Katharina Crepaz · Ulrich Becker
Elisabeth Wacker *Editors*

RESEARCH

Health in Diversity – Diversity in Health

(Forced) Migration, Social Diversification, and Health in a Changing World

Springer VS

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ISBN 978-3-658-29176-1 ISBN 978-3-658-29177-8 (eBook)
https://doi.org/10.1007/978-3-658-29177-8

This Springer VS imprint is published by the registered company Springer Fachmedien Wiesbaden GmbH part of Springer Nature.
The registered company address is: Abraham-Lincoln-Str. 46, 65189 Wiesbaden, Germany

Preface

Migration is an international topic, of interest to policy makers and scholars around the globe, and with a strong impact on the shape of modern societies. However, despite its inherent character as a transnational issue, decision-making and research on migration often remain confined to nation-state borders, and thus offer only a limited perspective on the many different aspects of the topic. The conference series "South-East African and European Conferences on Refugees and Forced Migrants" is our attempt to counteract Eurocentric views, and to foster mutual learning processes. The idea was to design a conference with our colleagues from Pwani University in Kenya, with whom both the Max Planck Institute for Social Law and Social Policy and the Technical University of Munich have a long history of collaboration in research, teaching, and scholarly exchange. For decades, Kenya has been engaged in large-scale migration within its own borders, supporting refugees from neighboring countries and providing health care for people living in shelter camps for generations; it thus provided a highly productive setting for scholarly debate about migratory movements. The conference was to be both interdisciplinary (open to scholars from legal studies, political science, sociology, anthropology, among others) and transcontinental, bringing together researchers from African and European countries in order to compare, evaluate, and possibly learn from each other's findings on migration-related topics.

The first conference, titled "Social Rights – Care – Mutual Benefits?" took place in Kilifi, Kenya, in 2016, and focused on the inclusion of (forced) migrants into host societies, on re-designing asylum procedures and systems, as well as on adopting a more benefit-based perspective on migration instead of the prominent deficit-oriented view. The event was very successful, and especially lauded for its truly international and bridge-building character; this confirmed our view that we were offering a unique scholarly gathering, and prompted the decision to make the conference a recurring event, accompanied by an edited volume to allow for public access to the topics discussed at the conference.

In March 2019, the second edition, titled "Health in Diversity, Diversity in Health?" was held in Kilifi. While the first conference was relatively open-topic, the second edition had a clear focus on the connection between (forced) migration and health. How can health care systems respond to increased diversity?

Which challenges do professionals face when dealing with diverse patient groups? What is the impact of forced migratory movements on individual health? Which preventive measures and/or new technologies might be helpful when dealing with diversity and health? These were only some of the questions raised in the presented papers as well as in the lively discussions that ensued. We are very happy that we have, once again, managed to compile an edited volume that preserves the research presented as well as the connections established at the conference by making the papers available to the interested public. We hope that scholars, practitioners and public decision-makers will find the contents of this book interesting and useful for their personal work, and would be delighted to open up a broad international dialogue on the issues raised in the present edited volume.

Elisabeth Wacker

Contents

1. Perspectives on the Nexus between (Forced) Migration and Health in Increasingly Heterogeneous Societies

Katharina Crepaz[1]

Keywords: Refugees, (Forced) Migration, Health, Africa, Europe

Abstract

This contribution introduces some general ideas on the nexus between (forced) migration and health in heterogeneous modern societies. It does so by first providing UNHCR data to set out a framework for the continued and even increased relevance of refugee issues in both Africa and Europe, by giving a definition of health as a human right, and by then focusing on the connection and reciprocal effects of health and (forced) migratory processes. Finally, and most importantly, an outlook on the papers featured in the edited volume and their contents is given.

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K. Crepaz et al. (eds.), *Health in Diversity – Diversity in Health*,
https://doi.org/10.1007/978-3-658-29177-8_1

1 Forced Migration and Health: International Comparative Perspectives

According to the UNHCR (2019), there are currently 70.8 million forcibly displaced people worldwide; 37,000 people a day are forced to flee their homes because of conflict and persecution (UNHCR 2019) – we are thus witnessing the highest levels of displacement ever recorded. At the time of compiling our last edited volume, in 2018, numbers were already alarming, with 65.6 million forced migrants (UNHCR 2018, quoted in Crepaz & Wacker 2019), but the situation has again worsened dramatically. Additionally, about 80% of refugees live in countries neighboring their countries of origin, which puts an uneven amount of pressure on the Global South when dealing with refugee issues; it is therefore those countries, often poverty-ridden and politically instable, who are most directly involved in hosting forced migrants. How European and African approaches to refugees and forced migrants differ and where possibilities for mutual learning and the exchange of best practices might be found was the topic of our last edited volume (entitled "Refugees and Forced Migrants in Africa and the EU: Comparative and Multidisciplinary Perspectives on Challenges and Solutions", published with Springer VS in early 2019). In the present second edition, we focus on how the current record number of (forced) migratory processes affects health and well-being on a variety of levels, and again explore a comparative outlook given by authors from both African and European countries.

In 1948, the Universal Declaration of Human Rights was established, followed in 1951 by the UN Refugee Convention as the most important international legal document on refugees and their rights and the UNHCR as its 'guardian'. Article 14 of the Universal Declaration of Human rights states that "everyone has the right to seek and enjoy in other countries asylum from persecution" (UN 2015: 30), while the Refugee Convention establishes who can be defined as a refugee: "[any person who] as a result of events occurring before 1 January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it" (UNHCR 2010: 14). The Refugee Convention also introduces the principle of 'non-refoulement' in Article 33: "No Contracting State shall expel or return ('*refouler'*) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race,

religion, nationality, membership of a particular social group or political opinion" (UNHCR 2010: 30) 'Non-refoulement' thus prohibits to expel refugees; however, there can be exceptions from this principle if a refugee has been convicted by a final judgement of a particularly serious crime, or if they are considered to be a danger to public security.

Although the UN Refugee Convention remains the most important international legal document on forced migration, it falls short of reflecting some of the more recent international political developments. The Convention had been established as a response to refugee and displaced persons movements in Europe after World War II, when the powers forcing them to leave their homelands were almost exclusively nation state governments. Nowadays, the actors responsible for forced migratory movements are often terrorist groups (e.g. the so-called 'Islamic State'), and refugees frequently come from what is referred to in political science as 'failed states' (e.g. countries in which the state government is not capable of establishing sovereignty and control over the whole territory, often then ruled by clans or warlords). With climate change as one of the biggest current global threats, people may also leave their homes because of natural disasters (flooding, draughts), which no nation state can be held accountable for. The Convention is also not equipped to deal with large-scale international forced migratory movements, such as the one brought about by the civil war in Syria. Despite these shortcomings, the Refugee Convention establishes an important framework of rights, and also mentions provisions on health. However, health is not mentioned in a distinct article, but is tackled in Article 24, which deals with "labor legislation and social security". It outlines that refugees shall be accorded the same treatment as nationals in respect to "[s]ocial security (legal provisions in respect of employment injury, occupational diseases, maternity, sickness, disability, old age, death, unemployment, family responsibilities and any other contingency which, according to national laws or regulations, is covered by a social security scheme)" (UNHCR 2010: 25). This social security provision contains a number of factors that could also influence a person's health status, as well as their ability to participate in work and society, and their general well-being.

Even though the article is not health-specific, it is still in line with the WHO's definition of health, which is outlined in the preamble to its Constitution of 1946: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2019). Like the provisions outlined in Article 24 of the Refugee Convention, the WHO definition is broad, and encompasses many aspects of a person's possible health status. As can be imagined, a state of "complete physical, mental and social well-being" is an ideal type, and something usually quite removed from those forced to flee their homelands. Flight conditions do not normally allow for a person to reach

such a state; however, the WHO Constitution also refers to "the highest attainable standard of health" (WHO 2019), thus making clear that certain environmental and personal framework conditions may keep a person from reaching the ideal state of complete well-being. The WHO explicitly states that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"; this highest attainable state is thus a human right, which cannot be denied on the grounds of e.g. lack of citizenship or legal status in a host country. The definition of health as a human right is vital for refugees, as it means that access to at least basic healthcare has to be provided regardless of their present status, and regardless of the country they are currently in. However, implementing this right in practice is not always easy and there are pitfalls and restrictions, as some of the contributions in this volume also highlight. Difficulties in providing health care for refugees may arise from unresponsive authorities, from the lack of provisions for mental health or – from a public health perspective – from difficulties in convincing the resident population that refugees themselves are not a threat to the host country's health or health care system. Such threat-based views could then in turn be used by anti-migration political actors to deny health care services to refugees, especially to those without official status. Lack of access to health care can thus also be viewed as a sign of social exclusion (Bivins 2013: 145). Besides political willingness to provide health care services, limited resources also constitute one of the main barriers. Some of the African countries receiving large numbers of refugees already struggle with providing health care, and especially mental health treatment, to their own populations. Similar developments are visible in Europe, where mental health is often not included in the basic healthcare provisions available for refugees, and even if it is, lack of cultural mediators or professionals trained in foreign languages and customs makes receiving appropriate care very difficult. Researchers therefore argue for the implementation of community-based approaches, rooted in the involvement of staff with a migratory or refugee background as outreach screeners and counsellors (Hecker & Neuner 2019: 68). Through these approaches, societal diversity could step beyond being viewed solely as a problem for health care systems, and in itself represent the first step towards reaching a better health care status for refugees and (forced) migrants, pursuing the goal of "health in diversity".

2 Contents of the Edited Volume

How societal diversity and improved health chances for all groups present in heterogeneous societies may be reconciled is also the topic of the present edited volume. After the first South-East African and European Conference on Refu-

gees and Forced Migrants was held in 2016, it became clear that we wanted the common international and interdisciplinary forum for discussion to continue, as it constituted one of the rare chances to interact with scholars coming from different geographical areas and also different disciplines. While the first conference was relatively open-topic, the second edition – held in March 2019 in Kilifi, Kenya, as a joint project of the Max Planck Institute for Social Law and Social Policy, the Chair of Sociology of Diversity at the Technical University of Munich and Pwani University – had a strong focus on the relationship between (forced) migration and health. Through presentations and in-depth discussion, the scholars aimed to shed further light on how migratory movements may influence the health status of both refugees and the general populations, and how societies can be designed to be more receptive for diversity also in their health care systems. Mental health and migration, vulnerable groups (e.g. persons with disabilities, women) and health in refugee camps were also among the topics discussed. We are delighted to be able to make the papers presented in Kenya available to scholars, practitioners and public decision-makers in the form of this edited volume, tackling health and diversity from the points of view of different academic disciplines as well as different geographical contexts.

First, Ulrike Kluge and Gordon Omenya will provide some historical and current perspectives on migration and health. Ulrike Kluge focuses on the mental health care situation of refugees in Germany. She presents approaches from the Center for Intercultural Psychiatry and Psychotherapy at Charité Berlin (ZIPP), and gives an overview of the barriers that refugees may face when aiming to get mental health care in Germany. Kluge argues that multi-dimensional and multi-professional approaches are necessary to provide good mental health service for refugees.

Gordon Omenya presents some historical reflections on health and migration in the East African region. Omenya argues that the region has been conflict-ridden due to the colonial powers' division of land without paying attention to the inhabitants. He then traces how colonial governments installed health care systems in the area, and how these systems dealt with refugees leaving their homelands due to a continued stream of armed conflicts. In conclusion, Omenya provides some suggestions as to how health care systems could become more inclusive and move away from exploitative to mutually beneficial relations.

Moving from historical to legal perspectives and from Africa to Germany, Cornelius Lätzsch's contribution explores the accessibility of health care and social services for asylum seekers with disabilities in Germany. The UN Convention on the Rights of Persons with Disabilities (CRPD), the EU Reception Conditions Directive (Directive 2013/33/EU) and the German Asylum Seekers Benefits Act (AsylbLG) follow different and sometimes conflicting approaches: While the UN CRPD and the Reception Conditions Directive open doors to

specific support, the Asylum Seekers Benefits Act limits accessibility. Refugees with disabilities thus have to deal with inaccessible housing and restricted access to health care. Lätzsch argues for a closer collaboration between academia, social work, and politics, in order to overcome the marginalization of asylum seekers with disabilities.

Providing additional legal reflections, Letlhokwa George Mpedi's contribution focuses on the health care rights of refugees in South Africa. The article posits "health" and "refugee" as key terms, and does so by looking at important documents such as the Constitution of South Africa of 1996, which also contains the right to health. Mpedi then evaluates the current situation in South Africa by describing some of the challenges refugees face when trying to access health care services, including an imperfect public and expensive private service, limited ability to enforce the right to health care, language barriers, lack of access to information, as well as ignorance and xenophobia.

In the first paper on political perspectives, Andrea Göttler looks at the health of (forced) migrants through the life course. She reviews the role of social determinants of health associated with labor and forced migration, and discusses how studies on older labor migrants in Germany show the long-term effects of health risks in the receiving country. Göttler argues that improvements for the recognition of long-term socioeconomic barriers to health are still needed, and provides an outlook on possible future health risks of current (forced) migrants in Europe.

Geoffrey Nato's contribution then deals with micro-level possibilities for health improvement, through an analysis of more eco-friendly and sustainable energy provision options for refugee camps. He argues that creating sustainable energy options has been neglected so far, putting pressure on the environment and possibly also on the relationship with the host community that has to provide energy for the camps. Nato looks at three potential eco-friendly solutions (sustainable firewood, energy-efficient cooking stoves, alternative sources of fuel) and concludes that cultural preconceptions and ideas of hygiene must also be kept in mind when designing new and more sustainable energy sources.

Returning to Europe, Albert Scherr's article focuses on the social integration and instances of racist discrimination against young African refugees in Germany. Through biographical interviews, Scherr analyzes the problems refugees face after their arrival, and identifies a non-transparent constellation of legal and institutional conditions as well as uncertain future perspectives as some of the most pressing issues. He argues that in order to allow for inclusion, both informal and institutional support and considerable personal contributions on the part of the refugee are necessary.

Following the legal and political framework conditions, the prerequisites for ensuring a good quality of life when dealing with diversity and health are

discussed. Isabella Bertmann-Merz's paper focuses on the question of access to health (care) for vulnerable groups, and on how diversity aspects are reflected to the extent that health care is available to all people without barriers and/or discrimination. The text draws on governance issues, and distinguishes between globalization and health governance, global governance and health, and governance for global health as key concepts. Bertmann-Merz focuses on the diversity dimensions migration and disability, and argues that inclusive approaches need to be intensified, while already established initiatives should be re-thought from a diversity perspective.

Sellah Lusweti, Obeka Bonventure and Halimu Shauri look at coping strategies and innovations among forced migrants in encampment in the Tana Delta (Kenya). They argue that forced migration is characterized by difficult living conditions and few job opportunities, and that forced migrants thus have to be innovative to create new support mechanisms for their life in camp surroundings. The interview data collected by Lusweti, Bonventure and Shauri in three refugee camps suggests that forced migrants in the Tana Delta have shown resilience by coming up with new solutions and/or new applications of existing products, technologies, services and organizational models to keep up with the realities of life in encampment.

The next section of the edited volume looks at refugee camps, living conditions and health possibilities/problems there in more detail. Ulrike Krause discusses violence against women in camps, and explores the links between refugee camp conditions and the prevalence of violence. Based on empirical research conducted in Uganda, Krause argues that sexual violence, domestic violence and structural discrimination constitute the main risks female refugees face in encampment, and that these forms of violence exist despite humanitarian efforts to protect and assist refugees, and especially women. She concludes that these special efforts may even sometimes contribute directly or indirectly to frustration and violence, along with the limits imposed by the camp and hierarchical procedures.

Fathima Azmiya Badurdeen's paper focuses on how trauma associated with sexual and gender-based violence (SGBV) may be resolved; it does so through looking at transcultural refugee contexts in Kenya. Based on qualitative data collected in in-depth interviews with women and girl refugees in Dadaab and Kakuma refugee camps, the article presents the context of trauma faced by women and refugees of SGBV, and the ways in which they resolve trauma and health issues using social networks and professional health care services. Azmiya Badurdeen emphasizes the need for an exploration of cultural interpretations of trauma as well as for flexible and adaptive approaches by professionals for interpreting and treating mental trauma.

Finally, the present edited volume also offers technological and economic perspectives on diversity and health, and looks at how information technology may improve access to health care. Annalies Beck and Ayca Nina Zuch investigate how new technologies may help forced migrants dealing with health issues, and provide suggestions on how the development of digital services for this target group may be improved. Beck and Zuch analyze the problems that refugees in Germany face when in need of health support, and then propose the e-ICI (e-Inclusion and Cohesion Based Innovation) approach as a possible solution. E-ICI is user-centered, and focuses on dealing with health issues in a culture sensitive way by choosing the appropriate technology (e.g. mobile apps, social media, blockchain or AI). To render such innovation possible, Beck and Zuch argue for a collaboration of doctors, scientists, developers, designers and experts in information technologies, but also the potential users themselves.

Samuel Mwakubo's paper focuses on the costs and benefits of forced migration in Kenya, arguing that forced migration may not only be a burden but also a possible asset for the host communities. The results of a Cost-Benefit Analysis (CBA) conducted for Kakuma Refugee Camp show that supply chains for goods and services demanded by refugees were formed, and that the benefits are substantial for Turkana County, but marginal for the overall country. In order to minimize the associated costs (e.g. damage to the environment), Mwakubo argues for close collaboration between governments, NGOs and UNHCR, especially in ecologically fragile areas. He thus also highlights that human health also depends on a healthy environment, following a "one health" approach.

The present volume offers a collection of African and European perspectives on (forced) migration and health, ranging from accounts of the historical development of the issue, the challenges in finding fitting approaches in law and politics, the problems and solutions in ensuring quality of life and health for diverse populations, and dealing with health risks and violence in refugee camps to the potential for health inclusion offered via new technologies and to replacing a pure burden-sharing perspective with one also focused on (forced) migrants as a possible asset. The comparative framework reveals that while there may be some differences in the challenges faced (e.g. refugee camps as a primarily African issue), the similarities prevail: both African and European countries have to find new ways of dealing with the diversification of societies, while also implementing the WHO's principle of health as a human right. Migration and health care both constitute topics to be addressed at a global scale; it is therefore important to establish research on these issues from a comparative international perspective which also allows for mutual learning processes.

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2. Historical Perspectives: Health and Migration in a Globalized Society

Mental Health in Times of Increasing Flight and Migration - A German Perspective

Ulrike Kluge[1]

Keywords: Refugees, Mental Health, Trauma, Mental Health Care Professionals, Global Mental Health

Abstract

The chapter gives a brief introduction to the mental health care situation of refugees in Germany, presenting recent developments and discourses exemplary of one research and care delivery facility in Berlin. The impact of living conditions and access barriers on the mental health situation are presented and the main challenges regarding treatment and service structures are discussed.

Contents

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K. Crepaz et al. (eds.), *Health in Diversity – Diversity in Health*,
https://doi.org/10.1007/978-3-658-29177-8_2

1 Introduction

Impacted by political, social and ecological crises, migration and flight have become central topics in European societies in the last few years. This is challenging the mental health care system, its supply structures of psychosocial, psychiatric and psychotherapeutic care services. As a response to this, there is a growing demand for specialized treatment as well as short-term interventions (Adorjani et al. 2017). At the same time, there has been an increasing demand for training in the field of cross-cultural competences and on trauma-related issues for professionals as well as voluntary care givers in shelters and psychosocial support structures (Mehran et al 2019).

At the Center for Intercultural Psychiatry and Psychotherapy (ZIPP)[1] at Charité Berlin we have been working in this field for over 16 years. As part of a university medicine structure, the ZIPP comprises three areas: healing, research and teaching/training. The **(1) care delivery facility** is the ethnopsychiatric outpatient ward that is integrated into the psychiatric outpatient ward at Charité, Campus Mitte (besides five other specialized outpatient wards). The treatment comprises psychodynamic single and group therapy, psychopharmacological treatment, social work and reports during the asylum-seeking process. The team includes psychotherapists, psychiatrists, social workers, nurses and language and cultural interpreters from various cultural backgrounds (Kluge et al. 2017). The interdisciplinarity and diversity of the cultural backgrounds and migration histories of the team creates a many-voiced transcultural space. Transcultural encounters between patients and therapists from diverse cultural contexts facilitate reflection on the common grounds as well as differences. To overcome the higher degree of strangeness in trans- and intercultural understanding (Kimmerle 2000), it is necessary "to allow certain aspects to remain temporarily or permanently without being understood, to respect and acknowledge incomprehensible aspects of foreign cultural backgrounds“ (Kimmerle 2002).

In 2017, we established an additional service: TransVer[2]- a psychosocial network structure with the goal of enhancing intercultural opening of the community psychiatry service system for migrants and refugees. TransVer is based on three pillars: training for mental health care workers (including supervision and case support), transfer into appropriate care delivery facilities for users and professionals, as well as a database on services. The transfer is a main part, because there is a large, fragmented community mental health system. Even mental health professionals are not familiar with the variety of services and

1 https://psychiatrie-psychotherapie.charite.de/en/patients/outpatient_department/center_for_intercultural_psychiatry_psychotherapy_zipp/

2 http://transver-berlin.de/

specialized treatment facilities. Obviously, this is even more challenging for immigrants and refugees who do not speak the language and lack information and knowledge about the German (mental) health care system. In summary, the overarching goal of those mental health services is the intercultural opening, including the reduction of language and administrative access barriers, increasing the quality of mental health care delivery for those groups and providing information to all actors and stakeholders in the field.

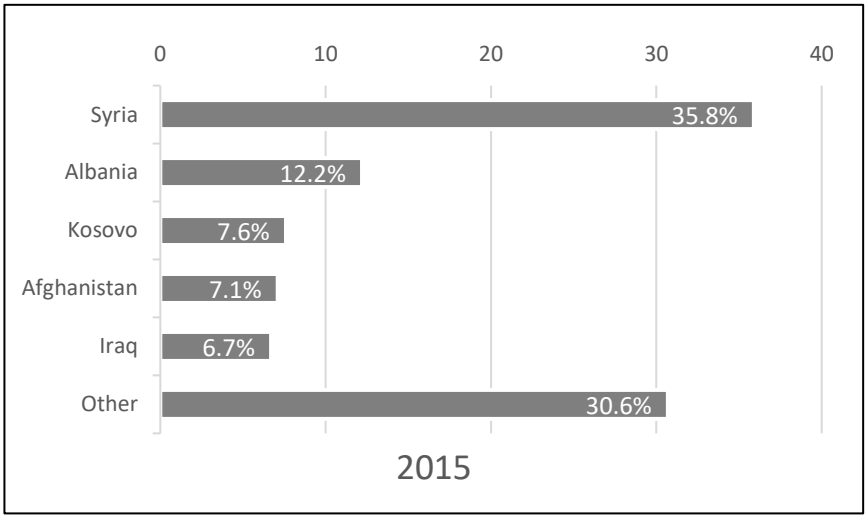
The (2) research at ZIPP takes place at two facilities, namely within the Research Group on Transcultural Psychiatry (TP) and the Research Group on Global Mental Health (GMH). Both groups combine the natural sciences and humanistic approaches and quantitative and qualitative research methods, ranging from epidemiological methods to ethnological fieldwork. Whereas the research group on Transcultural Psychiatry comprises Medical Humanities, Diversity Studies, Intercultural Psychotherapy, Transcultural Psychiatry, Medical Anthropology and Ethnopsychiatry, the research group on Global Mental Health integrates theory and methods from Global Mental Health, Public Mental Health and Epidemiology. Critical reflection of concepts, terms, categories and definitions used in this research area, such as culture, race, ethnicity, migrants, people with a migrant background, intercultural opening, cross-cultural competence, acculturation/integration etc. is a base of our research. TP focusses on (a) the development of new treatment approaches, tailored to refugees and immigrants, including treatment approaches via language and cultural interpreters, (b) the extent to which transcultural and migration processes have an impact on the migrating subjects and how do these processes effect identity building. Further fields of interest are (c) ways in which diverse healing systems/cultures deal with mental disorders. The research group on GMH addresses mental health disparities and mental health service delivery especially in low- and middle-income countries. The group supports the goals of the Movement for Global Mental Health (http://www.globalmentalhealth.org.).

The two research groups are closely connected to the Berlin Institute for Integration and Migration Research (BIM). BIM is an interdisciplinary research-based institute at Humboldt University that integrates 6 disciplines (Political Sciences, Sociology, Ethnology, Educational Science, Economics, Psychology, Medicine, and parts of 6 other institutes).

In this interinstitutional network, the recent research projects focus on (a) mental health and flight, (b) inclusion, exclusion und social cohesion in close cooperation with local networks, neighborhood initiatives and cultural institutions, (c) transgenerational transmission of losses and trauma narratives, (d) neurourbanistics, (e) psychosocial and labour market integration of refugees in the countries of origin, transit countries and receiving countries in relation to host community solidarity.

2 Refugee Situation in Germany in the Context of Mental Health

Worldwide, there are 68.5 million forcibly displaced people as a result of persecution, conflict, violence, or human rights violations (UNHCR: The UN Refugee Agency 2018). In Europe, Germany is the country that takes in the most refugees: approx. 1.1 million (UNO Flüchtlingshilfe 2018). As shown in figure 1, there are refugees from a variety of countries in Germany. For example, 24.7% refugees are from Syria. In 2015, about 477 000 asylum seekers filed an asylum application in Germany – 442 000 were initial applications. These numbers show an increase of 135% over the previous year (see Mediendienst Integration: https://mediendienst-integration.de). However, the Federal Office for Migration and Refugees (BAMF) only decided on 283 000 asylum applications during this period. Of relevance for mental health care is the fact that asylum seekers and refugees still receive limited medical benefits under the Asylum Seekers Benefits Act (AsylbLG § 4 and § 6).



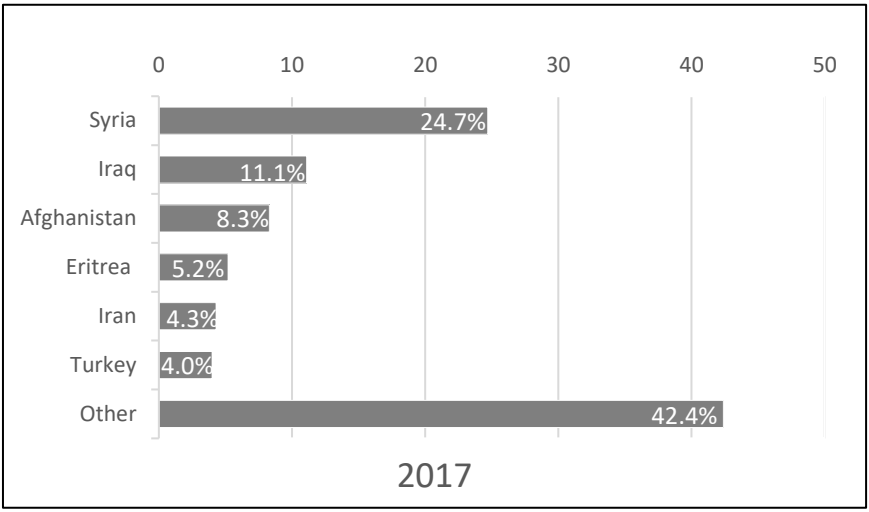


Figure 1: Countries of origin by refugees in Germany in 2015 and 2017 (after BAMF 2015, BAMF 2017).

2.1 Living Conditions in Germany

But what are the specific challenges in mental health care for asylum seekers and refugees in Germany? The biographies of refugees are often marked by uncertain living conditions in the countries of origin, potential traumatizing experiences (like war, torture, expulsion) in the countries of origin, during the flight and after arriving in the destination countries, including the risk of separation from the family and close relatives due to life-threatening events (Kluge 2016).

Most basically, existential uncertainties, e.g. concerning residential status, shape the reality of life. Moreover, refugees/asylum seekers in Germany have fewer rights compared to the German host community and the majority of society, especially as regards health care. Isolation and exclusion from the majority society shape the refugees' living conditions, particularly with regard to the housing situation (e.g. living in shelters), language barriers, discrimination experiences and other factors. Due to the existential uncertainties and limited rights, the lives of asylum seekers and refugees are characterized by passivity. Limited access to working permissions is another obstacle to integration and creates difficult financial situations. All this said, in treatment and therapy one addition-

al factor usually burdens asylum seekers and refugees intensely: the expectations of those left at home in the country of origin, resulting in feelings of guilt, shame and often helplessness. Separation from family and close relatives due to life threatening events and the flight itself are also main factors that have an impact on mental health conditions of refugees, as well as difficulties to find a place to stay in the receiving country after the flight. After arrival, difficult living conditions in the receiving countries and, in a lot of cases, the impossibility to return influence the mental health of refugees. (Thöle et al. 2017). See figure 2 for an overview of living conditions of those groups in Germany.

The emotional burden resulting from those experiences and life histories is obvious. There are no epidemiological data on how many refugees of those who arrived since 2015 do have a mental disorder. From clinical evidence we do know that about a quarter of those asylum seekers and refugees who seek help show signs of PTSD, about 40% evidence unipolar depression, etc. The mental health burden is very high, but it is not in all cases that those challenging living conditions in the countries of origin, transit and arrival do result in a mental health disorder.

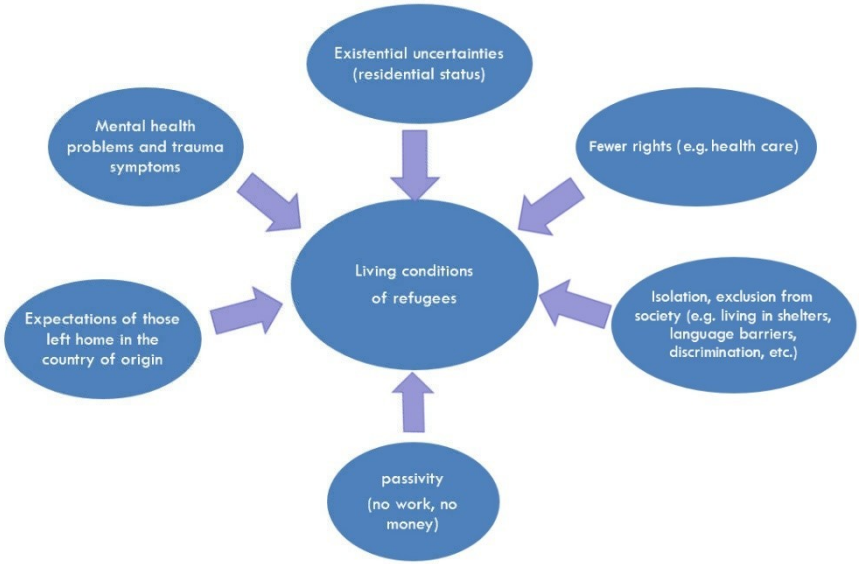


Figure 2: Living conditions of asylum seekers and refugees in Germany.

2.2 Language- and Culture-Related Barriers

As mentioned before, isolation and exclusion from society as well as from the health care system results partly from language- and culture-related barriers. In the health care system in Germany there is still only a limited availability of professionals who speak the mother tongue of foreign patients, depending on regions and facilities in Germany. Additionally, there are no standardized training manuals for interpreters for (mental) health care: Therefore, competences are very heterogenous.

Moreover, professionals are often reluctant to involve interpreters due to concerns about reduced therapy quality. To increase the quality of interpreter-accompanied therapy we need standardized training for professionals as well as interpreters in this field, easily accessible interpreting services structures (including face-to-face, video and telephone interpretation), and the respective financial and administrative structures for those services (Kluge et al 2012).

In addition to problems revolving around mother tongue therapists and interpreters, cultural biases are another main barrier, too: They result in misunderstandings, prejudice and, in clinical practice, in uncertainties in diagnostics and treatment.

2.3 Administrative Barriers

In addition to language and culture-related barriers, asylum seekers face administrative barriers in their efforts to access mental health care in Germany. They do have fewer rights, especially in the context of health care, as mentioned above: entitlements to health care are defined by the Asylum Seekers Benefits Act (AsylbLG), § 4 and § 6, with limited coverage for the first 15 months of a person's stay in Germany (apart from some communities: Hamburg, Bremen). Moreover, mental health care for asylum seekers and refugees is still fragmented and dependent on local provisions.

2.4 Mental Health Conditions

There are single reports on the prevalence and frequency of mental health problems occurring in asylum seekers and refugees: For example, the PTSD rate is ten times higher in refugees than compared to the general population (Crumlish and O'Rourke 2010; Fazel et al. 2005), and symptoms of anxiety and depression are documented in 84.6% and 63.1% of this population group in Switzerland (Heeren et al. 2014). For Germany, no prevalence rates have been established so far.

Regarding psychiatric diagnoses, there is a resurgence of interest in the construct of complicated grief in mental health, given the importance of this

reaction for refugees (Silove et al. 2017). The majority of refugees do have experienced multiple losses and separations in the context of gross human rights violations (Momartin et al. 2004). In addition, the long-debated category of complex PTSD, comprising elements of disrupted self-organization, will be included for the first time in the forthcoming ICD-11 (First et al. 2015). Early evidence suggests that the diagnosis can already be identified among refugees. There is a growing body of studies documenting cases in which PTSD is associated with psychotic-like symptoms or a genuine psychosis among refugees and post-conflict populations (Tay et al. 2015, Nygaard et al. 2017). There is now compelling evidence that schizophrenia and other psychotic disorders are more prevalent among refugees resettled in high-income countries as compared to other immigrants and host populations (Hollander et al. 2016).

Needless to say, the above-described living conditions of asylum seekers and refugees in Germany or other countries of destination and the resulting large number of social burdens require additional social and psychosocial support besides specialized treatment, such as trauma-focused treatment and therapy.

The discourse on trauma in the psycho-social field is not a new one. But it underwent a challenging renaissance in Germany and other European countries starting in 2015. There had been two main images in the media and in society: that of refugees as traumatized victims - or that of threatening perpetrators. Sverre Varvin, a Norwegian psychoanalyst argues: "Professionals, and to a large degree the public, identify the refugee's psychological suffering as problems that are "trauma-related" (Lesley & Varvin, 2016). "(…) the refugee experience is complex and comprises much more than "trauma". "Trauma", in these contexts, tends to become less of a theoretical concept and more of an object containing the deepest of human fears and images of the most terrifying violence" (Varvin, 2018).

3 Conclusion

The field of refugee mental health overlaps considerably with the larger movement of Global Mental Health: Both focus on the mental health needs of deprived populations from low-income countries.

But how can sufficient, good quality mental health services for asylum seekers and refugees in Germany be guaranteed in the future? There is a necessity for integrated care, consisting of social, political, cultural, medical and psychosocial stakeholders. There is especially a need for integrated mental health care systems, addressing psychological and social stressors in an appropriate manner, differentiating between needs ranging from psychosocial support to specialized treatment such as trauma therapy. Moreover, language and cultural barriers, as well as legal and political circumstances, need to be considered.

And what could be done? Multidimensional and -professional approaches are necessary to offer good quality mental health services for refugees. More specifically, low-threshold approaches, on a professional level as well as volunteer approaches, are needed. Psychosocial services need to be strengthened and professionals, including interpreters, have to be trained to offer adequate services for those groups.

The mental health situation of refugees in Europe is a global issue and should be understood as such in research and in the development of support structures including the expertise of professionals and researchers in the exit, transit and arrival countries.

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