The Manna Society Newsletter
Spring 2017

A volunteer's perspective

By

Sarah Coates

A year ago I started volunteering at The Manna Society working in the kitchen. I had no idea what to expect and was fairly apprehensive. I had had a very positive experience working at Crisis for Christmas and wanted to do something similar on a regular basis. I looked around at various charities but chose The Manna Society because, just like Crisis, they provide a wide variety of services including benefits advisors, healthcare, hot showers, a clothing store, as well as food. Its' approach feels more like a helping hand rather than a hand out.

So there I was on a grey January day standing in a lovely warm kitchen feeling decidedly unqualified to do anything at all. I was welcomed, shown around and given some rather lovely pink marigold washing up gloves and then taught how to wash up on an industrial scale. Limited supplies of plates and cutlery means that everything needs to be washed and returned to the eating area at speed so that everyone (and I mean everyone) gets fed. Irena, the chef, works a daily miracle. Standard meals are supplemented with donated extras from individuals, markets and businesses. This is recycling at its creative best.

There is no typical volunteer; ages and backgrounds vary. We are a random group of individuals brought together because we each have a few hours to spare and have had just enough courage to think that maybe we could be useful. And it works.

The Manna Society is a welcoming, inspiring and valued project. It is a privilege to feel part of something so precious. And if my few hours can help it to continue to be that place of hope for the guests that it serves then I am delighted to roll up my sleeves and put on those marigolds!

“Alcoholism is a very frustrating illness”

By
Karolina Muszynska
Housing & Welfare Advice Worker

Recently I went to The 12 Steps programme workshops organised by Southwark Council and run by the recovering addicts from Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The 12 Steps is an addiction recovery programme created by the founders of Alcoholics Anonymous. The programme was successful in its early years so other addiction support groups adopted the steps to their own needs. Nowadays we have many 12-step programmes for various addictions and compulsive behaviours, ranging from Cocaine Anonymous to Debtors Anonymous. While I was doing research for this article it struck me how many manifestations addiction can take. People get addicted to all sorts of things to name just a few: eating, gambling, working, exercising, sex, shopping, using the internet, stealing etc.

Before I say more about the workshops let me first explain why I went there. I have been working for the Manna Day Centre over six year and I find it really frustrating to watch how addiction literally destroys some of our clients lives. Addiction and homelessness are a dangerous combination as one fuels the other. Abusing alcohol and drugs can have a very harmful impact on the life of the individual, it can rob them of everything including their job, family, possessions and friends. It can easily lead to homelessness.

Homelessness is a very stressful experience so it is understandable why many homeless people will use substances to attain temporary relief from their problems. However the relief is only temporary and in fact often makes the real problem bigger. Under the influence it is easier to forget about appointments, to lose money, documents, mobiles etc. It does not help with a job search or with reconnecting with your family. It seems to be a vicious circle that is very difficult to break. Moreover street drugs, cheap drinks, poor diet, sleep deprivation, poor hygiene, cold, damp, stress and loneliness have a devastating impact on both the physical and mental health of homeless people. It is really sad to see over the years the speed of physical deterioration among our abusing clients. I felt powerless and frustrated because it became clearer to me that if the person does not genuinely want to stop drinking there is nothing miraculous we can actually do to make them stop. We can support them, we can confront them, we can refer to various services but if the person has no desire to stop nothing will happen. This is why I decided to try and understand addiction and the recovery process better and so I went to The 12 Steps workshop.

There are many addiction theories. The 12 Steps programme is based on the disease model where addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive substance seeking and use, despite harmful consequences. As NA explains on their website “*Our experience with addiction is that when we accept that it is a disease over which we are powerless, such surrender provides a basis for recovery through the Twelve Steps ... We treat addiction as a disease because that makes sense to us and it works”.* Therefore *a*ccording to 12 Steps the only way to stop the disease from progressing is lifelong abstinence.

As I mentioned at the beginning of this article the workshop was run by recovering addicts from AA and NA and it started with each of them telling us their personal history of addiction and how the AA/NA fellowship helped them to overcome it. I was particularly interested to find out if something specific happened that inspired them to start recovery. What had planted that seed? Ewan from NA said that for him it was an outreach team who mentioned to him the 12 steps recovery programme. He has been struggling with drug addiction for years and it was the first time that he had heard of the NA fellowship. For Ian from NA it was a tough year spent in prison. For Martin, AA, it was the threat of divorce from his wife. For Eileen, when she was very ill, it was the realisation that if she did not drink the first one during the day she would not have a problem for the rest of that day.

I asked if there is anything we can do as advisers to help motivate people to start recovery. Ewan answered that we can only continue to offer support and provide information as he believes the person needs to be ready to give up in the first place. Eileen said that she was in denial for 4 years, despite seeing that her life was falling apart and being confronted by family and friends. "Alcoholism is a very frustrating illness" she concluded. They all agreed that the recovery first milestone for them was to actually admit that they were addicted. You cannot address the problem, until you believe you have one.

Ewan, Martin, Eileen, Ian kindly offered to come to The Manna to chat with our clients, who are interested in giving up so I am starting to ask our service users if they would like to meet them. Hopefully by creating that connection we can facilitate the change to happen.

At the end I would like to share with you interesting and inspiring explanation of addiction by Johann Hari. He believes at the root of addiction is disconnection and social isolation. He explains: *"Human beings have an innate need to bond and connect. When we are happy and healthy we will bond with people around us. But when we cannot because we are traumatised, isolated or beaten down by life we will bond with something that will give us some sort of relief … The opposite of addiction is not sobriety, the opposite of addiction is connection".*

Fancy raising money for us by running 10k through central London?

The British 10K London Run takes place on Sunday 9th July.

Starting at Piccadilly & finishing on Whitehall
Passing St James Palace, Trafalgar Square,
St Paul's Cathedral, Big Ben,
Westminster Abbey & Parliament Square.

We have 6 places for this 10K Run.

If you feel up to the challenge and can raise a minimum of £200 we would be delighted to hear from you.

Please contact Paddy at paddy@mannasociety.org.uk

More information about the run itself can be found at https://uk.virginsport.com/event/westminster-2017

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Responding to a changing environment

By
Margaret Shapland
Housing and Welfare Advice Worker

"Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek" - Barack Obama

I looked back on Homeless Link's latest annual review into single homelessness published in 2016 and see if any of the issues they have highlighted had been subject to material change.

35,727 bed spaces

The number of accommodation projects has reduced by 5% and the number of bed spaces reduced by 2%. Accommodation projects have been reducing in size certainly over the past decade as it is felt smaller projects offer a better level of support, which certainly feels like a sensible assumption. Most are operating at full capacity. That means there are waiting lists. This is particularly true of the accommodation projects such as hostels or shared housing that we are able to access on behalf of our clients. Over the last year, we have experienced numerous closures of waiting lists or closures of referral lists.

This is largely due to the lack of available move-on accommodation. Homeless Link reported that Access to move -on accommodation is an issue - 30% of clients were ready to move but were not currently able to do so. This is absolutely entwined with lack of affordable accommodation – a third of services reported this to be the main barrier (34%).

We know in London that it is almost impossible to achieve a room in a shared house for less than £500 a month and that will be in boroughs such as Ealing etc. and not a central London borough which is where most people would prefer to be due to accessibility to a workplace to college or because of social ties – this can involve some hard decisions for people.

For those under 35, this will almost always mean that a top-up over and above what a local authority is prepared to pay – let's look at the Ealing example. Ealing falls into 2 local housing allowance rates areas. For a shared room, you will either get £479 per month (meaning a top up of £21) or £423 a month meaning that a top-up of £77 per month will be needed. For someone under 25, that is quite a hefty contribution given that the amount they will receive in benefits as a jobseeker will be £57.90 per week - £250.9 per month so up to a quarter could go on topping up rent before the rest of their needs are taken into account – food, utilities, travel etc.

The waiting times

Homeless Link have reported that accommodation projects stated three out of ten (30%) people currently staying in their services were waiting to move on but had not been able to. Of those that were waiting to move, 45% had been waiting for up to three months, 28% for more than three months but less than six months, and just over one in five (27%) had been waiting for six months or more.

This is mirrored in our experience of trying to settle the under 35 clients we see – with some housing providers quoting up to six months waiting times.

Private renting is a good route if you have a client who can produce a budget that demonstrates that they can afford to consider a private rented property and are trained to understand how the housing benefit system works and how it will change when joining or returning to the workplace. It highlights the reality they will encounter and sometimes this will encourage reconciliation with the parents and a return to the family home.

We are currently working with one young client who is earning less than £200 per month. It would be irresponsible of us to put them forward for private rented accommodation unless they can show they can keep themselves - £200 a month equates to £46 per week, below the applicable weekly amount for a person their age (£57.90) but to achieve the top-up from the Department of Work & Pensions they have to demonstrate that they are making sufficient efforts to seek work

– otherwise they will be sanctioned. Realistically, they need support to satisfy the DWP's requirements and to look perhaps at ways of increasing their income.

In terms of a reality check, we are working with another young client who is earning about £600-£800 per month. They had been placed in a hostel where the contribution to rent had been worked out to about £80 per week. In London terms, this would be considered on the low side for your own room with great security and a high level of safety given this is a vulnerable person. They considered it too high, got into arrears and regrettably were evicted. They are now sofa-surfing.

We are going to work with them on a budget that includes a contribution to rent and it may be possible that we can introduce them to someone who can take them in as a lodger in a family environment. Our opportunities to re-house the client are limited as there is now a history of arrears, which precludes them from a number of projects we refer to. This again was a factor in the Homeless Link survey where 18% of clients were excluded from access to housing providers due to previous behaviour such as debt, rent arrears, or antisocial behaviour. This was reported by 75% of all accommodation projects contributing to the survey.

That is why, we are glad that we have been successful in a recent grant bid that may allow us to pilot a scheme of a leased house where we hope to place under 35 year olds and see that with support, this client group can make a go of it. If the experiment is successful, then we can apply for further grants to offer more spaces to this particular group.

Increasing Levels of complex need

From our experience, it appears that higher thresholds for someone with real support needs are being applied by local authorities and that means that many more clients with relatively high levels of need are approaching our service and more are approaching us having been refused support from the local authority. Homeless Link's report states that 73% of accommodation projects have had to turn people away as their needs were assessed as being too high.

We work really hard at determining routes for such individuals and to acquiring the background information that allow us to make the best quality referrals to accommodation providers. For example, we have recently been approached by a client who has a hearing disability. We would like to refer them to a project that is geared to helping people into work as this client is perfectly able in other ways. Their main concern about entertaining them is whether they will be able to hear a fire alarm. To help support the client, we have referred them to a local GP who will be referring them to an audiology department to ensure that the hearing aid currently used is fit for purpose. In addition, the client previously lived in what appears to be a general needs tenancy. We have contacted that provider to establish if the client was able to live independently in that tenancy – if so; our case in putting forward this individual will be strengthened.

Being able to link people into services is critical and particularly so on the area of substance abuse. Most accommodation providers we work with require someone to be linked into services. Previously, if someone was unable to make such a commitment, there was a chance that we could refer them to a "wet" hostel or a hostel where clients with ongoing substance abuse issues could be accepted. With increasing "localism" and with the majority of hostels who work with such clients being gate kept by the local authority and referrals being accepted only through that route or local outreach teams or specialist substance abuse or mental health teams, we depend more and more on working with partnership agencies to help us access those valuable placements

Over the years changed methodologies for working towards the best result for a client have been at the heart of our work – that is something that will continue. It was Benjamin Franklin who said "*In this world nothing can be said to be certain, except death and taxes*" – well, I'd like to add change to that as that too appears to be a certainty in our area of work.

An oasis in our urban desert!

By

Bandi Mbubi

Manna Centre Director

In our last snapshot survey, in January this year, we counted 145 people who came to our day centre, near London Bridge. In the last two years we have been in our new building, numbers have fluctuated between 130 and 170 people, from day to day. Whereas in the old building, which was more spacious, we usually catered for 150 people to 200. Having said that, apart from the overall number of people, other statistics have remained more or less the same. Like in previous surveys, we found that about 60 % of our service-users are homeless, out of whom 40 % sleep rough and 10 % find hospitality with their friends. Of course, not everyone who comes to us is homeless. Roughly 25 % stay in social housing and 15 % live in hostels. For many who continue to use our centre, even after they have been rehoused, we remain an important source of support and accompaniment.

We try not to judge but instead we try to accept people as they are; made in the image of God. We are open every day, including Saturday and Sunday. For us, it is not just a question of finding accommodation for homeless people, but it is also accompanying them during their journey of resettlement. It is clear to us that a home is more than a building. It is where we sleep and eat, entertain friends and family, think and play and losing a place means having to live without everything which goes with it. To be in such a situation for a significant amount of time can be very debilitating. It can affect the way we see ourselves and the world and the way the world looks at us.

At the Manna Centre we address people's basic physical and emotional needs. Altogether we offer seven services to those who turn to us for help. By far our most popular service is food. We serve breakfast from 8.30 in the morning till 11.30. It usually consists of a sandwich from Pret A Manger between 8.30 & 10 and porridge or cereal from 10 till 11.30. Lunch begins to be served from 11.30 till we close at 1.30 in the afternoon. Throughout the day, there is always tea and coffee. For most of our service-users, this is their main meal and we are glad we are able to offer it to them.

It goes without saying how important our shower facilities are to homeless people. They are in constant use. Alongside this service, twice per week, on Mondays and Wednesdays, people get a change of clothes. We are lucky that we have a dedicated and reliable team of volunteers who manage our clothing store and keep it running for people to use.

Our team of two full-time and a part-time housing and welfare advice workers do wonders as they see over 1300 people per year. Out of those who seek help from our advice team, at least 500 people do it for housing-related issues and over half of them are placed in some kind of housing. Increasingly, we are seeing people who though working full-time are not able to meet their housing costs and are having to rely on us to find affordable accommodation. Thankfully, we are still able to pass on furniture we receive from supporters at very low costs to our clients.

A challenge for many homeless people is accessing medical care as often GPs ask for proof of address before they can have you in their books. Thankfully, we have nurse-practitioners who hold their surgeries twice per week, on Mondays and Fridays, to deal with people's physical needs. Similarly, we have a community mental health team, called the START Team, who assist people who have mental health problems. Once every

fortnight, we meet together with them and others to agree joint-action on mutual clients. With the School of Osteopathy, we get students in their final years, accompanied by their more experienced supervisors, to administer treatment to our service-users. A chiropodist also comes on the first and third Tuesday of every month to treat people's feet.

A computer has long stopped being a luxury item for most of us. Yet for many homeless people, it still is. So in 2011 we introduced a computer suite for people to use for educational, leisure and vocational pursuits. Whilst many homeless people now have smart phones, the cost of internet however can be prohibitive to them. Our computer suite gives people the opportunity to access the internet, Monday to Friday, from 10.30am to 1pm.

Altogether, we have 12 paid staff, two of whom are part-time, and about 60 volunteers a year. The Roman Catholic Archdiocese of Southwark generously provides us with the building free of charge. They have been doing so since we first opened in 1982. Individual supporters account for about 50% of our income, Grant Making Trusts for about 25%, our local borough Southwark 12% and the remainder comes from churches and companies. The wider Christian community helps us too with clothing and food donations, especially during Harvest Festival and other Christian festivals.

In the past five years, rough sleeping has doubled across England. In London alone, around a thousand people are sleeping rough. Budget cuts have meant that there has been a severe reduction of supported housing accommodations for people with multiple and complex needs. It is an uphill battle to significantly reduce homelessness. With your continued support however, the load feels lighter.

Bridging the Health Inequality Gap

By
Rachel
Homeless Specialist Nurse

The NHS was created in 1948 in the belief that access to good healthcare should not depend on personal wealth and should be free from judgement and discrimination. In terms of public health, it benefits all of us for our society is healthier, fitter and happier.

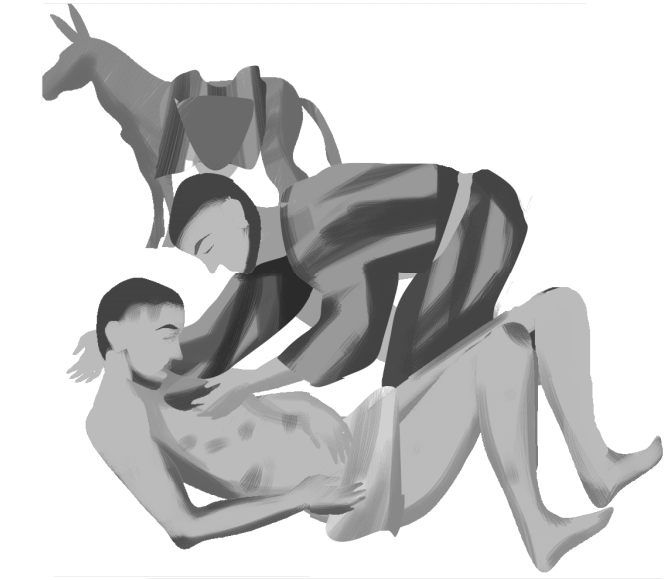
Although this belief remains at the core of the service, the reality is changing. Health inequality has widened in recent years with vulnerable migrants and the homeless facing the greatest disparity [(1)]. Shockingly, the average age of death for a homeless male is 47[(2)] (43 for women) compared to the life expectancy of 79 and 83 years for the general population respectively. Sadly, the homeless are twice as likely to die from simple infection with preventable poverty-related diseases such as TB posing a real risk. Those most in need are becoming the most distanced from the system, but why?

Everyone present in the UK is entitled to register and receive treatment from a GP for free, without exception[(3)], however many homeless people report great difficulty registering with a GP, know little about their health access rights and report discrimination when accessing health services[(4)]. This is the same for vulnerable migrants who rarely access information about their right to free GP care, but frequently see news about increased vigilance on claiming back overseas visitor charges and passport checks. This can lead to mistrust and avoidance during the early signs of ill health. In fact, research shows that when homeless people eventually have to attend hospital, they will be much sicker than the average person and stay 3 times longer in hospital[(5)]

This year, the government have just brought forward a proposal on NHS charging which includes: up-front charges for EEA *(*European Economic Area) migrants; charging non-EEA migrants 150% of the NHS tariff; GP identification of those

liable for charging (although GP care will remain free)[6] which could include direct communication with the Home Office. Many respondents to the initial consultation argued the proposed changes would see an increase in discrimination towards the homeless who may be unable to prove their eligibility through lack of documentation, as well as increased fear of access from vulnerable migrants. These proposals indicate the problem of access may worsen, rather than improve. So what can we do?

If we are to start reducing this inequality, we first need to find these groups, gain their trust and attempt to stand beside them through the process: empowering them to know their rights and to access treatment. The Manna Centre is at the forefront of challenging this inequality by working with local NHS services running twice weekly nurse clinics at the day centre. Access to health advice, vaccinations, screening and same-day treatment are open to all on a walk-in basis. The nurses make around 500 patient contacts a year, many of which will result in first-time diagnosis of long-term conditions, GP registration and successful engagement in treatment. This partnership allows for a unique combination of health, practical social care and support that is vital to overcoming such a divide.



If we truly wish to keep the founding ideology at the core of the NHS, we must further the examples of such relationships by continuing to seek out those in greatest need, showing them we still have a system which cares more about their health than the contents of their pockets.

Case Study – 51 year old British male "Simon". Name changed for confidentiality.

After his partner became unwell, Simon moved into her council flat to be a full-time carer, giving up work as a driver. They managed on her disability benefits and small cash-in-hand jobs. After 6 years, his partner died suddenly. Having never told the council about living in the property, he had no right to stay. Simon was evicted from the flat, returning one day to find the locks changed, unable to collect his belongings and documentation. After a period of rough sleeping, he developed a cough. Being previously well, he had no local GP so Simon tried to register but was turned away as he had no ID or proof of address. The cough got worse so he went to A&E. He said he felt "humiliated" being examined when he hadn't been able to have a shower. He was given antibiotics but unfortunately they were stolen along with his bag two days later. Due to his experience in A&E, Simon didn't want to go back to hospital. One of the other day centre clients convinced Simon to see the visiting nurse. He was diagnosed with pneumonia and needed urgent admission to hospital. Reluctantly, he agreed to go and the nurse went with him for advocacy and support. Simon was subsequently admitted and felt he received good care in hospital. On discharge he came back to the nurses, was helped to register with a GP and referred for treatment of his depression. Simon continued to see the nurses at the day centre regular for health support until he was assisted into private rented accommodation by the day centre, where he easily registered with a local GP.

1. Faculty for Inclusion (2013) *Health Standards for commissioners and service providers* Version 2.0.
2. Crisis. (2001) *Homelessness: A silent killer. A research briefing on mortality amongst homeless people*
3. NHS England (2015) *Patient Registration Standard Operating Principles for Primary Medical Care (General Practice)*
4. Department of Health (2014) *Hidden Needs Identifying Key Vulnerable Groups in Data Collections: Vulnerable Migrants, Gypsies and Travellers, Homeless People, and Sex Workers*
5. Department of Health (2010) *Healthcare for Single Homeless People*
6. Department of Health (2017) *Sustaining services, ensuring fairness Government response to the consultation on migrant access and financial contribution to NHS provision in England*.