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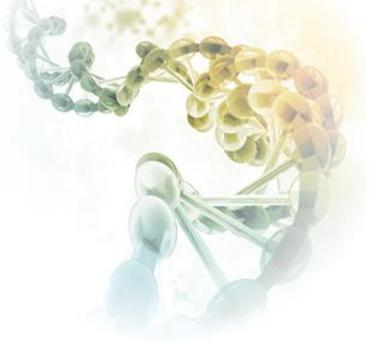
Mental Healthcare Provision for Refugees and Asylum Seekers in Germany Since 2015

By Kristianna Klammer,

College of Liberal Arts, May 2019

Honors Thesis Advisor: Rick McCormick, PhD

Reviewer: Stephen Parente, PhD, MPH, MS

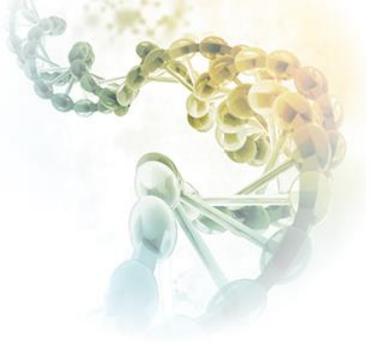


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Mental Healthcare Provision for Refugees and Asylum Seekers in Germany Since 2015

For a typical German citizen, Germany's healthcare system is universal and federally regulated to assure all citizens are guaranteed health coverage. There are both private and statutory health insurance or *Krankenversicherung* options for citizens to receive care from. Though there are certain requirements to receive private insurance, everyone is guaranteed coverage by the public system, including coverage for mental health services. Costs have been controlled by copays since the 1980s, and other costs are covered by a combination of employer and employee premiums. However, many refugees and asylum seekers just arriving in Germany have no regular income and are not yet considered citizens- and may never be. While there was a yearly influx of refugees in Germany before 2015, after 2015 the rate increased nearly four-fold. The vast majority of these refugees and asylum seekers are coming to Germany with nothing from their war-stricken home countries, and many are in need of psychological health care.

This paper aims to address the mental health care that Germany's healthcare system in various states of the country offers to refugees and asylum seekers, and how the system supports the care they provide for them. Important points that will be taken into consideration are the conditions that refugees suffer from, the extent of care in terms of coverage for services, barriers to services, and any restrictions that apply. With so many refugees and asylum seekers entering the country there must be resulting stresses on the system, and conversely a plan to combat them and maintain the sustainability of the system. I will evaluate what the country has done since 2015 to increase its capacity to provide care for refugees and asylum seekers. Included in this evaluation will be the changes at the levels of insurance companies, the professionals that

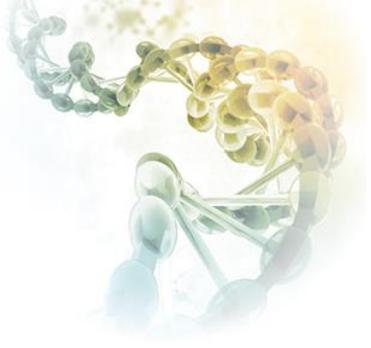


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provide care including doctors and nurses, as well as financial elements such as what has changed to reduce financial strains. Additionally, the paper will seek to explore any anticipated changes for the future being proposed to maintain the sustainability of the system and capacity for care while still providing and quality reliable care for regular citizens.

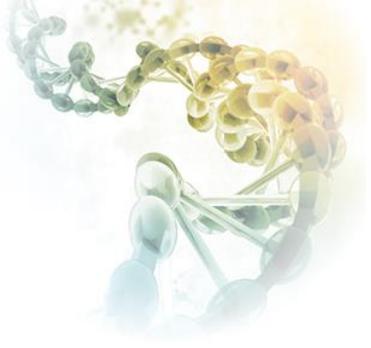
The paper will conclude with an analysis of where the German healthcare system stands in terms of its capacity to provide mental health care, as well as whether it has the capacity to support another wave of incoming refugees if another traumatic event occurred. The underlying issue with refugee mental healthcare is not the lack of services specifically for refugees, but an underdeveloped mental healthcare system overall. Stable mental health and the provision of mental health care to guarantee it, is important both for the refugees and for Germany as a whole. The sustainability of the healthcare system relies upon the integration of refugees and asylum seekers and the expectation that they will begin to contribute to said system. Those suffering from PTSD, depression, and other psychological conditions related to the trauma suffered in their home countries have a limited to nonexistent ability to integrate and participate in society. Thus, the provision of legitimate mental healthcare is of mutual benefit to Germany and the refugees seeking protection there.

Understanding the mechanisms through which mental healthcare is provided to refugees and asylum seekers in addition to the other types of care they are granted first requires a base knowledge of Germany's healthcare system for its citizens. In Germany, health insurance is mandatory for all citizens as well as permanent residents. This is what is meant when it is said that Germany has universal health care; everyone is guaranteed coverage. Germany's health



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insurance system consists of two components: both public and private companies. Publicly provided insurance is termed as Statutory Health Insurance, abbreviated SHI, in the German system (Bluemel). The public insurance is also referred to as *Krankenversicherung* or “sickness insurance.” Statutory health insurance companies are competing, not-for-profit and non-governmental organizations which are obligated to provide coverage for low-income citizens as well as cover their dependents free of charge (Bluemel). This component of the healthcare system accounts for 86% of all provided care, and as of 2016 there were 118 entities providing this type of insurance (Bluemel). The second component of the German health insurance is optional private health insurance, abbreviated PHI. (Bluemel). The sector of health insurance provides care for approximately 11% of the population and includes 42 companies, 24 of which are for-profit, as of April 2016 (Bluemel). Private insurance is available only on an opt-in basis under certain conditions, primarily provided that their total annual income is over a fixed limit or a *Versicherungspflichtgrenze*. Citizens may choose to opt in for private health insurance if they are civil servants or if they are self-employed (Montgomery 158). PHI primarily provides coverage for the self-employed and those whose healthcare costs are partially refunded by their employers (Bluemel). Part of opting into private health insurance includes paying a risk-related premium in addition to separate premiums for dependents (Bluemel). In a broad scope, SHI covers a wide range of care to legal citizens including “regular dental check-ups, child check-up immunizations, check-ups for chronic diseases, cancer screenings, inpatient and outpatient physician, mental and dental, optometry, physical therapy, prescription medications,



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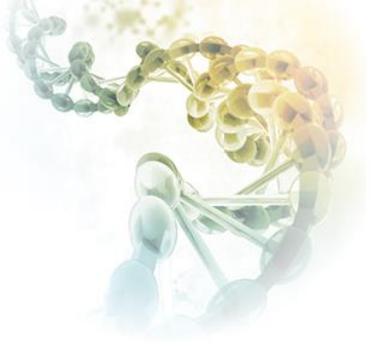
rehabilitation, hospice and palliative care, and sick leave compensation” (Bluemel). One of the benefits of PHI is the ability to negotiate areas and levels of care coverage with the provider.

Mental health care coverage varies between inpatient and outpatient care systems, but for both long term care insurance, abbreviated LTCI, is mandatory (Bluemel). This care includes coverage for any person with a physical or mental illness, or a disability, and any person who has contributed to the system for a minimum of two years can apply for these benefits (Bluemel).

Approval for LTCI coverage depends upon two things: one is an evaluation of “individual care needs” by the SHI Medical Review Board, and the other is a designated limit of certain maximum amounts that depends on the level of care granted by the board (Bluemel). The three main levels of care in the German system are inpatient care, outpatient care, and rehabilitation facilities. The actual care provided after insurance is granted varies. Inpatient care, when needed, is provided in the psychiatric ward of general hospitals, but the number of patients being treated for conditions necessitating these conditions is low (Bluemel). Hospitals can also be authorized to offer outpatient treatments in the psychiatric department; but, there are 35,000 psychiatrists, neurologists, and psychotherapists providing care in their office environment (Bluemel).

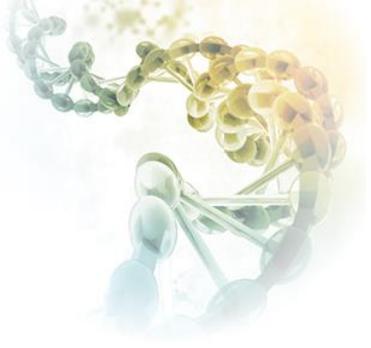
Additionally, general practitioners are qualified to provide basic psychosomatic services (Bluemel).

While the health care provided in Germany can originate both from public and private sources, it is all federally regulated. However, the regulations are not exceedingly involved. In Germany, there is no federal authority or administration that finances or manages a National Health Service; in other words, the government does not interfere in the financing or delivering



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of healthcare (Salize 93, Bluemel). Regulations are typically limited to the provision of a basic legal framework for general healthcare or welfare legislation (Salize 93). Essentially, the regulations are meant to describe the structure for statutory health insurance (Montgomery 158). Generally, the regulations that do exist are assigned to self-governing associations within sickness funds and provider associations (Bluemel). These two regulation groups together are represented by the *Gemeinsamer Bundesausschuss* or Federal Joint Committee, abbreviated FJC (Bluemel). Private health insurance is primarily regulated by the government to “ensure that the insured do not face large premium increases as they age and are not overburdened by premiums if their income decreases.” (Bluemel). Outside of the federal level, providing public healthcare is the responsibility of the individual states. They are mandated with planning hospital capacities and covering their investment costs (Montgomery 158). Mental health care, on the other hand, is organized as a subsidiary system (Salize 93). Generally, planning and regulating of mental healthcare is the responsibility of the sixteen federal states and it is done by passing state-level health legislation (Salize 93). However, due to the nature of the subsidiary system, federal authorities can organize provision of mental health services if other organizations, such as private or volunteer providers, are not equipped to provide care (Salize 93). When states have control over certain provisions of care, the quality of care has the propensity to vary greatly depending on the financial status of each state and the political parties and coalitions that rule each region (Montgomery 158). Mental health care, since it is largely controlled by the sixteen states individually, is no different. Provision of care is distributed among the many states and their municipalities and thus is characterized by significant regional differences (Salize 93). This

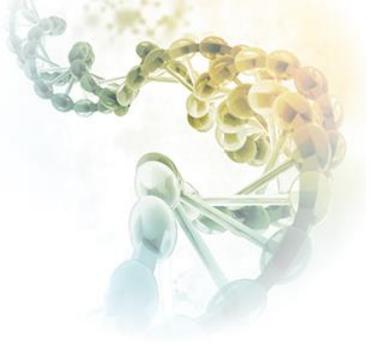


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means that the mental health care both German citizens as well as incoming refugees receive may vary greatly depending upon where they reside.

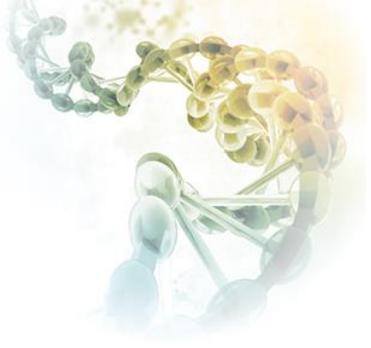
The mental healthcare services available to citizens vary between the level of healthcare under which they are categorized. Inpatient mental healthcare includes services such as inpatient psychiatric care, long-stay services, psychiatric hospitals, child psychiatry services, and psychosomatic hospitals (Salize 95-97). Many of these facilities will offer a multitude of treatments for mental health conditions. Outpatient resources include psychiatric outpatient departments, social-psych centers that may include community treatment centers, outpatient psychiatrists who function out of their own practices, general practitioners who are qualified to provide low level mental health services, psychotherapy which may be provided by licensed psychiatrists or psychologists, and rehabilitative care services (Salize 97-99).

Health insurance for Germany's citizens is financed both by the employee and the employer. Financing derives its funding primarily from the contributions of employers and employees, and a smaller portion subsidized by the federal government (Montgomery 158). A percentage of the employee's gross wage, specifically 14.6%, is shared equally between the person receiving care and their employer (Bluemel). All the contributions are collected into a collective healthcare fund, which is the source of the insurers financing (Montgomery 158). Outsides costs do typically include copays, but copays only range between five to ten euros depending on the service being provided. Specifically, regarding mental health care, government spending on services in Germany account for 11% of the total government health budget (Sijbranij 3). This is a rather high percentage in comparison to other European countries.



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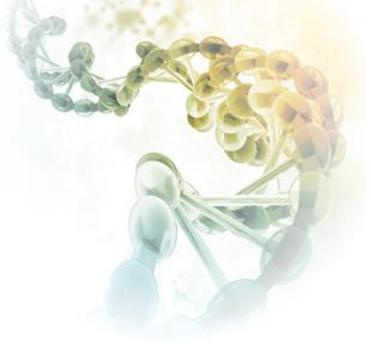
In 2015, Germany experienced an unusually high influx of asylum seekers compared to the previous year. Despite the borders they crossed and EU regulations for asylum at that point in time, Germany welcomed many refugees across their borders and into their country. Most of the people crossing the border were able to stay in the country due to the nature of the circumstances that drove them out of their own country. In Germany, a refugee is defined as a person who has the right to asylum. What constitutes the right to asylum is designated in 16a of the German Basic Law or *Grundgesetz* (Gesley). By this definition, asylum is granted to any person who “flees political persecution” if said persecution is perpetrated by the state (Gesley). Political persecution can be further defined as “...persecution that causes specific violations of individual rights and, due to its intensity, excludes the individual from the “general peace framework of the state unit” (Gesley). Not every hardship that an asylum seeker endures in their home country is necessarily considered applicable in being considered for asylum. In Germany, the existence of this “constitutional right to asylum protects human dignity and reflects the view that no state has the right to persecute an individual for his or her political or religious beliefs or other personal characteristics that mark him or her as different” (Gesley). Additionally, the Geneva Convention Relating to the Status of Refugees states in Article 1(A)(2) that a refugee can be defined as a person who “owing to a 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 to, or owing to such fear, is unwilling to avail himself of the protection of that country” (Gesley). This is relevant to Germany both because it was a signer of the aforementioned convention as well as the fact that this section has since been added to



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section three of the German Asylum Act or *Asylgesetz* (Gesley). Two of the most relevant and important immigration laws in Germany include the Asylum Act and the Residence Act, *Aufenthaltsgesetz* (Gesley). These two laws are significant because “[t]he Asylum Act codifies the process and consequences of granting and denying asylum, whereas the Residence Act provides rules concerning the entry, stay, exit, and employment of foreigners in general” (Gesley). In general, these two laws together define the rules to be followed in all refugee matters concerning their admittance into the country and the handling of their claims (Gesley). This is important because a refugee’s residence status plays a large role in the medical coverage they are or may be granted.

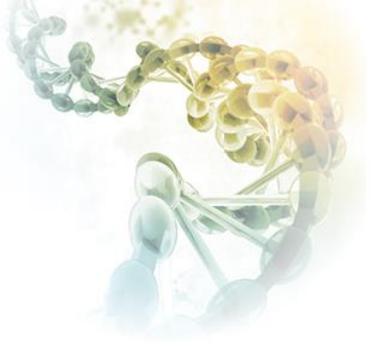
War is happening almost constantly around the world, but infrequently is the turmoil of war so severe as to force as a large portion of its population to flee to other countries as in 2015. War and violent conflict in Syria, among other countries, persisting for an extended period, have resulted in a one quarter to one third displacement of its population, many of whom decided to seek refuge abroad (Sijbrani 7). In 2015, just between the months of January and November, Germany received 425,035 asylum applications, 57,816 of which were received in November alone (Gesley). Altogether in 2015, 476,649 of the refugees who entered the country submitted applications for asylum (Belz 596). Not including those who crossed the border but did not submit an asylum application, the number of applications since the previous year more than doubled (Gesley). Many of the people flooding into the country filled out and submitted their applications shortly after entering Germany within the refugee reception centers (Belz 596). The applications came from people relocating from a variety of countries including but not limited to:



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Syria, Afghanistan, Iraq, Albania, and Kosovo (Gesley). Of these applicants, Syrians had the highest majority and the highest rate of approval at 94.8% (Gesley). Overall, 45% of all applications for asylum in 2015 were approved (Gesley). For the number of refugees who entered the country in 2015, this is still a significant increase in the amount of people that the healthcare system will need to provide care for. Even in the following year, 2016, Germany remained one of the primary destinations for asylum seekers, accounting for over 720,000 of the 2.8 million worldwide applications (Goodman 1). As is seen in the statistics previously listed, not everyone who applied was approved for asylum in Germany during this time. Those whose applications were not approved are mandated to leave the country or risk deportation (Gesley). Also, important to note is that the statistics listed are just the percentages of refugees who entered the country. The number of people who leave Germany to move on to other European countries, such as Norway or Sweden, or to return to their home countries is not tracked (Montgomery 157). Additionally, it is extremely difficult to determine how many asylum seekers whose applications got denied but then continued to live undocumented in Germany; or similarly, how many refugees simply decided not to register for one of several reasons. It is estimated that somewhere between 140,000 and 330,000 “undocumented” individuals still reside in Germany (Montgomery 157). Children of parents who are not granted asylum and thus have no legal residence status are often completely cut off from medical services (Montgomery 159).

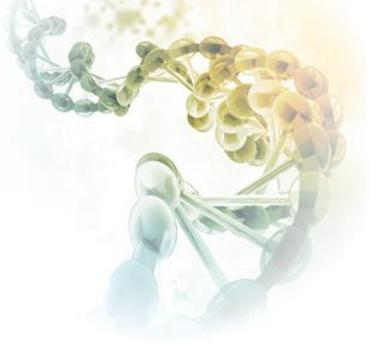
From the moment that they enter the country, refugees have access to some form of healthcare which is regulated by federal law; however, the scope of care they can access varies widely depending on their asylum status and how long they have been in the country



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(Montgomery 158). For the first fifteen months after entering the country, asylum seekers are granted access to limited treatment based on need for cases such as acute illness, pain, and unspecified emergencies (Montgomery158). The law covers a compulsory preventative medical examination and officially recommended vaccinations (Montgomery158). The initial care may also extend to treatments required by women who are pregnant or have recently given birth, including medical and nursing care as well as access to midwives, medication, and surgical dressings (Montgomery 158). As it stands, health care coverage in the first fifteen months does not extend to chronic disease or access to general preventative medicine (Montgomery 158). Mental health care, such as psychotherapy, is also not covered since it is not classified as an acute condition (Koesters 396). Refugees are often relocated to different municipalities within the first fifteen months which are responsible for providing at least basic benefits (Bauhoff 2). At this time, it is an unfortunate reality that mental health screening and coverage are not considered basic benefits.

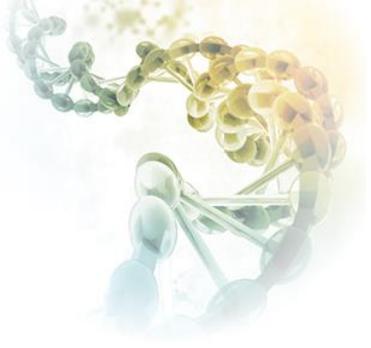
Refugees need to officially be granted asylum before they can gain access to higher levels of care, including mental health care. Recognition of a person as having been granted asylum dictates that under the *Asylbewerbergesetz* that individual may receive some form of a residency permit, either temporary or permanent (Ansar). Both permits allow the person access to the statutory German healthcare system (Ansar). Depending on the status of the person in terms of receiving a work permit, access to care may be financed through either the labor tax, which regular citizens pay as the employee contribution to the health insurance fund, or through social welfare (Ansar). Through the residency permit, refugees have access to all the typical healthcare



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needs in addition to certain components of mental health care. Included in their rights is access to various forms of mental health treatment, if and where they are accessible, including the ability to attend both state- or health-insurance- funded psychotherapy (Sijbrandij 3). However, since planning and regulation of mental healthcare services is up to the discretion of the individual states, the policies regarding access to mental health services are largely inconsistent (Montgomery 157). In addition to services, billing procedures and eligibility of certain benefits may vary not only from state to state, but also from municipality to municipality (Montgomery 157). Each state will determine policy details with their municipalities (Montgomery 157). Variation of care on so many regional levels leaves refugees in a sort of limbo when applying for asylum and seeking care. This is because the system for placing refugees in the country is unclear. Due to the arbitrary nature of the system by which refugees are placed in the country, a person with more severe PTSD or mental trauma may end up in a state or municipality with limited resources for mental health care. This highlights the primary issue for refugees and asylum seekers who need access to mental health care. After being granted residency, it is not a lack of resources specifically for refugees, but a lack of mental health professionals, programs, and resources in general that separates refugees from accessing mental health care. Refugee mental health care is simply access to the pre-existing mental health care in the German system.

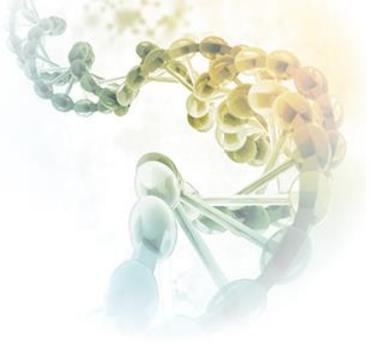
Residency is the first step for refugees toward access to stable and substantial health care through the German system. Throughout the asylum procedure, refugee benefits are outlined by the Asylum Seeker's Benefits Act or *Asylbewerberleistungsgesetz* (AsylbLG) (Böttche,



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Psychotherapeutische Versorgung 1138).¹ After an application is accepted, access to care becomes more readily available and more accessible. Those awarded asylum received a residency permit or *Aufenthaltserlaubnis* (Gesley). At this point in time, refugees essentially have access to all the amenities and resources to which a regular citizen would have access. This includes the mental health resources that are granted to citizens. After the initial three-year residency permit, a settlement permit or *Niederlassungserlaubnis* may be granted further securing access to healthcare (Gesley). In response to the unusually high influx of refugees settling in the country that Germany experienced, an effort was made to secure basic needs, such as medical care, to this new population (Goodman 2). Ultimately, the goal of many refugees who decide to continue to reside in Germany is likely to be naturalized and make Germany their permanent home country. To do so, several criteria must be met. Included in these criteria are adequate skills in the German language, and “[i]ndependent means of supporting him or herself and dependents without resorting to welfare payments and unemployment benefits” (Gesley). Early access to mental healthcare plays an important role in achieving these requirements in the long term. A person suffering from post-traumatic stress disorder, depression, or any other condition, whether preexisting or caused by the trauma of the environment they were escaping, will have a much more difficult time obtaining these requirements. For a new migrant, seeking employment in a new country is a difficult enough task without the burden of untreated mental illness and unattainable care.

¹ “Für die Dauer des Asylverfahrens (gesetzlicher Titel: Aufenthaltsgestattung) sind die Leistungen durch das Asylbewerberleistungsgesetz (AsylbLG) festgeschrieben.”



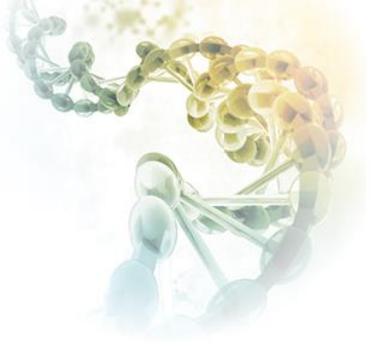
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The clear majority of refugees and asylum seekers who have flooded Germany's borders since the beginning of 2015 were coming from war-torn countries. For many, it took months to years to reach their final destination in Germany (Böttche, *Sequenzielle Traumatisierungen* 621).² Many of these people have undoubtedly experienced a great deal of trauma and loss, not just in what they experienced in their home country, but also in being forced to leave their homes and likely being separated from family members. Due to the typical nature of the situation that forces refugees and asylum seekers to flee their home countries and seek shelter in Germany, it can be assumed that they are at a higher risk for mental morbidity (Böttche, *Psychotherapeutische Versorgung* 1136).³ Just getting into the country, refugees may experience violent escape routes or violence at the EU's external borders (Böttche, *Psychotherapeutische Versorgung* 1136).⁴ By the time they cross the border to Germany, many are, at the very least, malnourished and sleep-deprived (Classen and Jager 2). More morbidly, a study uncovered that "trauma-related mental health disorders comprised half of mental health diagnoses" for the refugees attending clinics in Germany (Goodman 1). Studies have determined that the most common diagnosis of mental illness in refugees is post-traumatic stress disorder (PTSD), accounting for 17.7% of all diagnoses (Goodman 5). This was followed by "unspecified depressive episode (12.7%), adjustment disorders (10.6%), somatization disorder (6.83%), and

² "Die Menschen, die nach Europa flüchten und dabei mehrere Transitländer durchqueren, sind in der Regel Monate bis Jahre unterwegs."

³ "Es kann jedoch davon ausgegangen werden, dass unfreiwillige Migration (d.h. Flucht aufgrund von Krieg und Verfolgung) mit einem erhöhten psychischen Morbiditätsrisiko in Verbindung steht."

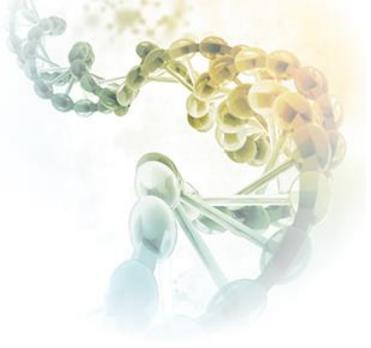
⁴ "Geflüchtete Menschen sind in ihren Heimatländern sowie auf der Flucht oftmals mit einer Vielzahl traumatischer Ereignisse konfrontiert (z.B. durch lebensgefährliche Fluchtrouten oder Gewalt an den EU Außengrenzen)"



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unspecified somatoform disorder (5.59%)” (Goodman 5). The combination of these diagnoses account for 47.5% of the total of all mental health related diagnoses made in the study (Goodman 5).

In a study conducted by Belz et. al., nearly the entire sample reported experiencing some type of traumatic event (601). Many of the refugees who came into Germany in 2015 were fleeing actively warring countries, thus all refugees ran a high risk of experiencing man-made traumas that were repeated or prolonged. This type of trauma, which can be described as cumulative, poses the highest risk of resulting in PTSD (Belz 596). Man-made traumatic events, events caused by another human, include sexual assault, violence, rape, war, torture, etc. (Belz 598-599). Of those who reported experiencing traumatic events, over 91% reported experiencing multiple events and 100% of the events reported in the study were man-made (Belz 601). In this study, like many others, post-traumatic stress disorder (PTSD) was found to be the most frequently diagnosed condition. Belz et. al. categorizes PTSD by the International Classification of Diseases Edition 10 (ICD-10) as being the result of “a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone” (596). Though the percent of the sample afflicted has been found to vary between studies, in this case PTSD was diagnosed in 81.2% of the sample (Belz 600). Overall a total of 95.29% suffered from some mental disorder, with the second highest diagnosis being mild, moderate, or severe depressive episodes (88.2%) (Belz 600). Other conditions diagnosed at lower percentages, but still pertinent, include acute self-harming behavior, and acute or latent suicidal thoughts (Belz 601). For many refugees, the probability of



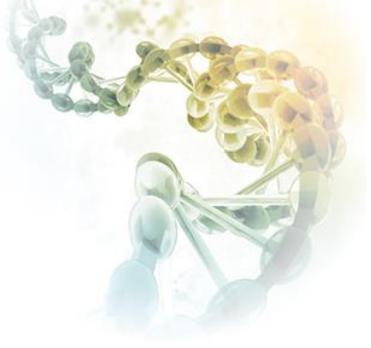
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experiencing depressive episodes if they were already suffering from PTSD was high (Belz 601). Though in many studies the percentage of the random sample that suffers from PTSD or other mental illnesses is high, the overall percentage of diagnoses relative to the total number of refugees and asylum seekers who go through reception centers is low. Belz et. al. determined that a high percentage of unreported cases of mental illnesses can be assumed because even though 22,294 refugees came through the reception area where the study was being conducted, the prevalence of PTSD diagnoses was only 30-40% compared to the approximately 80% of the sample (605). Other meta-analyses of those who have experienced trauma and displacement have shown prevalence rates of 30.6% for posttraumatic stress disorder and 30.8% for depressive disorders (Böttche, *Sequenzielle Traumatisierungen* 621).⁵ Though percentage prevalence of these disorders varies between studies, the diagnoses are always high enough to be significant, and PTSD is typically the most frequent diagnosis. In addition to disorders caused by pre-migration trauma, post-migration stressors can induce mental disorders in refugees. Common post-migration stressors include insecure residence, prolonged asylum process, restricted social participation, separation of family members, loneliness, and discrimination (Böttche, *Psychotherapeutische Versorgung* 1136).⁶

Undiagnosed cases of PTSD and other mental illness have a negative impact on the health care system in the long run. The main symptoms of PTSD sometimes present themselves

⁵ “Metaanalyse bei Opfern von Folter und Vertreibung, so zeigen sich Prävalenzraten von 30,6% für die posttraumatische Belastungsstörung und 30,8% für depressive Erkrankungen”

⁶ “Hierunter fallen u.a. aufenthaltsbezogene Probleme(z.B. unsicherer Aufenthalt, lang andauernder Asylprozess), eingeschränkte gesellschaftliche Teilhabemöglichkeiten, Trennung von Familienmitgliedern, Einsamkeit oder Diskriminierung.”



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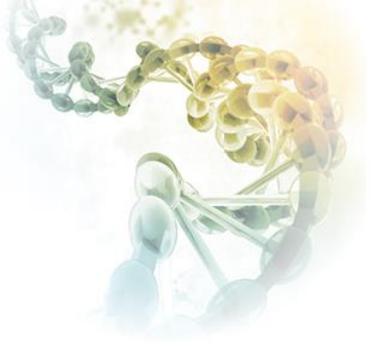
with a time latency and may appear weeks to months before they are apparent (Richter 5).

Untreated, PTSD can lead to chronic symptoms requiring more treatment over a longer period of time thus putting more stress on the system and potentially raising the overall costs of care (Belz 605). In the case of PTSD and time latent development of symptoms, early intervention and initial frequent follow-up can prevent growth of symptoms and “chronification” of the disorder (Richter 5). Studies have found that limited healthcare for refugees and asylum seekers ultimately leads to about a 40% increase in costs compared to refugees who are granted regular access to healthcare (Böttche, *Sequenzielle Traumatisierungen* 623).⁷ Barriers to care or treatment that is inaccessible may lead refugees down this road of worsening conditions, ultimately detrimental to refugees and asylum seekers as well as the German healthcare system.

The psychological or mental disorders that refugees are suffering from cannot be treated by psychotherapy alone (Böttche, *Psychotherapeutische Versorgung* 1136).⁸ The overall refugee situation is too complicated for one mode of treatment to be sufficient. Richter et. al. also recommends the best way to diagnose and treat mental disorders in a population of refugees and asylum seekers is with a multi-professional and multilingual team that has a background in cultural psychiatry (5). Care should extend past medical provisions and include the principles of promotion of social integration through means of education, vocational training, and reducing social isolation (Koesters 369). Additionally, Adorjan et. al. discusses the development of a

⁷ “Bozorgmehr und Razum zeigen, dass bei Asylsuchenden mit eingeschränktem Zugang die Kosten für die Gesundheitsversorgung um etwa 40% höher lagen als bei Asylsuchenden mit regulärem Zugang.”

⁸ “Hier ist zu betonen, dass allein psychotherapeutische Ansätze für die Bedürfnisse und Belange dieser Patienten gruppe oft nicht ausreichend sind.”



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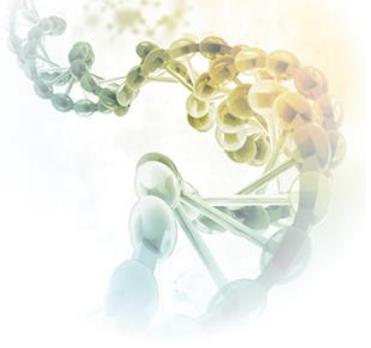
cooperation network that connects various levels of mental healthcare to close gaps in care provision (990). The network would tie together the main providers of care: hospitals, community psychiatric networks, and the medical association (990).⁹ As part of this network, the Departments of Psychiatry and Psychology proposed a ten-point plan that includes the improvement of care for acute conditions and continuing education programs (990).¹⁰ This program combines psycho-social aspects to improve quality of mental health care by extending methods across multiple levels of care. Stepped care models have also been proposed which functions somewhat similarly to cover all levels of care. In the Stepped and Collaborative Care Model (SCCM) that Schneider et. al. propose, level two of care includes peer-to-peer counseling to help overcome cultural and language barriers (14).¹¹ Refugees who have been in the country longer may even aid in initial levels of care by serving as qualified lay-helpers to provide basic psycho-educational information and an orientation to the healthcare system to new arrivals (14).¹² Receiving initial help from other refugees is an efficient way to ensure new refugees and asylum seekers are comfortable and understood in conversations about their mental health.

⁹ „Die Versorgung wird durch Krankenhäuser, gemeinde psychiatrische Netzwerke oder vom Ärzteverband organisiert.“

¹⁰ „Infolge des Flüchtlingszustroms wurde zur Gewährleistung einer qualitativ hochwertigen Versorgung im psychiatrischen und psychosozialen Bereich ein sog. 10-Punkte-Plan von der Klinik für Psychiatrie und Psychotherapie erarbeitet. Neben der Verbesserung der Akutversorgung beinhaltet er u.a. Fort- und Weiterbildungsprogramme sowie die Bereitstellung einer Wissensdatenbank zur Evaluierung und Prüfung von Projekten.“

¹¹ „Vor diesem Hintergrund sollen Peer-to-Peer-Beratungen und internetbasierte Verfahrenszwei prototypische Maßnahmen näher erläutert werden: Peer-to-Peer-Beratung zielt auf die Überwindung der sprachlichen und kulturellen Hindernisse, die gegenwärtig bei der Beratung und Behandlung psychischer kranker Flüchtlinge existieren.“

¹² „Hierfür können Migranten und geflüchtete Personen zu Laienhelfern qualifiziert werden, die anderen psychoedukative Grundinformationen vermitteln, einfache Entspannungsübungen vermitteln und Orientierung im Gesundheitswesen bezüglich möglicher Anlaufpunkte bei weitergehendem Bedarf geben.“

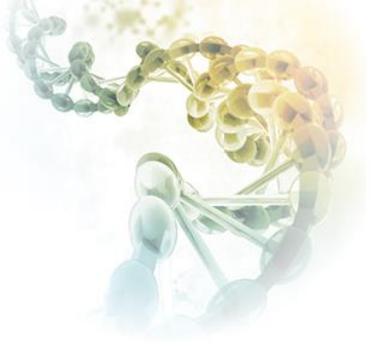


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Barriers to mental healthcare stem from multiple levels but all generally consolidate to a mental healthcare system that is underdeveloped for a country of German's size and significance. Oftentimes it can be difficult for refugees and asylum seekers to access medical care due to both administrative and practical barriers (Sijbrandij 3). Waitlists account for a large part of the relevant administrative barriers to receiving care, especially for a more specific service such as mental health care. In many areas of the country, refugees with and without asylum are required to obtain treatment vouchers before they can obtain any level of care at treatment facilities (Montgomery 159). The vouchers are available at the municipal social security offices and are valid only for 24 hours (Montgomery 159). Since the vouchers cannot be saved for a later date, many times sick people must stand in line for hours to get a voucher and seek treatment (Montgomery 159). Even once vouchers are obtained, there are further administrative barriers to care for more specialized treatment. Due to the high influx of refugees in 2015, the waitlists for specialized mental health care during that time were as high as six months on average (Sijbrandij 4). This means that thousands of refugees were not receiving the care they need and their progress in society was hindered and delayed even further. Of the estimated 379,848 refugees that sought out mental health treatment in 2015, only 19,472 received the care they needed (Sijbrandij 4).

There is a large discrepancy between the psychological and psychiatric care that is needed and the care systems that actually exist (Böttche, *Psychotherapeutische Versorgung* 1138).¹³ Structural reasons for this include: lack of implementation of the EU on identification

¹³ “Bedarf und tatsächlich vorhandenen psychosozialen und psychotherapeutischen Versorgungsstrukturen.”



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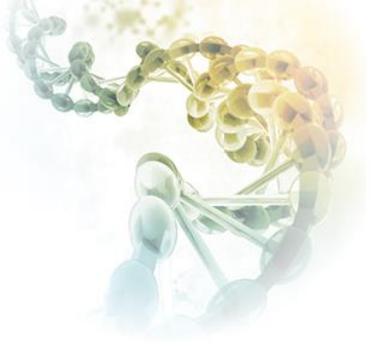
and care of vulnerable people, lack of training of psychosocial staff, lack of billing and funding of specialized centers through statutory health insurance, and lack of funding or funding arrangements for interpreters (Böttche, *Psychotherapeutische Versorgung* 1138).¹⁴ The lack of funding for interpretation presents a blatant supply barrier for people who do not have sufficient German language skills (Böttche, *Psychotherapeutische Versorgung* 1139).¹⁵ This is dangerous because a quality interpreter may well mean the difference between an accurate diagnosis and a mental disorder that goes unnoticed and untreated. Currently, funding for interpreters from the Social Welfare Office only spans the first fifteen months after entry while the individual's health care is provided under the Asylum Seekers Benefits Act (Böttche, *Psychotherapeutische Versorgung* 1139).¹⁶ After those first fifteen months, funding for interpreters, like many other aspects of care, disappears.

At an even earlier stage, there are also barriers due to a lack of necessary personnel in making diagnoses. Independent and qualified evaluators are required to accurately determine if a refugee needs psychotherapeutic treatment, and there are nowhere near as many as are needed in the refugee reception centers (Montgomery 159). In many intake areas, office workers of the Federal Office for Migration and Refugees evaluate refugees' reasons for seeking asylum (Belz

¹⁴ “z.B. fehlende Umsetzung der EU-Richtlinie zur Identifikation und Versorgung besonders schutzbedürftiger geflüchteter Menschen, fehlende Weiterbildung des psychosozialen Personals, fehlende Abrechnungsmöglichkeiten und fehlende Finanzierung spezialisierter Zentren über die Gesetzliche Krankenversicherung, fehlende Finanzierung bzw. Finanzierungsregelungen für Dolmetscher.”

¹⁵ “Die mangelnde Finanzierung für Dolmetscherkosten stellt eine eklatante Versorgungsbarriere für Menschen dar, die keine ausreichenden deutschen Sprachkenntnisse haben.”

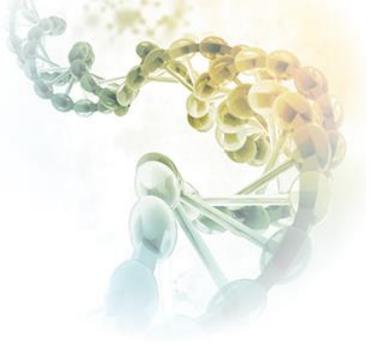
¹⁶ “Derzeit können Dolmetscherkosten nur in den ersten fünfzehn Monaten nach Einreise in Deutschland finanziert werden. In diesem Fall erfolgt die Gesundheitsversorgung nach dem Asylbewerberleistungsgesetz; Dolmetscherkosten können beim zuständigen Sozialamt beantragt werden.”



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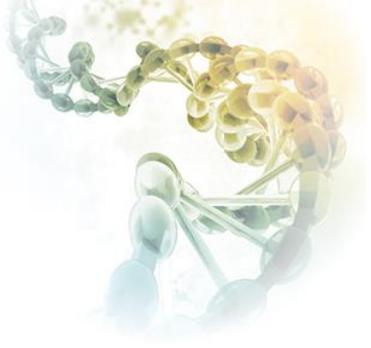
596). These non-clinicians must attempt to determine whether the refugees are suffering from any mental disorders as a direct result of the traumas they may have experienced, a decision which plays a large role in whether the individual will be granted a residence permit (Belz 596). The longer refugees stay in the reception center, the higher the risk that their symptoms of trauma related disorders worsen, or manifest new mental and physical symptoms of depression, anxiety, and somatic symptom disorders in addition to aggravating preexisting symptoms of PTSD (Belz 597). Additionally, the shortage of qualified interpreters causes miscommunications, and consequently, vital information may not make it past the language barrier (Montgomery 159). The negative effect of barriers to mental health can be directly seen in the high levels of admissions to inpatient programs and hospitalizations for mental health (Bauhoff 7). Refugees with and without asylum must struggle through so many barriers to access care that they never end up receiving the preventative treatment they need and ultimately end up admitted to hospitals or inpatient programs. This ultimately also leads to higher average hospital expenditures, 1.3 times higher than normal, for these groups, a direct example of how early preventative care and short-term costs can decrease costs for the healthcare system in the long run (Bauhoff 8).

Though asylum seekers are granted a restricted level of care when they first enter the country, higher levels of care are often necessary depending on the severity of conditions. Indeed, even the restricted access to care expires after fifteen months, and being granted asylum can take years (Montgomery 159). There are no explicit details of healthcare provisions that refugees are guaranteed during the in between time or if asylum is restricted to a limited number of years (Montgomery 159).



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The Electronic Health Identification Card (EHIC) is a new system of gaining access to care that is starting to expand in popularity in states across Germany. The card essentially allows refugees to go directly to physicians whenever they need care without first obtaining vouchers. Since 2015, the introduction of the EHIC has been one of the largest technological advancements towards providing refugees with better and more accessible care. The introduction of the card has the potential to remove several administrative barriers between refugees with and without asylum and getting the care they need. However, the EHIC has only been introduced in select states across the country. By 2015, every federal state of Germany had the ability to distribute EHIC's to refugees and asylum seekers right from the beginning of their arrival (Classen and Jager 2). As of February 2016, only the states of North Rhein-Westphalia, Bremen, Hamburg, and Schleswig-Holstein had issued the health identification cards to the refugees residing in their regions (Stafford 1). In North Rhein-Westphalia, the municipalities are free to decide where or not to implement the system; however, by the end of 2017, nearly all the federal states, except for Bavaria and Saxony, had decided for the EHIC system or were in consultations to implement it (Classen and Jager 2). Administration of the health identification cards to refugees and asylum seekers follows the same process as if they were being administered to unemployed citizens in need of welfare services; this holds true for all federal states regardless of size (Montgomery 159). Systematically, the care of non-paying clients, in this case asylum seekers whose applications have not yet been confirmed, is covered by sickness funds which reimburses the local municipalities (Montgomery 159). The major drawback now is the EHIC limits the range of services to a select index of acute diseases (Montgomery 159). As it stands, even if the EHIC

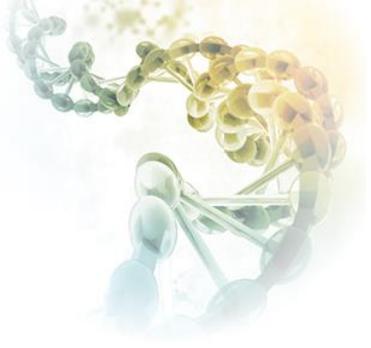


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system is implemented after the first fifteen months in the country, the application of psychotherapy treatment will still be mandated by AsylbLG (Böttche, *Sequenzielle Traumatisierungen* 624).¹⁷ Generally, this means that access to mental health care would require explicit approval; this is a failure to reduce the barriers to mental health care (Bauhoff 2). Due to the administrative and social barriers to health care that the EHIC eliminates, the implementation of this system across the country would be a promising change for the future of refugee mental health care. The result would be no more waiting in line for vouchers and none of the difficult interpersonal interactions while trying to communicate through language barriers in order to get them.

Barriers to care on all levels pose a serious risk of worsening the mental disorders many refugees are experiencing due to lack of intervention. The large wave of refugees resulted in a shortage of medical and social personnel to support refugee services in reception centers. During the peak influx of refugees, shortage of staff in reception centers resulted in reduced numbers of refugees that were assessed for psychological conditions (Belz 606). With reduced staff numbers, the ones that were present were over-worked and had less time to assess the psychological state of the refugees (Belz 606). Often in these situations, mental disorders are overlooked when physical symptoms are present (Belz 605). Once the refugees have been assessed, those determined to be suffering from mental disorders encounter either restricted access or barriers to mental health care or both (Belz 605). Insufficient and under qualified interpreters have the

¹⁷ “Die Einführung der elektronischen Gesundheitskarte nach 15 Monaten Aufenthalt in Deutschland (bzw. die Handhabung des Bremer Modells), erleichtert zwar den allgemeinen Zugang zum Gesundheitssystem, jedoch wird der Antrag auf Psychotherapie weiterhin nach den Bedingungen des Asylbewerberleistungsgesetzes geprüft.”

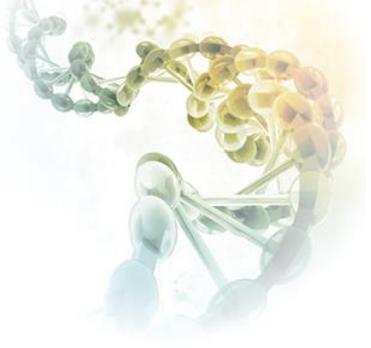


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potential to worsen conditions due to inaccurate diagnosis resulting in misdirected treatments or over-medication (Böttche, *Psychotherapeutische Versorgung* 1140).¹⁸ This deteriorates the condition of the refugee, not to mention increases costs. Finally, inherent barriers such as perceived social stigma of seeking mental health care prevents refugees and asylum seekers from accessing treatment.

With the influx of refugees in 2015, Germany and the systems that provide medical care must adapt quickly in order to continue to provide adequate care to all those, old and new, residing in the country. Volunteers, particularly those that are healthcare workers, helped prevent the quickly forming “bottleneck” of refugees and asylum seekers rapidly entering the country (Montgomery 160). Since then, the expansion of the EHIC has played a role in increasing Germany’s capacity to provide healthcare, including mental health care, to refugees with and without asylum. In addition to the EHIC, some areas have made further accommodations in an effort to close the gap between mental health needs and access. Belz et. al. cites a mental health support project that was created in cooperation between a German refugee reception center and a psychiatric clinic due to the inherent high risk of mental disorders among refugees (597). The proposed cooperation network of hospitals, community psychiatric networks, and the medical association could also have a large impact on provision of care in more isolated regions (Adorjan 990). Smaller service providers in a coverage area can be tied into the network so that they can

¹⁸ “Weiterhin führt eine mangelnde sprachliche Verständigung häufig zu Fehldiagnosen und fehlgeleiteten Behandlungen bzw. einer Übermedikalisierung und trägt damit zu erhöhten Behandlungskosten bei.”



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supply care more extensively (Adorjan 990).¹⁹ Additionally, the four-level method of care discussed by Schneider et. al. guarantees mental health care for refugees and asylum seekers at the level of care that they each require (14). At the first level of care, patients are simply monitored; interventions not requiring medical experts, such as peer-to-peer counseling and internet-based interventions, are introduced in the second level (Schneider 14).²⁰ In the third level, expert medical care is introduced in a group-setting as a cost- and resource-saving method (Schneider 14).²¹ Finally, native-language interpreter-assisted expert therapies are introduced as a fourth level step (Schneider 14).²¹ The advantage of this system is that the lower levels of psychiatric, psychological, or psychosomatic care for refugees are carried out outside of the larger healthcare facilities, leaving room for those who require expert level therapy (Schneider 14).²² Multiple levels of mental healthcare for refugees assures maximum efficiency in resource use and maximum provision of care for those who need it.

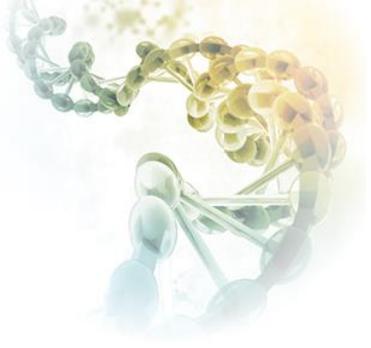
In the future, there is a possibility of a limited number of “life threatening or serious illnesses” exempting a person whose asylum application was rejected from being deported due to

¹⁹ „Kleinere Leistungserbringer im Versorgungsgebiet können dabei ebenfalls in das Netzwerk eingebunden werden. Obwohl sie oftmals örtlich günstig gelegen sind, können sie keine umfangreichen Versorgungspflichten wahrnehmen. Deshalb kommt ihrer Anbindung und Kooperation mit den regionalen Partnern eine besondere Bedeutung zu.“

²⁰ „In diesem Versorgungsmodell würden Patienten auf der untersten Stufe 1 aufmerksam beobachtet werden („watchful waiting“). Auf der nächsten Stufe kämen solche Interventionen zum Einsatz, die keine oder nur eine geringe Begleitung durch medizinisch-psychologische Experten benötigen (Stufe 2, z.B. Peerto-Peer-Ansätze oder internetbasierte Interventionen).“

²¹ „Es folgen unterschiedliche therapeutische Maßnahmen, die ressourcensparend in einem expertengeleiteten Gruppensetting durchgeführt werden (Stufe 3). Schließlich sieht das Konzept auf der letzten Stufe 4 muttersprachliche oder dolmetscherunterstützte Expertentherapien (Stufe4) vor.“

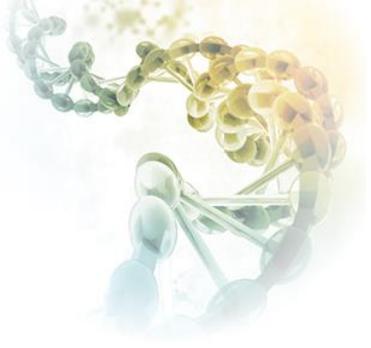
²² „Der Vorteil dieses Modells ist, dass die Behandlung psychisch kranker Flüchtlinge auf unteren Behandlungsebenen eine Therapie außerhalb psychiatrisch-psychotherapeutisch-psychosomatischer Krankenversorgungseinrichtungen vorsieht und erst bei manifesten Erkrankungen auf die Expertentherapie zurückgreift und somit–insofern die Behandlung adäquat ist – eine besondere Kosteneffektivität zu erwarten ist.“



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the danger of the condition worsening (Stafford 1). Currently, these new deportation regulations do not classify depression or PTSD as life threatening or serious illnesses (Stafford 1). This would be a step back, rather than a step forward for refugee healthcare in Germany. The president of Germany's Psychotherapy Association has spoken out criticizing these new regulations, and the German Medical Association has expressed their disapproval of the policy as well (Stafford1). With the purpose of determining the most cost-effective method of providing care to refugees and asylum seekers, the Robert Bosch Foundation established a board of experts to analyze the situation (Montgomery 159). The board concluded the best solution would be to immediately integrate asylum seekers into the German health insurance system when they enter the country (Montgomery 159). The immediate care refugees would be able to access includes psychiatric care (Montgomery 159). This is one of a few suggestions currently circulating; however, all revolve around the same concept of lowering the threshold for access to care on a nationwide level (Montgomery 160). On a related note, digital options for translating services and psychological treatments may be a widespread option in the future. Short-term, internet-based interventions for clearly defined mental disorders would help extend access to those living in rural areas outside the scope of immediate care; initial studies for this treatment approach are already in progress (Böttche, *Psychotherapeutische Versorgung* 1142).²³ Web-based interpreting services could be added via video conferencing to examinations or diagnostic appointments as an

²³ "Zum einen internetbasierte Kurzzeitinterventionen für klar definierte psychische Störungsbilder, die von muttersprachlichen psychosozialen Professionellen ortsunabhängig durchgeführt werden können. Hier gibt es bereits erste Studien zur Wirksamkeit dieses Ansatzes für Menschen mit der Traumafolgestörung PTBS aus dem arabischen Sprachraum."

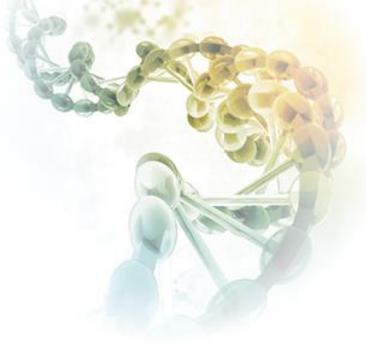


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easily accessible way to eliminate the issue of language barriers in diagnosis (Böttche, *Psychotherapeutische Versorgung* 1142).²⁴ Other recommendations include expanding human and financial resources in the public health center and clarifying medical, administrative, financial, and legal accountability among public authorities (Montgomery 160) Concerns about the distribution of refugees and the wide variation in provision of care across the nation have also been raised. Transparency in the system of distributing refugees, even at the European Union level, would be an important step towards ensuring refugee access to healthcare (Montgomery 160).

With such a high influx of new asylum seekers, there will undoubtedly be an initial shortage of resources to provide them all with care. Naturally some areas end up overburdened due to too many incoming refugees, lack of resources, or both; this is precisely what happened in Berlin in 2015 with the first major wave of refugees (Montgomery 159). Since the refugee crisis in 2015, the care refugees receive when they initially enter the country has been largely provided by public health services, volunteer physicians, nurses, psychotherapists, and many other volunteer individuals (Montgomery 159). For example, in Munich, the medical care of refugees, asylum seekers, and their children is coordinated by the volunteer medical organization, Refudocs (Montgomery 159). For this reason, Munich has much more stable conditions despite the large reception centers (Montgomery 159). Doctor Frank Ulrich Montgomery, President of the German Medical Association, described these people as the backbone of the early medical

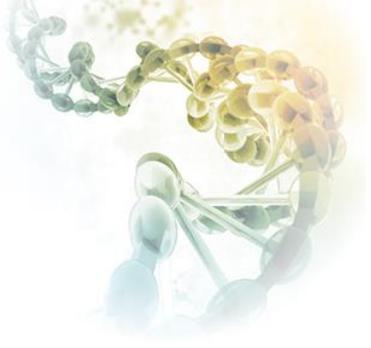
²⁴ “Zum anderen webbasierte Dolmetscherdienste, die mithilfe von Videokonferenzen z.B. zu Untersuchungen oder Diagnostikterminen hinzugezogen werden können.”



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care refugees receive (159). However, Dr. Montgomery also describes the number of doctors that Germany has in their workforce, and how, given that number, there should be no reason that any refugee or asylum seeker could not access to medical care due to a shortage of personnel (158). In 2015, Germany had 485,500 doctors in their workforce; there is no shortage of physicians in Germany (Montgomery 158). The problem, however, does partially lie in distribution of refugees with and without asylum throughout the German *Bundesländer*, as well as a lack of doctors in the specialties that treat mental health conditions. In the long term, the absence of easily accessible preventative care for refugees with and without asylum puts strains and cost burdens on the German statutory health care system. Bauhoff et. al. determined that “[s]tudies of longer-term migrants in Germany indicate a continued over-reliance on emergency care and under-use of preventive care, frequent switching of primary care providers, low health literacy, and different conceptions of illness and the health care system” (9). A lack of early reliable access to healthcare results in long term refugees that do not know how to use and trust the preventative healthcare system. This leads to many people who do not seek treatment until emergency medical intervention is needed and struggle with all aspects of normal healthcare understanding.

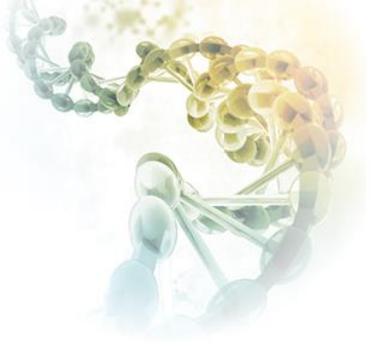
Since 2015, Germany has struggled to provide care for the high number of incoming refugees, but that is not to say they do not have the capability of doing so. Germany has proved in the past that it has the capacity to adequately provide for large groups immigrating into the country. Historically, between 1986 and 1992, Germany had similar quantities of migrants enter the country from Russia, yet there was much less significant strain on the healthcare system (Montgomery 160). This indicates that Germany has handled dramatic increases in population in



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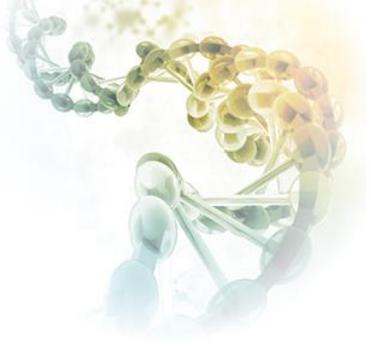
the past and it has the potential to do it again. Based on the research being done, the ideas proposed, and the changes being made with EHIC and when refugees have access to care, Germany theoretically should be able to handle another wave of refugees. However, with the current standing of changes that have, or more accurately, have not been made, they would not. Despite its efforts, Germany is still struggling to integrate the most recent influx of migrants (Bauhoff 1). The biggest difference between the Russian migrants who entered Germany in 1986 and the refugees and asylum seekers entering the country now is the fact that the Russian migrants were granted permission to work from the moment they entered the country (Montgomery 160).

The underlying issue keeping refugees and asylum seekers from mental healthcare is the lack of resources Germany has to offer and the many barriers to care. The issue is not a lack of mental health treatments specifically for refugees but an unsatisfactory amount of resources overall, and a lack of access to the resources that do exist. If by January of 2019 a new wave of refugees, the same magnitude as 2015, started to pour into Germany, the country would not be able to provide mental health care for all of them. The lack of intervention in mental disorders such as PTSD would ultimately lead to difficulties in integration of refugees and asylum seekers. One of the largest barriers to refugee integration and strains on the healthcare system stems from the inability of refugees and asylum seekers to access the labor market upon arrival in Germany. Dr. Frank Montgomery postulates that if Germany allows refugees a fast and low-threshold approach to the labor market, integration will happen on its own (160). Germany currently has the capability to provide sufficient mental healthcare for the current population of refugees with



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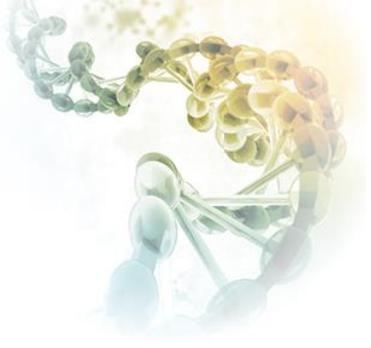
and without asylum, but they are functioning below capacity. If the recommended changes to the healthcare system are made, within a few years Germany may be able to withstand another wave of refugees and asylum seekers. In its current state of affairs, the health care system would not be able to handle the weight of another significant increase in population.



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