

A Concept of Clinical Care for Refugees on a General Psychiatric Ward

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Abstract

Refugees and asylums seekers can present as a highly vulnerable group with an increased risk for the development of mental disorders. We developed and established a concept of clinical psychiatric care for refugees on a general psychiatric ward that systematically takes into account the social, cultural and legal dimensions relevant for mental health of refugees. This concept presents a framework for treatment, which not only offers security and orientation for the patients but also for the treatment team. The present treatment guide should provide structured working in apparently hopeless situations, which due to language difficulties, trans-cultural features and serious diseases at least in the short term seem to be unchangeable. Due to the implementation of the treatment concept, from the perspective of the team, there is a noticeable relief and significant improvement concerning the interaction with refugees on the ward. We have experienced that handling patients according to this treatment concept has mutually influenced both, the treatment outcome of refugees as well as the clinical setting. It became possible not only to integrate refugees on a common psychiatric ward but opens the way for reciprocal exchange between treatment team, refugees and other patients in terms of acculturation. We expect that in the future the number of asylum seekers will remain high because of wars across the globe. Therefore, it can be assumed that there will be a need for differentiated and flexible treatment concepts for the inpatient treatment of refugees also in the future.

Keywords: Refugees; Post-traumatic stress disorder; Treatment; Psychiatric ward; Clinical care

Introduction

Over the past decade, millions of individuals from war torn countries have fled their homes to find asylum in Europe, Canada, and the United States. Over one million refugees entered Germany between 2015 and 2016, many of which have witnessed traumatic events, including deaths and destruction, leaving them with memories of terror, often meeting diagnostic criteria for trauma and stress related disorders like post-traumatic stress disorder (PTSD, according to DSM V) and other serious mental health concerns (depression, anxiety, addiction, etc.). As a result, upon arrival to their new "homes", refugees often require psychiatric or psychotherapeutic care, which can be challenging because of unique spiritual, social, cultural and legal aspects of migration. In this article, we present a concept of clinical psychiatric care for refugees in a general psychiatric hospital that systematically takes into account the social, cultural and legal dimensions relevant for mental health of refugees. First, we provide an overview about the medical and psychiatric dimensions of refugees' health, followed by a chapter about the social, cultural and legal aspects. Later, the definition of nine principles for comprehensive psychiatric care of refugees and asylum seekers, derived from the multi-agency guidance note on mental health and psychosocial support for refugees [1] will be presented. Finally, we will describe the practice concept for the treatment of refugees, its implementation at the Giessen University Hospital as well as the resulting consequences for the treatment process and the therapeutic "setting", respectively. This concept was developed in an ongoing institutional developmental process starting in 2011 in response to the growing number of refugees demanding psychiatric treatment.

Mental Health of Refugees

Refugees and asylums seekers can present as a highly vulnerable group with an increased risk for the development of mental disorders. In international surveys the prevalence of psychological trauma-related disorders in refugees are in the range of 30-70% [2-6]. In clinical samples of victims of torture as many as 80-90% may meet

diagnostic criteria of PTSD [7]. In their study of asylum seekers living in Germany, Gäbel et al. found a prevalence of 40% of individuals meeting criteria for PTSD [3]. Traumatic experiences may not only contribute to the development of symptoms of PTSD, but can also cause a broad range of other serious mental health problems such as depression, anxiety disorders, addictive disorders, personality disorders as well as somatoform disorders [8]. Furthermore, there is a significant interaction between psychological traumatization and its effect on the immune system, potentially triggering physical illness. Psychological traumatization is associated with a number of diseases, such as diabetes [9] or coronary artery calcification [10]. Vice versa, physical illness can affect the course of mental health [11]. However, the relation between psychological trauma and physical health is complex and more studies are needed to clarify the relationship more detailed. Nevertheless, 60-100% of individuals who meet diagnostic criteria for PTSD also have additional medical or mental health disorders [12-14]. In general, the risk of developing PTSD results from a complex interaction of several risk factors (genetic predisposition, early adverse childhood experiences, lack of social support systems, lack of control, resilience to adverse events) and traumatic experiences and almost linearly increases with the frequency of repeated psychological traumatic experiences, up to nearly 100% when direct confrontation with fatal experience of violence continues [15,16]. This is especially important in the context of forced migration: Traumatic experiences mainly happen in the country of origin (e.g. war associated trauma, persecution), but also during the

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migration process, which is often associated with experience of extreme and often fatal violence, hunger, loss of relatives and/or friends and even incarceration and torture. Even after arriving in the country of destination several factors can maintain or even intensify symptoms of PTSD – in contrast to the expectations of refugees, expecting to find security and opportunity for recovery.

Legal research confirms that residence status is essential for non-citizens to gain access to social systems in host societies [17]. Lack of security stemming from insecure residence status hinders refugees to access adequate health-care. Existential fears of being deported impede therapy. Standard therapeutic approaches that ignore the legal dimension not only fail to account for the real needs of refugees, but also abstain from using legal counseling as an essential resource for “syndemic care” of refugees [18]. From a medical point of view, the importance of the legal status and legal practice is evident when it comes to recovery; therapeutic efforts to reestablish the very basic human need to feel safe are hampered by the legal status and affect a sense of inner stability, a necessary precursor for successful treatment outcome of PTSD. As we have shown before, the legal status, which often remains unclear for a long time, and the complicated asylum procedure can undeniably be seen as factors that essentially maintain the disorder, compromise psychotherapy, and intensify past traumas [19]. In this respect, the diagnosis of posttraumatic stress disorder is actually not accurate because there is no “post”-traumatic situation [20].

This finding corresponds to trauma-theoretic approaches like the “sequential traumatization” [21], but also to empirical studies on the importance of safety, social support and compassion for victims of traumas in the host country, to assure for a positive psychological prognosis of traumatized refugees [22,23]. Moreover, multiple stressors well-known to negatively impact mental health often cumulate in refugees and asylum seekers: Desolate housing situation, loneliness, helplessness, lack of meaningful activities, the loss of social structures, grief, loss of families and feelings of guilt. Examples specifically related to the situation of refugees, are the loss of families resulting from migration-related lack of contact information or the real death of their relatives. Often the families of the refugees have financed the escape from the war zone with large input of desperate financial resources and resulting expectations that the escaped refugees have to support those left behind financially or have to initiate a family reunion in the future. According to this, feelings of guilt might arise towards family-members (e.g. children, husband/wife) who have to remain in ongoing dangerous living situations while the escaped refugees are not able to perform these obligations. Beside this resulting pressure, the subjective fear of deportation, often due to the lack of understanding the legal proceedings in asylum trials, can enhance helplessness, uncertainty and confusion. All in all, these factors imply ongoing high stress for the individuals and impede psychological healing or recovery, but even worsen existing mental health problems and accelerate the development of new ones.

Challenges for Psychiatric Care

For clinicians the aggravating impact of social, political, legal and economical factors on mental health issues of refugees and their deleterious interaction with therapies and treatment outcome is a daily experience.

When offering psychiatric care for refugees, both formal and substantive difficulties will have to be overcome. In Germany, due to a lack of therapists, even patients with health insurance coverage have to wait six months on average to get outpatient psychotherapeutic care [24]. Refugees who are in the asylum seeking procedure usually receive psychiatric-psychotherapeutic care only under the Asylum Seekers

Benefits Act, which covers only the bare minimum of healthcare. Secondly, clinicians often have limited knowledge of trauma therapy, with the additional obstacle of language barriers, which compromise successful treatment and recovery from mental health concerns. In most cases, practitioners have very little experience with psychotherapeutic treatment settings that include interpreters; even if an interpreter assignment is being considered, the financing of the interpreter is another issue, which has to be clarified [25].

Although refugees often suffer from psychological or psychiatric disorders, other symptoms lead to acute hospital admission in most cases. Predominantly, refugees often report somatic complaints and pain such as headache, chest pain, stomach pain or sleep disturbances instead of describing psychological symptoms [26] and it is currently not ensured that accompanying or underlying psychiatric disorders can be detected in an adequate way. In addition, many refugees with mental health problems are also often afraid of being stigmatized when they make use of psychiatric-psychotherapeutic treatment [27].

From our clinician perspective after more than ten years of caring for large numbers of refugees, we address some obstacles in developing sufficient treatment plans for refugees in psychiatric hospital settings, especially if the continuity of symptoms results from chronic, ongoing psycho-social stressors, legal difficulties (pertaining to immigration status) and the individual's difficulty with introspection and describing their emotional status.

Patients often expect an active part of the doctor or the psychotherapist; they also expect clear advice or procedures and frequently perceive the therapist as “incompetent” because he or she is engaging the patient in the development of a treatment plan, frequently adding to gaps in communication.

Beyond that, from the health professionals and the patients' point of view, cultural and religious issues are perceived as challenging in treatment and care. In the course of intercultural encounters, for example between medical staff and refugees, the importance of cultural orientations related to the country of origin has to be viewed with caution for the problem of stereotyping instead of approaching the identity, values and needs of the individual [28]. Refugees have left their familiar surroundings and the meaning of cultural identities, values and orientations can be seriously affected and modified during the migration process. Moreover, many refugees do not have a lot of social inclusion or reliable social contact to people in the host country and live in a very particular social situation defined by legal status, elements of cultural diaspora and a marginalized social position. A further important aspect to be considered consists in the “culture” on the side of health professionals and medical staff, both regarding the “professional culture” with its specific understanding of and approach to (mental) health and illness [29], as well as the individual's identity and personal culture and possible presuppositions and even prejudice about members of foreign origin or ethnicity.

According to our experience, in clinical practice the most important challenge for culturally sensitive care is not to focus on the (assumed) culture of the “other”, but to emphatically approach “what matters most” to the patient [28]. In the particular case of migrants, a superficial use of “culture” entails the danger of preventing to see relevant aspects of the migration process and of the current living conditions [30]. In case of asylum seekers, for example, daily life and social relations are shaped to a large extent by the particular situation of housing in a shared accommodation with all activities and prospects being strongly conditioned by the strict demands of the complex asylum procedure.

Obviously, the resident status is a very concrete and decisive factor that defines the lives of refugees and asylum seekers in Germany and is thus of utmost relevance for the therapeutic relationship and process. Previous trauma and negative treatment experience in the home country can result in fear and distrust towards the treatment team, only jeopardizing successful treatment of PTSD, and are assumed as “doubling of paranoid attitude towards the situation” by Henningsen [31]. On the other side, the treatment team may feel helpless without power and lack of established treatment concepts for brief, psychiatric inpatient treatment for refugees [19].

Because of the aforementioned reasons traumatized refugees are only rarely treated in an adequate clinical way, in consequence, e.g. PTSD or severe forms of psychosis may become chronic and may lead to recurring acute psychological decompensating, possibly endangering themselves and others and requiring emergency mental health interventions in an in-patient setting. Acute treatments often remain superficial and from a clinical or financial point of view ineffective.

Within the last six years, the present treatment concept has been designed and developed practice-adapted based on the long-standing experiences in the treatment of traumatized refugees, in order to cope with the difficulties mentioned above, to improve the quality of treatment and to ameliorate both, the patient’s and the therapist’s satisfaction with the treatment.

Based on theoretical considerations, clinical experiences and inspired by the “Multi-Agency Guidance Note” of the Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe [1] we identified the following nine major principles to guide psychiatric care for refugees in clinical settings which are described in clinical practice in the next chapter. It will be noted that these principles are essentially based on general principles of human rights and medical ethics that of course apply for all patients, but are of particular relevance for the treatment of traumatized refugees in clinical settings.

1. Treat patients with dignity and respect, support self-reliance
2. Respond to refugees in distress in a humane and supportive way
3. Provide information about services, supports and legal rights and obligations
4. Provide relevant psycho-education and use appropriate language (with a translator)
5. Strengthen family support

6. Make interventions culturally relevant and ensure adequate interpretation
7. Be prepared/help to provide ongoing psychotherapeutic treatment after discharge from hospital – if necessary
8. Monitoring and managing wellbeing of staff
9. Do not work in isolation: Coordinate and cooperate with others

A Hospital’s Concept for Psychotherapeutic Treatment and Care

In our clinic we have implemented a treatment concept for refugees’ care answering the mentioned features with integrative approaches. Our objective is to offer specialized psychiatric and psychotherapeutic treatment with explicit consideration of the particular needs of refugees and asylum seekers and support for the treatment team in challenging situations.

Starter package for refugees

Immediately after admission to the hospital, the treatment-related admission interview is implemented by the physician responsible, supported by the primary nurse and, if required, an interpreter. Refugees get detailed information about the treatment concept, for spatial and contextual orientation. The primary nurse providing information about the ward process, the ward order, the contents of the offered therapies, the German Skills Training and the social services, answers outstanding issues, questions and wishes of the patients. In addition, a guided tour around the ward and the clinic is offered. This information and orientation procedure is repeated after one week. In this context, any open questions can be clarified, and the patient is invited to give a feedback regarding his first week of treatment.

To introduce the multimodal treatment concept to the refugee patients, the procedures and contents of the different treatment offers are explained. In an introducing session with an occupational therapist the concept and goals of the occupational therapy and exercise therapy are presented and the new patients are assigned to the individual ward groups, consistent therapeutic visits take place. Besides the initial diagnostic assessment, the therapeutic need is basically reflected and the patients are assigned to their individually responsible therapists. The individual single session treatment is based on the guidelines as mentioned below.

Right from the start, all patients’ contacts are interpreter-aided in case of need (Figure 1).

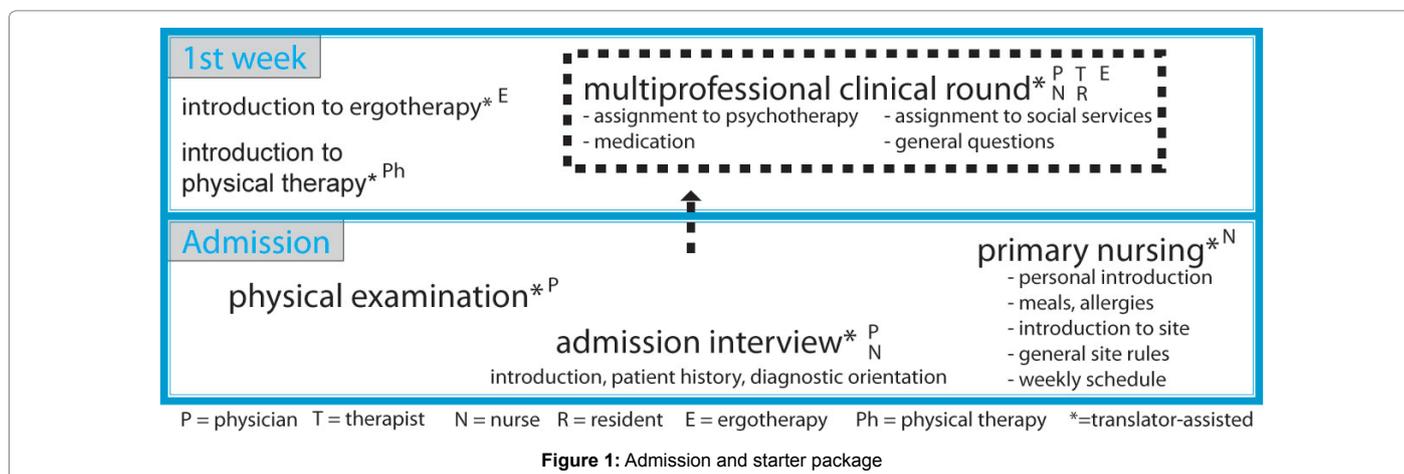


Figure 1: Admission and starter package

Therapeutic sessions

During the individual psychotherapeutic treatment of refugees, the therapeutic alliance and the patients' feeling that the therapist is on their side, is of crucial importance. Especially for traumatized refugees, psychotherapeutic "security" is essential so that despite of external unpredictability, a sense of stability and optimism can be established and a "safe space" for the subjective experiences before and during the flight can arise. In this context, also contradictions within the therapeutic "story telling" about the escape from terror and the personal history are possible without fear of negative consequences and can have a positive impact on treatment success - in contrast to concerns regarding their credibility, as it is unfortunately often the case at interviews in the asylum procedure.

Distrust and unrealistic expectations towards the treatment need to be taken into account. Therefore, the patient's expectations towards a German psychiatric hospital, which also covers previous experiences with or knowledge about psychiatric hospitals in the respective country of origin have to be discussed in all the details. It is also important to clarify if the patient can orientate himself in the clinic, if he is surprised by anything, if anything meets his expectations, and the clarification of unresolved questions. Subsequently, basic knowledge of functioning in German psychiatric hospitals or goals of psychotherapeutic treatment should be conveyed. In doing so, not only information about somatic, psychiatric and psychosomatic disease models is to be conveyed, but also the responsibilities of the individual professional groups in the psychiatric hospital have to be explained. At the end of one therapeutic session, stabilization techniques like attentiveness, body awareness techniques, and the Butterfly-technique are to be introduced gradually. The patient needs reassurance that he or she is safe now and past experiences are not part of their daily lives and cannot hurt them anymore. For stabilization legal consult is added and provided by the lawyer of the person concerned and/or the Refugee Law Clinic, to get advice for the asylum processing.

Furthermore, the patient is asked to describe the main psychiatric and physical symptoms, which may lead to a more intensive diagnostic process and specification of concrete and realistic treatment goals. Therefore it should be clarified, which role in the therapeutic process the patient plays in his point of view: For example, a passive patient may expect an active leading role of the therapist, while a cautious, restrained and inquiring therapist might be considered as incompetent. However, we try to establish a partnership of patient and therapist in terms of shared decision-making and empowerment of the patient. That is why the roles of both, the patient and the therapist must be explained and reflected in order to avoid misconceptions and disappointments.

Parallel to that, further stabilization techniques like 'Position of Power' [32], 'Safe Place Imagery' [33,34], 'Absorption Technique' [35], dealing with emergencies, dissociation breakpoints and CIPOS [36] can be introduced. The described symptoms are sorted, possibly summarized to clusters, a trauma map is created, among other instruments the Impact of event scale [37] and the Dissociative experience scale [38] are used for further diagnostics. The primal anamnesis is supplemented by the information and data gathered and if necessary, a written medical opinion about the type and extent of the disease, type of the necessary treatment as well as the prognosis according to the principles of scientifically sound expert opinion on further legal instigation is created.

Psycho-education dealing with PTSD in general and the individual symptoms in particular follows; also there are other imagination

exercises introduced and possibly progressive muscle relaxation can be conveyed. Exercises, which have already been introduced, are repeated and the patients are reminded that it is necessary to practice regularly and independently; if necessary, imagination exercises get translated by interpreters and digitized as sound file (mp3, smart phone) in the mother tongue.

If necessary, further tools for stabilization and safety can be conveyed. In case of sufficient stabilization, techniques for working through trauma can be carefully introduced.

After clarifying the further approach, still existing individual issues and symptoms of the patient are handled separately, if necessary by taking into account the further family members.

Generally, it is advisable in communicating information to allow the patient taking notes, but at least to have him sum up what has been said in his own words.

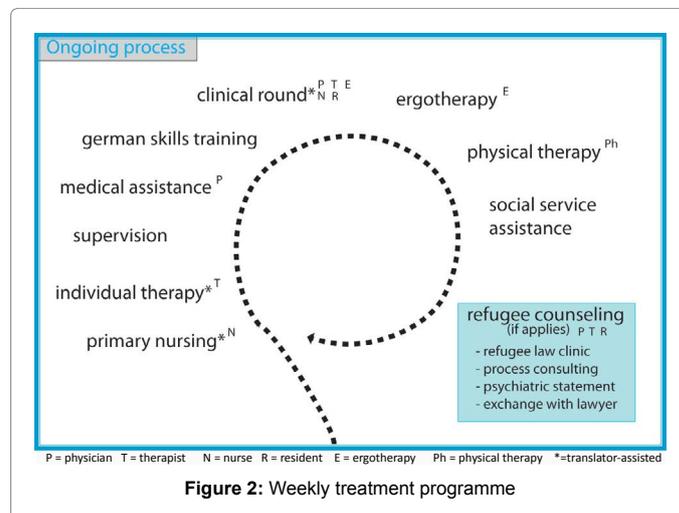
In order to improve the integration into the everyday life of the ward, recreational activities include board games, table tennis, cooking together and Nordic walking. It might be helpful to assist the individual in attending group therapies at the beginning of treatment.

The preparation of the discharge includes the planning of the follow-up outpatient treatment, contacting for example the trauma outpatient department or resident therapists (Figure 2).

Language and interpreting

If there are any language barriers, interpreters are deployed as language and cultural mediators in medical, nursing and therapeutic conversations. The 24 h on-call service of the commissioned interpreting agency is also in acute cases a prompt support, for example for the emergency ward when there are urgent admissions. The language and cultural mediators get involved into the treatment context in preliminary and follow-up talks and provide valuable support for scenic and "cultural" understanding.

The inclusion of interpreters includes the information of the interpreter about the expectations of the hospital towards confidentiality and privacy of the patient. This includes that the interpreter and the patient get to know each other before the individual therapeutic consultation and clarify in which language they can talk to each other. During the consultation, the interpreter is supposed to translate as literally and completely as possible, without own interpretations, even



if the patient's statements seem illogical, unpleasant or inappropriate. Translations are to be performed in first person view, including the translation of own inquiries, as well as the translation of emotional expressions and colorings. In that regard, the interpreter is obliged to ask questions if, for example, medical details are not understood correctly. The interpreter is requested to give a feedback after the interview to clarify if he had the impression that the patient was able to understand everything and follow the conversation, and also if there were any critical points and characteristics during the interview from his point of view. Care should be taken that there is a stable interpreter contact. The hospital covers all expenses for interpreters.

Furthermore, the patients can improve their linguistic competence and skills of daily life, e.g. dealing with authorities, in the daily "German Skills Training", offered by a linguist. The patients are introduced to the German language and culture; skills are conveyed in the form of role-plays, e.g. simulation of a telephone conversation.

Supervision

Within the framework of monthly carried out trans-cultural supervision, all the "cultural" meanings, ideas, and value judgments, which are relevant for the treatment context, can be reflected within the team. In contrast to the concept of culture, which understands culture as a parameter that is static and "can be learned", the underlying idea is that the patient's own and incomparable biography in the ethnographic interview and the behavioral dynamics becomes palpable and comprehensible in the here and now. Besides trans-cultural supervision, there is also behavior therapeutic supervision, as well as, depth psychologically oriented supervision every two weeks.

Legal questions

The lack of a residence permit, for example in case of suspension of deportation or threatening return flight, is essentially an etiological factor for mental disturbances of refugees and impedes therapy. Through close cooperation with lawyers of the Refugee Law Clinic (RLC) in Giessen and legal advice centers, the legally complex issues can be integrated into the treatment. The RLC is an interdisciplinary and practice-oriented training site at the Department of Law of the Justus Liebig University Giessen. The students are enabled to advise asylum seekers under supervision for legal counsel. Clinicians of the Hospital for Psychiatry and Psychotherapy give lectures on mental traumatic disorders at the RLC and offer an additional supervision to the students of the RLC. At the same time, the RLC offers legal advice to patients with questions concerning asylum law at the Hospital for Psychiatry and Psychotherapy.

During the treatment process, in collaboration with lawyers, the current status of the asylum procedure is clarified. In case of need, a medical statement describing the actual medical and psychiatric condition of the patient will be written down, for subsequent legal purposes. The inclusion of legal aspects in the treatment process offers the possibility to achieve relative stability of the current living condition and might create the prerequisites for further trauma-focused interventions.

Even though legal advice can be delivered in the hospital setting, unrealistic expectations of the refugees towards the hospital might arise, associated with the hope that the hospital can have a decisive influence on the asylum procedure or can even take legally binding decisions independent from the responsible authority. To avoid misunderstandings, the explanation of the differences between the roles of the treatment team, lawyers and responsible authorities in the

asylum procedure is of decisive importance.

Internal continuing education

The trauma-therapeutic skills mentioned above are trained and deepened in a modularized curriculum for inter-professional mediation of trauma-therapeutic basic competence that has been developed and approved in the hospital. The curriculum consists of 7 two-hour modules and comprises theory, self-awareness and practical training (in e.g. mindfulness, imaginations such as "inner safe place", techniques from EMDR such as butterfly technique, absorption technique or position of power) in small-group work. Training also includes the preparation of a trauma-associated anamnesis-report and a trauma map; the Impact of Event Scale (IES) and the Dissociative Experience Scale (DES) are introduced. The participants get personal experience in mindfulness, are introduced to working with the "inner child" and dealing with emergencies, dissociation breakpoints and CIPOS technique (Constant Installation of Present Orientation and Safety).

Networking

In order to improve the outpatient treatment opportunities in the field of trauma, the Trauma Therapy Center Giessen at the Department of Psychiatry and Psychotherapy at the University Hospital Giessen opened in 2015.

The clinic also functions as part and home of the Trauma-Network for victim support and victim emergency aid in Hesse. The Trauma Network was founded in 2012 under the leadership of the Department of Psychiatry and Psychotherapy in Giessen and connects the regional supply structures, enables a cross-professional exchange and offers the opportunity of continuing education. The Trauma Network Middle Hesse includes physicians and psychologists from various psychiatric and psychosomatic hospitals, pastors, resident doctors and psychological psychotherapists, interpreters, volunteers, employees of the Refugee Law Clinic Giessen, employees of welfare associations and employees of psychosocial centers.

To improve the often still deficient interface between in-patient and out-patient treatment there are contacts to networking with the outpatient department of the Department for Psychotherapy and Psychoanalysis Giessen as well as the behavioral-therapeutic health care center at the Department of Psychology at the Justus Liebig University Giessen.

An interdisciplinary contact to the Department of Law consists in two respects: scientifically the seekers are attached as members of the research group migration and human rights (FGMM) and there has been a co-operation with the Refugee Law Clinic (RLC) since several years.

Summary and Conclusion for Clinical Practice

Considering the high case numbers - in 2015 the Federal Office for Migration and Refugees in Germany accepted 467.649 asylum applications - 441.899 of them were first applications and 34.750 subsequent applications [39], it is expected that in the future the number of asylum seekers will remain high, because of wars across the globe - it can be assumed that there will be a need for differentiated and flexible treatment concepts for the inpatient treatment of refugees also in the future.

This concept for the treatment of refugees in an inpatient psychiatric setting represents an attempt to integrate refugees in a mental health unit along with other patients who do not share the same stories. Even

though the experience of fleeing a warzone is very unique and may require a specific type of psychological treatment, integration with other patients is very important. We believe that this concept is necessary because it presents a framework for treatment, which not only offers security and orientation for the patients but also for the treatment team and thus allows flexibility to fulfill the respective individual needs of all of the patients. Inpatient psychiatric treatment of refugees often starts in acute, escalated crises, which has multiple triggers including previous trauma history, current conflicts, experiences of loss, prior illness and legal issues, in some cases with the threat of deportation. They often present with severe anxiety, depressive symptoms and signs of PTSD, addictive behavior, physical complaints and suicidal tendencies. Despite of often existing references for an indication of the presence of PTSD, trauma therapy in the classical sense with acutely decompensated refugees is not possible because of the severity of symptoms. It is really important initially, to offer a safe place where the person in crisis can calm down within a psychiatric hospital, and being taken seriously when it comes to their anxieties and concerns. It is also important to address the individual with an appreciative, validating and respectful approach, while providing reassurance that they are not "in trouble". Our observation shows that such a supportive setting often leads to de-escalation of the patient and enables further stabilizing therapeutic work, even though external circumstances cannot be changed (e.g. housing situation).

Apart from the therapeutic approach, our concept also includes a mediating function in both directions. On the one hand, it assists in the process of providing support in understanding German immigration policies during the asylum procedure and also to inform them about support services, such as social counseling or legal advice. On the other hand, preparing meaningful psychiatric expert statements for asylum seekers may help authorities to develop a better understanding in recognizing and critically acknowledging mental illness, especially PTSD, in refugees. The present treatment guide should provide structured cooperation and optimism in apparently hopeless situations, which due to language difficulties, trans-cultural features and serious mental illness, at least in the short term, seem to be unchangeable.

Due to the implementation of the treatment concept, from the perspective of the nursing staff, there is a noticeable relief and significant improvement concerning the interaction with refugees in the mental health unit. In particular the "Starter packet" offers safety for the nursing staff as well as for the patients and alleviates the admission process and also the treatment process. The framework of the treatment concept offers both, grounding and liberties. The successful establishment of transcultural supervision has promoted the whole treatment team to sensitize and work on the issue "flight from warfare and mental health". Treatment and care for the refugee patients could be simplified and improved because of better communication due to supporting of interpretation services, clear agreements by the help of the "Starter packet" and a better comprehension of the individual life circumstances of refugees and the resulting possible actions with the aid of the transcultural supervision. Furthermore, we have experienced that handling patients according to this treatment concept has mutually influenced both, the treatment outcome of refugees as well as the clinical setting. It became possible not only to integrate refugees on a mental health unit but the process opens the way for reciprocal exchange between treatment team, refugees and other patients in terms of acculturation.

In the future we aim to establish specific group-oriented psychotherapy for refugees, in addition to individual treatment.

Currently we have coworkers (psychologists, physicians, nurses, social workers) from various countries (Turkey, Serbia, Russia, Iran, Eritrea) and we are continuing to hire clinicians from different ethnic and religious backgrounds to assist with the treatment of traumatized refugees. The establishment of a psychosocial and psychotherapeutic center for a central contact with core competencies in consultation, treatment, prevention, research, coordination, continuing education and linking supply structures for vulnerable refugees is planned to improve further care structures and interfaces between outpatient and inpatient treatment. This can provide the basis for a model of systematic and individualized care for refugees according to the broad framework of actual needs for treatment.

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