

European Network of Homeless Health Workers (ENHW)



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Stefania Del Zotto, Policy Officer, FEANTSA

Dear Readers,

First of all, I would like to wish you all the very best for 2010!

As you might know, 2010 is the [European Year for Combating Poverty and Social Exclusion](#), whose key objectives are to raise public awareness and renew the political commitment of the EU and its Member States to combating poverty and social exclusion.

I am pleased to share with you the latest edition of the ENHW newsletter, which covers a wide range of topics. Articles include: the results of a research on homelessness, health and accessibility of health care services in Slovenia, which shows how difficult access to health care remains for vulnerable groups of the population; an example of shelter-based convalescence for homeless patients in the Netherlands, which addresses the problem of discharge from hospitals to no fixed abode; an article on a dental clinic targeting excluded people to be set up in Denmark, which raises the issue of dental health as an important aspect of general good health and well being; a theoretical framework for a multidisciplinary approach to health involving professionals such as psychologists, anthropologists and cultural mediators being implemented in Italy and which might be of interest to other countries as well.

In the resources section, you will find information on the St Mungo's report on mental health and homelessness, as well as details about an internet-based translation tool aimed at health professionals working with non native speaker patients, which is now available in English as well. In the forum section, you will see that FNARS is currently looking for partners in the framework of an EU lifelong learning call for proposals.

We hope that these examples will stimulate further reflection and interaction, which could take the form of articles for the next issue. We would also be pleased to receive information on any relevant research or events you might be aware of.

I would like to extend my warmest thanks to everyone who has contributed to the current issue. Please do not hesitate to send your answers, comments, questions and contributions for the next issue of the newsletter to stefania.delzotto@feantsa.org.

Sharing Experiences

Research on homelessness, health and accessibility of health care services in Slovenia

By Špela Razpotnik and Bojan Dekleva,
*Faculty of Education, University of Ljubljana, Slovenia**

Homelessness in Slovenia is rather a new phenomenon. Until the end of the previous decade there were almost no research projects on homelessness done or articles/monographs published. Till 2008 there have also been no data collected or discussion held on the topic of health care and accessibility of health care system in Slovenia. But in 2009 a research was carried out on this topic and a book with its results published. This research was a result of cooperation of different actors: homeless people themselves (active within

the Association Kings of the Street), researchers (from the Institute of public health of Republic of Slovenia and from the Faculty of Education, University of Ljubljana), practitioners from the Association Kings of the street and Ministry of health (Sector for health care of vulnerable social groups) who funded this research and organised the seminar with the purpose of the presentation and dissemination of the results. Principal researchers and authors of the book were Špela Razpotnik, Bojan Dekleva and Dušan Nolimal. Two main research approaches were used: a survey (questionnaire) on health related issue used on the 122 homeless people from six towns of Slovenia and a focus group with homeless people on their experiences with the health care system.

Analysis of the survey results

The purpose of the survey was to explore the area of basic health needs of homeless persons, their experiences with, and perceptions of health system, including its accessibility, and levels of confidence and trust to this system by the homeless. Special emphasis was devoted to addictions (nicotine, alcohol and illicit drugs), nutrition issues, mental health problems, use of prescribed drugs and medication, social support networks and patterns of social in/exclusion.

In the sample there were 64 % people from the capital Ljubljana and the rest from five smaller Slovenian cities. In Ljubljana people were sampled in five different locations, including streets. The sampling was opportunistic. Because four of the sampling locations were drop in centers and shelters for homeless people the research dealt mainly with street homelessness.

Among the respondents there were 84% men. The age of respondents was between 20 and 77 years, with an average age of 42.7 years. Males were on average five years older than women. The highest completed education of respondents was mostly high school (49.5%) and completed primary school (41.8%). Most of them were either single (52.5%) or divorced (31.2%). 58.2% of them had children.

The results were compared with results of three other Slovenian (health) surveys, namely the European Health Interview Survey (EHIS, Zdravje..., 2009), Homelessness in Ljubljana (Dekleva and Razpotnik, 2007) and Social inclusion and psychosocial health of unemployed youth (Dekleva et al, 2004). The comparison of data shows that in this research the prevalence of many health problems among homeless people was much greater than in other populations. The data for specific health issues (identified by the physician) were: arthritis (22,9 % versus 7,1 % in EHIS); chronic depression (22,7% vs. 4,6%); angina pectoris (18,8% vs. 5,3%); stomach or duodenum ulcer (18,5% vs. 8,4%); mental health problems (16,2% vs. 2,7%); liver cirrhosis (12,7% vs. 1,4%); chronic obstructive pulmonary disease (11,9% vs. 6,1%). For some of the diseases or health conditions there was no comparable result available in EHIS but they are all the same very interesting: alcohol dependence (33,9%); other drugs dependence 25,8; bronchial asthma (16%); hepatitis (15,3%).

Focus group

The main purpose of the focus group was to deepen our insight regarding the point of view of homeless people as users (patients) of the health care system. We chose people who already had had many experiences with the health care system. On the basis of the focus group discussions eight main topics were identified, which were pointing to different barriers in reaching and using the health care system. The following paragraphs start with a quote from the discussion (in italic) and give then a short description of the topic.

1. *"We are not the social service, they tell you. We are hospitals and not social institutions".*

Within health care institutions different not-health-related needs of the socially excluded users remain unmet and there are no other services that could compensate for that lack. Homeless people from our research report that they hear very often the sentence quoted above, indicating that their other-than-health needs are not to be taken into account in a health care context.

2. *"I was an alcohol addict and I was not willing to see the doctor".*

Our participants report frequent and long periods of not visiting doctors. This was also connected with their feeling of being stigmatized because of alcohol or other drugs addiction, with lack of trust, and the existence of many other difficulties. When entering health care system finally it was very often through emergency services.

3. *"They said to me "go home and rest", although in my medical file it was written that I was homeless".*

An important problem within the framework of health care is the lack of post-treatment institutions for people who are homeless.

4. *"Before I was picked up from the ground they asked me: do you have health insurance?"*

An important set of problems when discussing accessibility of the health care system for homeless people is connected to absence of health insurance. Health insurance is a necessary condition for benefiting from health care and many homeless people lack it. Health insurance is associated with permanent address, employment and social benefits. Lack of one of those conditions or exclusion from one of those causes problems also in

the other fields and thus perpetuates the vicious circle of exclusion.

5. *"In the waiting room the doctor said to me in front of other patients: "Next time you have to come clean and tidy". Where should I clean myself?"*

A common obstacle for homeless people to access health services is the feeling that the health care workers have a stigmatizing attitude toward them and that they blame them for the way they live or perceive them in a stereotypical way.

6. *"In the hospital room they look at you in a strange way..."*

The topic of differential treatment (or even discrimination) of drug users within the health care organizations was pointed out in the focus group. They report that sometimes they are treated in a "special way", which emphasizes their deficiencies or un-necessarily stigmatizes them.

7. *"Yes, I get the prescription for medicine but I cannot pay for them, so I go to the dispensary for persons without health insurance".*

Poverty is strongly connected with access to health and accessibility of health care services. There is one dispensary in Ljubljana (and another one in Maribor) for people without health insurance. These were established as a temporary solution to compensate gaps in the health care system during the transition (from socialism) in the 1990s and until the problem of uninsured people would be resolved systemically. But it still exists nowadays, which shows that the Slovenian health care system failed to include the most vulnerable groups of the population.

8. *"No one explained anything to me".*

One of the obstacles in accessing the health care system is the lack of information people receive regarding their health care, their rights, possibilities and choices of medical treatment. According to the focus group's perception, there is also a lack of information on their own health condition after the treatment and the follow up: what should and could they do in their actual living conditions to take care of their health problems.

Conclusion

Our research and several other studies pointed out the importance of post-treatment services for vulnerable groups of patients. Results (e.g. Kertesz

et al., 2003) show that relapse in addiction and also in homelessness is much more frequent when there are no accompanying aftercare services following discharge from the hospital. Further follow up services have the potential of reducing the revolving door effect.

Analysis of individual sub-groups surveyed shows that the health system and its accessibility is significantly worse for those who became homeless earlier in their life; those that have previously been institutionalized; those who have weaker social support networks; those who are addicted to drugs and have mental health problems. Obviously, the most vulnerable is the group of people with dual (multiple) diagnoses - co-morbidity.

Key findings of the survey show that the health situation of homeless people is much worse than the one of the general population in Slovenia; for a considerable part of them the health system is relatively poorly accessible. The system is more difficult to access for those homeless people who are more vulnerable and who are already faced with a worse health condition (in particular mental health problems and drug addiction), that have poorer psychosocial support and less positive experience with conventional life, and who therefore would need a better, enhanced, easier access to the health system.

On the basis of this research, suggestions were made, including:

- special services should be developed for special subgroups of homeless people (like people with double diagnoses, homeless youth, drug users, elderly),
- cooperation and coordination among different sectors should be developed and strengthened,
- assertive outreach services should be developed, targeted at the hidden population,
- after care or after treatment options/services for people who are homeless should be developed.

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The full report is available in Slovenian on FEANTSA's web site: http://www.feantsa.org/files/freshstart/Transnational_Exchange/ENHW/Materials/SRazpotnikBDekleva_research.pdf.

Shelter-based convalescence for ill homeless adults in Amsterdam: a case report

By **Igor van Laere, MD**

*Doctors for Homeless Foundation Amsterdam, The Netherlands**

Over the last decades, shelter-based convalescence care programmes (also termed respite, infirmary, recuperative and intermediate care), increasingly emerged in the western world [1-13]. Programmes differ from one another, though many provide room, board, on site 24-hours care, and a range of social and medical services. On average, these programmes are small, with an average of 13 beds, and reimbursement depends on patchwork funding [6].

The limited body of research in Australia, Canada and the US suggests that these programmes are cost-effective, reduce hospital readmissions, and have important social medical support and service-networking benefits for the clients [1-6]. However, it is argued that much remains to be learned about these programmes, including in relation to their funding sources, their relationships and arrangements with hospitals and other referral sources, and where patients go when they are discharged from these programmes [6].

In a recently published article [14], a seven-year period of shelter-based convalescence use was reviewed in Amsterdam, the Netherlands, to determine the demographics, medical diagnoses, referral patterns, length of stay, discharge locations, mortality rate, and use patterns. As regards the characteristics and diagnoses, it was found that among 629 convalescence users, most were homeless single males, around 45 years of age, and born in the Netherlands, with chronic problems due to substance use, mental health disorders and a frail

physical condition (the combination = trimorbidity), many of whom died a premature death.

In this article, a case report is presented to demonstrate the practicalities and benefits of a shelter-based convalescence programme in Amsterdam. The aim is to provide information that will help programme and policy makers to design or adjust shelters services that adequately fit the needs of ill homeless populations, and are efficiently linked to the healthcare system.

Case report

Johnny, a Dutch forty two year old homeless male, was found limping in the Amsterdam red light district by an outreach worker of a social drug service. After a few questions Johnny was invited to limp around the corner to the Salvation Army run shelter-based convalescence care facility named the Gastenburgh. As Johnny was willing to be admitted to the Gastenburgh, the outreach worker phoned an outreach doctor.

The outreach doctor went to meet Johnny in the Gastenburgh. After a social medical assessment the following problems were identified. Johnny had become homeless after eviction due to rent arrears. During the last four years he had been sleeping rough and was inhaling heroin and cocaine. Johnny appeared neglected, skinny and malnourished. His teeth were in poor condition, he had been coughing for two weeks and limping due to a leg ulcer and immersion foot. He had lived a withdrawn and solitary life and had no contact with family or friends. He had no place to sleep, no income and due to a lack of a health insurance he believed he was not entitled to visit a doctor.

Johnny was instantly admitted for convalescence care, as the Gastenburgh has no waiting list. The

outreach doctor made a care plan to be followed up on a weekly basis. Johnny was offered a bath and his leg ulcer and feet were cleaned and disinfected. His pneumonia was treated with antibiotics and he received daily methadone therapy for his heroin dependence. His leg was treated. An outreach psychiatrist diagnosed schizophrenia and prescribed anti-psychotics, and an outreach mental health nurse would provide him with follow-up care.

In the meantime, a social worker helped Johnny obtain an identification card, benefits, health insurance and registration at a general healthcare practice. A shelter worker accompanied him to a dental appointment. The benefits he obtained with the assistance of the social worker paid for his board and lodging in the Gastenburgh, and he was given pocket money on a weekly basis. Johnny started to look better and gained weight. He slowly became more active and helped to clean the shelter. After four months of convalescence care Johnny was transferred to a Salvation Army general shelter, where he still lives today and takes care of the rabbits in the courtyard.

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Kofoed's School opens a dental clinic for excluded groups in Copenhagen

By Ole Meldgaard

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Kofoed's School in Copenhagen is about to open a dental clinic for homeless and excluded groups. The initiative is taken in co-operation with an

association of dentists who do dental work for excluded people who, for various reasons, do not fit into the established system and don't have the money for treatment. The dentists work voluntarily and free of charge in their spare time.

The background for the dental clinic is a health research on excluded groups in Denmark highlighting that compared to the general



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population, the health situation of excluded people is poorer. Rough living conditions also leave their mark on the teeth of excluded people. The research showed that 44 per cent of the excluded people had less than twenty teeth in the mouth compared to 13 per cent amongst the general population. They have more toothache and difficulties in mastication resulting in collateral problems as bad digestion, stomach ache, under nourishment and bad health in general. Dental disease is also a mental barrier to social inclusion and access to the labour market. Although they are entitled to public dental care, excluded people refuse to go to the clinic or forget the appointment. 50 per cent have not visited a dentist in the last 12 months.

The idea behind the clinic is to reach the excluded groups in the environment where they are and offer them dental care. Every day about 500 people attend the activities proposed at Kofoed's School,

annually 3.500 people. It is expected that the clinic can better overcome dental phobia among excluded people by building up a closer relationship between the dentist and the client outside the usual context. And if the client loses courage and is not ready to start a treatment, it will be easy to get a new appointment and come again another day. The clinic will address tooth pain and dental destruction, rehabilitate oral health, and teach the clients better hygiene and better nourishment.

The dental project has received financial support for its establishment from the Ministry of Interior and Social Affairs and support for running costs from the National Board of Health and takes place in co-operation with the local authorities in Copenhagen.

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Towards a multidisciplinary approach to health: considerations for a European survey

By **Miriam Castaldo**,

*National Institute for Health, Migration and Poverty, Rome, Italy **

[Note from the editor: the Italian National Institute for Health, Migration and Poverty (NIHMP) has developed a specific health care methodology aimed at migrant and other vulnerable groups based on interdisciplinary teams composed of MD, psychologists, anthropologists and cultural mediators. The theoretical considerations underlying the model are described in the article below. The NIHMP model and protocol is currently being tested in a number of Italian cities. Italian FEANTSA member fioPSD is currently setting up a project aiming at assessing whether this model could be used in other countries as well. The first stage of the project is about to start with a limited number of partners, while organisations interested in participating at a later stage may contact fioPSD (see details at the end of the article).]

The medical practice, both for foreigners and Italians, should take into consideration the person as a whole, as a biological, psychological, social, cultural, economic and political subject. The concept of "human being" is not fixed; on the contrary, it is

the result of the constant relation between biological, psychological, social and cultural factors (Morin, 2000).

The NIHMP carries out a number of trans-disciplinary and trans-cultural clinical, social and research activities. Its main objective is to harmonize the communication between people with different backgrounds. This is both fascinating and complex. Teams gathering the various abilities and skills of anthropologists, cultural mediators, psychologists and doctors, are well aware of the importance of the resources that every professional can offer, transfer and receive. The services available at the NIHMP, which follow this approach, are:

1. Service for people who are homeless;
2. Service for asylum seekers, refugees and victims of torture "*Passaggi nei territori di Giano*" (Crossing the lands of Janus);
3. Ethnopsychiatry service "*Geografie del corpo*" (Geographies of the body);
4. An integrated and multidisciplinary project for vulvar pathologies "*Oltre lo specchio di Venere*" (Beyond the mirror of Venus);

[Among the professionals involved in the different health services provided for, there are psychotherapists, anthropologists and cultural

mediators. The description below gives an overview of their specific contribution to the therapeutic process.]

Psychotherapists

When facing a request for psychological help, therapists should ask themselves a fundamental question: «Which system of thought will allow me to define the relations involved in the psychic functioning of this patient?» (Nathan, 1996, p. 43).

It is therefore important to focus on the possible relation between the psychopathological event and its interpretation (Nathan, 1990, p. 115). In the clinical trans-disciplinary setting at the NIHMP, the psychotherapist conducts the interview while respecting the equal authority of the other professionals involved. He/she should facilitate the expression of different competences, in order to implement the diagnostic-therapeutic process. Anthropologists and cultural mediators play a central role in analyzing the systems of thought of the patient. The patient himself/herself is no longer a subject to be analyzed, but a person cooperating in a common research. This approach to psychotherapy is interesting for different reasons, including the fact that it leads to re-interpret, together with the patient, both his/her suffering and the theories behind it.

This formulation of the problem leads the therapist to interpret the disorder not as a natural fact, but as a phenomenon created by professionals. This is why the patient, who becomes an expert providing relevant information, is invited to share the responsibility and discuss with the therapist observations and hypotheses relating to his/her illness. In this context, relatives and friends of the patient become fundamental collaborators too.

Migrant patients always belong to two different worlds: the one of their culture, which is the centre of their psychophysical structure, and the one of the host country.

This is why it is so important for the setting to contain objects relating to their psychological and cultural identity. In order to obtain this, the setting should respect:

- their invisible beings: genii, spirits, gods, ancestors;
- their behaviours: original language, family alliances, traditional intermediaries, rites;
- their doctors: traditional healers;

- their cult objects: amulets, fetishes (in Nathan, 1996a, p. 13).

Anthropologists

Aime defined anthropology as the view of a world over another world (2007:26). It is possible to state that anthropology is the discipline of observation. Anthropology observes, but sometimes just looks; this discipline researches, asks, sometimes is silent, interviews, analyses, compares, examines, describes, sees problems with a sense of proportion or not, produces and reproduces knowledge. Its privileged object-subject is humankind, its culture, its society, its symbols and concepts. The analysis starts from field research, and the field can be either a place far from the cultural context of the anthropologist or a lecture hall, a library, a hospital: anthropology is where the researcher is.

Anthropologists do not know each people and culture. They analyze specific contexts and people, their visible and invisible worlds, their symbolic dimension, family relations and rites. They study the concepts of ethnos and identity in relation with the relevant population, write ethnographies to be compared with the work of other anthropologists.

Therefore, an anthropologist does not have a holistic knowledge about every human culture: he/she has his/her own practical, theoretical and methodological experience. He/she possesses an ethno-semantic approach allowing him/her to interact with the object of his/her study by reconsidering his/her social and cultural parameters.

In the context of ethno-clinical practice, the anthropologist's experience is continuously elaborated within the multidisciplinary setting together with psychologists and cultural mediators. Through the story of who is looking for help, the anthropologist carefully detects the migrant's techniques and aetiological systems, by recognizing their therapeutic power. The violence of the psychopathological vocabulary is abandoned to make room for what Beneduce (2007) calls different psychologies, with their own language and explicative models, and to recognize and legitimate the others. It is therefore necessary to create a setting, which is free from linguistic and conceptual impositions and is based on listening to and understanding diversity, since the objective of ethno-psychiatry is to meet health needs, whatever the manifestation.

Cultural mediators

Cultural mediators negotiate and create meanings based on their personal categories, they provoke dynamics, reactions and actions. It is important to remember that such dynamics do not only affect the relationship between the mediator and the person who is looking for help, but also the one between the mediator, the psychologist and the anthropologist.

Among the cultural references of the patient, the most important one is the language because:

- it represents a specific shape of the cultural system; «The language is typically the “thing” that only a group can create. Lessors produce everyday language – each lessor is in fact able to modify a term, an expression, a pronunciation, a syntax rule if the group adopts this change. “Since it is evident that the language is one of the most powerful systems that contribute to the creation of the individual, then the group produces something that, afterwards, produces each individual of the group”» (Nathan 2000 in Nathan, 2003: 75).
- The language, considered as something created by a group of human beings, is different from mere communication. It becomes an object to be analyzed. Its etymology, the comparison with other languages, and the different meanings of the words in contact with the history and the experience of their populations become interesting themes to be studied. The importance of the mother tongue in the therapeutic setting is therefore evident, not only for communication but as the main object of study.
- It has the power to evoke the physical, emotional, cognitive and experience universe of the person. This universe is the structure containing his existence and the one of his/her group.
- It is the basis for the construction of the system of thought, the membership and the relationships with the group of the individual (Nathan 1996a:13; Nathan, 1996a:49).

In clinical contexts, the language has also the task to:

- Differentiate the group from those who do not speak the same language;

- The translation and circulation of the different language spoken by the participants to the group interaction establish a communication and exchange relation with different cultural and psychological identities;
- It opens the possibility of meeting different cultural worlds and different dimensions of the same culture;
- It is through the language that traditional aetiologies brought by cultural mediators arise.

Mediators, besides stimulating change in the ethno-clinical setting, have a broad knowledge about their population, such as:

- culture;
- society;
- economic, political, social etc. problems of the country;
- health, juridical, school, political, economic, social, relational, cultural, etc. system of the host country;
- health, juridical, school, political, economic, social, relational, cultural, etc. system of the country of origin;
- family structures;
- relational system;
- system of thought;
- traditionally recognized disorders;
- conditions of migrants coming from the same area;
- migration experience, etc;

It is absolutely necessary for the mediator to understand what goes on in the ethno-clinical setting; indeed, he is stimulated to develop specific skills, such as:

- awareness of the patrimony of knowledge about his culture;
- passion for research on the specificity of the diagnosis and treatment systems of his culture;
- capacity to identify the problem brought by people of his ethnic group and their specific way to express suffering;
- capacity to enable the operator understand the problem;
- awareness of his/her feelings when dealing with a migrant person in need;
- capacity of understanding what belongs to the mediator and what to the person assisted;
- modalities and intervention strategies in multidisciplinary settings (Tumiati, 2008).

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* Miriam Castaldo is anthropologist at the NIHMP, contact: m.castaldo@inmp.it, web site: <http://www.inmp.it/en/>. If your organisation is interested in being involved in the European project being set up by FEANTSA Italian member fioPSD, please contact Marco Iazzolino formazione@fiopsd.org, web site: <http://www.fiopsd.org/>

Resources

St Mungo's "Happiness Matters" Report

FEANTSA London based member St Mungo's has launched a major consultation on mental health and homelessness in 2009 (1). The report "Happiness Matters – Homeless peoples' view about breaking the links between homelessness and mental ill health" is the result of a peer research exercise involving St Mungo's service users. The report

looks at issues such as access and barriers to services and support to mental health, the impact of drink and drugs, and emotional well being.

The report is available on [St Mungo's web site](#).

(1) See article by Peter Cockersell in the ENHW newsletter n°9.

Traducmed: Internet based translation tool aimed at health professionals now available in English

In the ENHW newsletter n° 9 Dr Charles Vanbelle* gave an overview of a web site he had developed to help health care practitioners to overcome language barriers and allow them to communicate with patients speaking a different language.

The website does not intend to replace the services of an interpreter, but standard, pre-recorded audio phrases from a medical consultation allow

practitioners to get by in an emergency medical situation, for free, 24 hours a day.

For your information, the web site contains now a English section as well. Please do not hesitate to disseminate the information to other colleagues who might be interested.

Web site : <http://www.traducmed.fr>.

* Contact: traducmed@free.fr.

Forum

FNARS is looking for partners - Grundtvig Learning Partnership

Deadline: 31 January 2010

FEANTSA French member FNARS is a federation of 750 French associations (2200 centres, shelters and services) active in the field of social inclusion and working in the areas of housing, employment, health, training, etc. FNARS members provide services to homeless people, youth, asylum seekers, women suffering of domestic violence, prostitutes, ex-prisoners, etc.

One of the main focus for FNARS in 2010 will be "precariousness and mental health". FNARS is currently working on a project proposal under the EU lifelong learning programme Grundtvig. The main aim of the project would be to have an overall picture of social workers' practices concerning mental health and poverty across Europe through an exchange programme for social workers from organisations based in different countries. It would address issues such as the scope of the problem, working methods, relationship and cooperation with other relevant actors (for instance psychiatric services).

Grundtvig learning partnership – call for partners



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Amongst other, the project would:

- produce guidelines for professionals of the social and the psychiatric fields in order to promote a better mutual understanding.
- organise a conference on December 2nd 2010 that will highlight good practices, experimental and innovative actions or network helping the links between social and psychiatric fields
- elaborate training modules for psychiatric and social professionals.

The duration of the project would be 24 months and working languages would be French and English.

In this context, FNARS would like to hear from organisations interested in being part of the project. If you are interested or would like to have more details, please do not hesitate to contact Lise Fender lise.fender@fnars.org by 31 January 2010.

FNARS web site: <http://www.fnars.org/>, Information on EU lifelong learning Grundtvig programme can be found at: http://ec.europa.eu/education/programmes/llp/guide/fiches/grund5_en.html.

Events

Housing, Homelessness and Substance Misuse: developing effective responses

Clydebank, Scotland, United Kingdom
Date: 8 February 2010

The Conference is organised by the Scottish Drugs Forum on behalf of the Homelessness and Substance Misuse Advisory Group. To read the information leaflet, please click [here](#) or go to FEANTSA's web site, calendar of events' section. Those interested in attending are kindly requested to contact the organisers as soon as possible.

Invisible wounds – Dignity and Vulnerability, SMES Europa European Seminar

Athens, Greece

Date: 24-26 February 2010

Relevant information is available [here](#) or on [SMES Europa web site](#). Although the deadline for sending abstracts is over, the organisers welcome late contributions, which will be made available to participants at a later stage. If you are interested in participating, please contact Luigi Leonori at smeseu@smes-europa.org

Health Inequalities on the Undergraduate Curriculum

Liverpool, England, United Kingdom
Dates: 26-27 April 2010

For more information, please read the relevant [leaflet](#).

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This programme was established to financially support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries.

To that effect, PROGRESS purports at:

- providing analysis and policy advice on employment, social solidarity and gender equality policy areas;
- monitoring and reporting on the implementation of EU legislation and policies in employment, social solidarity and gender equality policy areas;
- promoting policy transfer, learning and support among Member States on EU objectives and priorities; and
- relaying the views of the stakeholders and society at large.

For more information see: http://ec.europa.eu/employment_social/progress/index_en.html



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