A snapshot of consumers in Downtown Dartmouth using
Emergency Social Services as *Core Services*
User Survey 2006

Presented by The Public Good Society with the financial aid of Service Canada

I expect to pass through this world but once. Any good therefore that I can do or any kindness that I can show for any fellow creature, let me do it now. Let me not defer or neglect it, for I shall not pass this way again.

Ralph Waldo Emerson (1803-1882)

FOREWORD

Too often we may forget that the quality of life most of us enjoy is not available to all. Those excluded from participating in the economy and other social activities through illness, disability and isolation need access to basic social supports to alleviate suffering, meet basic human needs, and retain their membership in the community.

We are a group of concerned citizens reflecting community, business and government. Our observations led to concern for the level of support and its effectiveness in serving people living in vulnerable circumstances. The Public Good Society has set out to better understand these issues affecting the group of individuals who rely on emergency social service programs in the downtown Dartmouth core. Most notably we made contact with the users of the Feeding Others of Dartmouth Meal Program at Margaret's House, at the corner of Octerloney and Wentworth Streets.

F.O.O.D. is a fine community service struggling to meet ever-growing needs for nutrition support and other forms of service. We endeavored with the support of F.O.O.D., Service Canada, the NS Department of Community Services, Halifax Regional Municipality and the Community Health Boards to seek the input of the service users about their experiences and backgrounds. The results of our survey involving a sample of people who use the F.O.O.D. program, we believe, have enlightened us as to needs that could be met in a more effective, integrated and respectful fashion.

The efforts of the Public Good Society to show its concern for how social supports are delivered for vulnerable residents of HRM who frequent the core services in downtown Dartmouth, are predicated on the belief that social justice denied to some is denied to all. The public good demands that the whole community be involved with supporting those who are vulnerable and need support to recover, and who require ongoing support to remain part of the community.

The Public Good Society will continue to be focused on issues in our community that affect the public good without political interest or allegiance. We offer our findings and recommendations in a positive, constructive manner as encouragement for continued improvement in service delivery for the most vulnerable residents of downtown Dartmouth and the greater Dartmouth area.

Sincerely,

Terry M Brennan
Acting Chairman
The Public Good Society

Acknowledgements

First of all, I would like to acknowledge and thank the survey respondents. Without the participation of these citizens, this project would not have been possible. Many thanks to all the respondents for having the courage to tell their story and share pieces of themselves so others could understand the struggles they endure on a daily basis. Thank you to the consumers of Hope Cottage who participated, and Coordinator, Kevin for helping us conduct the Test Survey.

I would like to gratefully acknowledge the contributions of all those involved in the process of formulating, implementing and analyzing the *Core Service User Survey.*
The Public Good Society, Service Canada and Halifax Regional Municipality (HRM) who demonstrated true collaboration. Barbara Nehiley, *Senior Policy Analyst, Community Development, Social Policy Development, Halifax Regional Municipality,* who provided guidance and expertise, has made the difference. HRM has been an invaluable support through the entire project, providing much needed 'in kind' resources.

Thank you also to the Province of Nova Scotia, *Department of Community Services*, Councillor Gloria McCluskey, *District 5 Dartmouth Center*, Councillor Becky Kent, *District 8 Woodside-Eastern Passage,* and Marilyn More, *MLA Dartmouth South-Portland Valley*, who all provided financial contributions, continuing support and encouragement.   I'd like to thank Feeding Others of Dartmouth Society (F.O.O.D), Coordinator**,** Karen Goudie**,** for continued support and assistance while conducting the survey. Also for sharing her experiences and listening. This organization has been actively involved in the struggle of the poor for decades. Their efforts are to be commended. For helping find some 'office essentials', thanks to Diane West and Circle of Care.

Rose-Marie Thebeau, *Administrative Assistant*, whose dedication and 'never say die' attitude helped save many days that otherwise, would have been a wash! Next, is *The Survey Work Group.* As members of the Survey Work Group, Anna Jacobs *Southeastern Community Health Board* and Monique Mullins-Roberts *Dartmouth Community Health Board* have contributed time and expertise. And finally, to our Chair (Acting) Terry Brennan and all Board Members of *The Public Good Society* for undertaking the challenge of making a better quality of life for more residents of Dartmouth.

To everyon**e** involved in this project from inception to completion, your patience, guidance and unwavering support was instrumental in bringing this project to life, thank-you.

Gary Healey
Program Coordinator

Executive Summary

The purpose of *The Core Service User Survey* is to identify gaps in existing services and other services that are needed to allow *ALL* citizens to fully take part in our community. It is also an effort to give a voice to those without one.

A couple of terms that need an explanation, used throughout the report are *Emergency* and *Core* services. For this research, emergency services refer to meal programs (soup kitchens), food banks and shelters. Core services mean having safe, adequate, affordable housing, the ability (financially) to purchase and prepare your own food at home.

At first glance, there doesn't appear to be that much to discover from this research; the potential respondents appear to be 'down on their luck' or 'having a rough time'. But, there is so much more bubbling beneath the surface, including education levels, health issues and combinations of health and addiction issues.

The demographic structure of our survey sample was not balanced.
- Gender is split 2:1(female 35.1% male 64.9%)
- Family structure is primarily single – 90% (female 35.7% male 64.3%)
- Education levels are interesting- 53.5% more than Grade 12 (female 18.3% male 35.2%)

There is no evidence in this sample to suggest transience. Based on the survey:
- 58.6% of respondents were born here, or consider HRM to be their hometown.
- Migration from other areas, such as other Canadian Provinces and the USA is 28.6%
- Migration within Nova Scotia is 12.9%.

Ethnic Identity breaks down like this:
- Caucasian –84.5% (female-31.0% male-53.5%)
- African Nova Scotian-2.8% (male-2.8%)
- Aboriginal- 12.7% (female-4.2% male-8.5%)

There is a significant representation of Aboriginal people in this sample. In HRM, Aboriginal people account for 1% of the total population (*Statscan, 2001 Census Data*). In this study, they account for almost 13% of the sample population. This has been found in other research[1] and indicates this group is over-represented.

The contradictions in our findings are the most telling. While 57.1% of the sample felt that their basic needs were being met, 68.6% were depending on meal programs either daily or weekly. One would assume eating would be a basic need, yet *most* of the respondents stated a need to use meal programs and believed that their basic needs are being met.

The health situation is of concern. There were 83 incidences of specific health issues. These were not simple health concerns, but major illnesses needing regular medications and monitoring. It has already been well established that social and economic factors impact health more significantly than lifestyle alone[2]. This population has a triple threat of poverty, poor diet and lifestyle and chronic disease, particularly addictions.

The incidence of addiction is high. Over 50% of the sample indicated some form of addiction. 15.7% cited having more than 1 (or *multiple*) addictions. A notable percentage, 9.8%, reported having health problems and multiple addictions. That makes an already difficult situation more challenging.

The poverty level benchmark used in Canada is the *Low Income Cut Offs or LICO*. This is determined by number of people in a household, residing in a particular size of community. For HRM, the base is community population between 100,000 and 499,999. Three quarters of the sample is recorded as having a social income opposed to an earned income. A single 'employable' person on Income Assistance is entitled to an annual income of $4992. The *LICO* in HRM for a one-person household is $17,515. The level of income for this group is only 28.5% of the *LICO*.

More startling detail is that this has 82.3% paying more than 50% of income to shelter. 100% of the sample reports paying more than 30% of their income for shelter and at that, there are major issues with what they are paying for. Shelter cost has risen markedly in the past number of years. We have a strong economy and low interest rates to thank. The down side is that there are not enough '*affordable housing*' (means you pay less than 30% of income to shelter) rental units.

There are serious gaps and inequities in available supports. The *Department of Community Services*, responsible for the well being of most of those sampled is creating or has the largest gaps in service delivery. Information exchange is sparse and a lot of times it happens at the street level. The information is inaccurate, out dated or doesn't apply to each person the same way. There have been numerous studies done regarding this and many good recommendations made[3]. The Provincial government has been slow to implement. Community Services is not alone. Addiction services are not meeting expressed client needs.

People, who struggle with addiction, need help when they need it…not when a bed is available. Over half of respondents (52.8%) told us that they either didn't know where to get help or couldn't get help for their addictions. For example, the gambling help line is most times not staffed or you get a busy signal or voicemail[4]. If you've lost your last dollar in a slot machine and you are in emotional turmoil, voicemail isn't going to help.

The most important factor in any vibrant, sustainable community is that *all* of its citizens be included. To be included, you should be able to take part in the community and feel that you belong. Of this sample,
- 50.7% did not feel like they were part of the community
- 49.3% did not feel that the community cares about them

That tells us that this group does not feel included in the community they call home.

The underlying causes of needing to use *Emergency Services,* as *Core Services* have to be repaired in order to improve living standards. Also, when people have a sense of value and belonging, they can do remarkable things and give back to society. That's something we are all entitled to as residents of HRM, Nova Scotia, Canada and most importantly as *human beings*.

Recommendations:

1. Engage in a multi-pronged approach to address client needs. This approach means:
   - Establishing a priorities list based on a client's identified needs. Integrate the work of service providers (i.e. community service workers, mental health workers, food bank operators, meal program operators, church groups) to deal with specific needs identified by the client. This is more efficient and has a more positive impact on the client.
   - Adopting the determinants of health criteria as the guiding principle that moves this multi-pronged process forward.
   - Involve and actively connect all government departments and agencies involved in service delivery i.e. department of health, education, community services, justice.
   - Build intersectorial collaboration among community based groups, businesses and governments to achieve a common end goal.

2. Establish a community client service improvement committee to monitor and track client concerns regarding their experiences with the following:
   - Challenges and/or barriers to accessing information and/or services.
   - The appearance of inequitable treatment or service provided.
   - Perceived ineffective communications regarding being informed of services and/or resources that may be available to them.
   - Being unclear as to why decisions regarding their eligibility or referral or recommendation to resources is not recommended or approved.
   - The composition would include representatives from community and government service providers including but not limited to; Capital District Health Authority, the Department of Community Services, the Canadian Mental Health Association and independent client advocates. The committee would assist to delegate persons within their organizations to act as 'point of contact' for timely response to client service delivery concerns.
   - This committee would report quarterly on emerging concerns and/or trends to provide valuable feedback to service providers for process improvement opportunities. This would increase consistency in client access to their services, information and resources and transparency of the decision making process.

3. For the Government of Nova Scotia to work toward a strategy aimed at poverty reduction. Using such a strategy, success and progress can be tracked and best

practises established. A couple of key tenants of that progressive strategy could include:

- Adjust personal allowances to come closer to real costs. Include telephone as 'basic necessity'
- Adjust shelter rates to be more in tune with the market; actual heating cost, especially during the winter and actual power usage cost.
- Consider training and labour force incentives.
- Strengthen the mandate of rate review process to encourage movement towards meeting market costs.

4. Develop models and strategies to facilitate and support increased access to information and services within government and community resource systems through:

A) Active cooperation between Capital District Health Authority (CDHA), Department of Community Services, other government departments and community service providers and community organizations

B) An advisory committee comprised of community-based service providers to identify and address gaps and inequities in existing services. This advisory committee would also develop a go-forward strategy to be used by similar facilitation initiatives in the future.

C) The pursuit of funding avenues to link clients with existing services and opportunities.

D) The creation of a position such as a Community Access Worker to assist individual clients.

- This position would help facilitate the sharing of accurate information and streamline the process of accessing services that the client needs in a timely manner, with the aim of helping the client achieve personal success and independence.
- The strength of the enhanced individualized approach, which would increase client service process improvements and have the greatest positive impact for clients, would also empower service providers to build capacity and increase consistency in effective access and service for clients.

E) The cornerstones of this model and strategy should be respectful communication, accountability, accessibility and transparency for the service providers and the clients.

5. Continue changes to the Pharmacare Act to make it more accessible to the most vulnerable. There should not be co-pay for prescription drugs for income assistance clients. Additionally, continue the expansion of pharmacare benefits to low-income households i.e.: working poor, pensioners.

6. Strengthen access to the labour market and sustainable employment with improved transitional supports and increased incentives. Increase the ceiling on earned income before reducing income assistance benefits to strengthen

sustainable labour market inclusion for clients to participate in their communities through employment.

7. Utilize the existing affordable housing funds and the Nova Scotia Housing Trust Fund to increase the number of affordable housing spaces. The Government of Nova Scotia should put priority on new units for single person households. These could be regulated rooming houses or flats, providing safe, affordable housing.

8. Promote affordable housing through:
   - Encouraging municipalities to plan and maintain balanced communities with mixed income households and affordable housing.
   - Supporting the involvement of non-profit groups and agencies in starting up and managing affordable housing stock. There is demonstrated success with this method. Non-profits need the support of governments to be sustainable and provide a long-term supply of affordable housing stock.

TABLE OF CONTENTS

Introduction

The Public Good Society is a non-profit organization comprised of members from business, community-based social service, health and education sectors, interested citizens at large, and governments at all levels. One reason we have come together is to learn about and hear from the consumers currently using *emergency services* as their *core services*.

In an effort to truly understand the implications of what was presenting itself in the downtown Dartmouth core, *The Public Good Society* decided that its first order of business should be an attempt to identify the consumer group it would aim to assist in whatever forms that would take.

To understand the guiding principles of this research, we chose the Determinants of Health as prescribed by the Canada Health Agency in their Population Health approach.

1. [Income and Social Status](#)
2. [Social Support Networks](#)
3. [Education and Literacy](#)
4. [Employment/Working Conditions](#)
5. [Social Environments](#)
6. [Physical Environments](#)
7. [Personal Health Practices and Coping Skills](#)
8. [Healthy Child Development](#)
9. [Biology and Genetic Endowment](#)
10. [Health Services](#)
11. [Gender](#)
12. [Culture](#)

There is also the issue of adequate food and shelter being guaranteed under the Universal Declaration of Human Rights, adopted by the United Nations General Assembly on December 10, 1948. There is currently no direct legislation at the federal or provincial level to ensure these rights for citizens.

Methodology

The sample was not randomly selected. The sample of respondents was selected from a small group of service users each sharing some common experiences and not from the broader population. The sampling represents a qualitative research approach. There are certain limitations to the assumptions that can be made since self-reporting in some instances may have limited our knowledge to the experience and understanding of the respondents with regard to technical and administrative matters, but not in the reflected experience, understanding and feelings of the respondents.

Available and interested individuals were invited to participate in the survey through the food service program. Individuals were able to contact the interviewer and arrange an appropriate meeting time. Interviews were conducted in privacy. Volunteers for the survey were provided information sheet on the interview process and informed consent was received. Each interviewee was given the opportunity to receive the results of the survey. A total of 71 surveys were completed 51 short and 20 long. Over 2800 people use the meal program each month. (Based on April statistics - the month in which the research was conducted).

The protection and affirmation of the importance of the participants was handled very carefully. The Confidentiality Oath and Informed Consent were taken from (and modified for our purposes), from the *Government of Canada National Homelessness Initiative* website[5]. A Confidentiality Oath was also signed be each staff member and Board Member of *The Public Good Society*. The respondents were given a gratuity (based on length of time involved) for taking part in the project.

The research was conducted in two parts. The first being a short survey format where a group of questions were pulled from the larger survey and only these were asked without detail unless such detail was offered by the respondents and it was then captured by the interviewer. The second phase was an in-depth interview lasting up to one hour where the questions were more specific and the detail captured was significant. There was no prerequisite to be involved in the study only a willingness to voluntarily answer the questions, fully and truthfully.

Several service providers, with many combined years of trying to assist people in similar situations, provided another element of education and enlightenment.

In drawing fair and valid conclusions it is important to re-iterate that the sample was from a select segment of the population based on *Emergency Services (Shelters/Soup Kitchens or Meal Programs/Food Banks)* usage. The focus population was around the *F.O.O.D* facility at 43 Wentworth St. in downtown Dartmouth. This was picked as a focal point as there are many different consumers who use the facility.

A Microsoft Access database was created to house the data. This method was chosen for ease of use and the relatively small sample size. Functionality and manageability were key factors in making this choice. Once all the data was entered, the analysis was started.

While conducting the survey, it was made clear very quickly that the questions we were asking were not the kinds of things that had been asked before. However, as the

interviewer had first-hand knowledge of the kinds of things they struggle with everyday, the respondents were put at ease.

Since this is '*self-reporting*' the same kind of parameters need to be applied. This isn't meant to be representative of the entire low-income population. It is a snapshot of a selected group of program users, which should be viewed under the light of day. The people reporting on their experiences in this survey, also reflect similar experiences of others who also play a role as consumers of the core services to be found in downtown Dartmouth and they need to have a voice and guidance to *enable them to help themselves.*

We have given the data a face by taking direct quotes from respondents relative to each theme. This information has not been edited in any way. Confidentiality rules protect each person's identity but the messages are loud and clear.

Findings

Section I. Demographics

This survey sample was primarily taken from the consumers of *Feeding Others of Dartmouth Society* who use this facility on a semi-regular to regular basis. The *Feeding Others Of Dartmouth Society (F.O.O.D)* is located at 43 Wentworth St. in downtown Dartmouth. This *Society* was started in the 1960's as a cooking class for women receiving *Income Assistance*. The meals that were prepared went to the needy in the area. Even though the courses ended, the need in the community did not. The program was moved into its present location in 1989 and was formally turned into a Society in 1999. *F.O.O.D* serves lunch seven (7) days per week and supper on Monday, Tuesday and Wednesday[6].

The respondents fell within the *16 to 66-age* range. There was almost a 2:1 ratio of male to female except in the *under–19 age* group. Table 1 illustrates the data. This was consistent throughout the findings. The only significant variance was in the *under 19-age* group. This saw the female population out rank the male 2:1. This speaks to a cultural shift in the younger generation and a lack of supports for this segment of society.

The composition of the family revealed that 8% of females reported being '*coupled*' as opposed to 11% of males who indicated such a relationship. Only 3% separated the female and male identifications of relationship status.

Table-1	Age Group Based on Year of Birth									
	<19		20-34		35-54		>55		Totals	
	#	%	#	%	#	%	#	%	#	%
Female	2	2.8	4	5.6	14	19.7	5	7.0	25	35.2
Male	1	1.4	8	11.3	29	40.8	8	11.3	46	64.8
Totals	3	4.2	12	16.9	43	60.6	13	18.3	71	100

The education levels were surprising. The greater majority (53.5%) had more than *grade 12 educations.* This was strongest in the *20-to-54-age* group (66.2%). The education levels did not vary greatly based on gender until after the *54-age* bracket. Once this threshold was realized, the gender gap in education took a decidedly different turn. More females than males had at least grade *10-12 education*. The number of females with *less than grade 9* also fell markedly compared with males. Perhaps this points to the long held tradition of *Men* forgoing education to gain employment and in a lot of cases to '*help out the family*' and appears consistent with females opting out of education to '*raise a family*'.

The level of education over the whole population speaks to the urgent need for attention to the underlying causes of the predicament this group finds itself in. As referenced below, the level of education in this group clearly shows them to be sufficiently educated to be able to obtain entry-level work if that was the only barrier to employment.

Table-2 **Education Based on Gender**

	< Grade 9		Grade 10-12		> Grade 12		Totals	
	#	%	#	%	#	%	#	%
Female	4	*5.6*	8	*11.3*	13	*18.3*	25	*35.1*
Male	10	*14.1*	11	*15.5*	25	*35.2*	46	*64.9*
Totals	**14**	*19.7*	**19**	*26.8*	**38**	*53.5*	**71**	*100*

Table-3A **Education Based on Age**

	<19				20-34						Totals	
	<Grade 9		Greade10-12		< Grade 9		Grade 10-12		> Grade 12			
	#	%	#	%	#	%	#	%	#	%	#	%
Female	1	*1.4*	1	*1.4*	0	*0.0*	1	*1.4*	3	*4.2*	25	*35.2*
Male	1	*1.4*	0	*0.0*	1	*1.4*	1	*1.4*	6	*8.4*	46	*64.8*
Totals	2	*2.8*	1	*1.4*	1	*1.4*	2	*2.8*	9	*12.7*	71	*100*

Table 3B **Education Based on Age**

	35-54						>55						Totals	
	< Grade 9		Grade 10-12		> Grade 12		< Grade 9		Grade 10-12		> Grade 12			
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Female	2	*2.8*	4	*5.6*	8	*11.3*	1	*1.4*	2	*2.8*	2	*2.8*	25	*35.2*
Male	5	*7.0*	9	*12.7*	15	*21.1*	3	*4.2*	1	*1.4*	4	*5.6*	46	*64.8*
Totals	7	*9.8*	13	*18.3*	23	*32.4*	4	*5.6*	3	*4.2*	6	*8.4*	71	*100*

Tables 3A and **3B** above show the clear breakdowns in education relative to age group. As the rest of the findings will bear out, this is not the *only* or *most significant* barrier to meaningful work. The combination of health issues and addictions, and the persistent cycle of poverty keep this group stuck in a seemingly futile fight to improve their situations.

There was clear indication that these consumers are not transient by nature, as evidenced by **Table-4** and **Table-4A.**

Table-4	Original Hometown							
	HRM		Not HRM		Not Nova Scotia		Totals	
	#	%	#	%	#	%	#	%
Female	14	*20.0*	1	*1.5*	9	*12.9*	24	*34.3*
Male	27	*38.6*	8	*11.4*	11	*15.7*	46	*65.7*
Total	**41**	***58.6***	**9**	***12.9***	**20**	***28.6***	**70**	***100***

Table-4-A	Current Residence by Area													
	Civic Address													
Gender	**Bedford**		**CB EP WS**		**Dartmouth Other**		**Dartmouth Downtown**		**Halifax**		**Sackville**		**Total**	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Female	1	*1.4*	4	*5.7*	10	*14.3*	8	*11.4*	1	*1.4*	1	*1.4*	**25**	***35.6***
Make	0	*0*	3	*4.3*	16	*22.8*	22	*31.4*	4	*5.7*	0	*0*	**45**	***64.2***
Totals	**1**	***1.4***	**7**	***10.0***	**26**	***37.1***	**30**	***42.8***	**5**	***7.1***	**1**	***1.4***	**70**	***99.8***

(CB EP WS – Cow Bay Eastern Passage Woodside)   (Totals not 100% due to rounding)

The data clearly shows that the vast majority (*58.6%*) of the sample was born here or consider *HRM* to be their hometown. The interesting finding here is that the level of migration to *Nova Scotia* from outside the province (*28.6%*) is more than double the migration within *Nova Scotia* (*12.9%*).

Another facet of the Demographic is *Ethnic Identity.* The ethnic identity was represented as
- *Caucasian 85.5%*
- *Aboriginal Nova Scotian 12.7%*
- *African Nova Scotian 2.8%*

Aboriginal people represent 1% of *HRM* population and we find that they constitute almost 13% of this sample. This Ethnic population is very much over-represented. The same observation was noted in *Homelessness in HRM-A Portrait of Streets and Shelters 2004*.

Conclusion

Survey respondents were predominately male except in the under 19 years category but only 4.2 % of respondents were in that age group. Traditionally this population using drop in meal programs has been male dominated but perhaps the presence of young women is evident of emerging unattached youth issues and the need for women to be involved with such programs. Respondents reported high levels of secondary education such as high school completion yet income sources were primarily forms of government

income transfer such as provincial income assistance. There appear to be barriers to employment income opportunities. Either marketable skills or access to the labour force are not sufficient for economic sustainability or personal health status, permanent disability, such as mental illness or serious health conditions. These barriers do not appear to be addressed by current developmental or supportive services and his situation bears further investigation. A look at health status will likely provide a more in-depth understanding of employment barriers.

The respondents appear to be local and not transient. Most live in downtown Dartmouth. Aboriginal respondents are over represented in the survey and this may speak to the lack of aboriginal-centered support services in the Dartmouth area, another issue that warrants more examination.

Section II. Meal Program Usage
"How often do you use meal programs?"

The availability of and access to food is one of the things *most* Canadians and Nova Scotians take for granted. Not eating breakfast because you choose not to is different from not eating breakfast because you cannot afford it. Of the respondents surveyed, *78.7%* **(Table 5)** said that they don't eat breakfast. The reasons cited varied around a central theme of not having been able to have it for so long that now it just isn't something they do.

Table 5	Yes		No		Totals	
	#	%	#	%	#	%
Female	5	*7.1*	20	*28.7*	25	*35.7*
Male	10	*14.2*	35	*50*	45	*64.3*
Totals	**15**	*21.3*	**55**	*78.7*	**70**	*100*

Do You Eat Breakfast? (title spanning table header)

> There are *no breakfast programs* (*for adults*) in Dartmouth and the resources of the servicing agencies and groups are stretched very thin.

Using the numbers provided by the *F.O.O.D*, the usage patterns are predictable based on time of the week and time of the month. To provide meals to as many people as *F.O.O.D* does (*2813 meals in April*) [*], paints a telling picture of the plight that this group of people experience. Consumers at F.O.O.D. are rotating in and out and changing almost daily. See **Table 6** for the numbers of the sample using meal programs.

Table 6	Female		Male		Total	
	#	%	#	%	#	%
Daily	12	*17.1*	12	*7.1*	24	*34.3*
Weekly	4	*5.7*	20	*28.6*	24	*34.3*
Monthly	1	*1.4*	2	*2.9*	3	*4.3*
Occasionally	8	*11.4*	11	*15.7*	19	*27.1*
Total	25	*35.7*	45	*64.3*	70	*100*

Meal Programs Used (title spanning table header)

Statistics from *Feed Nova Scotia* (*formerly The Metro Food Bank Society*) affirm the year over year increase in food bank usage since their formation in 2002. The cross cultural and socio-economic boundaries are quickly vanishing when it comes to hunger. According to the November 2005 report - *Nova Scotia Hunger Count – Supplement[7],* during 2004 alone, food bank usage has increased 7.6%.

Single people and lone-parent families account for two-thirds of all food bank clients in the province. The disabled closely follow this group. Also increasing is the number of working poor (especially young people) who are barely scraping by on low-paying minimum wage jobs. The report notes, "***…if food bank demand is consistent, is it truly***

emergency food relief food banks are providing? Or is it accurate to say that food banks are filling a gap in our social safety net that places little importance on ensuring the most vulnerable in our society are food secure?"

* **Appendix VI**

While the *Department of Community Services* defines food as a basic necessity *three-quarters of the respondents to our survey* are receiving *Income Assistance*, and yet appear to be quite food *insecure.* As stated later in this report, Income Assistance is not sufficient to provide food security.

> *"F.O.O.D. program is great. No questions asked just nice people who seem to care. They do an awesome job."*
> **39- year-old female respondent**

Conclusion

Breakfast as the basis of daily nutrition was not an option for almost 80% of survey respondents. Affordability was the issue. It should be noted that there is no available breakfast program available in the downtown Dartmouth area for people in need of such a service. There is no daily supper program either.

One third of the respondents, half of whom were female, used the F.O.O.D. Lunch program on a daily basis. Another one third of respondents reported they used the lunch program on a weekly basis and most of those were male. It seems men may be able to find alternate food sources. This may perhaps be due to mobility issues and safety concerns. Since most of the respondents rely on a social income, primarily provincial Income Assistance Allowance it would seem that the allowances are not sufficient to keep the food budget reserved for nutritional requirements. If we look at the housing costs we can see where most of their limited income goes leaving little for addressing basic nutritional needs. Reliance on only a midday meal, daily or weekly, and the absence of breakfast meal likely has severe implications for sustaining overall health and well-being. Existing health conditions will be aggravated or heightened by improper diet. Extended periods of poverty is a link to the determinants of health. One could surmise that ongoing failure to nourish oneself will lead to greater health risks for the individual and ultimately higher health care costs.

Section III. Health
"Do you have health problems?"

World Health Organization:
Health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity[8].

Just under three-quarters (73.2%) of respondents indicated *health problems* (**Table-7**). These were defined as conditions of an on-going nature that negatively impact quality of life. For the most part, these were serious illnesses requiring regular medications and monitoring. They run the gamut from allergies and asthma to cancer.

Table-7	Health Problems					
	Yes		No		Totals	
	#	%	#	%	#	%
Female	20	28.2	5	7.1	25	35.3
Male	32	45.0	14	19.7	46	64.7
Totals	52	73.2	19	26.8	71	100

Figure A:Multiple Health Issues Reported by Respondents

December 2006
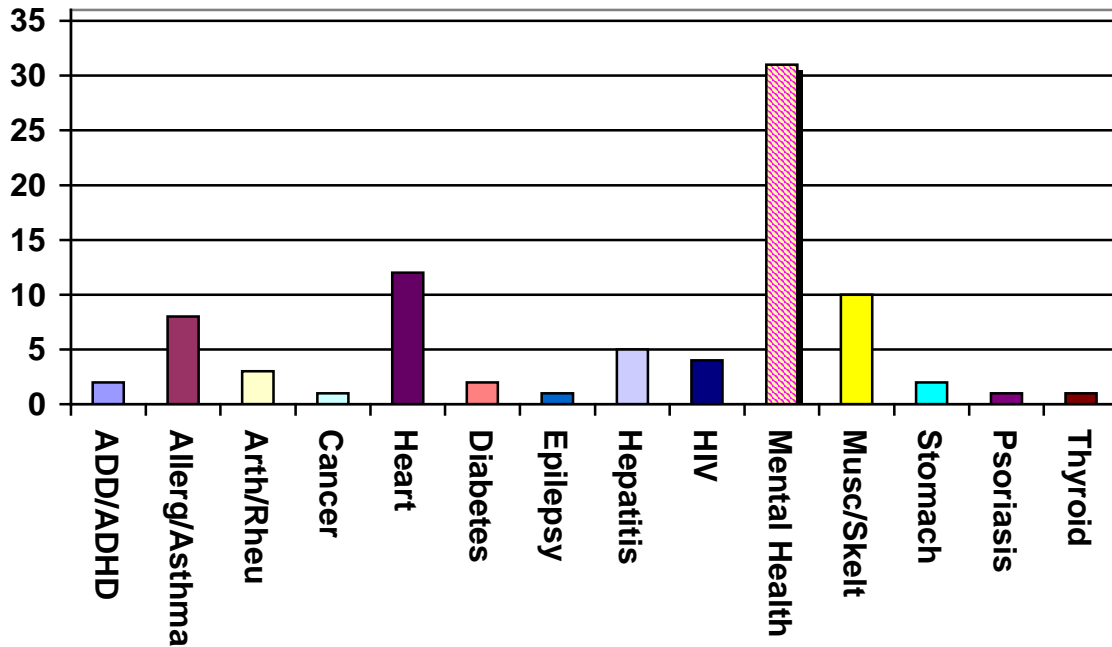
Chart 1 highlights the health problems reported. Not included in this count were the problems associated with getting older or the '*usual*' daily living pains.

Chart 1	ADD/ADHD	Allergy/Asthma	Arthritis	Cancer	Cardiac Related	Diabetes	Epilepsy	Hepatitis	HIV	**Mental Health**	Muscle/Skeletal	Stomach	Psoriasis	Thyroid	**Totals**
Female	0	4	0	0	7	0	0	5	3	**10**	3	0	0	0	32
Male	2	4	3	1	5	2	1	0	1	**21**	7	2	1	1	51
Total	**2**	**8**	**3**	**1**	**12**	**2**	**1**	**5**	**4**	**31**	**10**	**2**	**1**	**1**	**83**

(**Certain issues appeared more than once across gender**)

When we address the area of *Health,* it cannot be stated strongly enough that *health* is not only the absence of illness. To be truly *healthy*, one must be active and involved in, and feel part of society and the community in which one lives. Using these parameters, the survey has shown us that this particular group of people not only struggle with *medical illness*, they also face the greater challenge of *access.* Illness can be diagnosed and treated or effectively managed. Exclusion is a disease that we, as a society, have allowed to happen. There is documented evidence which states that segments of population who are unhealthy, adversely impact other segments of the population[9].

The socio-economic turmoil this population finds itself in is detrimental to their health. Continued existence in these circumstances only exacerbates an already difficult situation. The *health related costs of poverty and resulting chronic disease are estimated at $1 Billion annually in Nova Scotia*[10].

The following statement speaks to the heart of this research.

'*Health is multidimensional, involving physical, psychological, social and economic aspects. Social and economic factors are more influential than lifestyle.*[11]'

It is a widely held view that a *healthy lifestyle* is more apt to be practiced by those with higher incomes, reinforcing the earlier opinion that economic and social factors play pivotal roles in health and well-being.

The highest number in this table is *31 instances* of mental health problems. Also noteworthy is the number of HIV cases - 4 and Hepatitis cases - 5. This represents 12.0%

of the female respondents dealing with HIV vs. 2.2% of the male sample and 20.0%
(based on gender) of the females in this sample with Hepatitis.
The occurrence of cardiac related illness is high, with 16.9% reporting cardiac related
issues. The magnitude of these illnesses and the subsequent health problems only
compounds the situation.

Based on information from Statistics Canada, Nova Scotia is the unhealthiest of the
Atlantic Provinces and chronic disease related health care accounts for 60% of medical
costs. Additionally, Nova Scotia has the lowest, disability –free life expectancy in the
country[12]. Healthy lifestyle alone without changes in social and economic factors has
been found to be insignificant in changing health outcomes.

The increase in people experiencing multiple health problems in combination with
addictions (see **Table 8**) is further compounding the situation. The continuous
struggle erodes whatever level of health that did exist and lays the groundwork for
numerous other health-related issues.

Table 8		**Health Problems and Multiple Addictions**				
	Yes		No		Total	
	#	%	#	%	#	%
Female	2	*2.8*	23	*32.4*	25	*35.1*
Male	5	*7.0*	41	*57.7*	46	*64.9*
Totals	**7**	*9.8*	**64**	*90.1*	**71**	*100*

These problems are not going to get better. Over time they will worsen. Those who
are lucky enough to reach old age will be some of the unhealthiest, with the worst
quality of life.

*"Spent many years in the business community. Now my health is failing. CPP
disability doesn't cover drugs. I still feel like a drain on society. Shouldn't be that
way at my age and all I've contributed."*
   64-year-old male respondent.

Conclusion

It would appear that a population of people with fair to middling education and employability potential have been excluded from reaching potential because of long-term health conditions as well as poverty. Health problems are by and large serious in nature. The reported level of mental illness is notable. The range of health problems reported by respondents in the survey indicates that health issues are trumping education and employability characteristics. Mental illness is the most outstanding feature of the health profile for this population. Addictions seem to also play a role in compounding overall well-being. Supportive services for addressing long-term health problems and addictions should be further evaluated, in particular mental health strategies.

Section IV. Addictions
"Do you live with any form of addiction?"
Addiction was defined for respondents as daily reliance on the substance in question. Not occasional or recreational use. More specifically needing the substance to get through the day and having little or no control over usage. The addictions (alcohol, drugs and gambling) were self-identified by the respondents. Cigarettes were not included so as not to skew the results.

The knowledge that 51.4% (**Table 9**) of this sample indicated some form of addiction tells us that more than half of this sample has double the struggle. These addictions include alcohol, drugs and gambling. Gambling has no outward signs that the person is a 'user'. This complication added to the stress of struggling to survive impedes any manner of progress and makes the situation seem insurmountable.

The most telling thing on this topic is that the greater percentage of those with an addiction or multiple addictions is better educated. It appears that something in life just went the wrong way and getting back isn't that easy. It could be a major life trauma, illness or a combination of life events. Whatever the reason, the situation for these people just gets worse. **Table 9** through **14** point to the details uncovered by the research.

Table 9   Addictions

	Yes		No		Total	
	#	%	#	%	#	%
Female	9	12.9	16	22.8	25	35.7
Male	27	38.6	18	25.7	45	64.3
Totals	36	51.4	34	48.6	70	100

51.4% reported at least 1 addiction

Table 10   Alcohol Addiction

	Yes		No		Total	
	#	%	#	%	#	%
Female	2	2.8	11	15.5	13	18.3
Male	23	32.4	35	49.3	58	81.7
Totals	25	35.2	46	64.8	71	100

Alcohol   **35.2%**

Table 11   Drug Addiction

	Yes		No		Totals	
	#	%	#	%	#	%
Female	7	10	18	25.7	25	35.7
Male	15	21.4	30	42.8	45	64.3
Totals	22	31.4	48	68.6	70	100

Drugs   **31.4%**

Table 12   **Gambling Addiction**

	Yes		No		Totals	
	#	%	#	%	#	%
Female	3	*4.2*	22	*30.9*	**25**	*35.2*
Male	11	*15.5*	35	*49.3*	**46**	*64.8*
Totals	**14**	*19.7*	**47**	*66.2*	**71**	*100*

    Gambling   **19.7%**

Table 13   **Other Addiction**

	Yes		No		Total	
	#	%	#	%	#	%
Female	0	*0.0*	25	*35.7*	**25**	*35.7*
Male	2	*2.8*	43	*61.5*	**45**	*64.3*
Totals	**2**	*2.8*	**68**	*97.2*	**70**	*100*

    Other addictions   **2.8%**

Table 14   **Multiple Addictions**

	Yes		No		Total	
	#	%	#	%	#	%
Female	3	*4.2*	22	*31.0*	**25**	*35.2*
Male	8	*11.3*	38	*53.5*	**46**	*64.8*
Totals	**11**	*15.5*	**60**	*84.5*	**71**	*100*

    15.5% reported more than 1 addiction

More than half of those indicating some form of addiction reported they were not getting support in this struggle (**Table 15**).

Table 15   **Getting Help for Addictions?**

	Yes		No		Total	
	#	%	#	%	#	%
Female	4	*11.1*	5	*13.9*	**9**	*25*
Male	13	*36.1*	14	*38.9*	**27**	*75*
Totals	**17**	*47.2*	**19**	*52.8*	**36**	*100*

They also told us they didn't know where to get this kind of help (**Table-16).**

Table 16   **Know Where to get help for Addictions?**

	Yes		No		Total	
	#	%	#	%	#	%
Female	5	*13.9*	4	*11.1*	**9**	*25*
Male	16	*44.4*	11	*30.5*	**27**	*75*
Totals	**21**	*58.3*	**15**	*41.7*	**36**	*100*

To give perspective to these findings, it should be noted that the following questions were asked during the in-depth interviews. Of the 20 respondents who took part in that portion of the survey, 7 indicated living with some type of addiction. As indicated by **Table 16A**, the 'consequences' of addiction are evident within this sample as well.

Table 16A   **Issues Arising From Living With Addiction**

	Denied Service				Isolation				Legal Problems				Lost Family/Friends				Totals
	Yes		No		Yes		No		Yes		No		Yes		No		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Female	0	0	2	33.3	1	14.3	1	14.3	0	0	2	28.6	2	28.6	0	0	7
Male	1	16.7	3	50.0	3	42.8	2	28.6	1	14.3	4	57.1	4	57.1	1	14.3	13
Totals	1	16.7	5	83.3	4	57.1	3	42.9	1	14.3	6	85.7	6	85.7	1	14.3	20

Denied Service means not being able to enter a food bank, soup kitchen or shelter due to intoxication. Isolation means feeling disconnected from society as a direct result of having an addiction. Legal Problems refer to past or pending legal consequences resulting from addiction. Include but not limited to DUI, possession, and theft etc. Lost family and friends tries to gauge the impact of family and friends not knowing what to do to help the addict.

This speaks to how addiction affects their quality of life, well-being and overall health.

> "*Dry now 24 years. Struggle everyday. Especially now. Better physical activity program would help get a guy through that rough patch.*"
>   **53-year-old male respondent**

Conclusion

The reported levels of addiction are telling as well. Over half reported having addictions; a third identified alcohol and almost another third reported addictions to drugs. Almost 20% reported gambling addictions. Over half reported they received no support in addressing addictions problems. The reasons for this are varied and hard to pinpoint since the survey did not delve into this area. However, lack of access to the benefits of supportive services, participation in the life of the broader community and limits to participation in many other positive life experiences due to isolation and poverty could likely be linked to the notable level of addictive behaviours.

Investment and strategies related to supportive services that would address long term health and well-being needs are something that require serious consideration and review. Further investigation is required to determine if there are serious gaps or inconsistencies or access problems related to service delivery in this sector that could prevent or mitigate the impacts of poor health and addictions.

Section V. Income Source
"What is your main source of income?"

Income levels are a key component of the survey. Respondent's income level is one-quarter to one –half of the national LICO[13]. This puts their living situation into perspective.

Income Assistance rates are so low that most clients are in a deficit position at the beginning of every month. Rental rates are high[14] and most consumers are taking from their living allowance in order to pay the rent.

Based on 2004 figures published by the *Minister of Public Works and Government Services Canada,* Income Assistance Allowances for *Nova Scotia* were not the lowest in the country; (only PEI and Alberta were lower) however, they were in the lowest three (3) provincially. [15]

Table 17						
What is your main Source of Income?						
	Earned		**Social**		**Totals**	
	#	**%**	**#**	**%**	**#**	**%**
Female	5	*7.5*	18	*26.9*	23	*34.3*
Male	12	*17.9*	32	*47.7*	44	*65.7*
Totals	**17**	***25.4***	**50**	***74.6***	**67**	***100%***

Consider **Table 17**, where 74.6% of the survey sample indicated having a *Social Income*[*] rather than an *Earned Income*[**], and based on the *Income Assistance Allowances*[16] one might conclude that the pattern of need rises and falls with the receipt of income.

*Social income defined as government transfer payments to individuals such as Income Assistance or government provided Pension income other than CPP Disability.
** Earned Income defined as any other form of income including employment, work related pension, or CPP Disability that has an employment attachment in order to be eligible.

Below are the *Nova Scotia Department of Community Services Income Assistance Allowances* for 2004 **Chart 2**. A quick glance tells how extremely low Income Assistance rates are. When comparing the level of assistance with the *Low Income Cut Offs*, keep in mind that three-quarters of respondents receives this extremely low amount.

Chart 2   Estimates of Annual Income Assistance Allowances in Nova Scotia (2004)[17]

Nova Scotia	Basic *	Additional **	Child Tax Benefits	GST	Total	LICO ***
Single Employable	**$4992**			$220	$5212	$17515
Person with Disability	**$8592**			$249	$8841	$17515
Single Parent 1 Child	**$8772**		$3356	$556	$12684	$21804
Couple 2 Children	**$11544**	$150	$6229	$672	$18595	$32546

The Basic Assistance Rates are what the Province provides. The Child Tax Benefits and GST are primarily Federal and available to ALL Nova Scotians who fall within the qualifying income guidelines.

The cutbacks in government social spending at both the Federal and Provincial levels have created an environment where rates of *Income Assistance* would need to be more than tripled[18] to keep pace with the increasing cost of living. That is not to say that an infusion of money would '*fix*' the current situation.

When you factor in the increased charges and user fees governments have instituted, increases in electricity, heating fuel and gasoline, without providing an offsetting increase in social income, then *Income Assistance* levels are actually lower than they were ten years ago.

There is an abundance of research to point to the merits of a living wage versus a minimum wage. If business is allowed to continue to grow and flourish on the backs (and stomachs) of Nova Scotians because they are only 'required' to pay a minimum dollar amount per hour, living circumstances won't improve.

As cited in "*Time for a Real Raise. The Nova Scotia Minimum Wage*"[19], young people and other employed Nova Scotians are not choosing to stay at home longer; they simply cannot afford to move out on their own. They work, but too few earn enough money working for minimum wage to be able to pay rent, buy groceries, get around and have any kind of social life. A *living wage* would not cause such hardship, it would allow people the dignity to have their own place and not have to work 2 or 3 jobs to make ends meet. The culture that this system creates is independent, motivated and stable. We are already aware of the alternative and it's not working.

<div style="border:1px solid black; padding:10px;">

"***Work as much as I can. When I can't, go from EI to IA. Should be better system to let that happen. You try and you are punished. Pay taxes (when working) should be able to get services. Not fair.***"

45-year-old male respondent

</div>

  *   *Department of Community Services, ESIA Guide (2004)*
 **   *Additional benefits mean Christmas supplements and school supplies etc.*
***   *Statistics Canada Low Income Cut offs based on number of persons in household in population of 100,000 to 499,999.*

Conclusion

It is clear that poverty serious impairs the ability of the respondents to address many of the issues and challenges they face. The lack of income to acquire the goods and services including, the most basic housing, medical care, such as prescription drugs, nutrition, and healthy living activities, is a great contributor to their exclusion from the mainstream of community life. The mitigating factors of community supportive services appear also to be absent or inaccessible. This is not a new assertion. Most all observers would agree that the level of income is too

Section VI. Shelter and Related Cost

"How much of your income do you spend on shelter (add utilities if not included in rent)?" The most significant finding in this section is that 100% of respondents pay more than *30% of income on shelter!* This shelter cost to income ratio is to be expected. The absolute valueof a social incomes such as Income Assistance are so low that proportionally they cannot cover the real cost of shelter which is often almost half, if not more, of their total monthly allowance. In order for shelter costs to be covered and other basic needs not undermined overall Income Assistance rates must increase to cover real costs.

Table-18 indicates that:
- 82.3% of respondents pay more than *50%* of their income on shelter.
- 54.4% pay between 50 and 75 % of income on shelter
- 27.9% pay more than *75%* of income on shelter.
- 17.6% pay less than *50%* of income on shelter (the least % reported by respondents was *46%*, exceeding the *30%* ratio of income to shelter) [20].

Table 18							Shelter Cost as % of Income
	<50%		50-75%		>75%		
	#	%	#	%	#	%	**Total**
Female	5	7.4	9	13.2	10	14.7	35.3
Male	7	10.3	28	41.2	9	13.2	64.7
Total	12	**17.7**	37	**54.4**	19	**27.9**	**100**

(Total % based on 68 of 71 respondents answering this question.)

A very worrisome fact is that there are *no emergency shelters* (except for victims of domestic violence) *in Dartmouth*. If a *man* finds himself homeless, he has to get across the bridge to 'get in line' for *YMCA* or *Metro Turning Point*. The former is usually full and the latter is considered by many men not to be the safest of places.

As demonstrated by the data, the ratio of shelter cost to income is disproportionate. Bear in mind that this is in a population that starts each month in a deficit. Spending less on shelter doesn't put more food on the table, because under the current Income Assistance scheme, these consumers will not better their situation by finding '*cheaper accommodations*' because their shelter rates are tied to the *Actual Cost* of shelter up to the allowance maximums which are not tied to real costs.

According to the latest information available from *Statistics Canada*[21], the housing market has gone through a substantial shift in the past several years. The need for single person housing has outpaced construction in the '*affordable*' rental market. This is due in part to the fact that more single person homes are now comprised of seniors as spouses pass on and children have moved out. Also, more family units are breaking down, creating more lone-parent and single person situations.

The concerns for safe, adequate and affordable housing have been on the public radar for many years. These concerns have reached epidemic proportions in this country and here

in our province. Locally, we have the task of addressing the issue as we see more and more vulnerable and at-risk people on our streets.

Urban core areas, which are traditionally, the home of many as represented by our survey population. Pressures to intensify density in the urban core and consumer desire to move toward the urban centre can threaten the habitat for vulnerable peoples. Areas are being squeezed to accommodate new '*developments*' without consideration for the people at risk of being displaced by growth. Redevelopment of neighbourhoods can result in the loss of older homes that may have traditionally offered affordable rental housing such as '*rooms*' and '*bed-sits*'.

Some responsibility must be assumed on the part of developers to '*give back*' to the community that makes them successful. It is the responsibility of *society* to demand that it gets done… sooner rather than later. Many municipal governments provide incentives to builders and developers to include affordable units in their projects. Planning policies can also encourage more affordable units spread throughout communities. Communities can also be more involved in supporting affordability in housing by being more inclusive while also seeking good planning and development practices.

Chart 3   **Average Monthly Rents for Halifax CMA by Bedroom Type (2003-2005)**

Type of Dwelling	2003	2004	2005
Bachelor	$537	$560	$552
1 Bedroom Apartment	$596	$612	$626
2 Bedroom Apartment	$720	$747	$762
3 Bedroom Apartment	$955	$1,014	$946

Source: CMHC Annual Rental Market Survey Halifax CMA 2003, 2004, 2005[22]

Housing costs have risen because of a stronger economy and, the most vulnerable are left behind.

USA; *Stewart B McKinney Homeless Assistance Act (1987)* [23] includes in its definition of those at economic risk of homelessness as those **"… *spending more than 50% of their income on shelter.*"** According to our data, 82.3% are paying more than 50% toward shelter. The reality is that these people live in constant fear of becoming homeless. One unforeseen event or misstep completely upsets the delicate balance. This is not a new concept. *The Federation Of Canadian Municipalities (FCM)* has been trying to bring this issue to the fore since 1998, going so far as to call it "*Canada's national disaster*"[24].

If Income Assistance allowances are not changed to keep pace with the new market place, the most needy and 'at risk' will continue to pay a high price, both economically and socially and will become more '*at risk*'[25] or absolutely homeless. Ultimately, we all pay in lost productivity, reduced sustainable workforces and mounting health care costs.

Chart 4	Shelter Comparisons: Shelter Rates vs. Rental Prices		
Family Size	**Maximum Shelter Allowance Rent/Own Home***	**Average Monthly Rents for Halifax****	
1	$285	1 Bedroom	$626
2	$550	2 Bedroom	$762
3+	$600	3 Bedroom	$946

*Chart-2 page 19   **Chart-3, page 22

> "*Need social housing program. Landlords take advantage of us and DCS lets them. Been homeless and its not fun. If things don't improve I might be again.*"
>   **27-year-old male respondent**
>
> DCS means Department of Community Services

Conclusion

All of the respondents paid more than 30% of their income on housing. The 82.3% paying over 50% of their income on shelter can be considered homeless or at best at risk of homelessness. There is an obvious case to be made for a lack of housing security. The cost of housing is compromising the ability of the sample population to meet their most basic needs. But even more fundamental is the fact that low incomes are the real problem. People are not bringing in sufficient income to acquire and sustain decent, appropriate housing that does not cost more than 30% of their income.

Efforts by community based service providers and voluntary agencies such as churches are to be commended but they too require added supports from the broader community to adequately meet the needs of those they seek to assist. A coordinated effort to both raise income and contain or reduce the costs of housing is a strategy that should be more productive and should include an investment in housing support services for more vulnerable households.

Section VII. Access to Supports
"Can you get the support you need?"

Access to Community Support is one of the identified areas where more needs to be done to improve the lives of those in greatest need. Having the knowledge of and ability to access the support available can create immediate improvements in the lives of those affected.

With regard to this section, some interesting things came to light. There seems to be a huge gap in having the services available and getting the word out there. Information gathering is done at the street level.

When asked about how they get information about services like *F.O.O.D*, respondents by and large indicated word of mouth. They also told us that they get more information through the staff and volunteers at *F.O.O.D.*
2 of 20 (*10%*) of people indicated that their worker provided information on other services available. The following tables, **19, 19A** and **19B** indicate the inability of these respondents to access some of the services we all take for granted. These areas were addressed during the in-depth interviews conducted with 20 respondents.

Table 19 — **Most Important Supports**

	Specific daily supports needed											
	Employment		Food		Housing		Mental Health		Pharmacare		Totals	
	#	%	#	%	#	%	#	%	#	%	#	%
Female	0	0	2	10.5	3	15.8	4	21.0	2	10.5	7	**36.8**
Male	12	63.2	2	10.5	9	47.4	9	47.4	2	10.5	12	**63.2**
Totals	**12**	**63.2**	**4**	**21.0**	**12**	**63.2**	**13**	**68.4**	**4**	**21.0**	**19**	**100**

Table 19A — **Access to supports**

	Can you get this support?																			
	Employment				Food				Housing				Mental Health				Pharmacare			
	Yes		No		Yes		No		Yes		No		Yes		No		Yes		No	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Female	0	0	0	0	0	0	2	10.5	0	0	3	15.8	1	5.3	3	15.8	0	0	2	10.5
Male	1	5.3	11	**58.0**	1	5.3	1	5.3	0	0	9	47.4	2	10.5	7	36.8	1	5.3	1	5.3
Totals	**1**	**5.3**	**11**	**58.0**	**1**	**5.3**	**3**	**15.8**	**0**	**0**	**12**	**63.2**	**3**	**15.8**	**10**	**52.6**	**1**	**5.3**	**3**	**15.8**

Totals column: Female 7 | 36.8; Male 12 | 63.2; Totals 19 | 100

Table 19 B — **Access to supports**

	Do you know how to get this support?																			
	Employment				Food				Housing				Mental Health				Pharmacare			
	Yes		No		Yes		No		Yes		No		Yes		No		Yes		No	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Female	0	0	0	0	1	5.3	2	10.5	0	0	3	15.8	1	5.3	3	15.8	0	0	1	5.3
Male	1	5.3	10	52.6	1	5.3	1	5.3	0	0	9	47.4	2	10.5	8	42.1	1	5.3	0	0
Totals	**1**	**5.3**	**10**	**52.6**	**2**	**10.5**	**3**	**15.8**	**0**	**0**	**12**	**63.2**	**3**	**15.8**	**11**	**57.9**	**1**	**5.3**	**1**	**5.3**

Totals column: Female 7 | 36.8; Male 12 | 63.2; Totals 19 | 100

Sometimes this is a good thing and other times it has the opposite effect. As an example, if one person has a social worker who is empathetic and compassionate and '*gets*' something for a client, that will spread like wildfire. The clients will then try to get that worker assigned as their own. Not that a client getting something they need is a bad thing, absolutely not. Also, some clients are under the old Income Assistance model. They were '*grand fathered*' to certain things that may or may not be available in the current structure. So they learn from each other the possible support they can get.

There is a visible inconsistency in the quality of social work staff combined with inconsistent application of policy. Lack of access to Income Assistance programs shows the need to review practices and application of policy. There also needs to be a more visible support structure in the community for those suffering from Mental Health issues.

A possible solution would be informing *all* the clients about their *entitlements.* That will save a lot of confusion and frayed nerves for everyone in the long run.

> "*Now at Mount Hope. It's a good program. Before I was in and out all the time…like no one cared. Involved in meal program, community (NS Hospital) meetings, leisure planning, WRP (Wellness Recovery Program). I have so much hope now.*"
> **37-year-old female respondent**.

> "*Would like to get GED. Asked worker about it, she laughed in my face. Don't remember her name…it was a while ago.*" **38-year-old male respondent.**

Conclusion

The survey gathered responses from a selected audience and the responses are cause for grave concern. If the only access to community services and supports is through one worker who is dealing primarily with eligibility and financial assistance and has limited contact with their client it would appear that the individuals receiving income assistance do not have adequate access to the existing range of support services and thus poses the question of what gaps in service need to be addressed and supports put into place in order to raise the standard of care to more effective levels.

There is a *need* for someone to help others navigate through the system to gain access to programs not visible to the client on their own. Follow up and monitoring for success is also part of successful support. Accountability and performance measures need to be in place to document is the client was well served and their needs were meant.

Consistency of service delivery arises again. Much could be done to improve people's lives with moderate increases in expenditures. It is not surprising that one might conclude that more money is needed in the system to raise quality of life for vulnerable persons.

Section VIII. Community Interaction
"Do you feel part of your community?"
"Do you feel the community cares about you?"

Community is a term that evokes different things for all of us. We live and work in a community of some sort. Knowing that we belong and are cared for forms the basis of a strong and vibrant community. The absence of that basic feeling creates isolation and exclusion.

When you can't be part of your community because you don't have the economic resources to take part, you are excluded. That isn't a *choice.* You can *choose* to ignore your neighbour (s), but when you don't have bus fare and are unable to walk (due to health issues) to take part in the community, that isn't a *choice*. The inclusion of all members of society in *our community* is the best thing for all citizens.

When the participants were asked to answer questions based on community, they were told to use their own definition of community and what it meant to them. For the most part, they spent the most time (based on response time to the other questions) thinking about this question and how it applied to them. The responses might be considered surprising. However, given the context in which the respondents thought about the question it makes sense.

The answers to both questions (top of page) were split almost down the middle in both cases.
- *49.3%* felt they were part of the community while *50.7%* did not
- *50.7%* felt that the community cares about them while *49.3%* did not

What's most interesting here is that the gender split was in favour of males feeling positively in both cases.

The respondents were asked if they felt that programs like *F.O.O.D* are important in the community. As **Table 20** indicates, 83.1% said that programs in the community are very important.

Table 20	Importance of Programs in the Community					
	Very		Somewhat		Total	
	#	%	#	%	#	%
Female	21	*29.6*	4	*5.6*	25	*35.2*
Male	38	*53.5*	8	*11.3*	46	*64.8*
Total	**59**	*83.1*	**12**	*16.9*	**71**	*100*

This clearly indicates that these programs and services are valuable and valued in the community that they aim to serve.

> "*Who really cares about anyone…most of us hardly care about ourselves.*"
> **23-year-old female respondent.**

Conclusion

Social inclusion requires that individuals have open access to the systems and institutions of society overall and locally within their community. The ability to participate and contribute requires access to certain resources. Most of us would believe that each individual has worth and value and should be part of the whole community. Most philosophies of our different and diverse communities have tended to support such a position. No one is to be discarded because of lack of wealth, health, background, skills or education. Yet based on the results of this survey we find that almost all of the respondents are excluded from participating in our community due to poverty, physical and mental illness and disabilities, mobility status and housing. Half did not feel part of the community and half did not think the community cared about them. It may be that they are being overly polite. This observation should give us all pause to think of how we help those among us who need our support.

Endnotes

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11. IBID, p. 7

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21. Statistics Canada; http://www.statcan.ca/english/research/

22. CMHC Annual Rental Market Survey Halifax CMA 2203, 2004, 2005;
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Homelessness.* Mars and Springer. Toronto 1998.

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Appendix I Core User Survey - Themes

1. USAGE

How often do you use FOOD/Margaret's House for meals? # of meals and # of days

What similar types of services do you use? (Food banks, other meal programs, shelters)
(Will be dealt with in detail in another theme)

How did you find out about FOOD/Margaret's House?

How did you find out about other types of services?

Do you live close to Margaret's House?

If not, how far do you travel to get here?

How do you get here?

How essential is this program (FOOD) to help you maintain your health?
Do you feel safe coming here?

Is the food fresh, tasty and adequate?

Is the social aspect (meeting and making new friends and connections) of coming to Margaret's House important to you?

Have you developed new friendships by using this program?

2. NEEDS

What would you say is your most pressing **NEED** right now?

Have you indicated this to anyone who may be able to assist you? (Doctor, CS worker etc.)

Are your **BASIC** daily requirements being met today?

If not, what specifically are you lacking in maintaining an adequate life standard? Could you be as specific as possible?

Do you have adequate clothing? Where do you acquire your clothes?

Do you have adequate footwear? Is it waterproof? Is it suitable for winter?
Where did you acquire your footwear?

Do you have the essentials for your home? (Dishes, cookware, cutlery, cleaning supplies, personal grooming, laundry supplies)

3. HEALTH

Do you have health problems?
Please be specific as to what they are.
Do you require regular medications? If so, do you have access to them on a regular basis?

If you require and have access to regular medications, do you take them on a regular basis as they are prescribed?

Do you need assistance with your medications? (Reminders, injections etc.) If so, is that assistance available to you?

As a result of your health problems, do you require special foods?

Are you able to have those special food items regularly?

Have you been hospitalized for your health concerns? If so, most recently when and for how long?

If you have been hospitalized for your health problems, how did that affect the following:
    Income
    Housing
    Social Network (Access to friends & family)

4. SHELTER

Please describe your current shelter situation.
(Do you live on your own; share a place, rooming house, live with friends/family, transitional/supported facility)

Are you responsible for utilities?

What portion of your income do you spend on shelter (include utilities if not included in your rent amount)?

Do you feel safe where you live?

Are there issues with your accommodations that are not being addressed by your landlord or someone else?

How long have you been in that living arrangement?

Are you happy where you are?

Do you want to move but are unable?

Do you live close to things you need like transportation, grocery store, and drugstore, doctor?

5. INCOME

What is your main source of income?
If you work, how many hours/days do you work?
How do you get to and from work?
How long have you been there?
Is this work in relation to your training?

Is your Income Assistance sufficient to sustain your basic needs?
How much money are you short each month?

How do you make up that difference?
The old saying goes; "Something's gotta give."

What do you have to give up each month to survive?

6. ADDICTIONS

Do you live with any form of addiction?
(Alcoholism, drugs, gambling etc.)

Do you have any support in this struggle?

Do you know where to get the necessary help you need?

Are you discriminated against with regard to community support because of your addiction(s)?
(Not allowed into or ejected from shelters, day programs, soup kitchens.)

Do you have legal problems because of your addictions?
(Have you been arrested, jailed etc.)

Have you been shunned by family and friends because of your addictions?

7. SUPPORTS

What kind of programs do you use to help you survive?

Are you aware of the services available to you?

How important are programs and services like FOOD to your survival?

What would you say is the most important support system you need on a daily basis?

Do you have access to these supports? Do you know how to access them?

If you could develop a program to address support issues, what would be at the top of that list?

Are the existing systems working?

How do you think they could be changed to provide the best benefit?

What role, in your opinion, does government play in alleviating this situation?

Do you feel the government departments responsible are doing a good job?
What needs to be changed to deliver the best result to the most affected?

Appendix II Core User Survey - CONFIDENTIALITY AGREEMENT

By signing this statement, I am indicating my understanding of my responsibilities to maintain confidentiality and agree to the following:

❑ *I understand that names and any other identifying information about survey participants are completely confidential.*

❑ *I agree not to divulge, publish, or otherwise make known to unauthorized persons or to the public any information obtained in the course of this research survey that could identify the persons who participated in the survey.*

❑ *I understand that I am not to read information and records concerning survey participants, or any other confidential documents, nor ask questions of survey participants for my own personal information but only to the extent and for the purpose of performing my assigned duties on this research survey.*

❑ *I understand that a breach of confidentiality may include a termination of the survey.*

❑ *I agree to notify **The Public Good Society**, at the address below, immediately should I become aware of an actual breach of confidentiality or a situation, which could potentially result in a breach, whether this is on my part or on the part of another person.*

_____ _____ _____
Signature   Date   Printed Name

Service Address:
The Public Good Society
47 Wentworth St,
Dartmouth, NS B2Y 2T1
(902) 463-7619

Appendix III - INFORMED CONSENT FORM

Participation is entirely voluntary. (If at any time you are uncomfortable with any question or continuing the process, we will end the interview at your request.)
 Interview and Identity will be kept anonymous. (Full names or identifying information will **NOT** be used on any forms or the Survey)
The Survey papers will be given an identification number only. Only total numbers of answers to the questions will be used in the reports.
You can choose not to answer any question or you can stop the interview at any time.
Participation doesn't affect your use or need of services in any way. Only the Interviewer will know any person participated in the Survey. All people involved have taken an oath of confidentiality.

Do you have any questions about the Survey or what is expected of your participation?

Has everything been fully explained to you?

Please indicate if you:

 [] Agree to take part   [] Decline to take part

 "I will sign my name to indicate that I have agreed to participate as set out above, and I will only provide my initials or first name. (We are not asking you to sign your full name so your identity can be kept confidential and anonymous)."

_____   _____
Date   Researcher

_____
Participant's initials or first name   _____(Initials)

Case No.		

Appendix IV Core Service User Survey- **Interview Version**

Hi/Hello: Can I ask you some questions? Say why. Go over informed consent.

Year of birth [__/__/__]
Gender M [] F [] Other []
Ethnic Identity _____
Hometown_____
Family status
 Single [] Married [] Divorced [] Widow/er []
 # Dependants ____ Ages _____
Education []<gr.9 [] Grade 10- 12 [] >Grade12

Please describe your current housing situation.
[] Live on your own   [] Share a place
[] Rooming house   [] Live with friends/family
[] Transition/ supported facility [] Shelter
[] No fixed address
If you Rent /own is it private or public housing?
[] Y [] N
If Y, is it family or Senior housing?
[] Family [] Senior
Is there a kitchen or one you can use?   [] Y [] N
Is there a secure place to store food?   [] Y [] N

How often do you use meal programs?
[] Daily
Where? _____   # Meals? _____
[] Weekly
Where? _____   # Meals? _____
[] Monthly
Where? _____   # Meals? _____
[] Occasionally
Where? _____   # Meals? _____

If you couldn't come here where would you eat**?**
_____

Where do you eat breakfast**?**
_____

Where do you eat supper when F.O.O.D isn't open**?**
_____

How did you find out about (F.O.O.D)**?**
[] Family [] Friend [] Church [] Doctor [] Case Worker [] Government Agency [] Other [] No answer
How did you find out about other types of services?
[] Family [] Friend [] Church [] Doctor [] Case Worker [] Government Agency [] Other [] No answer
Do you live close to F.O.O.D/downtown?   [] Y [] N
 <3Blocks>5[]<5 Blocks >10 [] other part of city (If so, where?
(Bedford, Sackville, Westphall, Woodside, Eastern Passage)_____

Can you say where you live? Y [] N []
_____

How do you get here? Walk [] Bus [] Bike [] Car []

How long does it take to get there**?**
Minutes   Hour(s)
[]<10>20 []<20>30   []<1>2
[]<30>45[]<45>60   []<2

Do you find this place comfortable? (Safe/calming)
[] Always [] Sometimes [] Mostly   [] Seldom
[] Almost never

Is the social aspect (friends, connections) of F.O.O.D important to you?
[] Very [] Somewhat [] Not [] Other

Which phrases or statements best describe you when you visit F.O.O.D?
Do you talk to people?   [] Y [] N
Watch and listen   [] Y [] N
Get into the thick of conversations   [] Y [] N
Keep to yourself   [] Y [] N
Like the company of the workers /visitors   [] Y [] N
Have you made friends using this program? [] Y [] N
Do you come with others or alone?
[] Sometimes   [] A lot
[] Seldom [] Never

 Are your *BASIC* needs being met today?
[] Food (source of groceries)   [] Y [] N
Do you buy your own food?   [] Y [] N
Do you use food banks?   [] Y [] N
Nearby (walking distance)   [] Y [] N
Do you prepare your own food?   [] Y [] N
Do you have a phone or access to one? [] Y [] N
Explain_____

 If No, what are you lacking? Please be specific Comments:
_____

Do you have enough clothing?
(Coats, tops, pants etc.)   [] Y [] N
Where do you get your clothes?   [] Buy [] Others

Do you have good footwear?   [] Y [] N
Is it waterproof?   [] Y [] N
Is it comfortable?   [] Y [] N
Where do you get your footwear?
[] Purchase [] donation from others [] other _____

Do you have any foot problems?   [] Y [] N
If Y, please specify_____

Are you getting help for that?   [] Y [] N
Comment_____

When you purchase clothing and footwear, is it**:**
Nearby (walking distance)?   [] Y [] N
[] Affordable [] Unaffordable

Do you have the essentials for your home? [] Y [] N
[] 1. Equipment (furniture, dishes, cookware, cutlery)
[] 2. Cleaning/laundry supplies
[] 3. Personal grooming (soap, shampoo, toothpaste, shaving supplies, feminine hygiene)

Do you have health problems?   [] Y [] N
Please be specific. _____
(Refer to the Clinics section)
Do you require regular medications?   [] Y [] N
Can you get them on a regular basis?   [] Y [] N
Do you get prescriptions or samples from your Doctor?
                        [] Y [] N
If you need and can get medications, do you take them on a regular basis?   [] Y [] N
Do you need help with your medications? (Reminders, injections etc.)
[] Y [] N
 If so, can you get that help?   [] Y [] N
Do you need special foods?   [] Y [] N
Such as :_____

Can you get those special foods regularly?   [] Y [] N

Have you had a health related crisis?   [] Y [] N
 If Y, whom did you contact?
[] Family   [] Support group
[] Friend   [] No one
[] 911   [] Other _____
What happened after the crisis?
[] Referral to another Doctor
[] Discharge with/without advise
[] Don't know or don't remember
[] Other_____
You had a health crisis. Did it affect these?
[] Income [] Housing
[] Social Network (Access to friends & family)
[] Other

How much of your income do you spend on shelter? (*Add utilities if not included in your rent.*)
[] >50%   [] <50% >75% [] <75%
Do you feel safe where you live? [] Y [] N [] Not sure
Are there issues with your accommodations? [] Y [] N
[] Maintenance [] Safety / security
[] Rent too high [] Other_____
Do you know whom to contact?   [] Y [] N
Has contacting them helped?   [] Y [] N

How long have you been in your current living arrangement?
[] Days ___ [] Weeks ___ [] Years ___

How many addresses have you had in 5 years? _____
Were they in the same neighbourhood/area?   [] Y [] N
Do you remember any of the neighbourhoods?
_____

Do you live close to things you need?
 [] Transportation, [] Grocery store, [] Drugstore
 [] Doctor   [] Other _____

What is your main source of income?
[] Employment   [] E.I.
[] Income Assistance [] Pension (Source)
[] None   [] Other
[] Combination (Check all that apply)

If you work, how much do you work?
Days_____ Hours_____
How do you get to and from work?
 [] Walk [] Bus/transit [] Bike [] Drive
 How long have you worked there?
[] Days [] Weeks [] Months [] Years
Is this work related to your training?   [] Y [] N

If you don't work, would you like to?   [] Y [] N
How much could you work? Hours ____Days_____
What are the barriers preventing that? _____

Does Income Assistance meet your basic needs?
 [] Y [] N

Once your shelter costs are paid, what is your next most important purchase with the money you have?

[] Food   [] Prescription drugs
[] House/cell phone   [] Bus pass/tickets, gas
[] Clothes/footwear/gloves [] Entertainment
[] Cigarettes   [] Other

What do you do without each month?
[] Food   [] Medicine
[] Transportation   [] Entertainment
[] Other
Name what you couldn't get this month.
_____

Has lack of income led to eviction for not paying rent?
                                    [] Y [] N
If Y, what happened? _____

Do you live with any form of addiction?
[] Alcoholism [] Drugs [] Gambling [] Other
Do you have support dealing with this?   [] Y [] N
Do you know where to get help?   [] Y [] N
Are you or have you been excluded from service because of this? []
Denied service or [] isolated from others?
(Not allowed into or turned away from shelters, day programs, soup kitchens.)   [] Y [] N [] NA
Do you have legal problems because of your addictions? (Arrested, jailed etc.)   [] Y [] N
Have family and friends turned you away/avoided you because of your addictions?   [] Y [] N
What programs or activities do you take part in?
_____

What other services do you know about? _____
Which do you use? _____
If you don't, why not?
_____

How important are programs and services like food programs, training, recreation, health clinics, and support groups to you?
[] Very important   [] somewhat important
[] Not important   [] not sure

What would you say is the most important support you need on a daily basis? (Nutrition, Financial, Housing, Medical)
_____

Can you get this support?   [] Y [] N
Do you know how to get it?   [] Y [] N
Can you name 2 programs or services that could make a positive difference in your life?
_____

If health clinics (Blood Pressure, Cholesterol, Foot care, Diabetes, Mental Health) became available, would you like to be contacted?
[] Y [] N
How could we do that?
_____

Do you feel part of your community?   [] Y [] N
Do you feel that your community cares about you?
[ ] Y [ ] N

Comments_____
NOTES

Interviewer Initials:

Case No.			

Appendix V Core Service User Survey- Short Version

Hi/Hello: Can I ask you some questions? Say why. Go over informed consent.
Year of birth [__/__/__]
Gender M [] F [] Other []
Ethnic Identity _____
Hometown_____
Family status
 Single [] Married [] Divorced [] Widow/er []
 # Dependants ____ **Ages** _____
Education []<gr.9 [] Grade 10- 12 [] >Grade12

Please describe your current housing situation.
[] Live on your own   [] Share a place
[] Rooming house   [] Live with friends/family
[] Transition/ supported facility [] Shelter
[] No fixed address
If you Rent /own is it private or public housing?
[] Y [] N
If Y, is it family or Senior housing?
[] Family [] Senior
Is there a kitchen or one you can use?   [] Y [] N
Is there a secure place to store food?   [] Y [] N

How often do you use meal programs?
[] Daily
Where? _____   # Meals? _____
[] Weekly
Where? _____   # Meals? _____
[] Monthly
Where? _____   # Meals? _____
[] Occasionally
Where? _____   # Meals? _____
If you couldn't come here where would you eat**?**
_____
Where do you eat breakfast**?**
_____
Where do you eat supper when F.O.O.D isn't open**?**
_____
Can you say where you live? Y [] N []
_____

Is the social aspect (friends, connections) of F.O.O.D important to you?
[] Very [] Somewhat [] Not [] Other

Are your *BASIC* needs being met today? [] Y [] N
Do you have a phone or access to one? [] Y [] N
Explain_____
 If No, what are you lacking? Please be specific Comments:
_____

Do you have enough clothes?   [] Y [] N

Do you have good footwear?   [] Y [] N
Is it waterproof?   [] Y [] N
Is it comfortable?   [] Y [] N

Do you have any foot problems?   [] Y [] N
If Y, please specify_____
Are you getting help for that?   [] Y [] N
Comment_____

Do you have the essentials for your home? [] Y [] N
[] 1. Equipment (furniture, dishes, cookware, cutlery)
[] 2. Cleaning/laundry supplies
[] 3. Personal grooming (soap, shampoo, toothpaste, shaving supplies, feminine hygiene)

Do you have health problems?   [] Y [] N
Please be specific. _____
(Refer to the Clinics section)
Do you require regular medications?   [] Y [] N
Can you get them on a regular basis?   [] Y [] N
If you need and can get medications, do you take them on a regular basis?   [] Y [] N
Do you need help with your medications? (Reminders, injections etc.)
[] Y [] N
 If so, can you get that help?   [] Y [] N
Do you need special foods?   [] Y [] N
Such as :_____
Can you get those special foods regularly?   [] Y [] N

How much of your income do you spend on shelter? (*Add utilities if not included in your rent.*)
[] >50%   [] <50% >75%   [] <75%
How long have you been in your current living arrangement?
[] Days ___ [] Weeks ___ [] Years ___

What is your main source of income?
[] Employment   [] E.I.
[] Income Assistance [] Pension (Source)

[] None   [] Other
If you don't work, would you like to?   [] Y [] N
How much could you work? Hours ____Days_____
What are the barriers preventing that? _____

Does Income Assistance meet your basic needs?
 [] Y [] N
Name what you couldn't get this month.
_____
Has lack of income led to eviction for not paying rent?
                                                        [] Y [] N
If Y, what happened? _____

Do you live with any form of addiction?
[] Alcoholism [] Drugs [] Gambling [] Other
Do you have support dealing with this?   [] Y [] N
Do you know where to get help?   [] Y [] N

How important are programs and services like food programs, training, recreation, health clinics, and support groups to you?
[] Very important   [] somewhat important
[] Not important   [] not sure

If health clinics (Blood Pressure, Cholesterol, Foot care, Diabetes, Mental Health) became available, would you like to be contacted?
[] Y [] N
How could we do that?
_____

Do you feel part of your community?   [] Y [] N

Do you feel that your community cares about you?
                                                        [ ] Y [ ] N
Comments _____

NOTES

Interviewer Initials:			
Case No.			

Appendix VI- Feeding Others of Dartmouth Society Statistics April 2006

FEEDING OTHERS OF DARTMOUTH
AT MARGARET'S HOUSE

APRIL
2006 STATISTICS

DATE	DAY	LUNCH	SUPPER	
1	Sat	85		
2	Sun	46		
3	Mon	62	58	
4	Tue	69	52	
5	Wed	69	53	
6	Thur	59		
7	Fri	61		
8	Sat	51		
9	Sun	64		
10	Mon	85	80	
11	Tue	63	50	
12	Wed	68	49	
13	Thur	74		
14	Fri	48		
15	Sat	74		
16	Sun	113		EASTER DINNER
17	Mon	87	Closed	
18	Tue	94	70	
19	Wed	76	68	
20	Thur	86		
21	Fri	70		
22	Sat	80		
23	Sun	84		
24	Mon	100	59	
25	Tue	83	66	
26	Wed	43	31	
27	Thur	52		
28	Fri	62		
29	Sat	79		
30	Sun	90		

LUNCH IS SERVED
7 DAYS A WEEK
FROM: 12:00 -12:30

SUPPER IS SERVED
FROM 4:30 - 5:00
MONDAY, TUESDAY
& WEDNESDAY

OUR PHONE NUMBER:
464-2919

COORDINATOR
KAREN GOUDIE

SUPERVISORS:
Marie - Weekdays
Gerry-Weekends & Suppers

	LUNCH	SUPPER
SUB-TOTAL MEALS	2177	636
# DAYS	30	11
DAILY AVERAGE	73	58
TOTAL MEALS SERVED	2813	

List of Tables and Charts

NOTES

Back Cover

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