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Models of Co-operation between Local Governments and Social Organizations – Migration: Challenges and Solutions

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Social Services for Vulnerable Groups in Germany

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The Research Project

Models of Co-operation between Local Governments and Social Organizations in Germany and China– Migration: Challenges and Solutions (LoGoSO Germany China) is a comparative research project of the Freie Universität Berlin, the Westfälische Wilhelms-Universität Münster and the Chinese Academy of Governance, funded by Stiftung Mercator.

This comparative research project looks at the co-operation between state and social organizations (SOs) in China and Germany. It focusses on social service delivery in the area of integration of migrating populations with special attention to the fields of education, employment, vulnerable groups and social assistance (incl. legal aid) as a crosscutting issue to all of the fields. Within this subject area, the project wants to identify different models of state-SO co-operation and analyze which models are successful and why and where this co-operation is problematic. It aims to capture the different models of co-operation in Germany and China, to analyze and compare the underlying structures and to show potentialities for development.

Contents

1 Introduction

Certain groups of persons can be considered particularly vulnerable due to their personal circumstances which may hamper full participation in society, e.g. because of disabilities or particular needs. Therefore, the state should make special provisions to assist these persons in reaching their full potential and enabling them to participate on equal footing with others. Even so, the categories to be discussed in this report comprise very heterogeneous groups and should not be understood as implying that all persons included in them share the same needs or interests.

The legal framework for policies regarding vulnerable groups of refugees in Germany is set by the European Union. The EU Reception Directive (2013/33/EU) lists a number of vulnerabilities, including (unaccompanied) minors, disabled and elderly persons, pregnant women, single parents, persons with psychological disorders, and persons who have experienced torture, rape, or other forms of psychological, physical or sexual violence. All of these groups have a right to special treatment including the necessary physical and psychological care (Art. 21 Reception Directive). A clearing procedure to identify potential vulnerabilities should be conducted by the state "within a reasonable period of time" (Art. 22) after the application for asylum has been filed. However, Germany has so far not implemented this provision and no particular clearing procedure for vulnerabilities exists. [1] Only a first health screening is conducted in the reception centres to identify potential infectious diseases and provide recommended vaccinations free of charge (Robert Bosch Stiftung 2016: 6). Consequently, vulnerable persons are not always identified and do not necessarily receive the support they need.

Nonetheless, a number of special regulations exist regarding the treatment of vulnerable refugees in Germany. The following report will specify which provisions are made by German law and how they are implemented in practice. The report will begin with an outline regarding the access of asylum seekers and refugees to the health system, which is crucial for a number of different vulnerabilities (chapter **Fehler! Verweisquelle konnte nicht gefunden werden.**). The remainder is structured according to the different groups of vulnerability, discussing their respective needs and the support structures available to them (chapter **Fehler! Verweisquelle konnte nicht gefunden werden.**). It will focus on minor refugees; women and "queer" refugees as groups that may be particularly affected by sexual discrimination and violence; elderly and disabled refugees as groups that may suffer from special health conditions which require particular treatment; and traumatized persons – including victims of violence, torture etc. – as a group that may require special psychological treatment. The fourth chapter will assess

[1] Indeed, the European Commission is currently pursuing an infringement procedure against the German government for violations of European obligations (cf. https://www.willkommen-bei-freunden.de/themenportal/artikel/gefluechteten-mit-behinderung-und-ihr-zugang-zum-deutschen-hilfesystemvon-dr-susanne-schwalgin/, last accessed 08 May 2017). Some länder, including Berlin, have started pilot projects to test clearing procedures in collaboration with local non-profit organizations (MenschenKind 2015: 23).

the role of non-profit organizations[2] in delivering services to these groups, before a concluding section sums up the findings.

2 Access to the German health care system

According to different sources of international and European law, Germany is obligated to ensure the health of all persons on its territory – including by providing physical and psychological health care – as an element of their human rights (Baron and Schriefers 2015: 17f). In general, nearly the entire German population is covered by compulsory public (88 percent of the population in 2016) or private (12 percent) health insurance. Residents can select their insurance fund, but all companies have to ensure the same access to basic health care. The monthly insurance premiums to be paid by the population generally depend on incomes, whereas the contributions for poor people are paid from the welfare budgets. Treatment is provided by doctors and hospitals at little or no immediate cost to the patient. Even so, some direct contributions to pharmaceuticals, in-patient care or dental prostheses need to be made by the patient at the time of treatment.[3]

Refugees with a recognized status (according to the Geneva Convention or the German Constitution) are covered by this health system on a par with German citizens (Schimany *et al.* 2012: 235). This means that they are insured by a public or private health insurer, either paying their contributions from their incomes or having it covered by the social welfare office. In contrast, asylum seekers and persons with an exceptional leave to remain ("toleration") who are covered by the Asylum Seekers Benefit Act (*Asylbewerberleistungsgesetz*, AsylbLG, see task 13 of this project, report on social assistance in Germany) only have restricted access to the health system. They shall receive health care only in cases of "acute or painful illness" (§4 AsylbLG). After 15 months of their stay, asylum seekers are entitled to benefits along the lines of Book 12 of the German Social Code (SGB XII), including full coverage by public health insurance (§2 AsylbLG). However, "tolerated" persons who have influenced the duration of their stay in violation of the law are exempted from this shift and are only granted restricted access for the entire duration of their stay. Moreover, further restrictions are possible when it is suspected that persons have entered Germany in order to receive welfare benefits. In those cases, only those treatments that are "undeniably necessary" ("*unabweisbar geboten*") shall be granted (Alicke 2016: 39f).

Moreover, the administrative procedure for obtaining access to health care within the first 15 months of the stay is highly complicated. Asylum seekers usually have to apply

[2] Non-profit organizations can be defined as entities that are organized, non-governmental, limited profit-distributing, self-governing, and voluntary (Salamon and Anheier 1997; Salamon and Sokolowski 2014). In Germany, they comprise a broad variety of organizations such as the free welfare associations (*Wohlfahrtsverbände*, confederations of organizations active in various fields of social assistance, organized along ideological and religious lines), voluntary associations (*Vereine*), private law foundations (*Stiftungen des Privatrechts*), cooperatives (*Genossenschaften*), and non-profit private limited corporations (*gGmbH*) (cf. Zimmer *et al.* 2016). Besides these non-profit organizations, the non-profit sector also encompasses less organized voluntary initiatives or movements.

[3] For more information see OECD Health Systems Characteristics Survey at http://qdd.oecd.org/subject.aspx?Subject=hsc (last accessed 08 May 2017).

for a health care certificate by the local social welfare office before treatment, confirming that costs will be reimbursed.[4] As this procedure is highly bureaucratic and costly, some municipalities have begun to hand out blank certificates in advance. Others have taken over the "Bremen Model" of health care for asylum seekers. In this case, municipalities conclude agreements with health insurance companies who hand out insurance cards to asylum seekers. The insurance fund administers payments to hospitals and doctors on behalf of the municipality in exchange for a fee.[5] While this model facilitates the access to health care due to streamlined procedures, it also only covers reduced services for the first 15 months of the stay (Joksimovic *et al.* 2017: 294; cf. Bozorgmehr and Razum 2015). The practice of health coverage varies strongly between the länder and municipalities due to the federally shared competences and the level of discretion in legal provisions (Schammann and Kühn 2016: 17–19).[6] One problem is that the costs of health care for refugees directly accrue to the municipal budgets. Even if the communities are granted reimbursements or lump sums by the federal states, these are rarely sufficient to fully cover the costs (Aumüller *et al.* 2015: 29f).[7]

In addition to legal obstacles, cultural barriers can impede full access of refugees to the health system. They include a lack of knowledge of the German language and the structure of health care in Germany, as well as diverging understandings of illnesses and of the roles of doctors and patients. Moreover, some asylum seekers fear potentially negative implications for the asylum procedure or residence status from using health care (Schimany *et al.* 2012: 236–238; Riemer 2016b: 315). Some approaches for enhancing the intercultural openness of health care providers have been developed, but they have not (yet) been implemented nationwide (Joksimovic *et al.* 2017: 295f). In addition, non-profit organizations try to bridge the gaps in access and coverage by providing information, counselling or additional health services, drawing on donations or project-based assistance (Baron and Schriefers 2015: 23).

[4] This practice is criticized as implying that administrative staff without medical qualifications first needs to assess if the illness is "acute or painful" and thus covered by the Asylum Seekers Benefit Act. Wrong appraisals of the acuteness can lead to life-threatening situations (cf. Redaktion 2014).

[5] In 2015, the Federal Government has introduced legislation that empowers the länder to obligate insurance funds to participate in such models by concluding framework contracts with them. This shall facilitate the conclusion of contracts at the local level and the introduction of insurance cards for asylum seekers. Neither the länder nor the municipalities are required to participate in those contracts (Wächter-Raquet 2016).

[6] A recent overview of the provisions in different länder and municipalities has been provided on 17 April 2017 by the editorial office of the German Magazine of Apothecaries (https://www.deutsche-apotheker-zeitung.de/news/artikel/2017/04/15/gesundheitsversorgung-fuer-fluechtlinge-ist-ein-flickenteppich, last accessed 12 May 2017).

[7] In response to the accelerating costs for the accommodation and integration of refugees, the Federal Government has agreed to provide additional funds to the länder who shall pass some of the funding on to the municipalities. These programs will be discussed in Task 13, Report on Social Assistance.

3 Different categories of vulnerability

3.1 Minor refugees

Persons below the age of 18 are generally considered minors in Germany. Since 2015, this also fully applies to asylum seeking youth. In 2016, 36 percent of all asylum applications in Germany were made by minors (BAMF 2016: 7). This group is highly heterogeneous, of different ages and nationalities, and having made different experiences before, during and after the flight. As Germany is a party to the UN Convention on the Rights of the Child and has abolished a regulation exempting foreign children from its coverage in 2010, child welfare should now take priority in all matters regarding children irrespective of national origin or residence status (Cremer 2015). The wellbeing of the individual child or youth is also the primary consideration of the German Youth Welfare Act (*Kinder- und Jugendhilfegesetz, SGB VIII*, Book Eight of the German Social Code).

Schools are the key institutions that shall foster the integration of minor refugees and provide language training, either in preparatory courses or as an addition to regular schooling. They have to teach children of different mother tongues and educational backgrounds. Moreover, the prevalence of traumas among minor refugees is estimated to be high. This can lead to difficulties in schools, whose staff rarely has experience in dealing with traumatized children and youth (see also chapter **Fehler! Verweisquelle konnte nicht gefunden werden.**). Even so, schools and leisure activities can also be crucial resources for the children in dealing with potentially traumatizing experiences (Zito 2017).

3.1.1 Unaccompanied minors (UM)

A particular sub-group of minor refugees consists of so-called unaccompanied minors (UM) who come to Germany without a parent or legal guardian. Roughly 36,000 applications were filed by unaccompanied minors in Germany in 2016 (UNICEF 2017). Moreover, a number of UM does not apply for asylum or otherwise does not appear in public statistics, which is why the total number of unaccompanied children and youth can be estimated to be higher (Zito 2017: 240; Hahn-Hobeck 2016: 117). Many unaccompanied minor refugees have begun their flight together with their parents but have been separated later on. Others are sent to Europe by their families alone because the money does not suffice to pay for the travel and/or smuggling of more than one family member (Hahn-Hobeck 2016: 120). Unaccompanied minors are particularly vulnerable as they have to fend for themselves without any support by related adults. This has been recognized in German law, which submits unaccompanied minors fully to the Youth Welfare Act (SGB VIII) and provides the same support to unaccompanied refugee children as to German orphans. For example, health care for UM includes all the services available to German children, including psychotherapy. The costs are covered by the local youth office that reimburses health insurers (Alicke 2016: 42f). Even so, a number of particularities arise from the special situation of refugee children.

The increase in the number of unaccompanied minors has led to the introduction of a redistribution system along the lines of that for adults (Hahn-Hobeck 2016: 118f). The resulting stepwise procedure is criticized as leading to instability and lack of continuity

in the lives of the minors. The administrative procedure succeeding an asylum application by an unaccompanied minor (or after an unaccompanied minor is picked up by the police) is as follows: The UM is taken into preliminary custody ("*vorläufige Inobhutnahme*" according to §42 SGB VIII) by the local youth office which provides for accommodation and social benefits. The initially responsible youth office shall conduct a preliminary clearing procedure to determine the age of the youth and clarify within seven days if redistribution is necessary and possible. If the redistribution does not contradict the child's welfare, he or she is then redistributed to a municipality according to an allocation formula. The newly responsible local youth office conducts a full clearing procedure to assess the UM's support needs, health status, potential relatives within Germany, and appoints a legal guardian. Moreover, the further proceedings e.g. in terms of adequate education, social assistance, accommodation and health care are planned (Hahn-Hobeck 2016: 123–125; Wendel 2014: 57–60). [8] Unaccompanied minors shall be housed with adult relatives (priority according to §44 SGB VIII), with a foster family, in foster homes or other assisted living. The decision about the type of accommodation is taken by the local youth office based on the clearing procedure conducted with the UM, i.e. it is based on the needs of the youth (Alicke 2016: 20–22).[9]

In sum, support for unaccompanied minors is rather encompassing. The access of young refugees to this support system hinges on their identification as under age. Thus, processes of age determination may become crucial, since many asylum seekers do not have proof of identity (such as passports). Different procedures are possible, but they shall always be implemented with respect to human rights and dignity (Alicke 2016: 11; Hahn-Hobeck 2016: 124).

3.1.2 Accompanied minors

Other children enter Germany with their parent(s) or legal guardian(s). They are treated differently from unaccompanied minors, as they are not covered by the Youth Welfare Act but by the Asylum Seekers Benefit Act with all its restrictive provisions. Accompanied minors are redistributed across Germany together with their parents. They are usually housed with their family in regular reception centres and group accommodations during their asylum procedure. Those accommodations do not have to comply with the requirements for foster homes and are not always equipped with special facilities for children, such as playgrounds or recreation facilities. Moreover, only some länder make provisions that families shall be housed together in a discrete unit (Wendel 2014: 57–60).

[8] Some municipalities have established clearing centres for the first accommodation of unaccompanied minors. In the centers, pedagogues, therapists and others may be employed to provide the young migrants with necessary goods, services and counselling. However, the establishment of facilities for unaccompanied minors is currently hindered by a lack of available suitable real estate in cities with a tight housing market as well as by a lack of personnel capacity in the non-profit organizations involved in youth welfare (cf. Hahn-Hobeck 2016: 125–127).

[9] Even so, at times of quickly increasing numbers of unaccompanied youth, new facilities and foster families cannot always be acquired quickly enough, which may lead to a "second best" option until the necessary facilities have been installed, which can take months or years.

Some of the reception centres are in rather secluded places such as industrial areas, inhibiting the social participation of refugee children. Group accommodations often do not provide the stability and living environment needed by children and youth and may therefore hamper educational success and social integration (Zito 2017: 246f; Bendel 2016: 337). Some facilities also lack provisions to ensure safety and privacy, such as sanitary facilities that can be locked. Minor asylum seekers may thus experience violence or conflicts in the accommodations. Child care and educational facilities are not usually made available in reception centres (Alicke 2016: 28f; Bendel 2016: 339f), even if the rate of infants and toddlers among refugees is comparatively high (SVR, Sachverständigenrat Deutscher Stiftungen für Migration und Integration 2015). However, some municipalities strive for accommodating families with minor children primarily in decentral accommodations, i.e. apartments, depending on the availability of places (Alicke 2016: 15–17). Apart from this preference for decentral accommodation in some municipalities, there are hardly any provisions directed at families with minor children. Thus, accompanied minors can be considered more deprived than unaccompanied ones in many respects.

3.2 Vulnerability resulting from gender and/or sexual identity

3.2.1 Female refugees

Another group of vulnerable persons comprises refugee girls and women, who made up approximately 34 percent of asylum seekers in Germany in 2016. The shares of female refugees were particularly high among the age groups below eleven and over 50 years of age (BAMF 2016: 7). It is assumed that most female refugees live with their husband and/or family members, but no public data on their living situations is available. Their enhanced vulnerability derives from a number of characteristics. Firstly, women have on average received lower formal education and lower work experience in their countries of origin, which may inhibit their access to the German society and their independence. Moreover, they usually take up the task of caring for children or other dependent relatives, which further limits their work and educational opportunities (Worbs and Baraulina 2017).

Initially, female refugees were not considered a particular group in international or national law; it was "gender-blind". This has changed since the 1990s, when women were increasingly considered as potential victims of gender-based violence or discrimination. However, it should be noted that the flight can also have empowering effects for some women, while submitting others to strongly negative experiences such as sexual violence and loss of stability (Krause 2017). The living situation of refugee women in Germany can have discrete disempowering effects. For example, refugees are often forced to endure long waiting times and are reduced to passive "objects" in camps and reception centres by not being able to cook for themselves or decide where and how to live (Krause 2017).[10] Moreover, women may also suffer from the lack of privacy and security in accommodation centres and may be subject to sexual harassment or even assaults (Cremer 2014).

[10] Of course, this affects both men and women, as neither can continue their habitual roles and lifestyles.

Different support measures for female refugees are available. In particular, pregnant women and women in childbed have access to extended health care even within the first 15 months of their stay, i.e. they receive the same treatment as German women (§4(2) AsylbLG). Other activities more directly aim at enhancing the independence of female refugees. For example, the state seeks to support the participation of refugee women with minor children in integration courses by enhancing child care facilities for the duration of the courses (Worbs and Baraulina 2017: 12). Additional projects have been launched to foster the labour market participation of female refugees.

3.2.2 "Queer" refugees

Another group that may be subject to sexual discrimination is currently gaining attention in public discourse. It comprises so-called "queer" or "LGBTTI" refugees, i.e. lesbian, gay, bi- and transsexual, transgender, and intersexual persons. Their number is very difficult to assess, but estimations assume that app. 5 percent of all asylum applicants in Germany belong to this group. They have often experienced persecution or discrimination due to their sexual identity or orientation in their countries of origin. This is recognized as a reason for granting refugee status in Germany, even if it may be very difficult for the persons concerned to disclose such information in the asylum hearing (ASB 2016: 5). Some municipal administrations try to enhance trust and confidence by using e.g. stickers, buttons or bracelets in rainbow colours (an identifying symbol for this group) saying "queer refugees welcome" to indicate openness. One problem may be that many queer persons try to live in large cities, where they feel less exposed. However, asylum seekers in Germany cannot choose their location, and the recently imposed obligation to reside in a certain place ("*Wohnsitzauflage*") forecloses this option to recognized refugees as well. Applications for resettlement are not always granted even in cases of severe discrimination, indicating a further need for awareness-raising.[11]

3.3 Vulnerability resulting from physical conditions

3.3.1 Elderly refugees

In general, the prevalence of physical and psychological diseases increases with age. Migration can be an additional risk factor for worse health conditions. For example, migration is often linked with bad working conditions, risk of poverty in old age, cramped housing conditions, psychic strains, and a lack of German knowledge (Schimany *et al.* 2012: 211f). Many of these factors will probably accrue to refugees even more than they do to other groups of migrants. Thus, refugees can be expected to be particularly prone to lower health conditions than elderly Germans. However, there has hardly been any research on elderly migrants in Germany, let alone elderly refugees (Schimany *et al.* 2012: 44f). They usually make up very small shares of asylum seekers, e.g. only 1.2 percent of all applications in 2016 were filed by persons over the age of 60 (BAMF 2016: 7). Even so, as it can be assumed that very few refugees can return to

[11] Representative of the Network of LGBTI refugees (Vernetzungsstelle für die Belange der LSBTI-Flüchtlinge, http://queer-refugees-niedersachsen.de/) in Lower Saxony at the Integration Congress of the Friedrich Ebert Foundation on 6-7 March 2017.

their countries of origin, the total number of elderly refugees will be much higher[12] and can be expected to rise in the future.

3.3.2 Refugees with disabilities

Another group in need of particular health and social care are refugees with disabilities. There are no public statistics, but estimations assume that as much as 10 to 15 percent of refugees in Germany could be affected by disabilities (e.g. physical, mental, sensory or multiple impairments).[13] While some accommodations are available for disabled persons, they mostly focus on physical impairments whereas other disabilities are less recognized. The lack of adequate accommodations significantly hampers the social integration and independent living of these groups.[14] Moreover, the legally constrained access to the health system for asylum seekers within the first 15 months of their stay has been criticized. Within that time, additional health care for a disabled or elderly person can be covered by §6 AsylbLG if it is required to "secure the health of a person". However, granting this additional assistance is subject to the discretion of the local welfare office and practice diverges between municipalities (MenschenKind 2015: 4f). German law has also been criticized by international organizations as lacking provisions for persons subject to multiple disadvantages, such as disabled refugee girls or women (UN CRPD 2015: 2–10).

In general, disabled persons can obtain certain privileges in Germany e.g. in local public transit. In order to obtain this, a (severely) disabled person's ID card ((*Schwer-)Behindertenausweis*) needs to be obtained from the pension office. These benefits are also open to disabled migrants. In addition, care for persons with disabilities in Germany is supported by the compulsory care insurance that was introduced in 1995 and is funded by contributions on earned incomes (Schimany *et al.* 2012: 249f). In order to obtain benefits, persons need to be certified as fulfilling the criteria of one out of five different degrees of care needs (*Pflegegrad*), depending on the severity of the respective physical, cognitive or psychic diseases or disabilities. The criteria comprise both elderly persons and persons with disabilities if they are unable to live independently without support. Insurance covers either financial assistance for self-organized care, or in-kind care at home or in a facility, with the level of benefits depending on the support needs (§28 SGB XI, Book Eleven of the German Social Code). In general, this system is also open to recognized refugees, even if a lack of intercultural openness has been criticized also as regards the care system (Schimany *et al.* 2012: 234f, 252f).

3.4 Traumatized persons

The group of traumatized persons is a crosscutting group that can include members of any of the above-mentioned categories, e.g. women having experienced sexual violence,

[12] The total number of elderly migrants in Germany made up 1.5 million persons in 2010, mostly consisting of former guest workers (Schimany *et al.* 2012: 34-48, 208).

[13] Cf. https://www.willkommen-bei-freunden.de/themenportal/artikel/gefluechteten-mit-behinderung-und-ihr-zugang-zum-deutschen-hilfesystemvon-dr-susanne-schwalgin/ (last accessed 08 May 2017).

[14] Cf. http://www.institut-fuer-menschenrechte.de/monitoring-stelle-un-brk/meldung/article/versorgung-und-unterbringung-von-fluechtlingen-mit-behinderungen-monitoring-stelle-un-brk-hoert-zivil/ (last accessed 08 May 2017).

former child soldiers etc. These overlapping categories of vulnerability can increase the need for support. For example, unaccompanied minor refugees have more often experienced traumatizing situations and develop post-traumatic diseases than accompanied minors (Metzner *et al.* 2016: 645f; Baron and Schriefers 2015: 34f). A trauma can be defined as a situation of violence or danger, which puts an exceptional strain on a person. They can happen before, during and after the flight, which may lead to "sequential traumatization" (Keilson 1992). This means that the negative effects of one experience may be reinforced by later traumatizing situations, but also by a lack of resources and stability in the ensuing living experience. For example, the disempowering practice of group accommodations is criticized by experts as inhibiting treatment and potentially having negative effects on the mental health of the refugees. Moreover, the uncertainty of potentially long asylum procedures can have a negative impact on refugees. Spatial redistribution can interrupt existing or emerging social ties and thus increase vulnerability to trauma (Baron and Schriefers 2015). In contrast, an empowering situation as well as social support in the time following a traumatizing experience can prevent the development of posttraumatic disorders. Thus, traumatized refugees would benefit from an early screening procedure and preventive approaches for building resilience (Metzner *et al.* 2016).

Depending on the severity of the traumatizing situation and the resilience of the affected person, as well as the sequentiality of experiences, refugees may develop illnesses such as post-traumatic stress disorders (PTSD) or depression. Those illnesses require treatment, including psychotherapy, to avoid chronification and/or transferral of the trauma from one generation to the next (i.e. from parents to children). Some estimations expect up to 50 percent of all persons who have become victims of war, displacement and torture to suffer from PTSD (Metzner *et al.* 2016: 645f). Compared to this potentially high prevalence of trauma, the level of support in Germany is far too low. On the one hand, the treatment of post-traumatic disorders is restricted during the first 15 months of the stay. While psychiatric treatment is usually considered an "acute need" which is generally covered by §4 of the Asylum Seekers Benefit Act, psychotherapy can only be granted as an additional need according to §6. The discretion of municipalities in granting health services leads to dependence on the respective case workers who often interpret the law restrictively (Baron and Schriefers 2015: 18f). Once asylum seekers have remained in Germany for 15 months and receive treatment along the lines of the Twelfth Book of the German Social Code (SGB XII), psychotherapy is usually covered. However, reimbursements for the costs of qualified interpreters – which are a central requirement for adequate treatment – are another matter which can only be granted by the job centre based on a formal application (Joksimovic *et al.* 2017: 300; Metzner *et al.* 2016: 647f).[15] Apart from legal barriers, the low number of specialized doctors, therapists and facilities is a significant barrier to receiving adequate treatment (BzgA, Bundeszentrale für gesundheitliche Aufklärung 2013: 39–42).

[15] In contrast to adults, interpreters for unaccompanied minors can be covered by a special provision of the Social Code and have the highest chance of success.

4 The role of non-profit organizations in supporting vulnerable refugees

Non-profit organizations are involved in the support systems for vulnerable refugees as providers of a variety of services. In terms of youth welfare, they provide e.g. residential or ambulatory support services, open youth work such as youth clubs, but also outreach activities. A broad range of different providers exists[16], who act based on contracts with the local youth offices. The providers are also represented in the local Youth Welfare Committee (*Jugendhilfeausschuss*), which is part of the youth office. The Committee establishes the guidelines for local youth welfare policy, including youth welfare planning and the support of private and non-profit youth welfare (BMFSFJ 2014: 48–51). In addition, non-profit organizations often run foster homes and assisted living facilities for unaccompanied minors. These facilities usually also offer additional social support measures according to the Youth Welfare Act. Moreover, UM have a legal claim to additional support and counselling regarding their asylum procedure, which is usually provided by non-profits (Hahn-Hobeck 2016: 120f).

Apart from these activities that are usually based on close collaboration and/or contracts with the local youth offices, non-profit organizations, volunteers and private initiatives such as the foundation "Stiftung Lesehilfe" provide additional learning materials and tutoring to support the educational success of minor refugees (Aumüller *et al.* 2015: 74). In addition, volunteers and initiatives strive to improve the integration of families by e.g. establishing "family sponsorships" where German families take up mentoring for a refugee family, assisting them with everyday life and at the same time entering into intercultural exchange.[17] In some cases, municipalities support these efforts financially or in terms of coordinating voluntary activities (Alicke 2016: 25–27; Schammann and Kühn 2016: 22f). Moreover, non-profit organizations such as sports clubs open their regular activities for refugee children and youth and can become a crucial resource for integration in terms of an opening of the receiving society and providing opportunities for contacts and exchange.

Grass-roots initiatives are also an important source of support for refugee women and queer refugees. By interacting closely with them, the initiatives can assess the refugees' needs as well as their resources and can give them an active role in speaking for themselves and formulating policies (Freedman 2015). For example, some associations set up activities such as sports groups directly targeting refugee women for enhancing their opportunities for social contacts and empowering them (cf. Riemer 2016a: 302f). Such empowering activities by non-profit organizations are supported financially by the Federal Ministry for Families, Seniors, Women and Youth (BMFSFJ). The ministry also develops information materials in different languages on the various support offers that exist, such as help phones and sanctuary homes for victims of domestic violence. Moreover, the involvement of counselling organizations or volunteers who are well

[16] This variety is deliberate policy, designed to give families choice of the provider that most adequately matches their own ideology, religious orientation etc.

[17] See e.g. http://www.gemeinde-neuboerger.de/AG_Fluechtlinge/Familienpaten.html (last accessed 12 May 2017) or https://www.caritas-nah-am-naechsten.de/Freiwilligen-Zentren/Muenchen-Stadt-Land/Page010562.aspx (last accessed 12 May 2017).

acquainted with the needs of LGBTTI refugees can be an important source of support. They help the refugees with disclosing their sexual orientation or identity to public employees for receiving support. Furthermore, they can provide information or training for administrative personnel on the situation of queer refugees, or engage in general awareness-raising activities to combat discrimination (ASB 2016).

In-patient care for the elderly and for disabled persons has also traditionally been run by non-profit organizations in Germany. Even if the share of private for-profit organizations has increased since the introduction of the care law in 1995 – in particular in home-based care – the importance of non-profit organizations in care is likely to increase in the future. Due to the demographic ageing of the German society, voluntary contributions and professional care will be required to adequately address the needs of elderly and disabled persons, including refugees (Klie *et al.* n.d.: 41). Moreover, non-profit organizations provide counselling and support for refugees with disabilities or refugee families with a disabled family member. For example, the application procedure for being granted additional funding for devices such as a wheelchair or a hearing device is complicated and requires qualified communication in writing with the respective public departments. Non-profit organizations and initiatives assist refugees by drafting the letters and conducting the necessary steps of the application, sometimes also by pressuring the respective public authorities (MenschenKind 2015).

Traumatized refugees are often treated in specialized psychosocial centres that are usually organized in or connected to one of the large welfare associations. These centres are often the only available facilities for psychosocial treatment and patients travel up to 300km to reach one of them. They offer comprehensive support including psychotherapy, social assistance, counselling regarding the asylum procedure etc., based on the recognition that all of these aspects are crucial for the healing process of the patient. The centres are usually combining professional and voluntary work. As only part of the psychotherapy is covered by health insurance, the centres are acquiring public and philanthropic funds in order to cover their expenses. However, they have long waiting lists with waiting times of 6-12 months, and sometimes have to turn help-seeking refugees away due to lack of capacities (Baron and Schriefers 2015). In some cities, there are other local organizations that are also providing support, e.g. the public Child and Youth Health Services Neukölln in Berlin (*Kinder- und Jugendgesundheitsdienst Neukölln*) or the non-profit Berlin Centre for the Treatment of Torture Victims (*Behandlungszentrum für Folteropfer Berlin*) (BzgA, Bundeszentrale für gesundheitliche Aufklärung 2013: 58–61; Metzner *et al.* 2016: 648). A main problem is the lack of financial coverage for qualified interpreters in the health system. So far, voluntary interpreters or even family members help refugees with translations. However, this can lead to different problems of confidentiality and can foster the transmission of traumas from one generation to the next if e.g. children are involved in translating for their parents during therapy.

5 Conclusion

Different groups of refugees can be considered in need of special services and protection. Even so, advocacy organizations underline that they should not be viewed as

"victims" of negative experiences or "passive objects" of support measures, but that they should be actively involved in decision-making processes. This is necessary for two reasons: 1) knowing the needs of the respective populations and adequately tailoring support instead of assuming homogeneous needs; 2) empowering the persons themselves to live independently. To this end, the involvement of non-profit organizations is crucial. They are working closely together with the refugees and usually have good access to the groups who are often reluctant to approach public authorities due to negative former experiences. While some services such as psychotherapy can only be provided by professionals, other activities are just as important to meet the needs of the populations. For example, volunteers can become a vital resource for the refugees by fostering social relations and helping with everyday matters.

The role of public actors in supporting vulnerable groups is manifold. Firstly, as the main funder, the state is supporting non-profit organizations that provide the services needed. In doing so, it is respecting the tradition of subsidiarity and corporatism, which provides for a plurality of service providers and the right of clients to select their preferred provider. Even so, the state needs to maintain responsibility for ensuring an adequate supply of services in all German regions. It should ensure that vulnerable groups are served according to their needs irrespective of the municipality they are assigned to. Secondly, a standardized screening procedure for particular vulnerabilities would help to direct the refugees to the different organizations providing individualized support. Thirdly, by providing the legal frameworks regarding access to education, access to the labour market, access to health care etc., the state sets the framework for integration. The regulations should be sensitive to the needs of vulnerable persons. So far, the restricted access to the health system in the first 15 months of the stay is identified as a major barrier regarding the support of vulnerable groups. Moreover, the lacking intercultural openness of the health, care and education systems as well as public administration can hinder full integration.

A key question that remains regards the interaction between non-profit organizations and public actors in the field of support for vulnerable groups of refugees. Non-profits have to perform a balancing act between collaborating with the public administration, drawing on public funds and other resources, and maintaining their independence. This is particularly important regarding sensitive issues such as gender-based violence and sexual identity. Refugees may be reluctant in disclosing such information and the grass-roots connection of non-profit organizations can be crucial for gaining access and providing support. At the same time, volunteers may not be equipped for dealing with e.g. traumatized refugees. Therefore, further research should establish successful models of co-operation that can ensure professional support and protection while at the same time maintaining close contacts with the communities of (vulnerable) refugees. It should answer the following questions: Is there a difference between the involvement of more formal organizations and informal initiatives? How can volunteers be qualified and supported? Which role should the public administration take up? Should funding be provided unconditionally or should certain oversight be exercised? These questions will be addressed in the empirical case studies of this project.

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