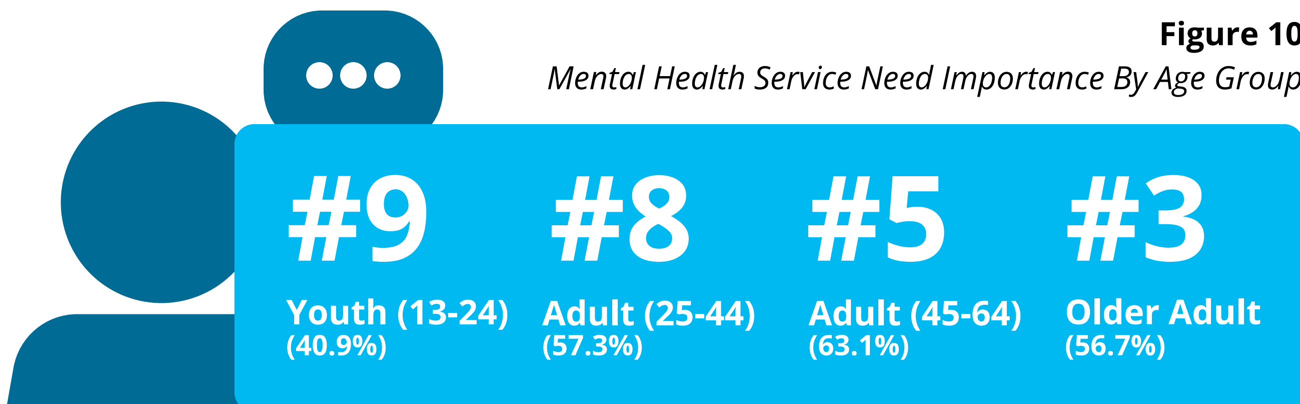
In comparison, sexual health clinics (41.2%) and addiction services (32.5%) were perceived to be some of the least needed services in the RS-MD community at #17 and #20, respectively.

Differences in health service needs were found across demographic groups, particularly between age groups. For example, older adults (65+) perceived a greater need for primary healthcare services (66.1%) compared to accessible dental services (56.5%). On the other hand, a majority of working adults (25-44; 45-64) heavily emphasized a need for accessible dental services (74.2%; 78.4%). Youth (13-24) found accessible dental services and primary healthcare equally vital (47.7%). Both dental and primary care were indicated as the #1 service need in RS-MD. The greatest variation between age groups was found when comparing the perceived need of mental health, addiction, and sexual health clinic services. Older adults also indicate a greater need for mental health services (56.7%) than accessible dental services (56.5%) and place addictions (30.6%) and sexual health clinic services (29%) as a low need.

The working age adult group had slight variation when split into 25-44 and 45-64 year old. Mental health services were seen as a more intermediate community need for individuals aged 25-44 (57.3%), while those aged 45-64 (63.1%) found a greater need for it. In contrast, those aged 25-44 (50%) would perceive sexual health clinics as an intermediate need and those aged 45-64 (42.7%) would perceive it as a lower need. Addictions services, however, were placed as the lowest need for those aged 25-44 (29.3%) and second lowest need for those aged 45-64 (37.3%). Finally, youth tended to consider mental health services (40.9%) an intermediate need and addictions (27.9%) and sexual health clinic services (18.6%) a low need.

Figure 9
#1 (Top) Community Health Service Need Perceived By Age Group

Figure 10
Mental Health Service Need Importance By Age Group



Increased accessibility and improvements to healthcare services were requested in survey open responses. In particular, staffing increases and accommodations for newcomers and undocumented individuals were commonly recommended. In fact, wishes for improved medical services made up almost a quarter (22.9%) of responses in the community improvements section.

PARTICIPANT

CAMH is good, but for people who don't have health insurance, it can be very expensive. So if there's something like Access Alliance for mental health, that would be really, really great.

Access to healthcare services was a predominant theme within focus group discussions and interviews as well. More specifically, healthcare that had little to no barriers (e.g., no cost, any insurance status, etc.) was a larger topic among working age adults and older adults. Uninsured residents (e.g., those with an expired visa) shared frustrations about finding healthcare services that would take them in times of medical need. Barriers in the form of price, distance, language, and system mechanisms often prevented individuals from seeking care. Even for those under the Ontario Health Insurance Plan (OHIP), experienced difficulties accessing needed health services in a timely manner. With a reported lack of appropriate healthcare resources in the community, individuals note resorting to attending services not originally intended for them (e.g., insured going to a non-insured clinic).

SERVICE PROVIDER

But just hearing from other community health centers, because they do try, clients do try to go there for healthcare, but because they don't have walk-in [health clinics], they do refer to [Access Alliance]... I think [Access Alliance is] the only one [with a non-insured] walk-in for the GTA.

General complaints regarding Ontario's healthcare system, beyond RS-MD's context, were also made. Participants commented on wait times, hospital care, budgeting inequities, and more. Each of these broader systemic factors was thought to contribute to felt helplessness or negligence regarding one's own health. However, as this theme is beyond the scope of this needs assessment, elements directly related to RS-MD will be evaluated instead. Findings for this theme are therefore narrowed to the focus on a lack of sufficient, quality healthcare resources in RS-MD.

PARTICIPANT

It's an emergency. You had to go through your family doctor. You call, they tell you, oh, [there are] available spots, like, after 4 months? ...You cannot see your doctor tomorrow or the following day. You need to wait for more than 2 weeks.

Currently available healthcare services, such as dental care and primary healthcare, are perceived as generally unknown and are typically learned about through word of mouth. Participants consistently communicated feeling unsure where to find relevant information and relied on family members or friends for information gathering. Service providers gave similar accounts of observing information being spread through personal connections. As a result, while some residents spoke of networking as an asset, residents also often seemed unsure about what was a reliable source and the various types of resources actually available in RS-MD. In other words, knowledge of existing healthcare resources was found to be isolated among RS-MD community members and ineffectively shared by service-providing organizations. This information gave way to a larger theme of knowledge mobilization and health literacy in the community that is directly connected to health accessibility.

PARTICIPANT

So, like, I have a couple of friends, who have had sickness or something, and they didn't know where to go. They didn't know what to do. They just... have to suck it up. So... it'll definitely be, like, for them, knowing where to get help.

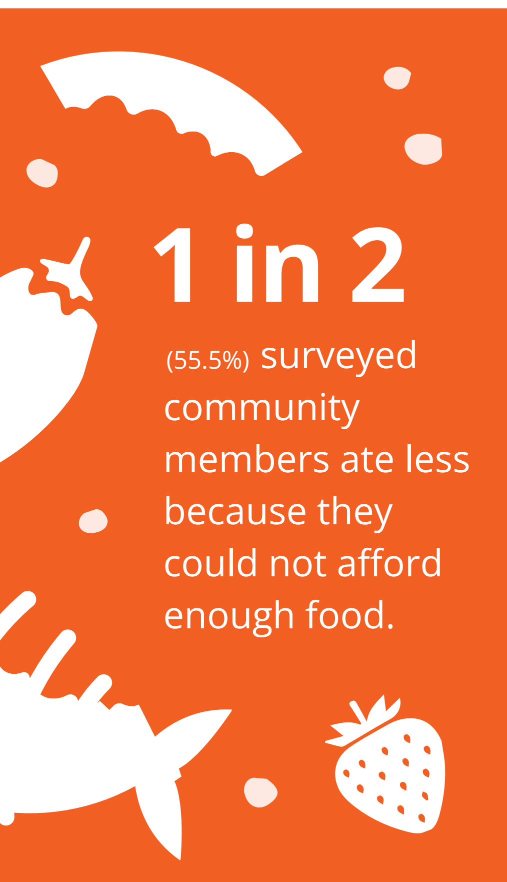
Reliance on word of mouth was shared by service providers to also be a potential source of misinformation. This was supported by participant experiences indicating lower levels of health literacy among residents. Discerning the meaning, validity, and relevance of health information was expressed to be somewhat difficult among several participants, which impacted their health and autonomy over care. Overall, healthcare accessibility in RS-MD was found to be highly complex, with multiple barriers and needs that influenced resident experiences of achieving positive health and wellness.

SERVICE PROVIDER

They get a lot of misinformation over WhatsApp or from family text chains and things like that, or, like, neighborhood misinformation, which can be challenging when we are trying to, you know, implement or do health work in the community... the reels and TikToks that people are showing of, like, this is how to cure this, and it's like, it's not real, but... people are just not informed or just unaware.

Community Concern: Food Security

Food security was another theme commonly found in both the survey and focus group discussions and interviews. While portions of the RS-MD community communicated adequate food security, a significant portion also indicated experiencing some form of food insecurity. Within the previous year (2025), approximately half (50.7%) of respondents reported eating less because there was not enough food or money to purchase food. More specifically, 14.3% of respondents indicated eating less at least once a month and 23.3% at least once a week. Similar responses are seen in the 'All About Food' questions in the survey. Responses indicate that 64.4% of respondents worry about affording adequate food, and 54.4% worry that their family may run out of food before they have the money to buy more.



SERVICE PROVIDER

I would say, like, maybe 90% of our clients are working adults. But based on our food insecurity issues, those people still have to access the food bank for food, even though they are working.

In line with the above data, getting healthy food ranked as #6 out of the 16 provided community concerns. However, it should be noted that the concern may have been interpreted by respondents as accessing all food, rather than specifically healthy foods. Regardless, the general need for food security in RS-MD was reiterated in the service needs question, where free or low cost food programs ranked at #3 (60.3%). The need for these programs (e.g., meal programs, food banks) was presented as a top priority for all respondents, with several open responses emphasizing a want and need for affordable food sources.

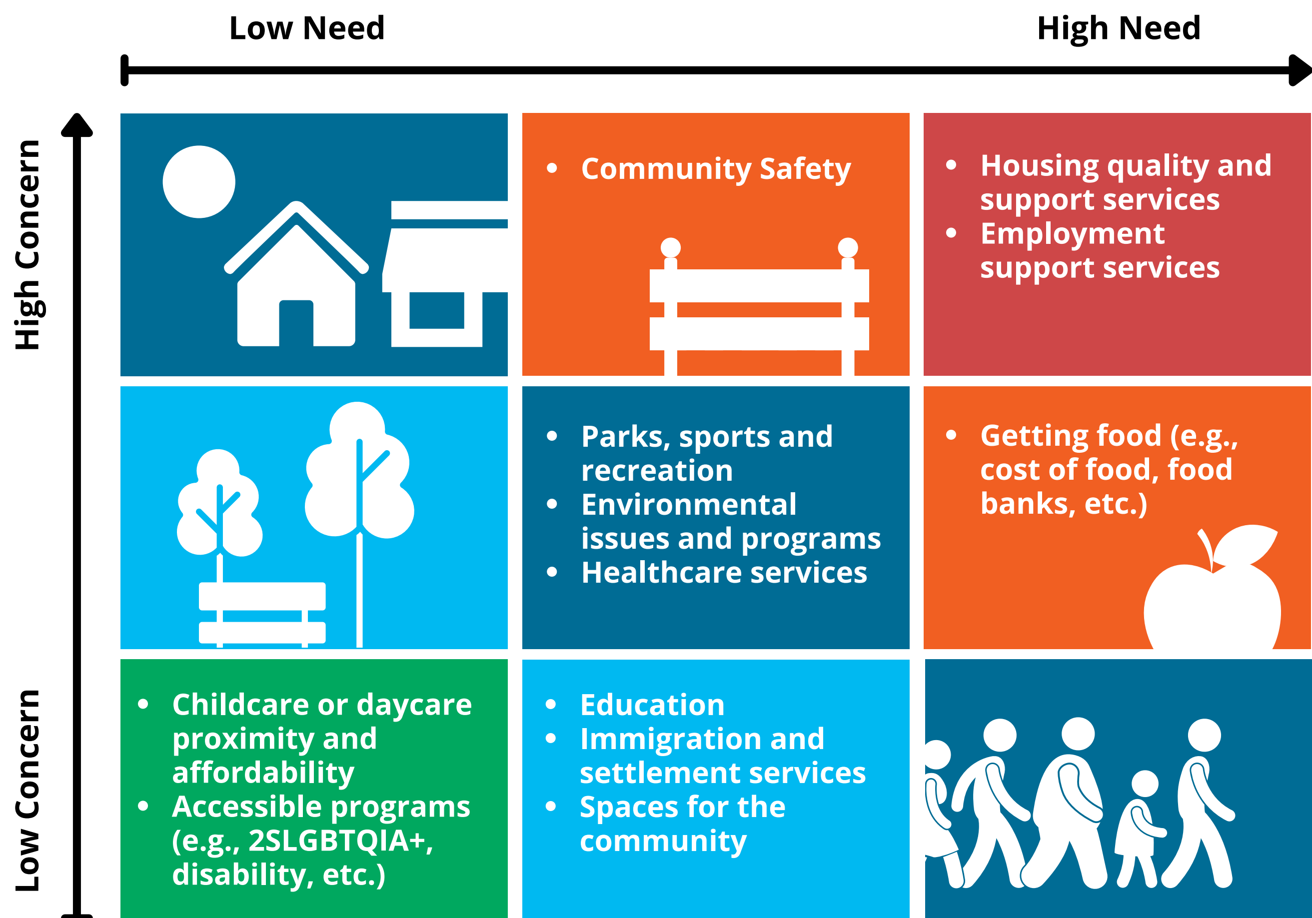
Several focus group participants mentioned the rising cost of food and negative experiences with food banks. These experiences were often connected with employment challenges and difficulties with expenses, forming the larger theme of 'Cost of Living,' which is expanded upon in the Discussion section.

Community Concerns and Service Needs Matrix

The following matrix (Figure 11) displays the intersection between respondents' reported community concerns and service needs. Percentile values were used for this intersectional analysis and visualized on a matrix graph. This matrix requires mindful interpretation when generalizing and considering actual needs and concerns in these communities. It is important to note that these issues are on a continuum, and individuals report their needs and concerns based on their lifetime experience and self-identified ideas. As such, items listed as low service needs or concerns do not negate them as potential or actual issues affecting the residents in these neighbourhoods. Finally, when interpreting this data, it is also important to consider that the ranking of issues can be impacted by broader systemic issues and stigmas such as those surrounding individuals who are immigrants or newcomers, affected by poverty, addiction, members of the 2SLGBTQIA+, etc.

Figure 11

Community Concerns and Service Needs Matrix

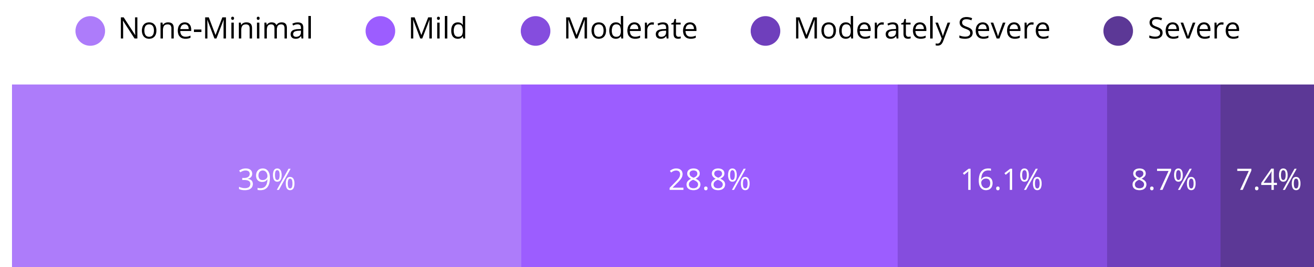


Mental Health Indicators and Status

The mental health status of the RS-MD community was analyzed using the Patient Health Questionnaire (PHQ-9), a validated tool to measure depression severity. Depression severity was used to understand the community's mental health status as symptoms of depression often coincide with general markers of adverse mental health. Thus, through PHQ-9 score analysis, the RS-MD community was found to have indications of an adverse mental health status.

Figure 12

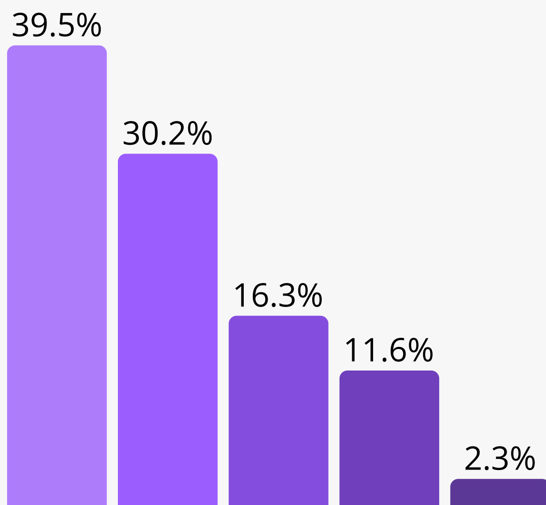
CHNA Survey Respondents' Depression Severity

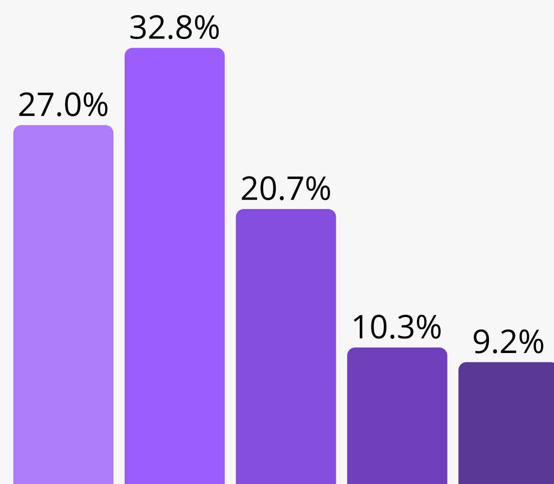


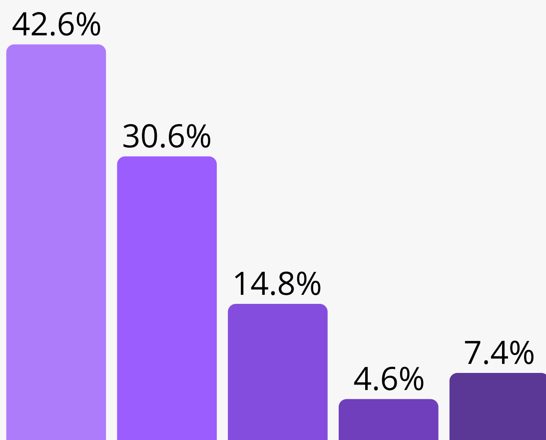
A majority of PHQ-9 survey respondents showcased some form of depression (61%). Within those subdivisions, older adults appeared to have the lowest percentage of individuals affected by depression symptoms, with 63.8% falling in the none-minimal symptom score. However, interestingly, the proportion of individuals showcasing moderately severe to severe symptoms is similar to that of other age groups, as seen in Figure 12. When combining the moderately severe and severe categories, older adults have the third-highest proportion of severe depression symptoms.

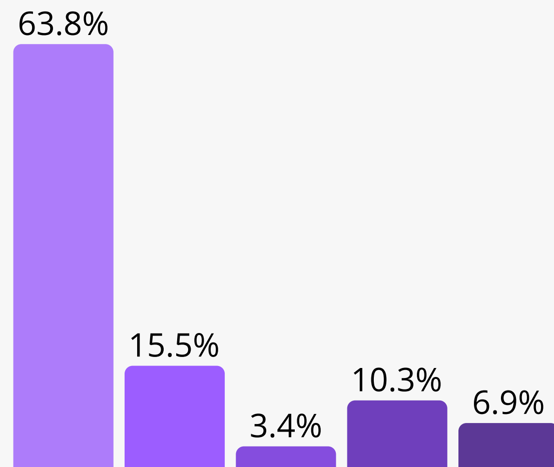
The working age group, split into 25-44 and 45-64, differs in terms of depression severity. The 25-44 age group has the highest proportion of individuals affected by signs and symptoms of depression, where only 27% experience minimal to no depression symptoms. They also have the highest prevalence of more severe signs of depression. Approximately 1 in 5 individuals aged 25-44 from the RS-MD community exhibits severe depression symptoms, whereas 1 in 10 individuals aged 45-64 from the RS-MD community exhibits the same.

Figure 13
CHNA Survey Respondents' Depression Severity by Age









PARTICIPANT

Yeah, I see a need for mental health, because sometimes you're hanging out at the park, and sometimes some people break down... You'll be at the park one day, right? And everything is going fine, and then someone may be sitting by themselves, going... because I saw someone crying, like, at the park. I didn't know how to approach it, because you have to be careful, right?

Youth display a similar pattern to that of the 45-64 age group, but have the greatest proportion of moderately severe depression. Furthermore, male-identifying respondents (44%) were slightly more likely to exhibit minimal to no depression symptoms compared to females (38.2%). The RS-MD neighbourhoods had a similar proportion of respondents with minimal to no depression symptoms, but had differing proportions of other depression severity categories. While Mount Dennis shows the greatest share of respondents experiencing severe depression symptoms, Rockcliffe-Smythe has more residents experiencing moderate or moderately severe depression symptoms.

PARTICIPANT

I think at school... I have, like, I've seen a lot of students who had, like, who suffer from mental illness. Depression. And depression, yeah. I think, like, there's a lot of students who, like, prepare to sit alone, and never socialize with others.

A variety of factors were shared eluding to adverse mental health in the community, with one of the most prominent factors being stress over the cost of living. Both community residents and service providers would comment on how the other mentioned challenges (e.g. housing, healthcare accessibility, etc.) would negatively impact individuals. However, help-seeking behaviour, especially for mental health, was also reported to be lower or rare among community members. Whether due to cultural stigma or not knowing where to go for mental health resources, residents seemed to be unsure of how to offload psychological burdens. Substance use in the community was mentioned alongside mental health struggles. Participants spoke to the vulnerability of individuals with substance abuse disorders and observations of its presence within buildings and other areas local to RS-MD.

PARTICIPANT

When you have mental patients, or people with mental illness in community housing, you know, in a building, you know, they are often vulnerable. And what happens [is] the drug gangs take them over, and take over their apartment, and then start doing the drugs and prostitution out of the apartment. So, I agree with you with the mental health thing, but it's really, it's tricky stuff.

SERVICE PROVIDER

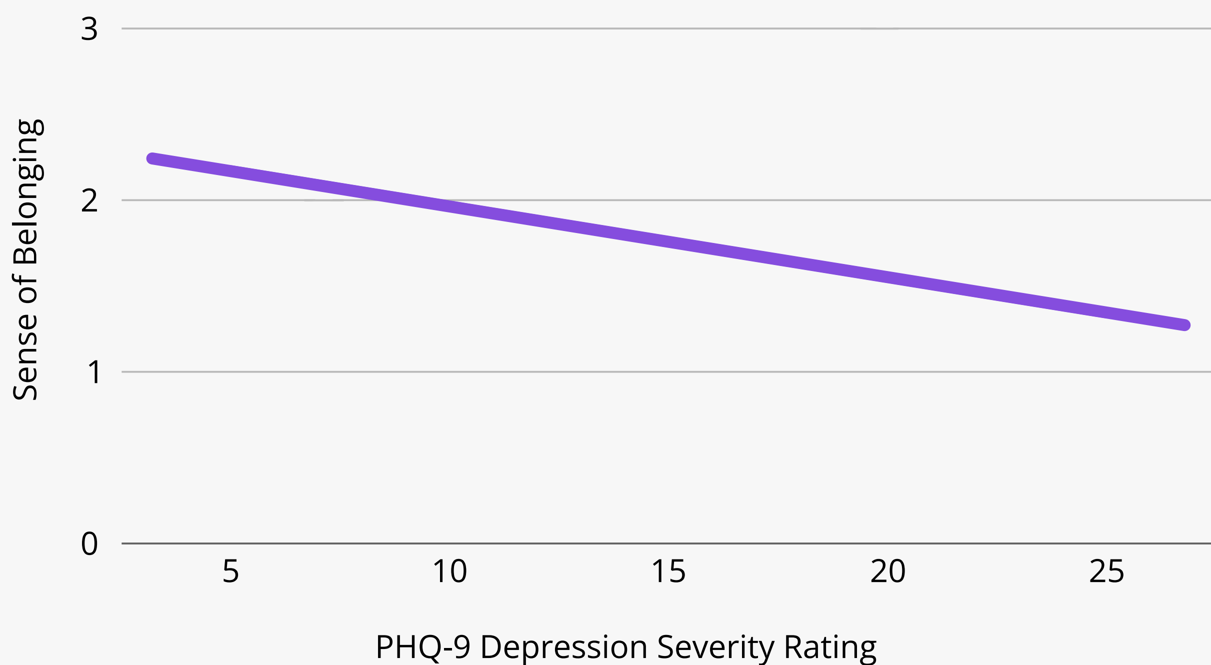
Just... just to cover the basic necessities, so we're not speaking about, like, the way their life said that they want to... just to survive, it's just, like, a survival mode, which affects their mental. Definitely.

SERVICE PROVIDER

One of my struggles when supporting clients is connecting them with mental health support. And when I say mental health support, it's, you know, these clients are really dealing with some pretty significant mental health, illness, and so they do need more professional support from a psychiatrist and/or a psychotherapist.

However, when comparing respondents' feelings of belonging to their community against their PHQ-9 scores, it was found that those with a stronger sense of belonging tended to have none to minimal symptoms of depression compared to those with a weak sense of belonging. Respondents who identified as immigrants also tended to have less severe signs and symptoms of depression the longer they stayed in Canada and the RS-MD community.

Figure 14
Respondents' Depression Severity Rating by Sense of Belonging (n = 391*)



Note. The above graph displays a fitted linear trendline illustrating the relationship between respondents' sense of belonging and PHQ-9 scores. Sense of belonging categories (very weak, somewhat weak, somewhat strong, and very strong) were numerically coded for visualization, with 0 = very weak and 3 = very strong. PHQ-9 scores were used as is, where scores of 0-9 indicate none to mild depressive symptoms, 10-14 moderate, and 15-27 severe. * 1 response removed as sense of belonging was not indicated.

Thus, while there is still a significant number of individuals who have positive mental health or minimal symptoms of depression, there is also a meaningful number of individuals with symptoms pointing towards adverse mental health. Shared experiences of social gatherings and stigma reduction have been shared as supportive factors for promoting positive mental health among RS-MD community members.

Discussion

The RS-MD neighbourhoods have strong assets, as community diversity, amenity accessibility and a strong sense of belonging positively impact individuals. However, issues stemming from cost of living and lack of accessible information have induced adverse experiences and negative health and well-being. The systematic and economic barriers facing both newcomers and long-term residents must be addressed to improve health outcomes experienced by the populations living and serving RS-MD.

Cost of Living and Employment

> **Costs of various essential resources, such as food, housing, and healthcare, are increasing in price, which impacts RS-MD residents in achieving optimal health and well-being.**

It should be noted that patterns of increasing cost of living is occurring across the region, rather than simply just in RS-MD (Smetanin et al., 2024; Statistics Canada, 2024). Regardless, lack of consistent or sufficient access to these basic needs is an ongoing concern heard from both community members and service providers. More importantly, cost of living interacts with employment in the community to jointly limit access to essential resources. Much-needed employment opportunities that provide adequate income and stability for residents appear relatively scarce, leaving individuals with limited means of covering expenses. Residents, therefore, require multiple part-time or shift-based jobs to afford daily necessities. Using most or all of their income to pay for daily necessities leaves little space for individuals when needing secondary resources and services, such as dental care or appropriate clothing for the season.

Newcomer populations in particular, who require an adjustment period, are vulnerable to homelessness and food insecurity if without pre-existing community connections (Alamgir et al., 2025). Newcomers often take longer to find essential resources and become disconnected from community and government support systems as they are unfamiliar with Canadian systems and contexts. This can lead to challenging experiences when trying to find employment and services or programs that help alleviate cost of living strains. Resultant isolation and lack of appropriate care often lead to negative health and wellness. Immigrants may also face discrimination due to their ethno-racial identity during their attempts to access basic resources and employment (Alamgir et al., 2025; Lane & Vatanparast, 2022). Furthermore, lack of employment or the need to work more hours to cover daily expenses takes time away from individuals wanting to participate in services, community events and programs.

Residents who are low-income are less likely to prioritize activities that inadvertently lose them money (through transportation fees, time taken from work, etc.) over paying essential bills. This further disconnects them, interferes with their sense of belonging, and compromises preventive care efforts (Alamgir et al., 2025). Furthermore, immigrants unable to integrate often have compromised health outcomes as they are unable to connect to the services they need to keep them healthy (e.g., therapy, diabetes consultations) (Alamgir et al., 2025; Bustamante et al., 2017). Remaining in a state of 'survival' (i.e., chronic stress) additionally induces adverse mental health states and potential mental health illnesses among residents (Bustamante et al., 2017).

Accessibility to Services and Programs

Understanding where to find validated information about services and programs, determining one's eligibility for them, and appropriately utilizing said resources is a vital process in attaining beneficial health outcomes for individuals. However, various systemic barriers can complicate this process and prevent people from getting what they need. For example, referral barriers between organizations may cause an individual with a psychiatric condition to go untreated, or not knowing where to find information about nearby shelters may leave an individual sleeping on the street for the night. It is therefore essential to combat these barriers with measures that address each stage appropriately and are adapted for the community's context.

> **For RS-MD in particular, a combination of systemic barriers, inadequate knowledge mobilization of services, and general lack of health literacy for accessing and using services is a large underlying theme to many other issues identified in this CHNA.**

Both community members and service providers pointed out that information in RS-MD tends to spread through word of mouth. While this can be a great strength within the community, it leaves newcomers and those without a strong community link unaware. Notably, there is no centralized information hub, whether online or in-person, that community members can easily access. Current resources appear to require residents to have sufficient digital literacy, in which individuals must figure out key search terms, website navigation, and reliable web sources, on their own. However, responsibility for finding information must not mainly lie on the residents, who are already impeded by various barriers, but health organizations and bodies in the community. In other words, the onus of knowledge mobilization ultimately lies with organizations that hold vital information and resources. Learning and implementing best practices for information dissemination in these bodies will subsequently equip community members with tools to improve their health and wellness.

Health literacy and language barriers also play a factor in accessibility issues and further impede service and program usage. RS-MD community members may have difficulty accessing services and programs that use misaligned language, whether from complex wording or lack of other language options. As a result, residents have communicated not knowing where to find existing resources. This can lead to increased levels of stress for community members as they feel a sense of helplessness, confusion, and lack of support options (Gyan et al., 2023). Both knowledge mobilization and health literacy must be improved to address this accessibility challenge and increase help-seeking behaviour.

The identified systemic barriers and a general reported lack of resources mainly contribute to experienced difficulties with service and program accessibility. The perceived scarcity of certain services, such as housing support and food banks, negatively impacts community members and leads to adverse health outcomes.

> **Residents have regularly recounted negative experiences with waitlists and expressed frustration with the lack of timely care and supports.**

By and large, while not always specific to RS-MD, these systemic barriers that inhibit information and resource dissemination can cause disproportionate harm to marginalized groups and further isolate those who may need the most care.

Substance Use and Addiction Services

Observed substance use, whether of drugs or alcohol, has been brought up as a concern by various community members and service providers. From RS-MD community members, a mix of stigmatization and genuine concern for affected individuals is conveyed when discussing substance use and addictions in the community. They note its prevalence in public areas and express concern that individuals who actively use substances should receive “help.”

> **Most residents express understanding that substance use is complex and that individuals with a substance use disorder (SUD) are vulnerable to worsened outcomes. However, awareness of how to help individuals with an SUD also appears relatively unknown.**

“Getting help” is often repeated in participant open responses and discussions. Some suggested sending these individuals to facilities designated to help addiction disorders; others had no clear answer. This sentiment was particularly highlighted in survey data, as addiction services often appeared last in service needs, and in focus discussions when brought up. Such happenings may be partially due to an unintentional ‘othering’

mentality, where residents separate themselves from community members struggling with an SUD. Understanding that SUDs are a medical condition and not simply a voluntary lifestyle choice or intentional public inconvenience among residents will require greater educational efforts from health organizations. Otherwise, the disconnect between perceived addiction service need and discomfort seeing active substance use is apparent, where community members do not want to see individuals with an SUD, but are uncertain and unaware of interventions.

However, it is important to note that residents are not responsible for assisting individuals with an SUD. Rather, it is the government's responsibility to provide appropriate and adequate care through accessible addictions systems and programs. Governmental bodies must be more aware of individuals struggling with an SUD and support surrounding communities impacted by substance use prevalence. Providing more addictions resources, such as **Ontario's Drug and Alcohol Helpline (1-800-565-8603)** or educational outreach, may further support residents with substance use.

Community Safety

While every discussed topic in the CHNA is complex and contextual, safety in the RS-MD community is a particularly nuanced topic as various facets of belonging, trust, and violence culminate into a spectrum of perspectives among community members. According to survey data, a majority of respondents felt a positive sense of belonging and social capital when prompted about community assets. Feelings of safety would also be commonly communicated as individuals would report perceiving RS-MD as relatively quiet or calm. However, while findings would generally convey these positive aspects, a portion of data pointed to feelings of distrust and concerns of violence.

Observations of violence in public areas like parks or nearby amenities were commonly shared, and several individuals would state feeling unsafe at night or in certain neighbourhood spots. Gaps between cases of violence and inadequate emergency responses are highlighted by community members and service providers alike. The gap ultimately serves as reason for many residents to either constantly push for more community safety resources or to distrust government involvement.

> **This duality of perceived safety in the community characterizes RS-MD and its current social context as a generally unstable community environment.**

More research is required to create a full, comprehensive outlook on safety and justice in RS-MD and implications for its social climate.

Mental Health

Mental health, in regard to overall community mental health status and prevalence of mental illness, is another primary theme. While pieces of mental health impacts are mentioned in other discussion sections, further emphasis needs to be given to the finding that overall mental health in the community is rather adverse.

> **As previously explained, a significant portion of community members are often in a state of 'survival'. This constant state of stress and anxiety is often observed to lead into a vicious cycle of negative mental health impacts that remain unbroken over an extended period of time.**

Efforts to break this adverse cycle will require increased collaboration from all levels present in the community. From individual behaviour changes to community-level actors to government policy, each must interact to support communities seeking out positive health and well-being. In other words, not all influences on mental health status are fully contingent on RS-MD context or stem from individual community members alone. Factors, such as province-wide health policies, can significantly impact mental health resources and behaviour surrounding help-seeking. Thus, both external influences and internal community context (e.g., employment scene) in RS-MD must be researched and collaboratively worked upon to improve overall mental health status.

Cultural contexts also play heavily into concepts of mental health among community members. Community members may be exposed to and influenced by a cultural environment where mental health is a taboo, and therefore ignore their health and well-being related to this aspect. This may be especially true for newcomers, who mayb be more immediately connected to their home culture and influenced by mental health norms in said culture. Furthermore, while it seems that a majority of individuals perceive that mental health services are required as a top service need, it is uncertain how many individuals actually want it for themselves, versus seeing need in the community and requesting these services for others.

> **Lower barriers to mental health support and expanded cultural sensitivity is likely required to help alleviate current mental health burdens in RS-MD.**

Overall, collaborative efforts are needed to address the influences on the community (e.g., cost of living) for successful management.

Planning Implications

Provided the findings and discussion implications, it is recommended that community and government-level actors engage the following identified issues to support the development of health and wellness in RS-MD.

Expanded Housing and Employment Services

Assistance with finding housing and employment to counter difficulties with accessibility and the rising cost of living is vital. Organizations may want to expand access to housing and employment services by developing teams or expanding service provider skills in assisting community members with finding adequate accommodations or employment opportunities. Free or low-cost educational and upskilling classes may also help with integration into the Canadian job market. Otherwise, advocating for affordable housing, employment assistance and acting in partnership with relevant service sectors can help initiate systemic change.

Local Community Food Programs

Government bodies and local organizations not already doing so should consider supporting community members experiencing food insecurity through local food programs (e.g., food banks, meal programs, food provisions within programming). A lack of nearby food programs with a sufficient amount of food, especially healthy and culturally relevant foods, can force community members to travel far distances to other food programs. This adds up in costs for travel, time taken from more meaningful activities and overall poor health. Alleviating food insecurity, even if only slightly, can help facilitate pathways towards good health.

Increased Collaboration and Centralized Knowledge Hub

Consideration of streamlined referrals between organizations and clear communication lines is recommended to supply timely and accessible care for community members. This can mean creating formal partnerships or alliances among multiple organizations to promote regular contact and create new service or programs where needed for community members. For example, a bulletin can provide clearer interorganizational communication and up-to-date eligibility criteria for services and programs, shared to providers and community members. This can encourage connectivity within the RS-MD community and increase awareness of existing services for residents. It is important, however, that methods used are available both online and in-person to support access to resources in a variety of ways. Additionally, providing resources in multiple languages can further reduce barriers.

Community Safety Strategies

Interacting with community members and creating programs to increase a sense of security is recommended as residents increasingly report observations of unsafe situations. This can include a community-led research initiative for current safety and social justice conditions, or a community crime prevention program. Activities of this nature can also help with advocacy concerning violence in the RS-MD community and push for systemic changes where identified.

Healthcare Accessibility

Dental Services

Increasing awareness of available support for dental care, as well as efforts to educate individuals with financial components of these supports, would be ideal to comprehensively provide for community members. Bringing increased awareness to programs like Healthy Smiles Ontario, Ontario Works, the Ontario Disability Support Program, and the Canadian Dental Care Program will support better access to dental care. Assistance with related eligibility criteria and enrolment should also be provided to cover all potential accessibility barriers. Also, providing support for financial literacy and management for addressing medical expenses.

Mental Health Services

Further investigation into breaking adverse mental health cycles in RS-MD should be conducted to improve overall community mental health. Increasing access to mental health services and programs by considering currently experienced barriers, such as language, cultural acceptance, or cost, should be explored in community organizations.

Addiction Services

Understanding patterns of active substance use in the RS-MD community and implementing supports at critical areas may assist in reducing public usage that concerns community members. Additionally, increasing awareness about what supports exist for individuals with a substance use disorder, such as safe use sites, can also be an important step to reducing substance use related harms. Finally, education about substance use embedded in programs and services may be ideal to reduce stigmatization and build further awareness of what can be done for individuals affected by substance use.

Conclusion

Rockcliffe-Smythe and Mount Dennis (RS-MD) are developing neighbourhoods with the strong potential to improve and support their community members in achieving positive health and well-being. Community assets, concerns, and service needs have been identified through this CHNA to pinpoint areas of focus and improvement. Final analysis of the data revealed perceived community strengths, such as amenity accessibility, positive social capital among community members, appreciation for the natural environment, sense of security, and public transportation accessibility. However, data have also pointed to several concerns and challenges present in the community that negatively impact health and well-being outcomes. Cost of housing and finding employment were primary concerns, followed by safety, healthcare service accessibility, and food insecurity.

CHNA findings suggest that RS-MD residents face a multitude of intersecting barriers that collectively undermine health and well-being, while adversely impacting mental health. Rising costs of living found across the Greater Toronto Area alongside limited employment opportunities restricts access to essential resources. This issue also disproportionately affects newcomers, who often require time and support to adequately adapt to the Canadian context but face discrimination and heightened risks of homelessness and food insecurity. Access to services and programs is further constrained by widespread gaps in health literacy. Essential information is often fragmented across multiple sources and lack cultural sensitivity or language considerations. Furthermore, accessibility to essential resources, such as housing or food programs, are limited due to increased demand but lack of space or funding to accordingly expand. Community perceptions of substance use and mental health also reveal a disconnect between understanding of currently available supports and usage of said supports. Similarly, while many residents report a positive sense of belonging and safety, concerns about violence and distrust of governmental interventions creates a sense of instability.

Collectively, the identified themes illustrate the need for increased collaborative efforts between community leaders and organizations, and creating coordinated, accessible services and programs across RS-MD. Enhancing health and wellness for community members requires increasing access and advocating for positive systemic changes. Overall, while limitations for this CHNA exist, insights and recommendations found in this report were identified to assist future planning and evaluation efforts in RS-MD to better health outcomes for community members.

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Appendix A: Methodology

The Community-Based Research and Evaluation team of Access Alliance Multicultural Health and Community Services (Access Alliance) conducted a Community Health Needs Assessment (CHNA) for the Rockcliffe-Smythe and Mount Dennis (RS-MD) area. The last attempted CHNA for the RS-MD community was during the COVID-19 pandemic in 2020, which was interrupted due to lock-down orders from the Ontario government. Thus, the last formal CHNA published by Access Alliance was in 2013 for the Rockcliffe-Smythe neighbourhood alone. The methodology for this CHNA followed that of the recent work for the 2024 Taylor-Massey Oakridge CHNA that the organization also completed. It was replicated and appropriately modified for the 2025 RS-MD CHNA.

AccessPoint on Jane (APOJ), Access Alliance's west-end hub in Toronto, acted as the main data collection site for both surveys and focus group discussions and interviews. Partner organizations and grassroots neighbourhood groups active in RS-MD were engaged to collaborate in data collection and invited to be part of an Advisory Committee. The final goal of the CHNA was determined to be identifying community assets, concerns, and service needs and formulating recommendations to support community development and progress towards positive health and well-being for RS-MD community members. Results from these findings are shared to encourage the development and collaborative work for bettering the health and well-being of other community residents.

This CHNA utilized a sequential, mixed-method participatory approach. Preliminary analysis of quantitative data informed subsequent collection of qualitative data. Data was then triangulated to investigate emerging themes and validated through community discussions.

Neighbourhood Profile

A Neighbourhood Profile was created before the start of data collection to understand contextual and population-level health details that surround RS-MD. Several data sources were used to create a demographic and socioeconomic profile, such as articles regarding the community's history and the federal Census by Statistics Canada. Health and chronic disease indicators were obtained from the Ontario Community Health Profiles Partnership. Furthermore, data from the Toronto Police Service Records Management Systems was used to present information on service calls and crime. Results from this context analysis were used to help inform comparative baseline data for final analysis, as presented in this report. The complete RS-MD Neighbourhood Profile can be found HERE.

Quantitative Methods

The main tool used in the CHNA survey for the quantitative phase included the Be Well tool. This is a standardized, self-administered well-being measure developed for the Association of Ontario Health Centres, now named Alliance for Healthier Communities (Association of Ontario Health Centres [AOHC], 2016). The tool was originally made in collaboration with the Canadian Index of Wellbeing to support health assessment of communities for evidence-informed services, where community-level data can be compared to higher-level indicators.

To support Access Alliance's understanding of community assets, concerns, and service needs, the following questions were added to the Be Well tool:

- Describe up to three things that you like most about your neighbourhood.
- What issues are you most concerned about in your neighbourhood? Please select a maximum of five items.
- The following is a list of programs and services. Please rate each one based on how much you feel that service is needed in your neighbourhood.

Access Alliance also included the Patient Health Questionnaire (PHQ-9), a validated, self-administered depression severity measure (Kroenke et al., 2001). While the PHQ-9 was originallydeveloped for primary care use, it has been widely applied in other health settings due to its reliability and validity (Wennerstrom et al., 2011). Thus, it is an adaptive tool used to screen for depression symptoms and track responsiveness to treatment(s).

The CHNA survey was translated into Arabic, Bengali, Farsi, Portuguese, Spanish, and Tigrinya. These languages were selected as they were among the most commonly spoken languages in the RS-MD community and APOJ. At the end of the survey, respondents could choose to enter a draw for a $25 gift card, express interest in attending a focus group discussion, or be sent the CHNA findings when published. Direct monetary incentives were not provided to limit potential positive response biases.

Sampling Strategy

The CHNA survey was administered both online and in-person at various community locations and events. Each location was purposefully selected, with considerations of partner community organizations and areas likely to be frequented by community members kept in mind. A convenience sampling approach was used to collect surveys at these locations.

The inclusion criteria for participation in the CHNA survey included the following:

- Must be a resident of, work, receive services, or go to school in the Rockcliffe-Smythe or Mount Dennis neighbourhood;
- Be above the age of 13, or have parental/guardian consent; and
- Have not previously completed the survey in the current data collection period.

Data Collection

The CHNA survey was administered both in-person and online using printed copies and the SurveyMonkey platform, a web-based survey product. Data collection primarily occurred on-site at APOJ and at community locations where RS-MD community members reside or access programs and services. In-person survey completion using iPads with SurveyMonkey was the preferred method as it would encourage completion and ensure data integrity. However, after pilot testing, printed surveys were also made available to accommodate areas with unstable Wi-FI connections, community members uncomfortable with technology, and participation of multiple community members at once. All members of the data collection team were trained in ethical and accurate data collection. Upon completion of training, team members supported outreach and assisted with in-person data collection.

CHNA surveys were also electronically shared with Access Alliance clients with a recorded email in Access Alliance's system of service and program attendees. SurveyMonkey's email tool was used to send a mass email that contained the survey link, in English and the translated versions.

Qualitative Methods

Upon completion of the survey data collection phase, a preliminary descriptive analysis was done to identify emerging themes. Focus group discussions and interviews with key groups (i.e., youth, working adults, older adults, service providers) were conducted to explore the emerging themes. Engaging different demographic groups allowed different perspectives of each theme to be revealed, giving context and highlighting variations in concerns across the community. Focus groups were targeted to contain 8-10 participants of varying demographics (e.g., gender, racial-ethnic identity) within the specific age group, thereby following a purposive sampling approach. Participants that expressed interest in a focus group through the survey were first contacted and invited. Following this process, individuals were directly recruited from APOJ to either participate in a focus group discussion or an interview. While the youth and older adults focus group was held without significant challenges, the project team had difficulty formulating a working adult focus group. This resulted in the need for individual interviews that accommodated the participant's schedule.

Focus groups were mainly held in-person at APOJ, but the service provider focus group and a few interviews were scheduled over Zoom, a virtual meeting platform, to allow the project team to meet individuals where they were. If required, childminding was provided to reduce childcare-related barriers. Participants received snacks and refreshments, $25 gift cards, and two TTC tickets in appreciation of their time.

Data Analysis

Descriptive and inferential analysis of quantitative data was conducted using MS Excel. Two separate analyses was conducted for survey data, one with a focus on CHNA data, and another with a focus on PHQ-9 data.

For the CHNA quantitative analysis, survey responses that fulfilled the following criteria were included:

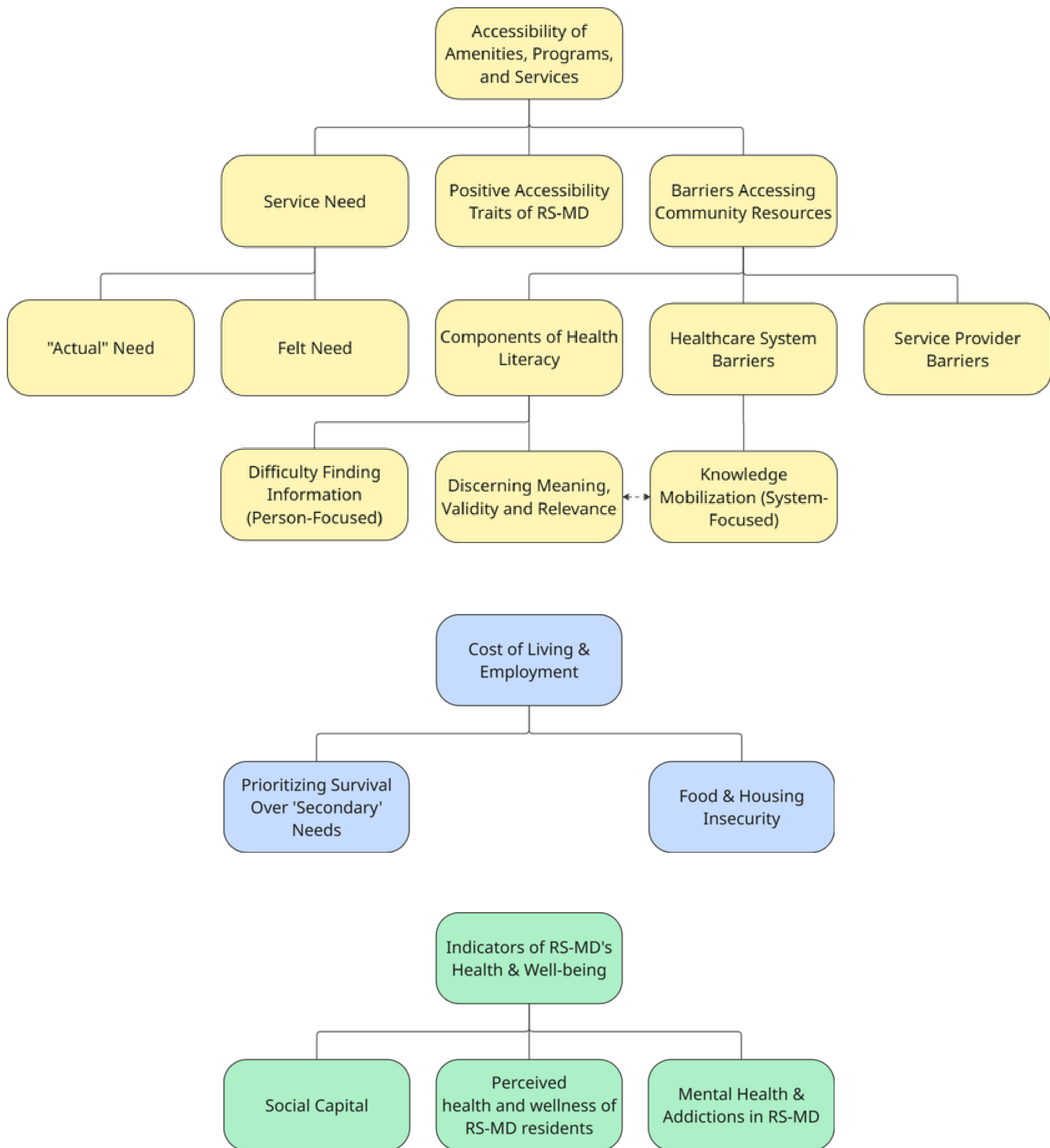
- **Question 5:** How would you describe your sense of belonging to your community?
  - *Criteria*: Completed
- **Question 42**: Describe up to three things that you like most about your neighbourhood.
  - *Criteria*: Described at least one positive or negative asset.
    - Responses with the words “nothing” and its synonyms were not counted.
- **Question 43**: What issues are you most concerned about in your neighbourhood? Please select a maximum of 5 items.
  - *Criteria*: Selected at least one issue.
- **Question 44**: The following is a list of programs and services. Please rate each one based on how much you feel that the service is needed in your neighbourhood.
  - *Criteria*: Rated 75% (16) of 21 programs/services.

For the PHQ-9 analysis, all surveys that fully completed the PHQ-9 (Question 47) were included for proper depression severity calculation.

Qualitative data was extracted from surveys through open responses and from focus group discussions and interviews. Open responses were analyzed by manually identifying a key topic for each response and then grouping said topics into larger themes for frequency analysis. For the focus group and interview data, Braun and Clarke’s framework for thematic analysis (2022) was utilized to identify supporting pieces of data. Per the framework, each discussion’s audio file was first made into a transcript and cleaned. NVivo, a qualitative analysis software, was then used to highlight potential codes of interest through key phrase identification and then formalized into final codes as seen in Figure A1. Notable segments of each transcript were then assigned to appropriate codes to support findings for the report. Themes and codes were reviewed and discussed until consensus was found among the principle investigator, project lead, and research student.

Figure A1

Final Thematic Codes Found Using Braun & Clarke's Thematic Analysis Framework (2022).



Limitations

Although steps were taken to reduce validity and reliability biases, the RS-MD CHNA may have several limitations that impact the validity. Sampling bias, as one example, can lead to an over-representation of some demographic groups. For this CHNA, while the age and racial-ethnic group distribution appear relatively proportional to the Neighbourhood Profile, there was an over-representation of women. The over-representation of female-identifying participants has historically occurred in previous Access Alliance CHNAs, but challenges remain in tackling this identified bias. The survey and focus group discussion questions utilized in this evaluation may also lack sufficient sensitivity to capture nuanced perspectives about themes, such as community safety, as findings indicate the need for further investigation. Future iterations of the CHNA may have to modify these aspects to increase the validity and reliability of findings.

Efforts were also made to make CHNA materials as accessible as possible (e.g., translation), but it is not guaranteed that meaning in responses was accurately captured, potentially impacting result validity. Length of the survey was additionally observed to potentially bias responses, as participants would experience possible response fatigue. Finally, individuals who requested support from the data collection team may have also experienced positive response bias. These were mitigated by collecting data at various locations and supporting respondents only when requested.

Appendix B: Additional Figures and Findings

Figure B1

Neighbourhood of Residence (N = 404)

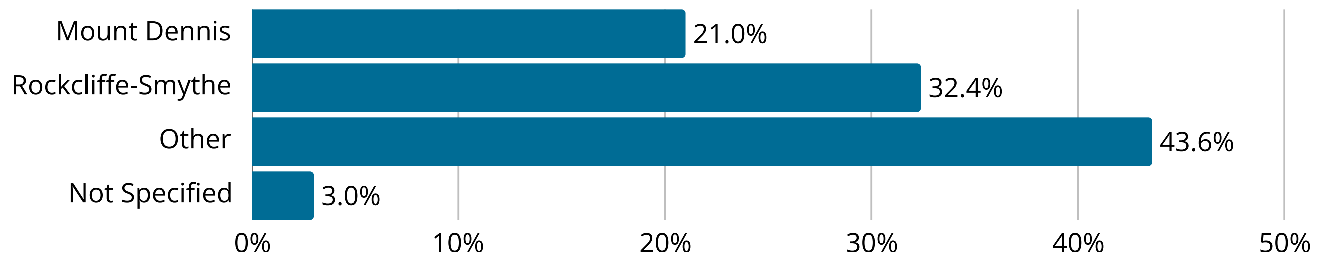
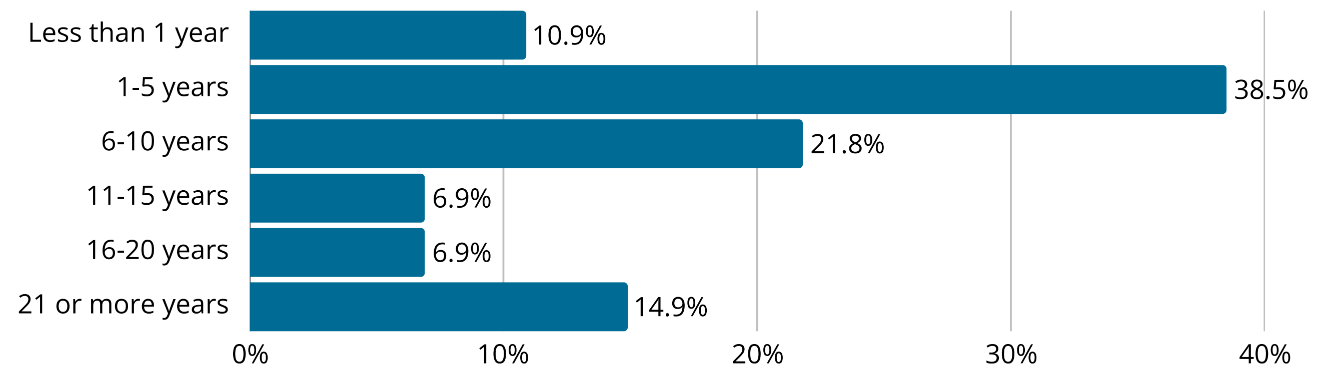


Figure B2

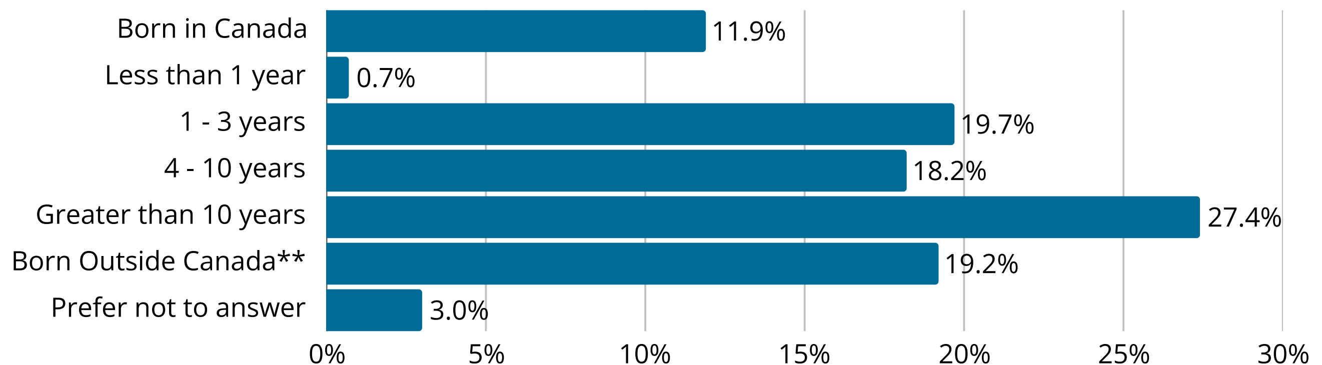
Length of Stay in Community (n = 403)*



** 1 response removed due to invalidity.*

Figure B3

Length of Stay in Canada (n = 402)*



** 2 responses removed due to invalidity.* *** Year of arrival not listed.*

Table B1

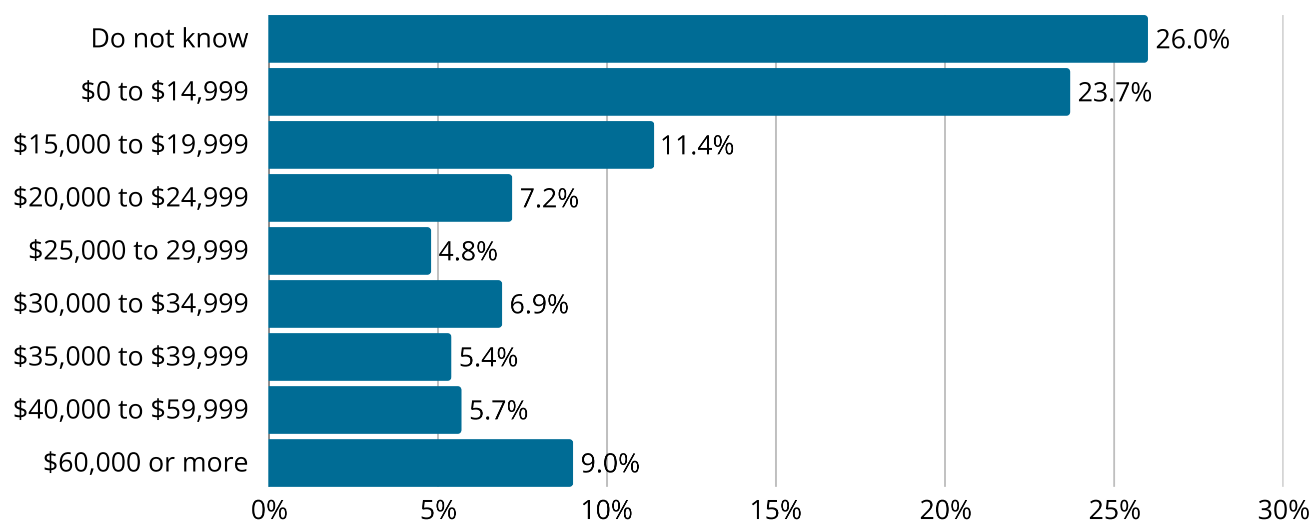
Racial-Ethnic Group (n = 389)*

Racial-Ethnic Group	Percentage of Respondents (%)
Latin American (e.g. Argentinean, Chilean, Salvadoran)	28.3%
Black – African (e.g. Ghanaian, Kenyan, Somali)	21.9%
Black – Caribbean (e.g. Barbadian, Jamaican)	12.3%
White – European (e.g. English, Italian, Portuguese, Russian)	8.2%
Asian – South (e.g. Indian, Pakistani, Sri Lankan)	7.7%
Prefer not to answer	5.9%
Asian – South East (e.g. Malaysian, Filipino, Vietnamese)	5.1%
White – North American (e.g. Canadian, American)	4.1%
Mixed heritage (e.g. Black – African and White – North American)	2.3%
Middle Eastern (e.g. Egyptian, Iranian, Lebanese)	1.5%
Indian – Caribbean (e.g. Guyanese with origins in India)	1.3%
Black – North American (e.g. Canadian, American)	1.3%

** 8 responses in Asian – East (e.g. Chinese, Japanese, Korean), First Nations, Indigenous/Aboriginal - not included elsewhere, and Inuit were suppressed due to low response (< 5); 7 responses in 'Do not know' were suppressed to assist with data visualization.*

Figure B4

Total Family Income Level (n = 334)*



** 5 responses removed due to invalidity; 65 responses in 'Prefer Not to Answer' suppressed to assist with data visualization.*

Table B2

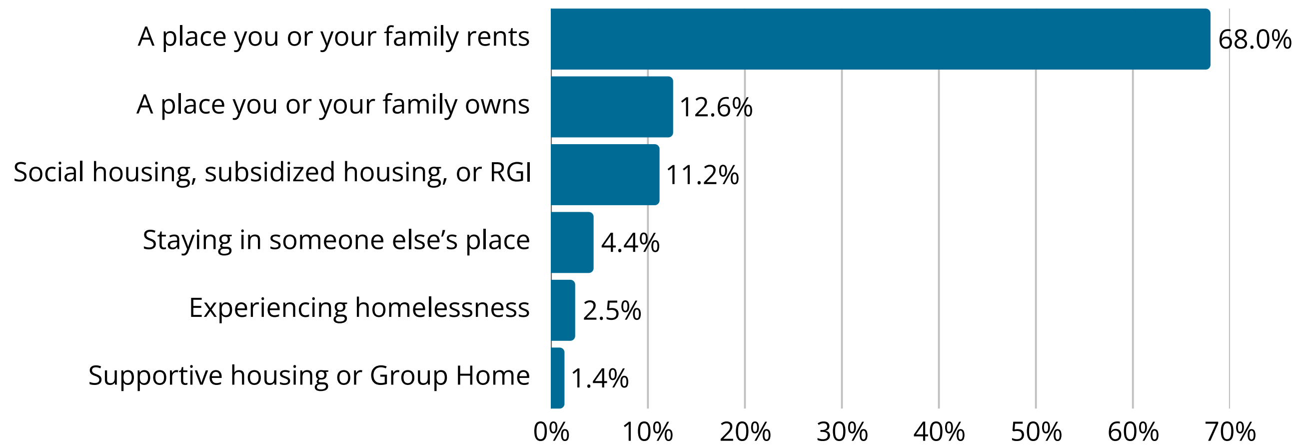
Primary Income Source (n = 387)*

Primary Source of Income	Percentage of Respondents (%)
Wages for full-time work	22.0%
Wages for part-time work (e.g., 1+ part-time jobs)	14.7%
Wages for casual work (e.g., seasonal, contract, on call)	8.9%
Retired with private pension	5.1%
Pension (Canada Pension Plan, Old Age Security)	10.7%
Employment Insurance, Child Tax Benefit, Alimony/Child support	4.4%
Some form of assistance such as PNA, Welfare/Ontario Works, ODSP	14.2%
Other (Personal finances unrelated to work)	1.1%
Other (Related to family wages)	3.3%
No primary source of income	15.6%

** 17 responses removed due to invalidity.*

Figure B5

Respondents' Housing Situation (n = 366)*



** 2 responses removed due to invalidity; 1 response in 'Long-term care facility' and 2 in 'Other' suppressed due to low response (< 5); 33 responses in 'Do Not Know' and 'Prefer Not to Answer' suppressed to assist with data visualization.*

Table B3

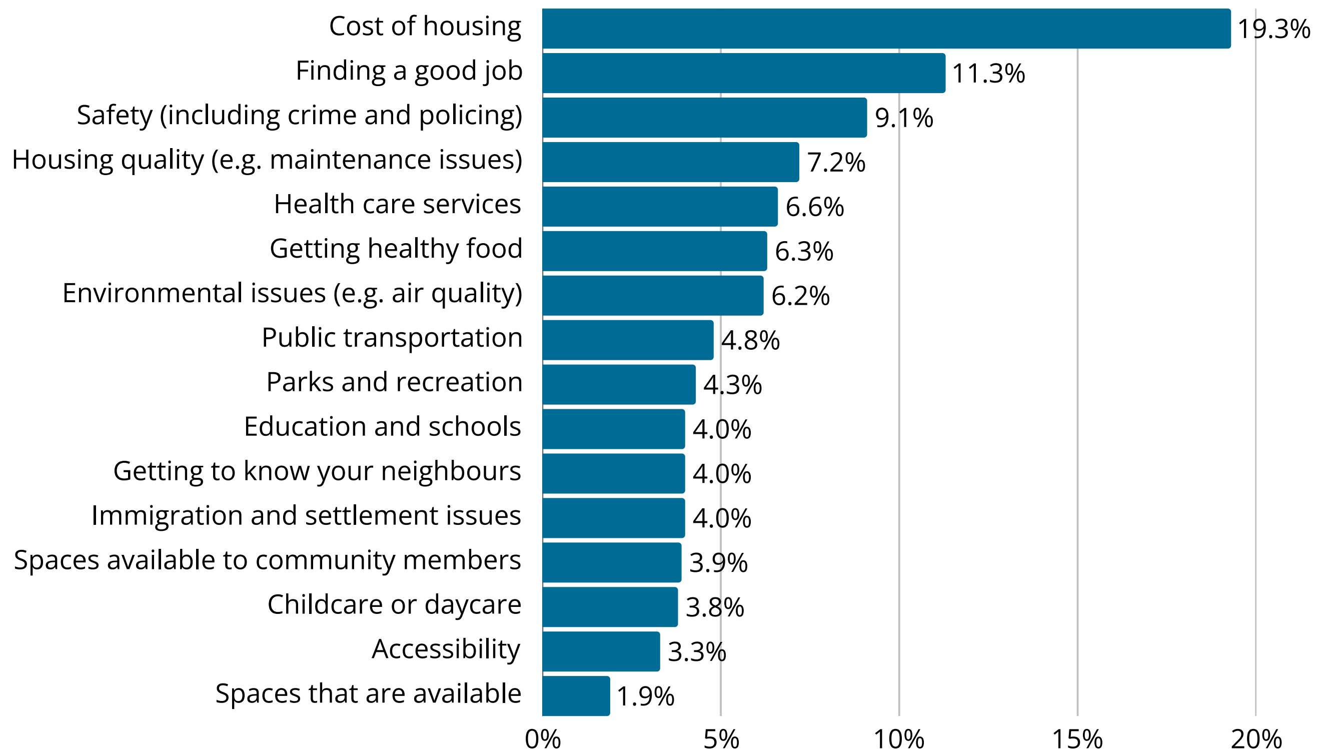
Household Types (n = 379)*

Primary Source of Income	Percentage of Respondents (%)
Couple with children	17.9%
Alone	16.9%
Couple	16.4%
Adult in shared accommodation	16.4%
Single parent or guardian household	14.8%
Child living with family	14.3%
Couple with children in shared accommodation	1.9%
Couple in shared accommodation	1.6%

** 4 responses removed due to invalidity; 9 responses in 'Intergenerational Household - Couple,' 'Intergenerational Household - Single,' and 'Single parent or guardian in shared accommodation' suppressed due to low response (< 5); 12 responses in 'Prefer Not to Answer' suppressed to assist with data visualization.*

Figure B6

Neighbourhood Concerns (n = 396)*



** 8 responses removed due to invalidity.*

Table B4

Top 5 Neighbourhood Concerns by Age Group

Rank	Youth, 13-24 (*n* = 44)		Adult, 25-44 (*n* = 175*)		Adult, 45-64 (*n* = 111)		Older Adult, 65+ (*n* = 57*)	
	Concern	%	Concern	%	Concern	%	Concern	%
1	Cost of housing	18.2	Cost of housing	18.8	Cost of housing	22.1	Cost of housing	15.3
2	Finding a good job	16.7	Finding a good job	13.4	Finding a good job	10.9	Environmental issues	13.6
3	Public transportation	9.8	Safety	8.6	Safety	9.9	Housing Quality	11.3
4	Safety	9.1	Housing Quality	7.0	Getting healthy food	8.2	Safety	9.6
5	Healthcare services	7.6	Healthcare services	5.9	Healthcare services	7.4	Parks & Rec / Healthcare services / Getting healthy food	7.3

** 3 responses removed from 'Adult, 25-44' due to invalidity; 5 responses removed from 'Older Adult, 65+' due to invalidity.*

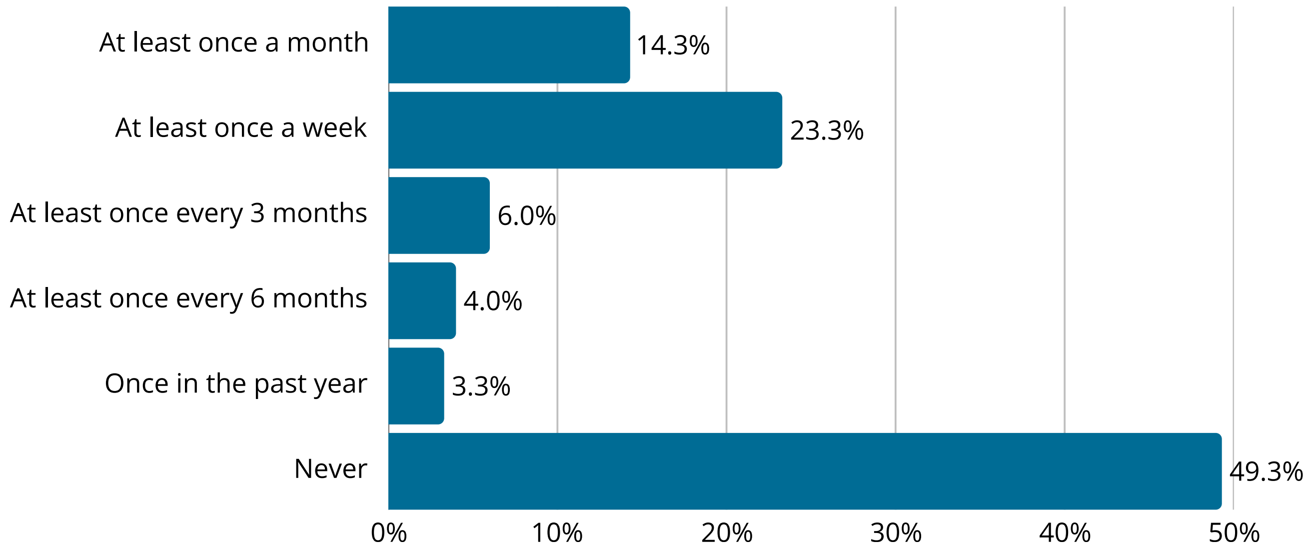
Table B5

Surveyed Proportion of High and Very High Service Need (N = 404)

Service Need	Percentage of Responses (%)
Free or low cost dental services	69.3%
Housing support services	60.8%
Free or low cost food programs (e.g. meal programs, food banks)	60.3%
Primary healthcare services (e.g. doctors, midwives, etc.)	59.8%
Employment Support Services	58.2%
Mental health services (e.g. counselling, support groups)	57.0%
Free or low cost English classes	55.9%
Free or low cost legal services	55.7%
Sports and recreation programs	54.0%
Community safety or crime prevention programs	51.5%
Programs/services for people with disabilities	50.6%
Settlement services (for recent immigrants and refugees)	49.8%
Community food programs	47.9%
Homework or tutoring programs (for children and youth)	45.9%
Environmental programs (e.g. tree planting)	45.7%
Free or low cost space for community meetings and events	44.4%
Sexual health clinics	41.2%
Religious or spiritual services	39.8%
Childcare or daycare	37.6%
Addictions Services	32.5%
Programs/services for people who identify as 2SLGBTQIA+	28.5%

Figure B7

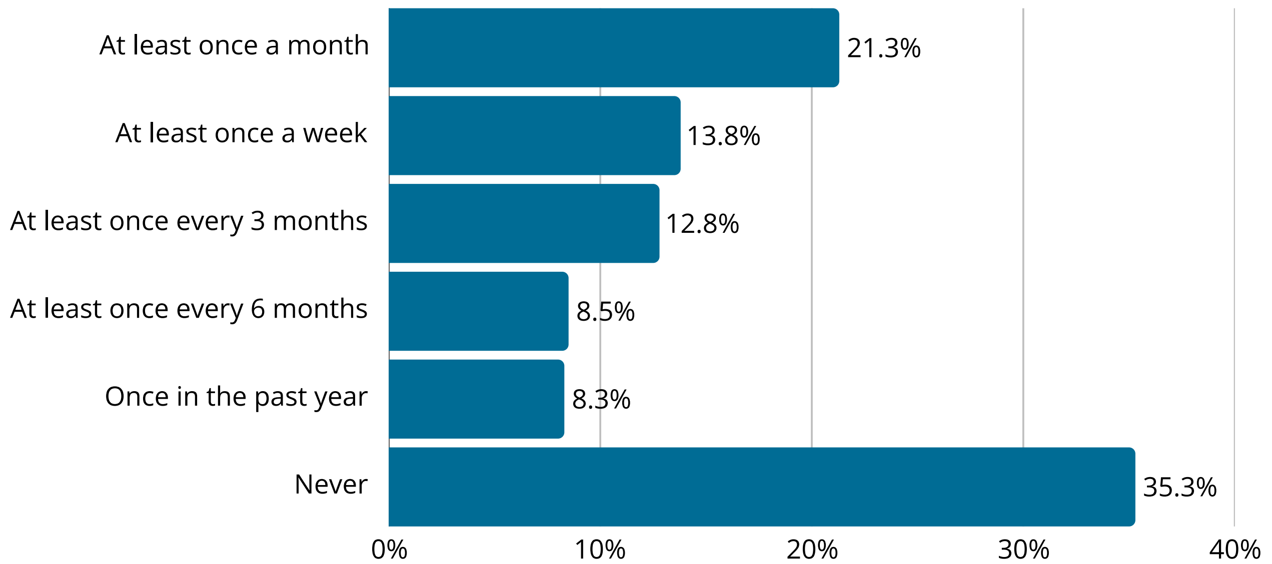
Reported Frequency of Eating Less Due to Lack of Money for Food (n = 400)*



** 4 responses removed due to invalidity.*

Figure B8

Reported Frequency of Experiencing Difficulty Making Ends Meet in the Last Year (n = 399)*

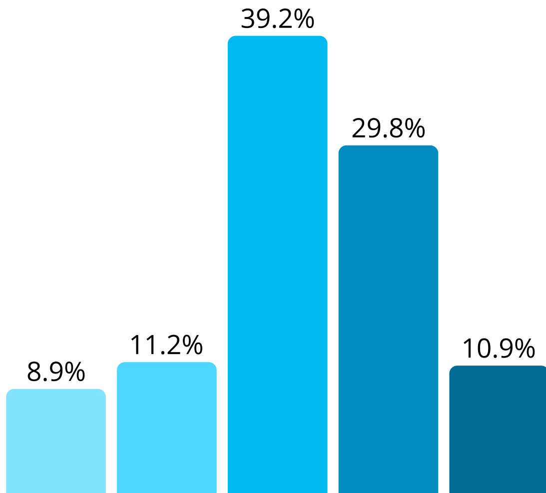


** 5 responses removed due to invalidity.*

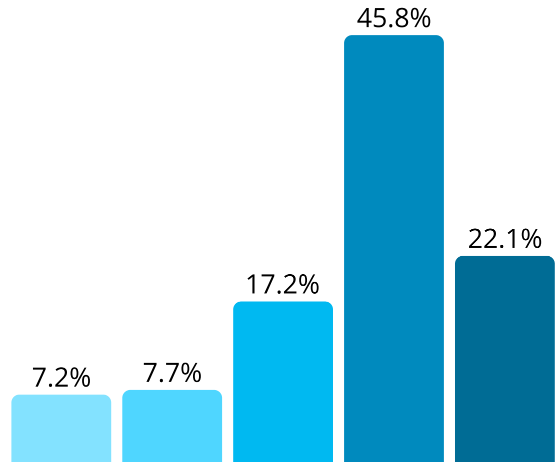
Figure B9

Strength of Agreement Regarding the Environment

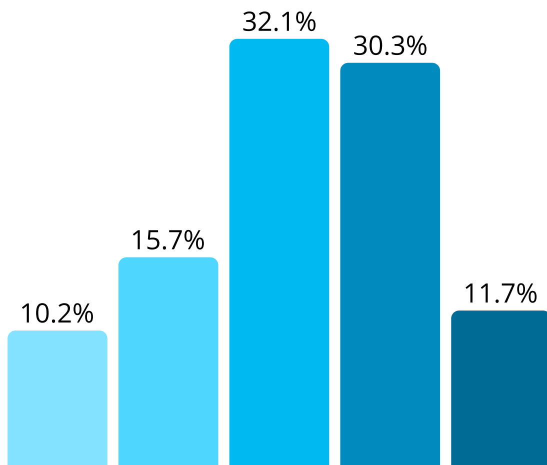
a) The quality of the natural environment in my community is very high (n = 403)*



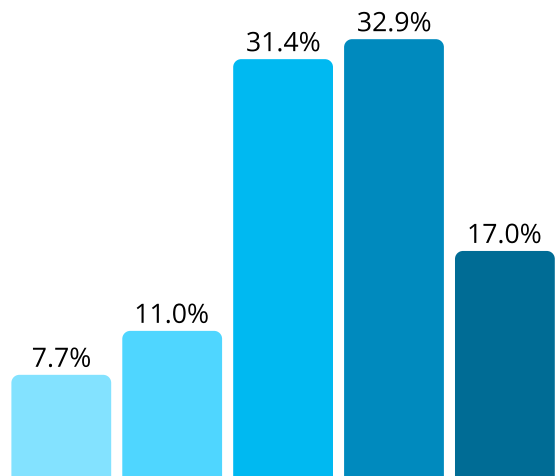
b) There are plenty of opportunities to enjoy nature in my community (n = 402)*



c) The air quality in my community is very good (n = 402)*



d) The water quality in my community is very good (n = 401)*

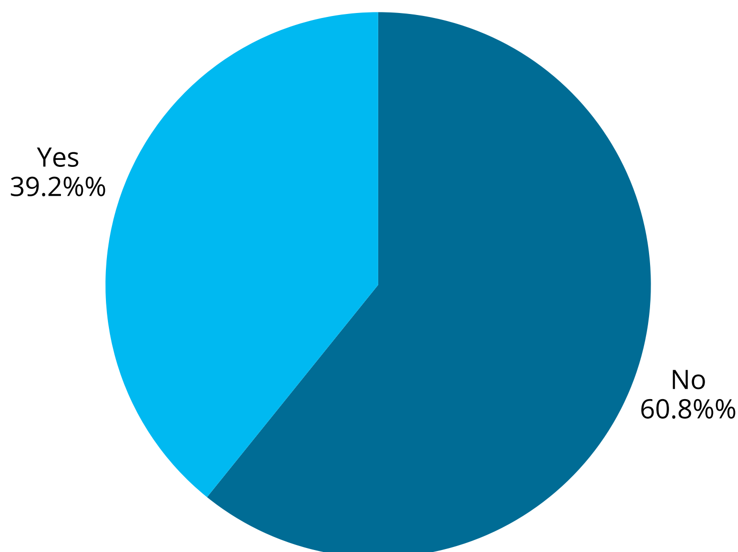


Strongly Disagree   Disagree   Neutral   Agree   Strongly Agree

** Responses removed from total of 404 due to invalidity.*

Figure B10

Proportion of Respondents Who Have Taken a Course in the Past Year (n = 401)*



** 3 responses removed due to invalidity.*

Table B6

Primary Reason for Taking a Course in the Past Year (n = 157)*

Primary Source of Income	Percentage of Respondents (%)
For personal development, interest, or enjoyment	34.4%
To help you get started in your current or a new job	24.8%
To prepare you for a job you might do in the future	21.7%
To improve your skills in your current job	15.9%
To lead directly to a qualification related to your current job	3.2%

** This follow-up survey question was for respondents who indicated 'Yes' to taking a course in the past year. 157 respondents indicated 'Yes.'*

Figure B11

Amount of Time Spent on Leisure Activity by Respondents on a Typical Day (N = 404)

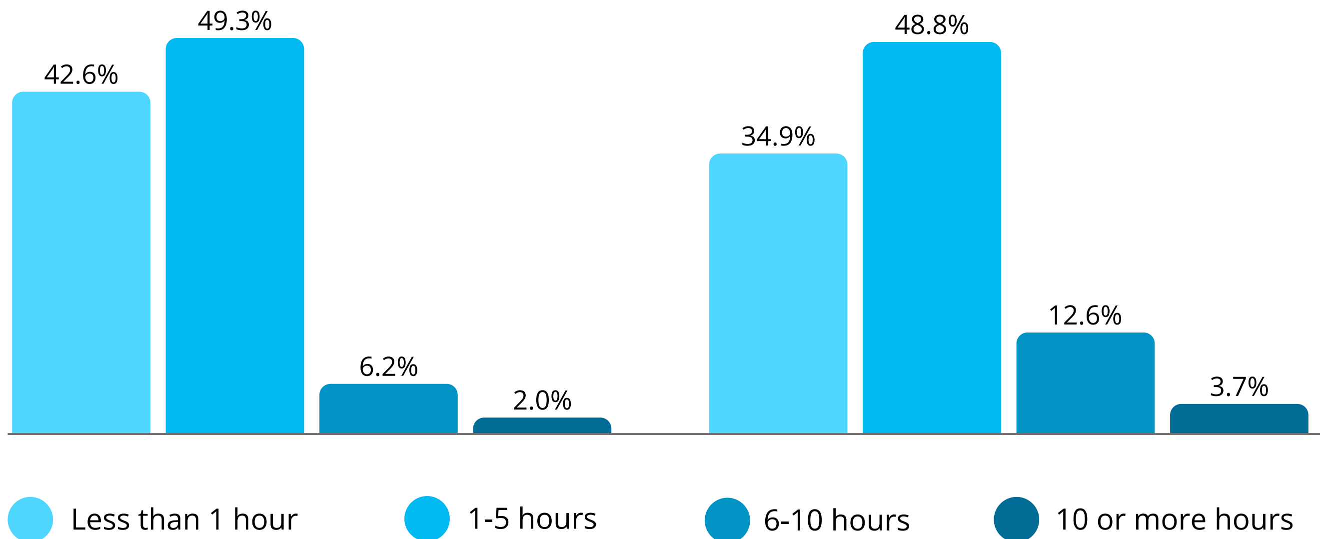
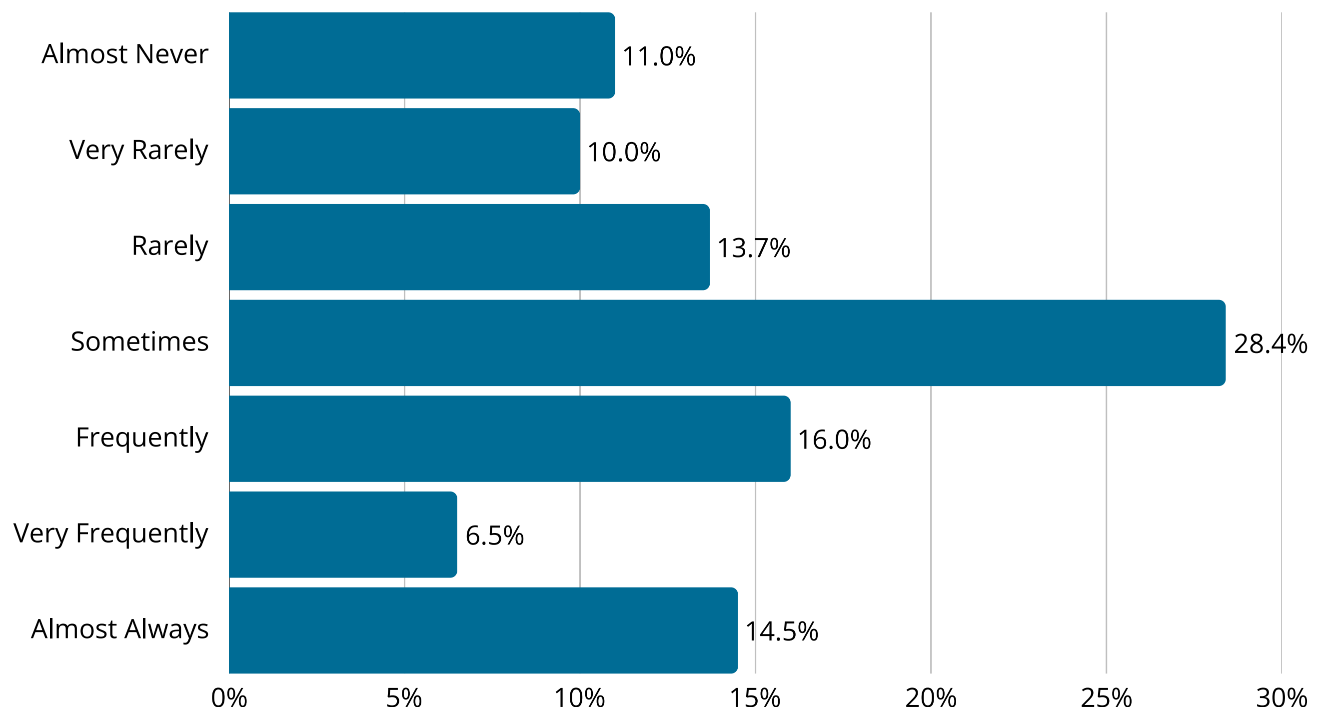


Figure B12

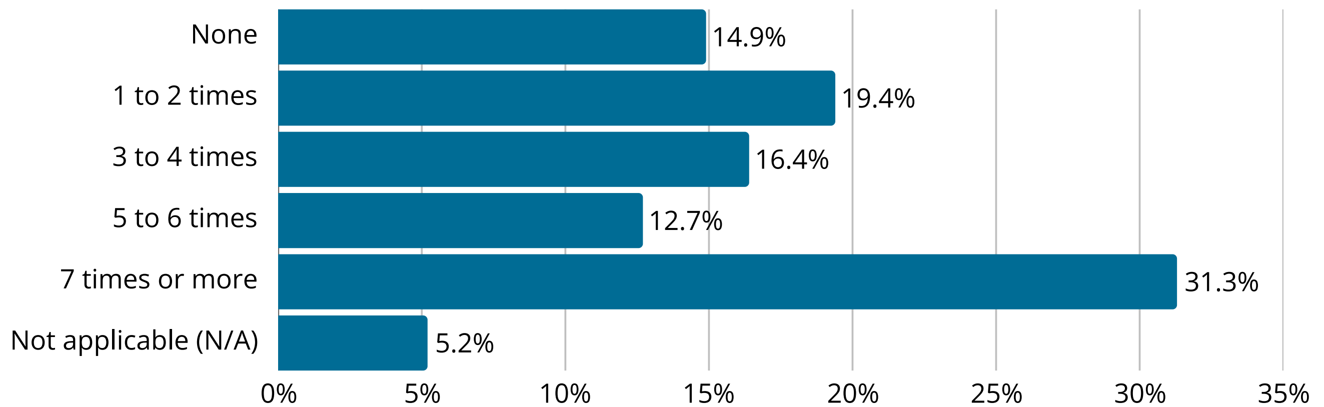
How Often Respondents Perceive Having Enough Time in a Day (n = 401)*



** 3 responses removed due to invalidity.*

Figure B13

Number of Times a Respondent had a Meal with Their Family in the Past Week (n = 402)*



** 2 responses removed due to invalidity.*

Figure B14

Sense of Belonging (N = 404)

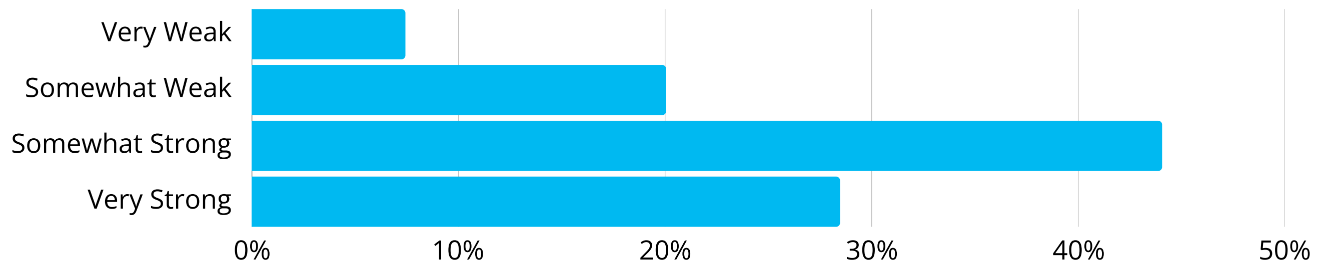
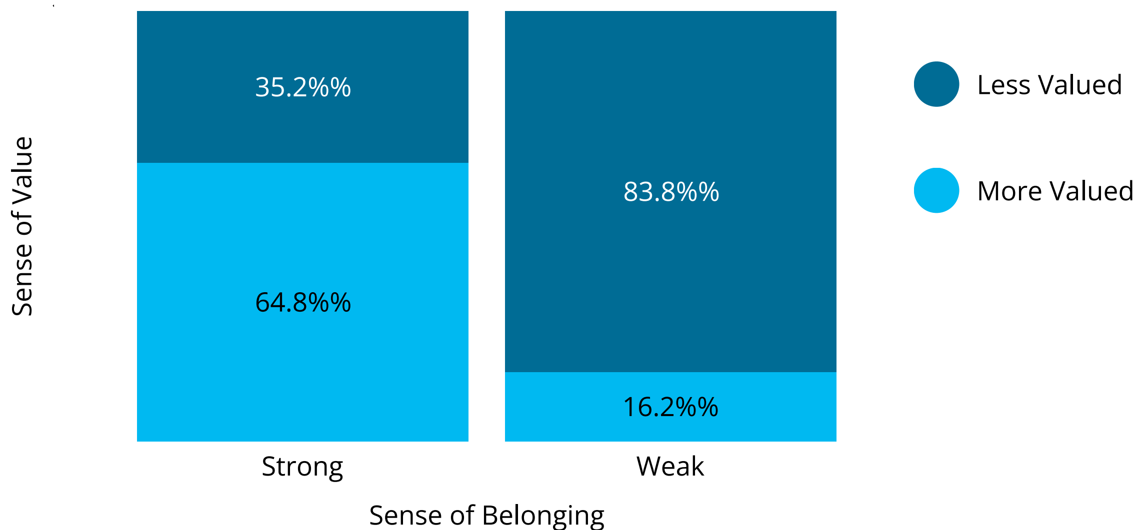


Figure B15

Sense of Belonging Intersecting with Sense of Value (n = 401)*



** 3 responses removed due to invalidity.*

Figure B16

Experiences of Discrimination in RS-MD (N = 404)

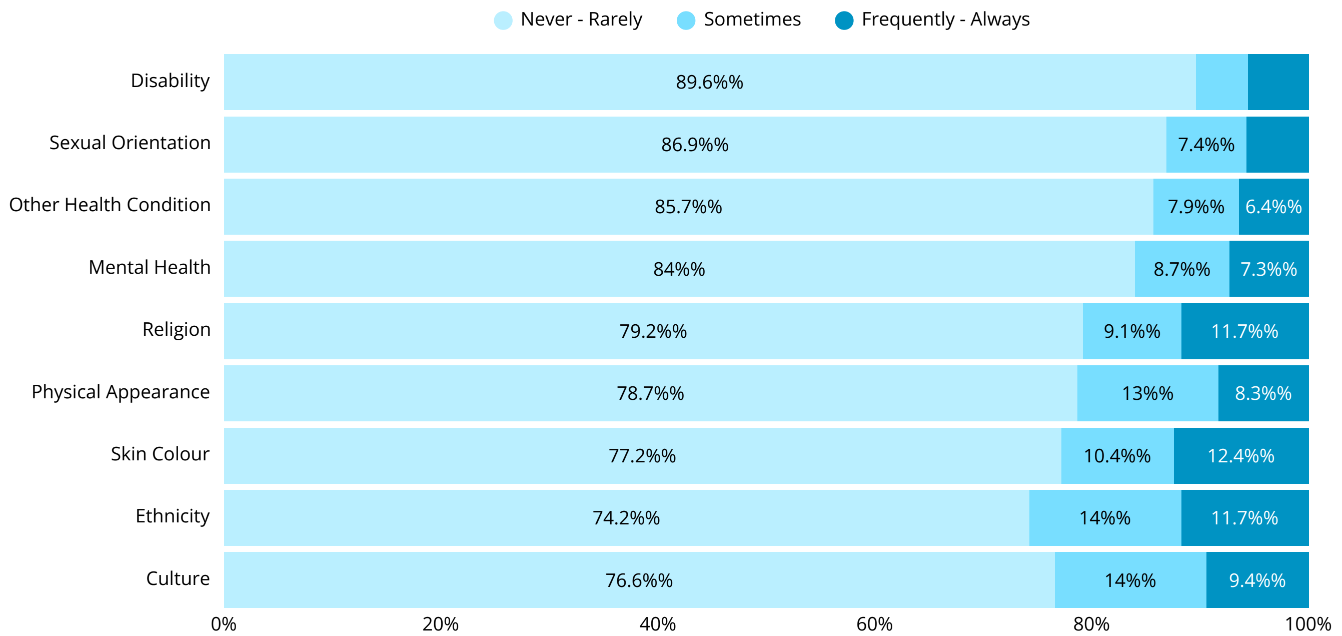
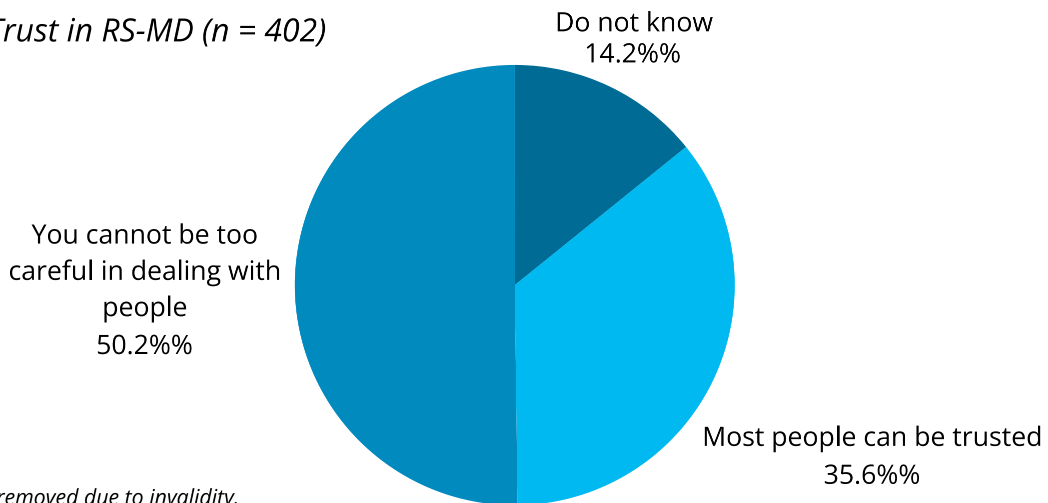


Figure B17

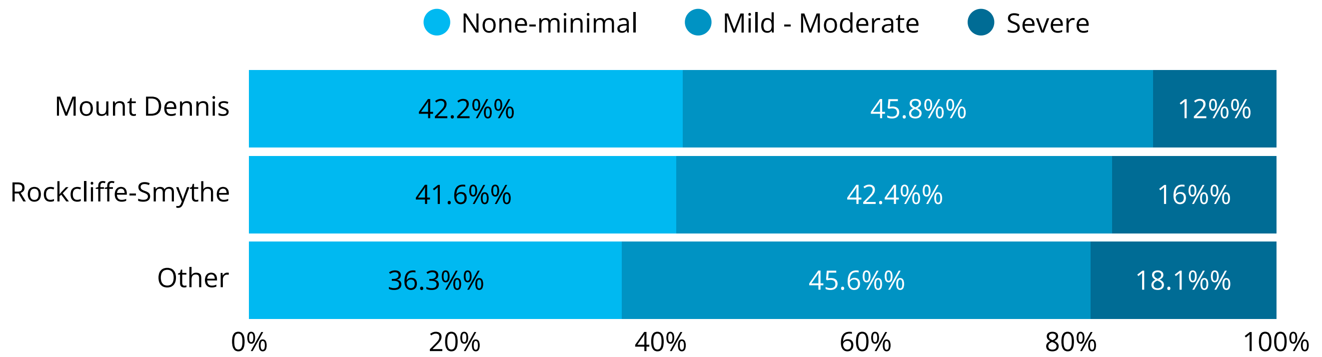
Sense of Trust in RS-MD (n = 402)



** 2 responses removed due to invalidity.*

Figure B18

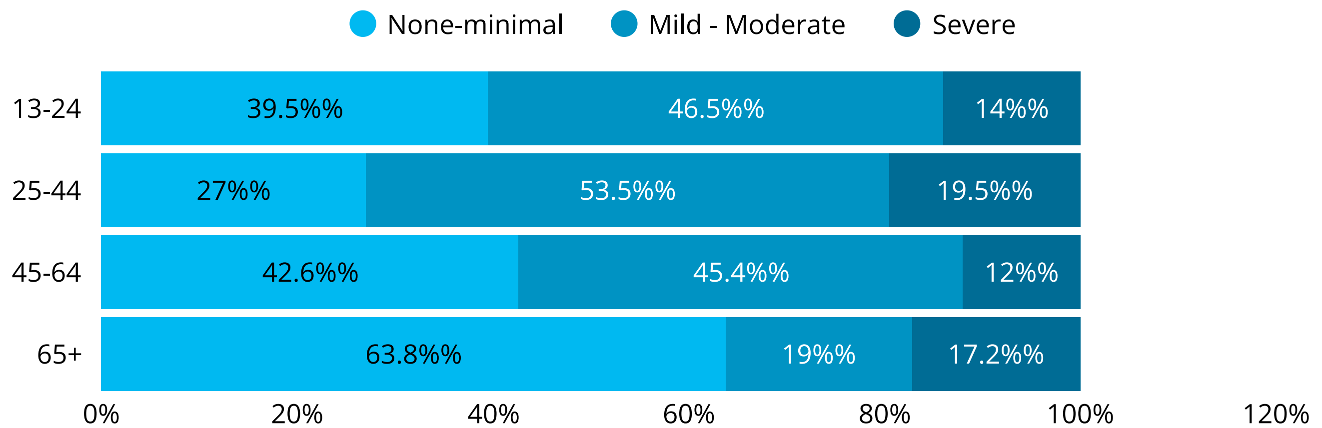
PHQ-9 Depression Severity by Neighbourhood (n = 379)*



** 13 responses removed as neighbourhood of residence was not indicated.*

Figure B19

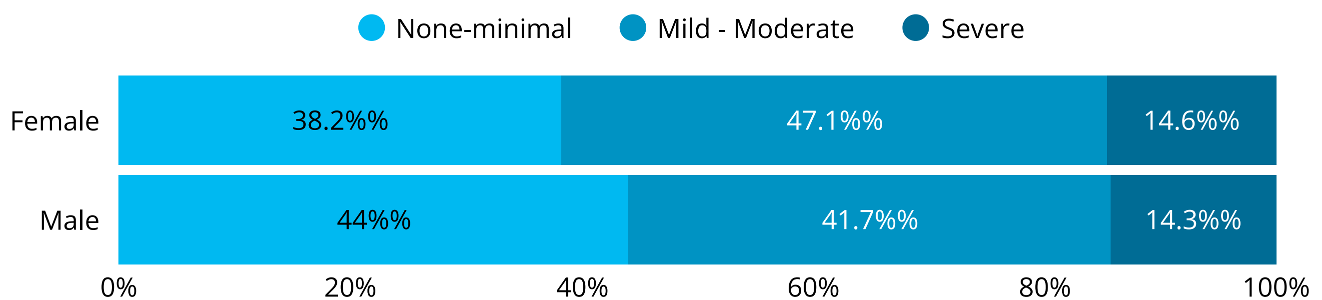
PHQ-9 Depression Severity by Age (n = 383)*



** 9 responses removed as age was not indicated.*

Figure B20

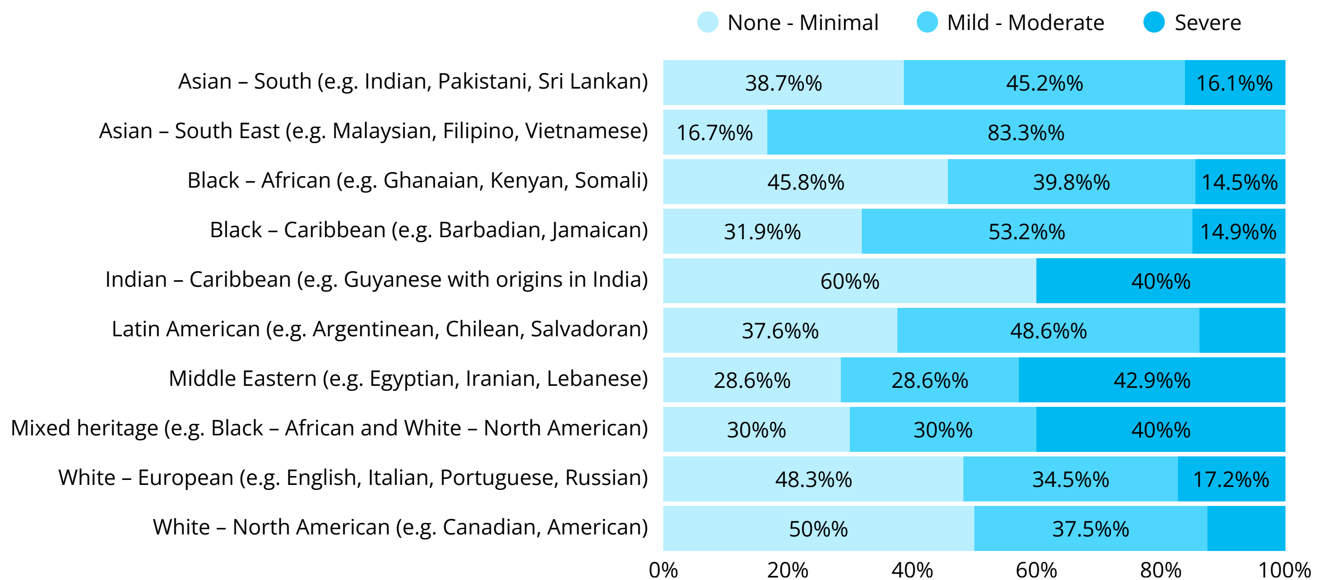
PHQ-9 Depression Severity by Gender (n = 371)*



** 1 response removed due to invalidity; 9 responses in 'Do not know,' 'Intersex,' 'Other gender identities (e.g., genderfluid, nonbinary),' 'Trans - (Female to Male, Male to Female),' and 'Two-spirit' suppressed due to low response (< 5); 11 responses in 'Prefer Not to Answer' suppressed to assist with data visualization.*

Figure B21

PHQ-9 Depression Severity by Racial-Ethnic Group (n = 355)*



** 9 responses in 'Asian - East,' 'Black - North American,' 'First Nations,' and 'Indigenous/Aboriginal - not included elsewhere' suppressed due to low response (< 5); 28 responses in 'Do not know' and 'Prefer Not to Answer' suppressed to assist with data visualization.*

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