Cross-cultural Opening – a long way to achieve substantial changes in the German mental health care system

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Throughout recent history Germany has gone through different phases of substantial migration movements. Currently almost 20% of the general population has a so-called migration background. Recent political milestones paved the way for Germany to move from being an informal to a formal immigration country. Still people with a migration background do not participate equally in important aspects of societal living. Cross-cultural opening is a movement that focuses on (health) organizations to reflect on their structure and processes in order to be more sensitive towards the special needs of clients with a migration background. With the focus on mental health care services in Germany, the barriers, milestones and (further) developments regarding improved diagnostics and treatment quality are outlined.

Historical Migration background in Germany

Migration played important roles in different phases after the Second World War in Germany. The first migration move in Germany, often forgotten in the current migration debate, lasted until 1949. Around 12 million so called "Heimatvertriebene" from the former eastern territories of Germany and former Austria-Hungary were received in Germany. After the foundation of the German Democratic Republic (DDR) in 1949 and the construction of the Wall in 1961, 3.8 million people moved from East to West Germany (Özcan & Grimbacher, 2007).

In the course of the economic growth in the 50s until the global economic crisis in the early 70s, 14 million foreigners in total came to Germany at least temporarily as working migrants (Kohlmeier & Schimany, 2005). In the year 1973, when Germany enacted the ban on recruitment of foreign workers, 2.6 million foreign employees were working in the Federal Republic (Butterwegge, 2005). As a consequence of the temporary status of the so called "Gastarbeiter", a long-term living perspective and necessary measures of integration were not in the societal focus at that time.

Another significant migration movement was when 4.5 million German resettlers came from Eastern and Southern Europe ("Aussiedler") mainly after the collapse of the Soviet Union in the 90s (Bundesamt für Migration und Flüchtlinge, 2013).

In the middle of the 80s the growing numbers of refugees and asylum seekers in Germany led to an emotional and ideological, political and medial public debate. In 1993 the so-called "Asylkompromiss" was adopted and the basic right of asylum was restricted. In the run-up the "massive abuse" of the right of asylum by "economic refugees" was postulated in different campaigns (Butterwegge, 2005).

The limitations of the right to asylum had the consequence that the number of registered asylum seekers decreased from 438,191 in 1992 to 127,210 in 1994 (Bundesamt für Migration und Flüchtlinge, 2012).

Current Societal background in Germany

Germany currently has 15.7 million people with a so-called migration background. According to the definition of the national micro-census, these are foreign-born residents and their offspring who have immigrated to Germany since 1950. This equals almost 20% of the general population of 81.7 million. In the future the proportion of people with a migration background will rise, as children with a migration background under the age of 5 currently represent 35% of the total population of that age group. One third of the people with a migration background are born in Germany. More than half of this population (55%) has German citizenship. The largest migration groups comprise people with roots in Turkey (3.0 million), in the succession states of the former Soviet Union (2.9 million) and in the succession states of the former Yugoslavia (1.5) (Statistisches Bundesamt, 2012a).

Comparing people with and without a migration background, it is striking that in spite of their heterogeneity both groups differ significantly in important socio-economical characteristics. For instance 14% of the people with a migration background have no graduation and 41% no professional qualification (compared to 2% and 16% respectively of people without a migration background) (Statistisches Bundesamt, 2012a). Families with a migration background are endangered of poverty twice as frequently as families without a migration background. For people with a non-German citizenship the risk of poverty is even three times higher than for people without a migration background (Bundesministerium für Arbeit und Soziales, 2013).

Apart from people with a migration background, 629.000 refugees and asylum seekers are living in Germany in (Deutscher Bundestag, 2015). In 2014 more than 150,000 new asylum seekers were registered (Bundesamt für Migration und Flüchtlinge, 2014).

According to estimates, between 100,000 and 400,000 people without a legal residence permit currently live in Germany. Basic rights as well as social and health care standards are withheld or cannot be asserted because of fear of detection and deportation (Vogel, 2010).

National Politics toward Multiculturalism

Though Germany had a long history of migration, the political will to perceive Germany as an immigration country was missing for a long time. Therefore the possibilities of participating in society were limited for people without German citizenship for several decades. Besides different socio-political dynamics, the implementation of the Independent commission on immigration in 2000 under the direction of the former president of the German Bundestag, Rita Süßmuth, and the public debates in the wake of the adoption and amendment of the Immigration Act in 2005 set an important milestone and paved the way for Germany to move from being an informal to a formal immigration country.

The successful integration of migrants became a national priority in all societal domains such as the labour market and education. The National Integration Plan, the Federal Integration Summits as well as the German Islam Conference, a dialogue board between the German government and the Muslims living in Germany organized by the interior ministry, emphasize the political efforts made by Germany as an integration country. To evaluate the political integration goals, an integration monitoring system including scientific reports on indicators of integration ("Integrationsindikatorenbericht") have been developed.

Cross-cultural Opening

In order to make public institutions such as administration, schools, police but also health care services more accessible to migrants, a movement called "Interkulturelle Öffnung" (cross-cultural opening) started in the 90s (Hinz-Rommel, 1994). The movement's aims are that organizations should reflect on their structure, processes, products and services in order to be more sensitive towards the special needs of clients, patients etc. Major practical instruments of this movement are the qualifications of employees by e.g. cross-cultural competence training, and the recruitment of migrants as staff members and the development of cross-cultural mission statements that should be mandatory for different parts of the organization.

Cross-cultural Opening in Health Care Services

Already in the Ottawa Charter of the United Nations, it was agreed that health care services should be sensitive and respectful with respect to the cultural needs pf patients (World Health Organisation, 1986). Since the 80s lots of different actors in the German health care system are working to improve the health care services to

the needs of patients with a migration background.

There were lots of different regional activities and movements, but a national focus on cross-cultural opening in health care services was first mentioned in the federal government's National Integration Plan (Bundesregierung, 2007). Major goals were the improvement of the participation of people with a migration background in the health care system and the extension of the cross-cultural opening.

This seems to be necessary when looking at the participation in the German health care labour market. Currently around 4% of the employees liable for social insurance and working in the health care system have a foreign citizenship, whereas almost 10% of the general labour force in Germany has a foreign nationality (Statistisches Bundesamt, 2012b).

Due to the demographic development and the growing ageing of the German society, the ageing population with immigrant background has been taken into account in the National Action Plan (Bundesregierung, 2011). In the section Health and Care, six strategic goals were defined: Improvement of the statistics on health situation and health care, improvement of the access of health care workers in the health care and care system, improvement of the access to prevention and health care promotion, reduction of health care risks, improvement of the access to facilities and health care services, and improvement of the facilities and services of care.

Cross-Cultural Opening in Mental Health Care Services

The movement of 'Interkulturelle Öffnung' has mainly been promoted by professionals from the mental health care system. In 2001 a national initiative by health professionals to improve psychiatric-psychotherapeutic health care services and primary care for migrants in Germany developed the "Sonnenberger Guidelines" (Machleidt, 2002). The guidelines promoted a number of quality standards such as: facilitating access to mental health care services by providing cross-cultural sensitivity and cross-culturally competent staff; using interpreters with some psychology training; providing information in migrants' native languages; offering further education in cross-cultural psychotherapy for mental health care staff, and initiating research projects in the field of mental health and migration.

In the last few years, improvements have been made in the mental health care system. One indicator is the slowly increasing number of specialized in and outpatient mental health care institutions in Germany who deliver culturally and linguistically sensitive care to certain migration groups. Nevertheless, the general mental health care service in Germany is far away from being cross-culturally opened. Selected examples will demonstrate the still existing major barriers.

Though immigrants suffer from mental illnesses at least as frequently as non-immigrants migrants with mental health disorders are underserved in outpatient mental healthcare services in Germany. Although several migrant groups are finding their way to psychotherapeutic treatment, the proportion of patients with a migration background in this healthcare sector is almost half of that in the general population (Mösko et al., 2013). With regard to inpatient mental health care utilization rate of patients with a migration background, a general undersupply is indiscernible, as the number of re-settlers (i.e. migrants with a German origin from the former Soviet Union) equates to its proportion in the general population. Nevertheless, the utilization rate by patients without German citizenship is up to three times lower than that of patients who are German citizens (Mösko, et al., 2011, Brzoska et al., 2010).

One of the reasons for this low utilization rate is that the cultural and linguistic diversity of mental health care service is limited due to a lack of therapists with a migration background. One of the serious consequences of this reality is that patients who are not able to speak sufficient German or the common European foreign languages are practically excluded from outpatient mental health care services as the cost of interpreters is not covered by health insurance (Mösko et al., 2013).

The allochthonous patients who seek inpatient treatment show a high psychopathological burden compared to German patients with mental/psychosomatic disorders. The highest burden is measured for Turkish patients and patients from former Yugoslavia. The outcome findings for inpatient mental health care patients show that there is no general negative treatment effect for migrants compared to German patients. Closer examination of the different migrant groups shows that Turkish patients and patients from former Yugoslavia have the lowest treatment outcome levels. The most relevant negative predictors for a treatment outcome are clinical as well as socioeconomic factors. A migration background by itself, however, does not account for the significant variance (Mösko, et al., 2011).

Also, the attitudes and behaviours of health care providers can have a negative influence on the treatment process. Encounters with 'foreign' patients in a German psychiatric inpatient unit triggered negative emotions amongst staff, and had a detrimental effect upon the development of a patient-provider relationship and treatment outcome (Wohlfahrt et al., 2006). Two surveys focusing on outpatient psychotherapists in Hamburg and Berlin show the challenge in the clinical exchanges with patients from a different cultural background. Though the majority had more than 20 years of professional experience, two thirds mentioned substantial challenges in their work with patients with a migration background (e.g. divergent value system, communication and language problems, different explanatory models of disease and the healing process, lack of adherence

to treatments) (Odening et al., 2013, Mösko et al., 2013) .

In clinical control trials of German psychiatric patients it was detected that migrants are exposed to a higher risk of misdiagnosis (Haasen, Yagdiran, Mass, & Krausz, 2000). Besides cultural communication problems, the naming of symptoms in terms of idiomatic concepts or phrases and cultural expression patterns are not always easily understood by the therapist (Glaesmer et al., 2012).

In order to avoid cultural misunderstandings in the diagnostic and therapeutic process the *Cultural Formulation Interview* with its supplements (American Psychiatric Association, 2013) is one approach that helps the therapists to reflect on the diversity of conceptions and attitudes towards life in the different cultural contexts (Wohlfart, Kluge, & Napo, 2009).

So far the Cultural Formulation Interview with its ethnographic approach has hardly found its way into the German mental health care service. One of the reasons is that the German mental health care system is ICD-10 oriented (WHO, 2010). So far such an instrument as well as a cultural orientation is missing in this classification catalogue. Nevertheless the Cultural Formulation Interview is getting more attention in a growing area of cross-cultural (further) education for health professionals.

Psychological and psychopathological questionnaires are increasingly used especially in German inpatient settings. The translation of tests requires a translation that considers content and linguistic issues as well as an extensive psychometric review. So far different language versions exist for the common German test procedures. Nevertheless only a few of these instruments have been psychometrically tested (Glaesmer et al., 2012).

(Further) Education training

In the light of a growing number of culturally diverse patients and the professional awareness of the need of cross-cultural opening, cross-cultural competence is becoming perceived as a more basic requirement for (mental) health care providers. The growing importance of cross-cultural aspects in (further) education of mental health care providers is emphasized by different examples. Medical students are increasingly getting in touch with cross-cultural learning content throughout their studies. The nationwide "Committee for cross cultural competence and global health" of the German Society for Medical Education has defined objectives and learning goals for cross-cultural competence and is trying to implement cross-cultural aspects in the 33 university medical clinics in the country. As one example, the University Medical Center Hamburg-Eppendorf offers all students a lecture and a seminar with the focus on "Medical communication on cultural diversity". The Cultural Formulation Interview approach has a prominent part in this section.

In the field of mental health, a survey among directors of psychiatric training institutions four-fifths reported a need for training in transcultural psychiatry (Callies et al., 2008). Beside psychiatrists and physicians working as psychotherapists, the largest group of mental health professionals for adults are psychological psychotherapists with their basic education in psychology. A nationwide *guideline for cross-cultural competence trainings for psychotherapists in basic, further and advanced trainings*, similar to the Canadian guidelines for training in cultural psychiatry (Kirmayer et al., 2012), has recently been developed in a consensus process together with representatives of professional associations and chambers (Lersner et al., in press). One of the mandatory learning contents in the guidelines refers to culture sensitive question techniques in the diagnostic procedure like the Cultural Formulation.

In two evaluated cross-cultural training programs, one for psychotherapists and one for multi-professional teams of mental health care institutions, elements of the Cultural Formulation Interview have been taught and practiced (Mösko, 2014). A growing number of more than 160 further educational institutions for psychotherapists in Germany are implementing cross-cultural aspects in their curricula.

Outlook

In the course of the cross-cultural opening movement, many improvements were accomplished for the mental health care system in Germany so far. Nevertheless, the mental health care system is still far away from being fully sensitive to the cultural and linguistic needs of patients with a migration background.

In contrast to other European countries like Sweden, mandatory legal guidelines for the health care of migrants following common basic principles of the EU for integration policy are lacking in Germany (Rechel et al. 2013). In fact, the national integration plan contains some guidelines but they are not legally binding.

Although lots of people and initiatives are involved in the cross-cultural opening movement, the number of mental hospitals that take this process seriously is still small. More decision makers in health care management and administration should be integrated in order to develop and monitor actions and concepts for a whole clinic or health care organization.

Health care related awareness, prevention or information campaigns and materials should be linguistically and culturally more adapted and published in different languages. Cross-cultural aspects in (further) education for mental health care professionals should be implemented in the general curriculum and be more looked at in supervision. Asylum seekers are practically excluded from standard mental health care service due to legal restrictions and administrative barriers. Also migrants with a residence permit but without sufficient German language confidence for psychotherapy hardly find a therapist in their native language. The non-treatment of these both patient groups is neither economically nor hu-

manely justifiable. Regional or national regulations are needed in Germany to end this practice.

Mental health care clinics and organizations have to adapt their diagnostic and treatment concepts. Because of the existing missing financial and structural requirements specialized institutions are currently necessary.

In terms of health care and clinical research with a scope on cross-cultural issues, there are several aspects that should be more focused on in Germany: In future studies, not only the biggest migration groups but also minor migration groups should be examined; differentiated treatment concepts for migrants should be developed and evaluated; differentiated educational concepts should be developed and evaluated; instruments and approaches (e.g. the Cultural Formulation Interview) should be adapted to the German treatment and educational context and should be evaluated; the economic impact of untreated or mistreated patients with a migration background should be investigated and finally the actions that have been taken in the course of cross-cultural opening should be evaluated and reflected on critically.

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Historik smt

Socialmedicinsk tidskrift startades år 1924 av kvinnoläkaren Waldemar Gårdlund som ett helt privat projekt. Gårdlund ägde själv tidskriften och den finansierades bl.a. av reklamintäkter. Gårdlund var själv privatpraktiker och till sin hjälp som redaktör hade han en annan uppburen praktiker från huvudstaden, Carl Bernhard Lagerlöf.

År 1928 övertogs Socialmedicinsk tidskrift av Sveriges läkarförbund i vars ägo tidskriften stannade fram till 1943 då nybildade Social-Medicinsk Tidskrifts Aktiebolag inträdde som ägare. Bakom aktiebolaget stod Sveriges läkarförbund tillsammans med ett antal delföreningar. År 1966 bildades Stiftelsen Socialmedicinsk tidskrift som tog över tidskriften. Professorer inom socialmedicin och medicinsk rehabilitering ingick i styrelsen, från 1970 också representanter från Föreningen Sveriges socialchefer.

Den anmälan som inleder det första numret i februari 1924 säger att tidskriften ”vill göra ett försök att bilda en litterär föreningspunkt för alla dessa olika socialt intresserade, som i ett eller annat avseende ha någon kontakt med sjuk- och hälsovård”. Tidskriften beskrivs två år efter start på följande sätt i det då just utgivna 38 supplementbandet av Nordisk familjebok: ”Socialmedicinsk tidskrift, organ för sjuk- och hälsovård, afser att meddela upplysning i social medicin både åt läkarkåren och åt allmänheten och behandlar allehanda sociala frågor, för hvilkas lösning medicinsk sakkunskap är af nöden, t.ex. sjukförsäkring, sjukhusbyggnader – deras tidsenliga anordnande till rimliga pris – de civila läkarnas ställning, Röda-korsangelägenheter mm.”

Under de första åren utkom också ett särskilt ”meddelandeblad” som bilaga till tidskriftens häften, ”endast avsett för dem av tidskriftens prenumeranter, som äro läkare”. Här fanns ett mer vetenskapligt innehåll med fokus på den praktiserande läkarens verksamhet. Det första bladets första artikel har följaktligen rubriken ”Vilka kliniska laborationer äro aktuella för den praktiserande läkaren?”

Under de första åren av Socialmedicinsk tidskrifts verksamhet återkom man gång på gång till de privatpraktiserande läkarna och deras villkor, särskilt praktikerna i Stockholm. Kritiken av sjukhusbyggande och av Karolinska institutet i synnerhet och dess rektor bottnade i att allt detta gynnade utvecklingen av en ”kommunalisering” av läkaryrket, dvs. läkare anställda i det allmännas tjänst. För många kan det te sig underligt att tidskriften 1928 övertogs av läkarförbundet, men med tanke på tidskriftens hållning i praktikerfrågan och det förhållande att tidskriftens grundare också var initiativtagare till Sveriges praktiserande läkares förening är kanske inte detta så underligt. Socialmedicinsk tidskrift var i sin begynnelse inte densamma som den senare skulle komma att bli.