Critical Condition
Vulnerable single homeless people
and access to GPs
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Executive summary

- Single homeless people are amongst the most vulnerable and socially excluded people in our society. Poor health is one of the major problems that they face. For example, TB amongst homeless people is 25 times the national average\(^1\) and at least one in five homeless people suffer from a severe mental health problem.\(^2\)

- GPs are the most important primary health care service. They account for 8 out of 10 patient contacts with the health care system and are the gateway to specialised services.\(^3\)

- In spite of their high health needs, many homeless people continue to have poor access to the mainstream primary healthcare. Crisis interviewed 100 homeless people who were nearly 40 times more likely not to be registered with a GP than members of the general population and were nearly three times more likely to have had no contact with a GP over the last year.\(^4\)

- The homeless people that Crisis spoke to were most likely to use A&E above any other healthcare service, if they couldn’t access a GP. They were nearly five times more likely than the general population to turn to A&E when they could not access a GP.

- Problems accessing GPs can be caused by structural barriers – such as a lack of resources, the attitudes and beliefs of general practice staff and the impact of homelessness on the individuals concerned.

Crisis recommends that:

1. All homeless people should be enabled to permanently register with a GP.
2. As a vital point of contact with the healthcare system for homeless people, A&E departments should respond to the presenting needs of homeless people whilst making an effort to link them into primary care services.
3. Primary Care Trusts should work closely with local authorities and the voluntary sector to ensure that the health needs of homeless people are tackled as part of a holistic and integrated approach to solving homelessness.

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4. General public and GPs data comes from the Mori study “Perceptions of GP Services” Mori/Crisis October 2002. Research among the homeless was conducted by Crisis.
Introduction

Single homeless people are amongst the most vulnerable and socially excluded people in our society. Poor health is one of the major problems that they face. Tackling these health problems and ensuring that they have access to good quality primary health care is an essential step towards their reintegration into mainstream society.

There is growing recognition of the need to address the question of access to healthcare for homeless people and recent years have seen a number of positive developments. The governments Cross Cutting Review, Tackling Health Inequalities,\textsuperscript{5} has called for targeted interventions on behalf of specific groups including rough sleepers and homeless people, the Royal College of General Practitioners Standing Group on Health Inequalities has chosen to work during 2001 – 2002 on the theme of homelessness\textsuperscript{6} and the number of Primary Medical Services with a focus on homelessness has grown to 71 nationwide.

Sadly however, homeless peoples access to mainstream primary healthcare is still limited. The problem is illustrated by the issue of access to GP services.

GPs are the most important primary health care service. They account for 8 out of 10 patient contacts with the health care system and are the gateway to specialised services.\textsuperscript{7} Yet in spite of their high health needs, many homeless people continue to find it hard to access these vital services.

Drawing upon primary and secondary research, this briefing paper explores the complex health needs of homeless people and argues that there are fundamental problems with the system that need to be addressed if these needs are to be met.
The policy context

Homelessness

Set up in 1999 with the target of reducing rough sleeping by two thirds by 2002, the government’s Rough Sleepers Unit (RSU) recognised early on the importance of tackling the specific health needs of homeless people.

“It is quite clear that the complex mental and physical health needs of those on the streets are not currently being met. Addressing these needs is central to helping people to come inside, and we are committed to doing that.”

As a consequence, the RSU set up a number of targeted services including 40 specialist mental health workers as well as specialists bed spaces in hostels. However, as this paper will show, the primary health care needs of homeless people continue to be met by fragmented services.

By 2001, the RSU had announced that it had met its target and in March 2002, the government set up the Homelessness Directorate to tackle the broader problem of homelessness, i.e. those homeless people who are not literally sleeping on the street but “Living with relatives, friends or in temporary accommodation.”

The Directorate’s inaugural report, More than a Roof, acknowledges that health is a key issue. Access to mainstream primary health care services is recognised as a problem. “People who are homeless, or at risk of it, often suffer from physical or mental ill health,” and “services for people who fall into this category are patchy.” Importantly, the report recognises that despite the need for specialist services, “There will always be a role for the mainstream in providing services for all, identifying problems early and helping to prevent homelessness.”

Health

Published in 2000, The NHS Plan made reducing inequalities in access to healthcare a priority and set national targets for the first time ever. It reiterated the NHS core principles, including:

"... The provision of a universal service for all based on clinical need, not ability to pay.”

The focus on reducing health inequalities represents a major policy shift and an acknowledgement of the socio-economic determinants of health, including poverty, housing, employment and education. The last five years have seen a series of white papers including The New NHS, Modern and Dependable, Saving Lives, Our Healthier Nation and Modernising Health and Social Services National Priorities Guidance. These have inaugurated major structural changes to the way that health care services are delivered in this country and a number of new initiatives have been introduced.

One of the biggest structural changes introduced are Primary Care Trusts (PCTs). These first came into operation in April 2000, devolving and delegating responsibility for the provision of services to GPs, nurses and other health professionals. PCTs are the principal budget holders for all local NHS services and have replaced health authorities as the commissioners of primary health care services.
Underlying PCTs is the core belief that local health care and social care professionals are best placed to understand the health needs of the local community. There are currently a total of 302 PCTs operating across the country.

New initiatives to increase access to primary care services have included the establishment of walk-in centres\(^{16}\) and NHS Direct. In addition, there are now more GPs within the health service and a commitment to ensure that patients will be able to see a GP within 48 hours by 2004 has been made by the Department of Health.\(^{17}\) GP services remain “Key in delivering the ambitious vision of the NHS Plan.”\(^{18}\)

Pilot Personal Medical Service (PMS) contracts for GPs have introduced new flexibility to primary care. This has made it easier for local solutions to be created for local problems and for GPs to work with marginalised groups, such as homeless people, refugees and drug users. There are now 1,300 pilot PM Ss operating across the country and 19% of patients in England are registered with PMS practices.\(^{19}\)

One GP who specialises in services for homeless people describes PMS contracts as: “The most significant favourable piece of legislation for homeless people since the start of the NHS.”\(^{20}\) His reasoning is that since the PMS framework has been in place there has been a continuous increase in the number of primary care centres specialising in meeting the needs of people who are homeless. Practices specialising in or with a special interest in homeless people now number 71.\(^{21}\)

But as the following part of this briefing paper will show, problems persist and homeless people are still not getting equal access to mainstream healthcare.

Efforts to improve homeless peoples access to GP services have also been encouraged by the Royal College of General Practitioners who this year issued a statement on Homelessness and Primary Care recognising that “all people have a right to equity of access to primary care services and to receive services that will enhance their dignity and independence.”\(^{22}\)

**Example of good practice**

GPs at the PMS Clowes surgery at the Whitehouse Centre in Huddersfield are able to give all their patients more time as part of this initiative and in addition are able to meet the complex health demands of homeless people and asylum seekers by providing 30-minute consultations. They are able to do this by not offering home visits, which are unnecessary, as a longer consultation will provide an in-depth health assessment and treatment.\(^{23}\)

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\(^{16}\) (2002) A Focus on General Practice in England, Audit Commission p56


\(^{19}\) 2002 (DoH) Website.


\(^{21}\) Personal communication DoH Inequalities Unit, 2002.


\(^{23}\) 19 December 2001, Society Guardian.
This paper draws upon secondary research but also the results of three surveys carried out in October 2002 on behalf of Crisis. MORI conducted a representative survey of the general public and another of a representative sample of GPs across England, Scotland and Wales. In addition, Crisis interviewed 100 hidden homeless people living in hostels, B&Bs, squats and with friends and family.

Technical note

MORI general public survey: MORI interviewed a nationally representative quota sample of 2,025 adults across 183 constituency-based sampling points throughout Great Britain. Interviews were conducted face-to-face, in respondents’ homes, between 17 – 21 October 2002. Data have been weighted to the known profile of the population.


Crisis hidden homeless survey: Crisis interviewed a sample of 100 homeless people across London. Respondents had slept in a hostel, B&B, squat or on the floors of friends and family the night prior to interview. Interviews were conducted face-to-face, in hostels, day centres and other services for homeless people, between 18 – 25 October 2002.

Methodology

There are no accurate figures on the single homeless vulnerable population. Crisis estimates that the hidden homeless population of England runs into the hundreds of thousands. This includes hostel dwellers, squatters, people sleeping on friends’ and family’s floors and those staying in overcrowded accommodation.

The homelessness legislation gives a right to housing to those single homeless people who are considered in priority need due to their vulnerability. This includes all 16 and 17 year olds, those who have physical and mental health problems, people who have experienced domestic or racial violence and people who are vulnerable following a stay in institutions. However, limitations in housing supply combined with the manner in which selection criteria is interpreted and applied means that many vulnerable single homeless people still do not have a right to local authority housing.
According to official statistics, there has been a 3.5% increase in the number of statutory homeless households in priority need between 2000 and 2002. This includes single people and people with families but there exists no breakdown for what percentage of those accepted are single or families. Of those who approach local authorities, 184,290 were found to be homeless by Local Authorities in England in 2001.

There has been a 3.5% increase in the number of statutory homeless households in priority need between 2000 and 2002.

This figure, however, does not reveal the full picture. Many single vulnerable people do not apply for local authority housing and of those that do, many are not successful. If a homeless person is applying to be accepted as a statutory homeless person on the grounds of vulnerability due to mental and physical ill health, they will often have to present documented evidence, which is normally provided by a GP. But if a person is not registered with a GP, they cannot present this information. This can create a catch-22 where a lack of access to healthcare can further exclude homeless people from access to housing.

Health and homelessness

“People who are homeless face an increased risk of mental ill health, physical ill health and of contracting infectious disease.”

Although statistics vary, studies have consistently shown that levels of poor health are far higher amongst homeless people than in the general population. Poor health is a cause as well as a consequence of homelessness. Overcrowded, cold, damp and unsanitary living conditions are highly conducive to physical and mental ill health - and the predominance of drink and drugs in the homelessness subculture is a growing cause of concern.

Crisis research has shown that nearly one in fifty of homeless people have TB - 25 times the national average and that at least one in five homeless people suffer from mental health problems. In addition, four out of five homeless people interviewed by Crisis in a report released earlier this year by Crisis were addicted to either drink or drugs.

Eight years ago, Wendy Bines undertook one of the most comprehensive studies of the health of homeless people, compared with that of the general population. The research found that homeless people living in hostels and B&Bs were eight times more likely to suffer from mental ill

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Health and homelessness

health than the general population. Chronic chest infections were twice as high and experiences of fits and loss of consciousness were five times as high.30

As part of Crisis’ survey of homeless people, interviewees were asked what, if any, health problems they suffered from. These were compared against questions from the latest British Household Panel Survey.

It should be noted that self-diagnosis will have had some impact on the accuracy of the results. In the case of the homeless people questioned, the researchers felt that respondents were likely to perceive their state of health was better than it actually was, possibly because of low expectations around their health.

Self-diagnosed health problems of homeless people and the general public compared

<table>
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<tr>
<th>Health problem</th>
<th>Homeless people31</th>
<th>General population32</th>
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<tr>
<td>Depression</td>
<td>51.0%</td>
<td>7.7%</td>
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<tr>
<td>Diabetes</td>
<td>7.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Mental health</td>
<td>32.0%</td>
<td>20.2%</td>
</tr>
<tr>
<td>Problems seeing</td>
<td>10.0%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>30.0%</td>
<td>14.2%</td>
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Many homeless people suffer from multiple health problems with physical and mental ill health being combined with drink or drug addiction. In a survey of 974 organisations working with homeless people, Homeless Link found that almost half (47.8%) of service users were identified as having multiple needs, many of whom had mental health problems and a drug or alcohol dependency problem and underlying physical health problems.33

32 The tabulations used in this paper were made available by ISER, University of Essex. The data were originally collected by the ESRC Research Centre on Micro-social Change at the University of Essex, now incorporated within the Institute for Social and Economic Research. Neither the original collectors of the data nor the University of Essex bear any responsibility for the analyses or interpretations presented here.
Access to GP services is the cornerstone of the NHS and the heart of primary health care in the UK. It is estimated that every year, general practices will undertake a total of five million consultations. A GP provides services around prevention, investigation, diagnosis and treatment. Furthermore, a GP acts as a gateway to all secondary care, including acute services and specialist services, such as podiatry screening and mental health services.

Whilst specialist GP services for homeless people are being developed, “many agencies pointed to the continuing difficulties of access to primary health care for rough sleepers and other homeless people.” The role of specialist services remains an issue of contention and although it is clear that they provide valuable services they are no substitute for mainstream healthcare. It is essential that they are closely linked to mainstream services to ensure that homeless people are not further marginalised. It is also essential that mainstream services have the resources, training and flexibility necessary to provide an adequate service to homeless people.

Barriers to accessing GPs

The Crisis survey found that the homeless people interviewed were almost 40 times more likely not to be registered with a GP than the average person. It also found that interviewees were nearly three times more likely than the general population to have had no contact with a GP in the last year. Research carried out by the Centre for Housing Policy on access to general practice for people sleeping rough included a postal survey of homelessness projects across England, such as direct access hostels, night shelters, day centres and resettlement teams. The report was consistent with the findings of the Crisis survey and concluding that access to GP services for homeless people “appeared to be poor throughout England.”

Crisis research has found that homeless people are 40 times more likely not to be registered with a GP than the average person.

GPs themselves are aware of the difficulties experienced by homeless people and 81% of the respondents to the Crisis survey recognised that it is more difficult for a homeless person to register with a GP than an average person. We explored some of the reasons for this difficulty. The perception of 34% of homeless people who responded to the Crisis survey was that the root of the difficulty was because they moved around a lot, 27% experienced it as prejudice and 24% felt that it was the bureaucracy. 81% of GPs feel that it is more difficult for a homeless person to register with a GP than the average person.

Research backs up these perceptions. GPs do feel that the transitory nature of homeless people’s lifestyle prevents them from providing long term and preventative care to the standard that they are accustomed to. Some GPs do hold stereotyped images of homeless people and expect them to present with problematic and disruptive behaviour, fear that they will abuse prescriptions or cause difficulties in the waiting room. Structural barriers also have their part to play. Addresses are a critical factor in homeless people’s access to GPs. Some GPs genuinely believe they need evidence of a permanent address before they can offer permanent registration. In fact

35 Randall & Brown (2002) Helping rough sleepers off the streets, A report to the Homelessness Directorate, ODPM
although the bureaucratic system might demand a post code if a homeless person has no address, the address of the surgery, or any other care/of address can quite legitimately be used instead.

Many homeless people are registered only as temporary patients. This means that their previous medical records do not get transferred to the practice they are with and this affects their continuity of care. GPs have expressed concern that they will lose money if they permanently register someone who then moves on soon afterwards.40

The Royal College of General Practitioners, in their statement on Homelessness and Primary Care, recommends that wherever possible homeless people should be registered permanently.41

The other issue is resources. Nine out of ten GPs in the Crisis survey felt that GPs need extra resources in order to provide homeless people with the same levels of access to GP services as the average person.42 Homeless people do present with multiple and complex needs which require extra resources and sometimes specialist knowledge. GPs and practice staff are not, in general, given any specialist training in understanding the specific needs of homeless people.

Ultimately however, the difficulties that homeless people face accessing GP services are best explained as part of a dynamic between the systems of service provision and the nature and experience of homelessness.

Homeless people can come to mistrust institutions and authority: if someone has had a bad experience trying to register with a GP it can put them off trying again. Expectation of rejection and anger can be quite near the surface and if a person does not get a good response from primary care practitioners it can spark off aggressive behaviour.43 Homeless people often experience feelings of low self-esteem and depression which make it hard for them to use mainstream services.44 The lifestyles of some homeless people also makes it difficult for them to keep appointments and fit into the inflexible working practices of a surgery.45

For people experiencing homelessness or facing the prospect of homelessness, health is often a secondary priority and is only addressed once the problem has become acute.46 Homeless people suffering mental ill health or using drugs may not be aware of, or may not prioritise their healthcare needs. Some homeless people simply don’t know where to go to get healthcare.

Unable to access appropriate health care through mainstream GP services many homeless people resort to other alternatives, such as Accident and Emergency, often waiting until problems reach crisis point.

“If I got the right help for my problems and had a proper GP, I would not be in the position where things get so bad that I have to use A&E.”47

Crisis believes that in order that homeless people receive the kind of healthcare they need and deserve, the option of permanent registration is absolutely critical.

40 Ibid p 33, 34.
42 Perceptions of GP services Mori/Crisis, October 2002.
43 Wright N (2002) Homelessness a Primary Care Response, Royal College of General Practitioners, Chapter 3
44 Hinton, Evans & Jacobs (2001) Health Hostels a guide to promoting health and well being among homeless people Crisis Health Action p15
45 Wright N (2002) Homelessness a Primary Care Response, Royal College of General Practitioners, p30
The use of Accident & Emergency

The homeless people interviewed as part of the Crisis research were over four times more likely than the general public to turn to A&E when they could not access a GP (43% compared to 10%).

Accident and Emergency departments are acute facilities normally associated with major trauma, (physical damage caused by accidents or force), and other emergencies. Victims of serious road traffic accidents will be treated alongside people who’ve had a heart attack and many others attend with minor accidents and injuries, ranging from relatively small cuts and sprained ankles, to more serious but non-life threatening conditions. There are also people who attend A&E with conditions that would be more appropriately treated by GPs.

Crisis research found that homeless people were over four times more likely than the general public to turn to A&E when they could not access a GP.

The homeless people interviewed by Crisis were more likely to use to A&E than any other form of healthcare if they couldn’t access a GP. In some instances, homeless people will use A&E because an untreated problem has become so acute that it needs immediate attention. In other cases, homeless people are simply presenting at A&E because they know it is the one place they can get treatment, whether it is appropriate for them to be there or not. However, there is some debate over what constitutes inappropriate use of A&E. A fundamental question to be asked, is, can homeless people’s use of A&E ever be said to be inappropriate where they lack access to other primary health care services?

Research has found that where homeless people are using A&E in place of GP services the cost is high. In a study of homeless people’s use of the A&E wing of the University College Hospital (UCH), Shelter estimated the cost of an attendance at A&E to be £44. Shelter compared this with £15.95 as the cost of a visit to a GP. The study calculated that UCH would make an annual saving of £60,000 if homeless people had where appropriate been referred to GP services.

What is clear however, is that for as long as homeless people are unable to access primary healthcare via GP services A&E departments will continue to provide a vital lifeline by addressing their health needs when no other service does.

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Primary health care options

As referred to in a previous section, recent years have seen the introduction of a number of new initiatives aimed at improving the access of socially-excluded groups to primary health care services by offering a broader range of primary health care services.

The government has approved 41 nurse-led walk-in centres and they currently deal with approximately 590 attendances a year. However their services are essentially designed to deal with minor illnesses and injuries and they often need to refer people to

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a GP. Furthermore no research has been carried out into their level of use by homeless people.

NHS Direct, the national telephone help line, focuses on the provision of information and health advice. A recent evaluation by the Audit Commission concluded that “There was not yet a visible effect on demand for NHS services overall, with volume still being relatively small.” Aside from the fact that it is not designed to replace GP services but to complement them, many homeless people will have difficulty using this service without easy access to a telephone.

There are currently 71 Personal Medical Services (PMS) nationwide, either specialising in or with a special interest in the primary care of homeless people. Whilst Personal Medical Services (PMS) have been described as a “practical way of getting mainstream healthcare to disadvantaged groups” there is as yet no comprehensive and up to date information on how effectively they are meeting the health needs of homeless peoples, but for as long as homeless people have problems accessing GPs and are turning to A&E instead it cannot be said that their health needs are being met.

Specialist services for homeless people raise the concern that they may effectively absolve local GPs from providing primary healthcare services and at worse serve to ghettoise homeless people rather than encourage their reintegration back into mainstream care. A recent unpublished report has identified the emergence of some specialist health services for rough sleepers, however it also recognises that “access to primary care services is only available via mainstream services in some areas”, where specialist provision exists effort must be made to ensure that it is “balanced with the need for mainstream understanding of needs, and the eventual movement of clients from targeted to mainstream services.”

The inverse care law was first described by Tudor Hart in 1971. It states that the availability of good medical care tends to vary inversely with the needs for it in the population served. As this briefing has shown, this certainly holds true when looking at the homeless population. Their health needs are demonstrably greater and their access to care poorer than that of the general population.

Providing homeless people with access to GP services is an essential step towards their reintegration into mainstream society. Yet it is clear that this is not happening, with great cost both to the individual and in turn, society at large.

Conclusion: The need for reform

The inverse care law was first described by Tudor Hart in 1971. It states that the availability of good medical care tends to vary inversely with the needs for it in the population served. As this briefing has shown, this certainly holds true when looking at the homeless population. Their health needs are demonstrably greater and their access to care poorer than that of the general population.

Providing homeless people with access to GP services is an essential step towards their reintegration into mainstream society. Yet it is clear that this is not happening, with great cost both to the individual and in turn, society at large.

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51 Personal communication DoH Inequalities Unit 2002.
54 Ibid p12.
1 All GP services should be equipped with the knowledge and resources to ensure that they are able to tackle the health needs of homeless people.

- GP practices, including practice managers, receptionists and primary care staff should be provided with training on homelessness and the specific health needs of homeless people.
- All homeless people should be enabled to permanently register with a GP.
- The Department of Health should issue a directive reminding GPs that they can and should register people who do not have a permanent address and give them details of the mechanisms for doing so.

2 Accident and Emergency departments should respond to the presenting needs of homeless people and make an effort to link them into primary care services or specialist services for homeless people.

- Resource packs about local homelessness services should be developed for use in surgeries and A&E departments.

3 PCTs should work closely with local authorities and the voluntary sector to ensure that the health needs of homeless people are tackled as part of a holistic approach to solving homelessness.

- PCTs need to recognise the homelessness population within the Health Improvement and Modernisation Plan and as part of the local needs assessment.

4 The statutory sector (health, social care and housing) should work in partnership to ensure homeless people have access to health services.

- Homelessness statutory sectors should work to ensure that health and social care for homeless people is on the agenda of their homelessness strategy. Developing shared protocols between HPU (Homeless Persons Unit) and health services on GP registration would be an example of what could be done.

- PCTs should introduce financial incentives to encourage the registration of homeless people.
- PCTs need to link in with local authority homelessness strategies.
- PCTs should address the need for the provision of specialist health services for homeless people and these services should encourage the reintegration of patients within mainstream services.
- All PCTs should identify a lead officer with responsibility for homelessness.
- Services for homeless people should be specified in GP contracts and clear monitoring procedures should be put in place.
**Hidden homelessness campaign**

Critical Condition: Vulnerable single homeless people’s access to GPs is a part of Crisis’ hidden homelessness campaign which focuses on the hundreds of thousands homeless people living in hostels, B&Bs, squats and on friends’ floors.

**About Crisis**

Crisis is the national charity for solitary homeless people.

We work year-round to help vulnerable and marginalised people get through the crisis of homelessness, fulfil their potential and transform their lives.

We develop innovative services which help homeless people rebuild their social and practical skills, join the world of work and reintegrate into society.

We enable homeless people to overcome acute problems such as addictions and mental health problems.

We run services directly or in partnership with organisations across the UK, building on their grass roots knowledge, local enthusiasm and sense of community. We also regularly commission and publish research and organise events to raise awareness about the causes and nature of homelessness, to find innovative and integrated solutions and share good practice.

Crisis relies almost entirely on donations from non-government organisations and the public to fund its vital work. Last financial year we raised £5.5m and helped around 17,000 people.

Much of our work would not be possible without the support of over 3,000 volunteers.

Crisis was founded in 1967 and has been changing the lives of homeless people for 35 years.