Questionnaire for the FEANTSA Annual Theme

The Right to Health is a Human Right: Ensuring Access to Health for Homeless People

AC members are asked to draft a national report for their country, based on responses to the questions outlined in this questionnaire. The reports should be 10 – 15 pages in length, written in either English or French and they should be submitted to the office by June 15th 2006. AC members are asked to consult with all FEANTSA member organisations in their country in the preparation of the reports; a copy of the questionnaire will be circulated to all FEANTSA members. The European report on Delivering Healthcare to Homeless People will be prepared over the course of the summer, on the basis of the responses received, and will be presented at FEANTSA's annual conference in Wroclaw on the 13th of October 2006.

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Preamble: health and homelessness:

When considering homelessness and the best ways to tackle it, one cannot fail to be aware of the close links between health and homelessness. Looking at health and how it relates to homelessness offers a view of homelessness in health terms that is very useful. A definition of health is set out in the preamble to the World Health Organisation Constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Given that being homeless will certainly affect at least one of these spheres of health, homelessness may, by its very nature, be considered as a state of ill-health.

There is a range of factors, which may lead to a person eventually becoming homeless and often health issues are among them. Health and homelessness have a relationship of both cause and effect: illness (such as mental illness, substance-abuse or illness leading to loss of employment) may be among the trigger factors that lead to homelessness. Once in a situation of homelessness, a variety of health problems may result, such as exposure to infectious illness, mental health problems, development or aggravation of substance-abuse and addiction, or health problems resulting from an unsanitary or overcrowded environment. These health problems may make it harder to break out of a cycle of homelessness. What is more, accessing healthcare is often very problematic for homeless people.

This health perspective offers many people a better grasp of homelessness and can serve to counteract stereotyped visions. Health is one of the elements that has been used to define homelessness in Australia for example: in Australian legislation, homelessness is defined in the Supported Accommodation Assistance Program Act 1994. This act defines a 'homeless' person as follows:
"For the purposes of this Act, a person is homeless if, and only if, he or she has inadequate access to safe and secure housing. "(Section 4) The Act goes on to define 'inadequate access to safe and secure housing' and the very first criteria that is used is that of health: "For the purposes of this Act, a person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: damages, or is likely to damage, the person's health; or threatens the person's safety…" This offers a concrete understanding of homelessness in terms of a threat to health and well-being that policy-makers are likely to be able to identify with and which is concrete enough to mobilise political will.

Health is a vital factor for social inclusion. Good health is a prerequisite to reintegration and is a vital factor in being able to access and maintain employment and housing. Conversely, having a home and a job are important to good state of mental and physical well-being. Thus the right to health underpins and reinforces the right to employment and to housing. What is more, the right of a person to enjoy the highest attainable standard of health has a strong place in international human rights law and is enshrined in international conventions and charters such as the International Convenant on Economic, Social and Cultural Rights and the European Social Charter. This right has been clarified in the General Comments of the UN Committee on Economic Social and Cultural rights, where it is set down that "the right to health is closely related to and dependent upon the realisation of other human rights, including the right to food, housing, work, education, participation…" So it is clear that health is a good way of framing and approaching these other needs, which are particularly acute in the case of homeless people.

Thus it is clear that health has a role to play in understanding homelessness and in communicating about homelessness. It is also true that health policy is a useful avenue for tackling homelessness in a preventative and also a holistic manner. Health services have a vital role in the fight against homeless, as meeting health needs is an important step towards tackling

homelessness and health services should be a gateway to other services. It is for all of these reasons that FEANTSA has dedicated 2006 to exploring the theme of health and homelessness. This questionnaire will try to establish a broad overview of the issues relating to health and homelessness across Europe. It will look at health profiles of homeless people, access to healthcare, training of health professionals, inter-agency working, data collection on health and the right to health.

The answers of Y-Foundation / Finland by Taina Hytönen

Q1: Health profiles of homeless people:

This section aims to establish an overview of the main mental and physical health needs of homeless people in Europe; the public health issues that arise from them; as well as common treatment problems. When answering the questionnaire, it may be useful to refer to the ETHOS (European Typology of homelessness and housing exclusion) categories in order to ensure clarity and comprehensiveness. You will find the ETHOS typology in Annexe 1. It is also useful to bear in mind that many homeless people will present with more than one health problem and that these multiple problems across a range of areas may interact with each other and add up to a high aggregate of vulnerability. Please take multiple needs into account when answering these questions.

For reference, here is a definition of multiple needs:

"A typical homeless or ex homeless person with multiple needs will often present with three or more of the following, and will not be in effective contact with services:

- mental health problems
- personality disorders
- borderline learning difficulties
- physical health problems
- vulnerability because of age.
- misuses various substances
- offending behaviour
- disability
- challenging behaviours

If one were to be resolved, the others would still give cause for concern."
(Definition from Homeless Link Good Practice Briefing "Multiple Needs" August 2002)

It should be noted that these multiple needs may also be complicated by previous bad experience of health or social services and a mistrust of health and social workers.

1.1: **Please outline the common mental, physical and substance abuse related health problems of the homeless people bearing in mind the conceptual ETHOS categories. Some of the health problems will reoccur in several categories.**

The health issue is often one part of a complex web of problems among the homeless people. It can be a trigger factor leading to homelessness (mental health problems, personality disorders, misuse of various substances) and it can be the main obstacle when trying to break out of a cycle of homelessness.

The more factors there are in the process of marginalization, the more demanding it is to find good solutions in improving the welfare of the homeless. The most vulnerable group are the roofless at least when the time-factor is added. When a person has adapted to the insecure life of a rough sleeper the measures to overcome the situation must be comprehensive. This is a challenge to the service system. A great variety of services are needed for various needs. Also tolerance is necessary to cope with relapses.

Systems abuse problems are one central factor affecting the health of the homeless. It can be a cause and an effect of homelessness but it is also a key factor that makes it difficult to solve the problem. Systems abuse problems are almost always connected to mental health problems, self-destruction, impulsive behaviour, personal losses and negligence in relation to oneself and in personal matters (Hynynen 2005, 10). Heavy drinking is the most common health hazard in Finland and the total consumption of alcohol is rising all the time. The increase in drug problems has caused other kind of risks, such as contagious diseases (hepatitis, HIV). Mental health

disorders are also causing homelessness and especially difficult is the situation is case of multiple problems.

The roofless are also most vulnerable for violence, infectious diseases and frostbites. Proper treatment is often threatened because of the chaotic lifestyle and the lack of decent conditions of living. This is why basic medical care is an important part of the homeless services.

The houseless people have a better situation if they are living in a shelter or some kind of supported accommodation since they have better access to help: any kind of address makes it easier to get treatment and the personnel can help in making appointments to doctors etc. After institutional care there happen dropouts in the service system since there is not enough out-patient care available and also possibilities to supported housing and services are limited.

1.2: Certain diseases, which are widespread among the homeless population, carry a clear public health risk. This is the case, for example, with tuberculosis. Tuberculosis incidence is much higher among homeless people than among the general population and there is a risk of the spread of this infectious disease and the development of multi-drug resistant strains. For this reason, some countries have put in place specific programmes or strategies to combat tuberculosis among homeless people. Please outline list any public health risks associated with the health of homeless people and actions taken to alleviate these risks.

In general the situation concerning health risks is relatively good in Finland thanks to the general health care system and a long term preventive work to improve public health and welfare. There are, however, new risks to tackle. They are partly due to new health issues such as the increasing use of illegal drugs. Also the global risks and the welfare situation of the neighbouring areas need to be monitored.

Tuberculosis has become a rare disease in Finland during the last 40 years. There are about 350 new cases diagnosed every year, most of them among old people who have been infected in their youth (Statistics of the Public National Health Institute). An increasing number of cases have been found among immigrants moving from countries with higher risk of tuberculosis. There have so far been only a few sporadic cases of tuberculosis resistant to drugs.

There is, however, evidence from the homeless services which suggest, that the infected are not diagnosed until they end up to a hospital or to a low threshold service for some reason.
There is a threat that the statistics give an optimistic picture of the situation.

Higher risks especially among homeless people with drug problems are other contagious diseases such as hepatitis B and C and HIV. Most intravenous drug users (70-80 %) carry the Hepatitis C virus. The situation of HIV is rather good in Finland, at least compared to many other countries (about 130 new infections diagnosed per year). Hepatitis C or HIV can not be cured but medication can greatly improve the well-being of the patient. Social services support the treatment by arranging better housing conditions and support. In Helsinki the city works together with the Helsinki Deaconess Institute, which provides special services for HIV positive drug users.

Harm reduction policies have been developed to prevent and repair the ill-effects of drug use. They include giving health care information and treatment, clean syringes and needles and in case of heroin addicts also substitution therapy. Harm reduction also aims at creating favourable circumstances and encouraging the users to seek rehabilitation.

One current health risk has recently been infectious diseases in hospitals. There have been about 1400 new carriers of MRSA per year during the past years, mainly in the capital are. It can be regarded as a general health risk but it affects the homeless people, too, as MRSA can cause a more serious infection among people who are already ill. In Helsinki, for example, the local

authorities have made special arrangements to offer the infected homeless people possibilities to recover and also to prevent the spread of organisms from one person to another.

1.3: Certain health conditions experienced by homeless people pose significant problems of treatment. (For example: tuberculosis treatment can be rendered difficult by a mobile and chaotic lifestyle and overcrowded conditions; there may be availability problems for mental health treatment and drug and alcohol treatment etc…) Treatment of mental health problems is evolving and deinstitutionalisation has taken/ is taking place in many countries, but this too has given rise to new challenges and problems. Multiple needs are another factor that can make treatment problematic. Please outline treatment problems encountered when trying to ensure access to health for homeless people.

The most challenging group also for the Finnish health care system are people with multiple problems. Good health care for them requires improvements also in living conditions such as accommodation, but there are not enough services available, at least with tolerance to relapses and patience to believe, that the treatment can be successful although several attempts are often needed. The results of treatment can not be effective when there are not enough suitable housing facilities available. If a person has multiple problems and also mobility disability the situation is even more difficult. A wheelchair can be an obstacle to attend services or live in supported housing or shelters, simply because they are situated in old buildings.

In mental health sector the deinstitutionalisation process was rapid in Finland especially in 1990´s, when there was a deep economic recession in the country. There was not enough outpatient care available and very limited supply of supported housing. Even today there is lack of service options and the mental health services and distributed unevenly in the country. Also improvement in the living conditions of mental health patients are needed, especially in housing as there are not enough good quality supported housing options available.

Emergency services for homeless people are an important gate to health services, but it is a challenge to improve even such basic facilities. The city of Helsinki is planning a new service centre to be situated in central Helsinki. During the spring 2006 there has been a lively public debate about the project. Now in June it seems possible that the political will to carry out the plan is strong enough.

Q2: Social Protection: Healthcare entitlements of Homeless People

The healthcare entitlements of homeless people vary from country to country according to the social protection system in place. It may also relate to their administrative status (whether they have registered). It may also vary according to whether the homeless people are nationals or non-nationals. This question seeks to examine the impact on access to healthcare and quality of care available to homeless people.

2.1: What are the healthcare entitlements of homeless people in your country (for nationals; for non-nationals, including asylum seekers and undocumented migrants)? What are the registration requirements etc.?

In Finland the welfare system is residence based and includes the principle of universal services and adequate social protection. All people living in Finland are entitled to care and protection and the economic, social and educational basic rights are safeguarded by the constitution.

The responsibility for organizing health care in Finland lies with the 431 municipalities across the country (Health Care in Finland, 7-8). These can either provide health care services independently or in joint municipal boards which maintain a joint health centre. Municipalities can also buy in

health services from other municipalities, non-governmental organizations or the private sector. Services are mainly funded from tax revenue.

The law lays down the basic nature and operating framework for the heath care but does not give detailed instructions concerning the scope, content or organization of services. There may therefore be differences in service provision from one municipality to another. Legislation does, nevertheless, prescribe the main primary health care and specialized medical services which all local authorities must provide.

Since March 2005 there have been new statutory regulations on access to treatment in Finland. The target is to improve access to health care and also to improve the regional equity in service provision. So far there are signs of shorter queues to some services but these regulations do not necessarily improve the situation of the homeless. There is a risk that resources are now allocated to acute somatic treatment instead of prevention, rehabilitation, support services and mental health services (e.g. Teperi 2005, 3). Also mental health organisations have criticized the effect of the regulations: they have not been able to guarantee sufficient, appropriate and good quality treatment to mental health patients.

2.2: Has the health system evolved in such away that it is getting harder for homeless people to access their entitlements?

The health care system has not in a large extent evolved in such a way that it is getting harder for homeless people to get services, at least in emergency situations. But the health care system has certainly not been able to develop sufficient and suitable services to match the lifestyle and various needs of the homeless people.

The financing of public health care as well as the welfare system in general is a critical question in Finland. There is an extensive re-organisation of service provision going on and also the structures of local administration are undergoing a thorough reform. These changes can be a threat to the homeless since this group of people needs welfare services but the financial resources to arrange support are limited. Also the application of the regulations on public procurement is making the service provision more difficult. If the public services are weakened also the services of the most vulnerable homeless people are weakened since there is not a real market of these services.

It has been estimated that in the capital region only about 30 % of the homeless can be helped by arranging them a home (Asunnottomien asumispalvelujen kehittyminen 2005, 11). The great majority needs special services: health care, mental health services, rehabilitation, services for intoxicant users, supported accommodation etc. This means a need to develop new and more comprehensive service concepts. A wider multi-disciplinary view of social medicine should be necessary in the health services.

There are more and more people suffering from addiction and mental health problems (double diagnosis or multiple problems) in Finland, but the welfare system is not able to help them in a proper way. In health care these people are often met in emergency departments in hospitals where they can not be properly diagnosed and treated. These patients drift from one crisis situation and emergency service to another without finding help. Patients are also often transferred from psychiatric treatment to substance abuse services and vice versa. This does not encourage the clients to stay in treatment.

There are also other vulnerable groups such as persons suffering from brain damage, amnesia, feeblemindedness or people who just are not able cope alone (Pitkänen & Kaakinen 2004, 52). They are excluded from the services for the disabled and do not find their place in the service

system. The number of these people is not necessarily very large but their possibilities to get care and support are limited.

2.3: What do you consider to be the main barriers facing homeless people in your country when they try to access healthcare (stigma, financial barriers, administrative barriers, etc.)?

The main barrier facing the homeless people seems to be the lack of suitable, easy access or low threshold services especially for the most vulnerable groups of the homeless (the roofless and the houseless). The improvement of their welfare requires cooperation with mental health and social services. Otherwise the lifestyle can prevent proper treatment. Especially difficult is the situation of people with multiple problems.

In spite of the general right to health care it must be admitted, that the services are not necessarily organised in the best way considering the needs of homeless people. There are no special health stations for the homeless and there is not a certain body responsible for developing services only for these groups or doing research. The workers in homeless services report that in spite of the principle of universal services the situation in real life is not very good. A report of the clients in a day centre Stoori in Helsinki indicates, that the homeless have more health problems than other clients but they also find it hard to evaluate the situation themselves (Törmä & Huotari, 2005, 32).

In Helsinki, for example, the homeless are entitled to use any health station they want. This works somehow in acute situations. If the clients need check-up calls or suffer from chronic diseases they are advised to another health station or clinic: the homeless are divided to the various health stations according to the month of birth. This system is not very clear either to the clients or to the staff and usually the health station checks the records of the population register centre to see if they can find some kind of address and send the homeless person to another station. Even the nurses in homeless services find it sometimes hard to get health care for their clients when they need treatment (Anttola 2006). Very often the homeless are sent to another place – and finally they end up to emergency departments of hospitals.

2.4: Have attempts been made to overcome these barriers? Have they been successful?

Since the public welfare system can not match the needs of all the homeless people there have been special projects carried out by NGOs to develop services. There are good examples of successful solutions for some groups of homeless people such as HIV positive drug abusers, prostitutes or ex-prisoners. Also the counselling and support work in homeless services is helping the clients to get health care services and some NGOs have been developing mobile services to the homeless in Helsinki.

The Helsinki Deaconess Institute provides special services for several groups such as the HIV positive drug abusers. This low threshold service combines health care, accommodation and housing services and daily activities including nutrition. The objective is to increase the well-being of the clients and to prevent the spread of HIV and other infectious diseases. There is no need for a referral and the services can be used anonymously, too.

The clients of this special service get health care (including laboratory), welfare benefits and housing services from the same place. There is a possibility for short-time accommodation for the homeless and also support services for those who have got a home. A mobile service was started a couple of years ago. It brings health care to the clients in different parts of the city (the car stops four hours in one place every week). It appears that for many clients this has been the only

contact point to the health care system. For some reason or another they do not go the public health stations although they might have very serious health issues.

This approach also brings together the services of an NGO (The Helsinki Deaconess Institute), the public health care and the city social work. This unit has been able to react quickly when there have been developing infectious diseases among the clients, such as a hepatitis A infection a couple of years ago or tuberculosis. In 2005 the MRSA situation needed much attention (Hampunen, 2006).

Another good example is the service centre Pro-Tukipiste (NGO) for prostitutes. It is also a comprehensive low threshold service: no appointments needed, the services can be used anonymously and without charge. The clients get health services as well as support services from one place. Supported housing is arranged in cooperation with the city social services. The basic health care is important for the clients (Saari 2006). Also the possibility to get substitution therapy of opiate addiction through the public health care system has been useful in improving the health situation, even though the clients must wait for months to be able to start the treatment after the evaluation is done in a hospital.

Nurses and counsellors in day centres and other emergency services for the homeless are helping the homeless in overcoming the barriers, too. In the Helsinki city day centre the nurse has about 150-190 clients per month. The work of the nursing staff consists of support in basic care and helping the homeless to other health care services. Also help in daily life (food, hygiene, laundering etc.) are crucial for the well-being of the clients (Tikanoja & Tikka 2006).

Another kind of service concept is a mobile service centre Yökiitäjä Lepakko, a bus offering social and health care services for the homeless in Helsinki. This service has been developed by the NGO Vailla vakinaista asuntoa ry.

In health issues an important source of help are possibilities to outpatient care, detoxification or institutional treatment for intoxicant abusers because apart from homelessness also heavy drinking or drugs can otherwise be an obstacle. During a rehabilitation period the clients can benefit from health and dental care services and also get social support to arrange accommodation. A-Clinic Foundation (NGO), the leading substance abuse services provider in Finland, offers both outpatient and inpatient service units and activities in the areas of prevention, training, research and information provision.

Q3: Ensuring Access to quality healthcare

This question will explore why homeless people across Europe have difficulty accessing the good quality healthcare that they need. There is a range of services that homeless people should access in order to enjoy good health: these include medical treatment; but also preventative services (screening, check-ups etc.); specialised services such as dental services; and health promotion services.

3.1: **Are you aware of specialist and/or outreach healthcare centres that have been put in place specifically for homeless people? Do you consider that this is a good way to meet the health needs of homeless people? What are the costs and benefits of targeting homeless people in healthcare provision?**

Apart from the services described in part 2.4 the homeless are treated in the general health care system in Finland.

A special healthcare centre for the homeless could have advantages but maybe also negative effects. When the homeless are treated in the general health stations they get same treatment as

anybody else. The disadvantage is that the special needs of the homeless are maybe not seen (the larger socio medical context). The service system is complex and by concentrating all expertise to one place the awareness of both the needs and services could be better. On the other hand in the general services the homeless are a part of the general welfare system, they are not excluded from other people. Also the general health care must tackle the problems of homeless, they can not be “sent away”. A health station for homeless could probably be possible in Helsinki, but not in other municipalities. A lot can be done by simply improving the access to services and making the entry to health care easier.

3.2: Are you aware of any health promotion/ preventative health initiatives that are accessible to homeless people? Do you think that these impact positively on access to employment?

Harm reduction policies mentioned in part 1.2 have a strong preventive target.

3.2: How do homeless people in rural areas access health care?

The public health care system takes care of the homeless people in every municipality.

Homelessness is mainly a problem of Helsinki and other larger cities in Finland. According to the last housing market survey in 2005 there are 7430 single homeless people in Finland and almost one half of them (3095) live in Helsinki and the majority (3960) in the capital area (Ikonen & Tiitinen 2006).

3.3: Do you consider the healthcare received by homeless people in your country to be comparable, in terms of quality of care, to that received by the general public? In what health areas is there the greatest lack of access to care and why?

In general there are not major differences in the quality of care once a homeless person has been able to contact the health care system even though there are problems in arranging suitable treatment to some groups of clients (as mentioned earlier in question number 1.3). The greatest lack of access seems to be in mental health care: there are not enough options available in outpatient care and supported housing. The welfare system is not able to treat people with multiple problems in a satisfactory way.

Research on the Finnish health service system has, however, shown a worrying trend: there are great differences both in the lifestyle and in the treatment services of various groups of the population. There is a clear correlation between health and social status. The access to health services is more difficult for people with low income and they do not get as good treatment as the more well-to-do citizens (Koskinen 2006, 14-17). It seems that people with higher education level have better qualifications to use the service system. This is why service counselling or case management are important approaches especially in the work with the homeless.

3.4: In some countries, a specific policy framework and action plan around health and homelessness has been put in place in order to ensure that homeless people can get full access to quality care. Has such an approach been tried in your country?

Since the health services are available to all residents there is not a special action plan around the health and homelessness.

The focus in the Finnish policy has been in tackling homelessness so that all people could have a home and full access to the general welfare services. There have been both a national programme to reduce homelessness (2001-2005) and another program for the capital region (2002-2005). The target to eliminate homelessness is in the programme of the present government, too.

An evaluation study on these action plans was published by the Ministry of Environment in June 2006 (Kaakinen, Nieminen, Pitkänen, 2006). The results show that the provision of reasonably prised rental flats has made it possible to stop the growth of homelessness is spite of the migration to the growth centres and even to reduce homelessness in Finland. In the capital region the number of single homeless people decreased by 32 % during the period 2001-2005 and in the whole country the decrease was 25 %.

The evaluation emphasizes the need of a new action plan focusing on the long term homelessness and support services as well as measures to prevent homelessness. The report suggests new ways of financing support work and recommends that the health sector should have a stronger role in tackling homelessness. The recommended measures (e.g. building 2000 service flats for the most vulnerable homeless people in 2007-2011) would be a remarkable improvement also to the health of this group of homeless people.

Q4: Training of health professionals

Homeless people sometimes encounter a lack of understanding and reluctance to engage with them from healthcare professionals that might be overcome through training for health workers on how to work with homeless people, as well as on their specific health issues. The problem of homeless people presenting with multiple needs can also be professionally challenging for healthcare workers. This is another area where training would be useful.

4.1: **Do you know of any such training courses (in all areas of healthcare – nurses and doctors, but also mental health workers, dentists, podiatrists etc.) or plans to put them in place, as part of medical training or as follow-up training?**

No information about this!

Q5: Interagency working

Ideally, accessing healthcare should provide a route into other care and integration services, through referral and transfer practices between homeless services, social services and health services.

5.1 Are you aware of instances of this kind of networking in your country?

Interagency working is a crucial part of the Finnish welfare system and its value is emphasised also in the action plans to reduce homelessness. The authorities are encouraged to continue and deepen the networks both on the local and on the regional level. Also service chains are favoured. As mentioned earlier (in part 3.4) there is a growing demand to increase the role of the health sector in tackling the homelessness in Finland.

There are several organisations working with the homeless in the Finnish “welfare mix”. Local authorities have the legal obligation to arrange services and cooperation is demanded between social and health services as well as with the housing sector.

Also the strong NGO-sector must be mentioned since these organisations have been active in developing new services and they work as partners to the public authorities. It has been estimated that the national NGOs working in social and health care produce nowadays about 17 % of all social welfare services and 5 % of health services (Vuorinen & all, 2004). As the examples in chapter 2.4 show the local authorities, health services and NGOs can also produce services together as in the case of the low threshold service centre for HIV-positive drug addicts.

The NGOs also complement services by arranging extensive peer support activities and voluntary work such as supported housing. The help of trained volunteers can remarkably improve welfare by helping to overcome loneliness and isolation (Kärkkäinen & all. 1998, 58).

The diaconal work of the Evangelical Lutheran Church of Finland is one partner in the service provision. The church arranges help to the most vulnerable people such as the homeless, ex-prisoners or the unemployed. In the capital region the parish of Vantaa has built a residential unit (Laurinkoti) for homeless families. Also there one member of the staff is a social worker financed by the city of Vantaa.

Local networking is important to create contacts between various service providers and to share information about service options and good practices. The lack of networks is not the main problem. Lack of suitable services is more often the main difficulty. Sometimes it also seems to be difficult to master all the information about various services and projects and to offer right services to people who can benefit from them. Local authorities are in a key position in coordinating the use of services but scarce financial resources and large organisational reforms make this work challenging. Also the short duration of developmental projects is a challenge because it is very hard to get permanent financing even to the best of the "best practises".

5.2: Are health and social services supportive of this type of working? Have administrative procedures or agreements been put in place to facilitate transfer and sharing of information and cooperation between different services? What are the discharge practices from hospitals in your country?

(The first questions: see part 5.1)

There are social workers in hospitals and they help the patients to arrange outpatient care, accommodation etc. together with the local authorities. There is, however, a shortage of resources in home care and home-help services. This weakens the chances of the most vulnerable patients to get proper housing conditions.

5.3: Have you encountered instances where there is an obvious breakdown in this kind of networking? (eg: homeless people being retained in hospital because no other option has been found for them to move on to other services).

The homeless are offered support to arrange their living conditions but the options do not always match the needs and wishes of the clients. The rules of a convalescent home or supported housing facility can bee too strict for a heavy drinker etc.

Q6: Health indicators, data collection and research

It is not always easy to access information on the health situation of homeless people. Yet such information can be crucial to making the case for political investment in healthcare for homeless people. This question

seeks to establish possible effective ways of accessing reliable data on the health situation of homeless people.

6.1: Is data collected on any area related to the health of homeless people in your country? (such as the different illnesses suffered by homeless people, number of homeless people using specialist health services, number of people using general services, causes of death, life expectancy, etc.) If so, who collects it? (hospitals, homeless service providers, A&E, youth care centres, psychiatric services, etc).

There is information available from some NGOs or statistics of the clients of various services but in general there is not much research on the health of homeless people in Finland. Data is collected on general health risks such as contagious diseases or on the use of services but the homeless-factor has not been the main point in the evaluation.

6.2: Do you know of any research undertaken on the health of homeless people by academic or other bodies? (eg: Government reports, NGO reports, scientific reports, etc.)

There is a "classic" in the field of social medicine, the doctoral thesis by Ilkka Taipale about homelessness and alcohol published by the Finnish Foundation For Alcohol Studies in 1982. In Finland homeless issues are more often dealt with as a social problem or as a housing problem.

6.3: Do you know of data collection in the following areas that might be relevant in relation to the health to homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

See part 6.1.

6.4: Do you know of any indicators used to measure the effectiveness policies/services in the following areas that might be used to get information on the health and well being of homeless people?
- Health determinants including lifestyle factors, drug and alcohol abuse and smoking
- Environment and health
- Access to health
- Mental Health

Sometimes "self-perceived health status" is used as an indicator to collect health data - do you think this is useful in relation to homeless people?

See part 2.3

6.5: In relation to housing, are you aware of any comparisons undertaken between the health of the well and poorly housed populations? In relation to employment, do you know if comparisons between the health and well being of homeless or formerly homeless people who have access too employment and those who don't?

There is research on the impact of the good housing conditions and supported housing on the general well-being of the homeless (e.g. Pitkänen & all 2004). In the present situation information

on the health effects – comparison of health status or the health service use between the homeless and formerly homeless – should be useful in campaigning to get financial resources to support services.

Q7: The Right to Health

The right to health is enshrined in several international human rights texts. You can find the articles on health brought together in FEANTSA's brief on the right to health. It is further strengthened by the right to non-discrimination in the area of access to health. Tackling health inequalities is an ongoing priority at European level. For this reason, expressing homelessness in terms of health has the potential to be a powerful political tool. The right to housing, the right to employment and to access to the services you need are all underpinned by the right to be healthy and to enjoy a state of well-being.

7.1: **Do you know of any examples where a rights-based approach has been adopted in relation to health for homeless people or other vulnerable groups, whether in the form of court cases or campaigns?**

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7.2: **Is the health of homeless people a political issue in your country? Could it be a useful campaigning point? Why? Why not?**

The health of homeless people has not been a political issue and the policies are targeted to eliminate homelessness.

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Please return your completed questionnaires to dearbhal.Murphy@feantsa.org before June 15th 2006.

Annexe 1: ETHOS TYPOLOGY

ETHOS
European Typology of Homelessness and housing exclusion

Homelessness is one of the main societal problems dealt with under the EU Social Inclusion Strategy. The prevention of homelessness or the re-housing of homeless people requires an understanding of the pathways and processes that lead there and hence a broad perception of the meaning of homelessness.

FEANTSA (European Federation of organisations working with the people who are homeless) has developed a typology of homelessness called ETHOS.

The ETHOS typology begins with the conceptual understanding that there are three domains which constitute a "home", the absence of which can be taken to delineate homelessness. Having a home can be understood as: having an adequate dwelling (or space) over which a person and his/her family can exercise exclusive possession (physical domain)*; being able to maintain privacy and enjoy relations* (social domain) *and having a legal title to occupation* (legal domain)*. This leads to the 4 main concepts of Rooflessness, Houselessness, Insecure Housing and Inadequate Housing all of which can be taken to indicate the* absence of a home*. ETHOS therefore classifies people who are homeless according to their living or "home" situation. These conceptual categories are divided into 13 operational categories that can be used for different policy purposes such as mapping of the problem of homelessness, developing, monitoring and evaluating policies.*

ETHOS European Typology on Homelessness and Housing Exclusion

Conceptual Category		Operational Category		Generic Definition
ROOFLESS	1	People Living Rough	1.1	Rough Sleeping (no access to 24-hour accommodation) / No abode
	2	People staying in a night shelter	2.1	Overnight shelter
HOUSELESS	3	People in accommodation for the homeless	3.1 3.2	Homeless hostel Temporary Accommodation
	4	People in Women's Shelter	4.1	Women's shelter accommodation

	5	People in accommodation for immigrants	5.1 5.2	Temporary accommodation / reception centres (asylum) Migrant workers accommodation
	6	People due to be released from institutions	6.1 6.2	Penal institutions Medical institutions
	7	People receiving support (due to homelessness)	7.1 7.2 7.3 7.4	Residential care for homeless people Supported accommodation Transitional accommodation with support Accommodation with support
INSECURE	8	People living in insecure accommodation	8.1 8.2 8.3 8.4	Temporarily with family/friends No legal (sub)tenancy Illegal occupation of building Illegal occupation of land
	9	People living under threat of eviction	9.1 9.2	Legal orders enforced (rented) Re-possession orders (owned)
	10	People living under threat of violence	10.1	Police recorded incidents of domestic violence
INADEQUATE	11	People living in temporary / non-standard structures	11.1 11.2 11.3	Mobile home / caravan Non-standard building Temporary structure
	12	People living in unfit housing	12.1	Unfit for habitation (under national legislation; occupied)
	13	People living in extreme overcrowding	13.1	Highest national norm of overcrowding

For more information please see FEANTSA's *2005 Review of Homeless Statistics in Europe* (Edgar et al.) at www.feantsa.org

FEANTSA is supported financially by the European Commission. The views expressed herein are those of the author(s) and the Commission is not responsible for any use that may be made of the information contained herein.