COMMENTS OF THE IMMIGRATION LAW PRACTITIONERS' ASSOCIATION ON THE HEALTH CARE ASYLUM INSTRUCTION

The Immigration Law Practitioners' Association (ILPA) is a professional association with some 900 members (individuals and organisations), the majority of whom are barristers, solicitors and advocates practising in all aspects of immigration, asylum and nationality law. Academics, non-governmental organisations and individuals with an interest in the law are also members. Established over 25 years ago, ILPA exists to promote and improve advice and representation in immigration, asylum and nationality law, through an extensive programme of training and disseminating information and by providing evidence-based research and opinion. ILPA is represented on numerous Government, including UK Border Agency and other 'stakeholder' and advisory groups. ILPA works closely with housing and community care practitioners through the Housing and Immigration Group. ILPA is grateful for the opportunity to comment on this draft instruction.

1. Does the draft Health Asylum Instruction (AI) provide sufficient guidance on the dispersal of failed asylum seekers with healthcare needs following a grant of section 4 support? If not, please can you provide any further suggestions?

1. The aspects of the draft instruction that cause most concern to ILPA apply to the dispersal of *both* people seeking asylum and those whose applications for asylum have failed. ILPA has set out its areas of concern for both groups in answer to the questions below.

2. In addition, page 11 ('Failed asylum seekers applying for section 4 support') fails to make clear precisely how the timescales in which section 4 accommodation is provided may be affected by processes relating to health needs. As the UK Border Agency is no doubt aware, the timescale for making initial section 4 decisions in particular cases is already subject to unreasonable delay. Destitute people whose claims for asylum have failed, with health care needs or potential healthcare needs, will require an expedited decision in relation to whether to provide support and in respect of decision as to the adequacy and location of the prospective accommodation. The draft instruction needs to set out the detailed steps that will be taken to provide section 4 accommodation within a specific time-frame to failed asylum seekers with health needs.

3. In addition, as the draft Healthcare Asylum Instruction makes clear, persons whose claims for asylum have failed granted support under sections 4(2) or s 4(3) are not currently accommodated in initial accommodation as a temporary measure awaiting dispersal. Instead the policy is for such persons merely to be identified as ' a priority case' (see p.18 ' Requesting the provision of section 4 accommodation'). The failure to exercise flexibility to provide initial accommodation to section 4 applicants prior to dispersal may lead to healthcare needs not being identified and met. In addition, in respect of persons with a disability, it may engage the public sector equality duty, see below.

2. Do you think the notification letters (outlined on pages 22-24 and 50-51 of the Health AI) assist the process? If not, do you have any further suggestions to improve the process?

4. Regarding the letters to General Practitioners, treating clinicians, etc. and the process generally, there is a flaw in the way that the pieces of guidance and law relate to each other. While it is helpful to align dispersal guidance for section 4 support with the guidance applying for section 95 support, the overall framework for dispersal guidance contained in this draft Instruction appears likely to be difficult for UK Border Agency staff to digest and apply consistently so that they act in accordance with law.

5. Firstly, while detailed guidance concerning persons with healthcare needs may be welcome in principle, it needs to be clear and easy to follow when making a decision. The draft guidance does not clearly distinguish between information of general assistance to the decision maker and the criteria for making particular decisions that require particular attention by a decision maker. In a document of over 50 pages, supported by a number of further word documents embedded in the electronic version of the guidance, the tasks to be performed by a decision maker in respect of each applicant need to be clearly picked out.

6. For example on page 4 ('Registering an asylum claim'), reference is made to regulation 4 of the Asylum Seekers (Reception Conditions) Regulations 2005 (SI 2005/7), in respect of 'vulnerable persons' as defined seekers. However, the reference does not articulate clearly who is responsible for deciding whether a person meets the definition of 'vulnerable', whether a decision on this must be made at that stage of the process (i.e.when registering a claim) and what the consequences are for dispersal policy. The reference to the Asylum Seekers (Reception Conditions) Regulations 2005 is left hanging on its own. Yet any dispersal policy concerned with healthcare needs is bound to have as its subjects, persons who are vulnerable or potentially vulnerable as defined. The relevance of the 2005 Regulations and the tasks that arise in respect of such persons to be set out clearly and simply in this healthcare dispersal guidance.

7. Secondly, all relevant guidance needs to be consolidated in one place or if not to be clearly cross-referenced via a process or flow chart that focuses on decisions that need to be made. The general policy on dispersal found in Policy Bulletin 31, Policy Bulletin 83 concerning the Asylum Seekers (Reception Conditions) Regulations 2005 and 'vulnerable persons' as defined in particular, and this new draft Healthcare Needs dispersal guidance, need to be integrated properly. The risk that exists at present is that islands of policy that should be interconnected and overlap in respect of their application to a particular individual applicant remain isolated.

8. For example, a child with special needs, may have problems that relate to education, healthcare, disability, and 'vulnerability' as defined. Policy Bulletin 83 states that there is no obligation on the UK Border Agency to carry out or arrange for the carrying out of an individual evaluation of a person's situation to determine whether s/he or his/her family members have special needs (para 5.3). While that may correctly state the position, the process of gathering information for the purposes of health care dispersal, involves notifying and contacting General Practitioners and other healthcare professionals who either have or may shortly have information enabling them to support findings of particular vulnerabilities as defined that are relevant to dispersal and which they would wish to volunteer to the UK Border Agency, were they to be informed about the relevance of sharing such information to the Agency's reaching a judgment.

3. If you think the notification letters are of value, should such notifications be issued by the Initial Accommodation Healthcare Teams for applicants accommodated in Initial Accommodation? Would these letters still be of value bearing in mind that the Initial Accommodation health check is voluntary and an applicant may not receive a health check for up to two days following arrival in Initial Accommodation?

9. A notification letter that serves to safeguard the healthcare needs of the person seeking asylum or the person whose claim for asylum has failed is a useful thing. Where such a person has urgent healthcare needs or requires urgent appointments, then a letter is a useful thing even if a health check has not yet taken place for whatever reason. The health of persons in initial accommodation is safeguarded where General Practitioners and other health practitioners are aware that such persons are in their area. Notification letters would enable a person in initial accommodation to have an established link to a General Practitioner/health care team for the time that they are accommodated in that area. It would also enable General Practitioners/healthcare practitioners to plan for services that are relevant to the numbers and particular needs of persons accommodated within their area.

10. It would be helpful to provide information to the medical professional currently treating the person of the date of the dispersal, in addition to the other information provided in the draft letters.

11. It would be helpful if, where pregnant women are to be dispersed (see our comments in this response on that question), a notification letter went to maternity services in the area to which they are to be dispersed.

4. Does the process outlined in the draft Health AI enable the UK Border Agency to fulfil its obligations in assisting in the continuation of care during the dispersal of applicants with healthcare needs? If not, do you have any further suggestions?

12. The process outlined in the draft Healthcare Needs Dispersal Instruction assists the UK Border Agency to fulfil its obligations to some extent but it could be improved. Various suggestions for improvement have already been set out above.

13. We make the following additional comments.

14. It is wholly unclear from the draft guidance whether consideration was given to the public sector equality duty in respect of persons with a disability. Section 49A(1)(d) of the Disability Discrimination Act 1995 provides that 'every public authority shall in carrying out its functions have due regard to…the need to take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons *more favourably* than other persons' (emphasis supplied). In relation to the draft Healthcare Needs Dispersal Instruction it is unclear whether regard was had to this duty and whether any equality impact assessment was undertaken.

15. For persons with a disability with healthcare needs, there may be occasions when it is incumbent upon the UK Border Agency to treat them more favourably than others. It is not clear what provision has been made in respect of this requirement. It is particularly important that if an Asylum Support Medical Advisor is to be used, as is envisaged by the instruction, that such a person be fully conversant with the public sector equality duty that applies to the UK Border Agency in respect of persons with a disability given his/her role in assessing medical evidence on behalf of the Agency.

16. The section on Accommodation Provider discretion to refuse to house those with health needs also needs to be considered in the light of equality duties.

17. The instruction envisages that pregnant women will continue to be dispersed. A woman can apply for section 4 support on the basis of pregnancy if she is over seven months pregnant. We do not consider that it is appropriate that a person over seven months pregnant face dispersal where she does not want to move, save in exceptional cases where she has been held not to be capable of making the decision for herself and there are reasons relating to holistic support and/or specialist care for her to be moved.

18. The UK Border Agency has a duty to safeguard and promote the welfare of children under section 55 of the Borders, Citizenship and Immigration Act 2009. At the moment those with a baby under four weeks old will not be dispersed, but those with a baby over four weeks old may be dispersed. We find it difficult to envisage circumstances where moving a tiny baby could promote the welfare of that baby or assist in safeguarding that baby and consider that to move a mother and child against the mother's will where this has the effect of disrupting post-natal care runs counter to the Agency's duty.

19. We consider that the use and role of the Medical Advisor should be reviewed. It is desirable that qualified medical practitioners assess an applicant for support in person and an assessment by a person who currently has responsibility for the care and treatment of a person and who holds their medical records is of greater authority than that of an Medical Advisor reviewing papers in connection with an application for support. Where there is such an assessment from a person's medical practitioner, or where such an assessment can be obtained, this should be preferred, and it is difficult to see what consideration by the medical advisor will add in such circumstances.

20. The guidance should set out clearly that once an applicant has been assessed as being destitute they should be given interim accommodation in the area in which they assert that they have a need to stay for a reasonable period that will enable them to obtain recent medical evidence, and also to cover time spent waiting for advice from the Medical Advisor on the information and evidence submitted. They must not be left destitute during the period that it takes to obtain evidence and this can take time in some cases.

21. In the section Role of the Independent Asylum Support Medical Adviser it would be helpful to see a cross reference to the statement in the instruction that:

    > *"Case workers should also be aware that some applicants and dependants may be used to a more holistic approach to mental health issues, which may rely more heavily on the support of family and other networks rather than counselling and medication. For this reason consideration should be given to requests for applicants not to be separated from existing support networks on a case-by-case basis.*

22. In may be helpful in this part of the instruction to clarify the roles of the Medical Adviser, if one is used, and the caseworker in dealing with the question of a need for holistic support of this kind.

23. If a person has serious mental health problems, or attends the Medical Foundation or Helen Bamber Foundation then once they have been assessed as being destitute they should be provided with accommodation in the area they have stated they need to live. They should be accommodated in this area during the time it takes to obtain any further evidence that the caseowner has determined to be necessary.

5. **Are there any areas of the process for dispersing applicants with healthcare needs that the draft Health AI does not sufficiently cover? If so, please specify?**

24. See above.

25. In addition, please note the comments below.

26. In the introduction it would be helpful to make clear that the instruction applies to support under sections 4, 95, 98 unless otherwise stated.

27. The instruction as a whole should have more information about confidentiality. The instruction envisages that people will be asked questions about medical conditions/pregnancy at the Asylum Screening Unit. These questions should be asked in a confidential setting and not an open 'counter-style setting.

28. It is always good practice to ask for people's consent to share information about them and a person should always have a clear explanation of what information about them will be shared, with whom and on what conditions of confidentiality, if they take up an offer of accommodation. A clear distinction should be made between information that will have to be shared with an accommodation provider as a condition of the person taking up the offer of accommodation with that provider, to ensure that a person and other residents of the accommodation can be kept safe, and information that should be shared only with a person's informed consent, freely given. In sharing information with accommodation providers the UK Border Agency should make clear the obligations of confidentiality imposed upon the accommodation provider.

6. Do you have any additional comments or suggestions that you would like us to share as part of the consultation process?

29. Yes.

30. People seeking asylum, or people whose claims for asylum have failed and who face the possibility of a forced removal, should not be dispersed to areas unless there is adequate provision for legal advice in that area. The Legal Services Commission is in the process of letting contracts for legal advice in immigration and asylum for the next three years. In some areas, no contracts have been let. People should not be dispersed to these areas until the problem of a lack of provision has been solved. In other areas there may be a shortfall in provision. There should be discussions with the Legal Services Commission to ensure that capacity in these areas is well understood and to avoid dispersing people to areas where lawyers cannot take their cases. Some of the Legal Services Commission's 'procurement areas for the new contracts are very large and providers may be distributed unevenly across the area. The location of providers may change under the new contracts from that with which the Agency is familiar. This may be of particular relevance to those whose health needs mean that they are in difficulty travelling long distances. The UK Border Agency should obtain detailed information from the Commission to inform its decisions on dispersal in these circumstances.

31. We trust that the comments below, which do not purport to be a detailed commentary on all aspects of this lengthy guidance, will serve as illustrations of the concerns addressed above and to pick up some specific points.

32. In the section 'Dispersal' following the paragraph: "Where an applicant has provided medical evidence obtained in the UK, ...Requesting of Up-to-Date Evidence ", the

requirement for medical evidence to be less than two months old should be confined to cases where this is of relevance. Where a medical practitioner has indicated clearly that a condition/disability is permanent and stable then a second medical certificate seems likely to be superfluous to requirements.

33. In the section on "Providing evidence to prove the medical need" it is necessary to refer not only to not providing information by the deadline, but to not having given a reasonable explanation for this.

34. It should be clarified that a reference to four hours as a 'reasonable travelling distance' to receive medical treatment is reference to a round trip and not a one-way journey. Two hours is an extremely long journey for any regular health appointment, as opposed to, for example, an annual check-up with a specialist, and a person's health condition or disability may make it all the less tolerable. What a reasonable will depend on the frequency of the journey and the state of a person's health and this should be clearly indicated.

35. Under the heading Determining the nature of accommodation required, , in the bullet point on "Those with HIV or Acquired immune deficiency syndrome (AIDs)" it should be stated that if a person needs their own fridge for the storage of their medication then they should not be accommodated in a shared bedroom. This is because it is likely that their HIV status would be disclosed if they had to share a room.

36. As to persons receiving assistance with daily living tasks, there is a very strong case for not dispersing those who receive such assistance from friends and family in the area where they are currently living.

37. We do not consider that it is adequate to refer to accommodating those at risk of suicide or self-harm in a ground floor room. There is a need for assessment as to whether dispersal may exacerbate the risks before a decision to disperse is taken. If it is taken, then connections to mental health services at the dispersal location should be made prior to the dispersal taking place.

38. There is a need for an additional bullet point on those with mental health problems. The comments above on suicide or self-harm are also relevant to persons with mental health problems. In addition, persons who have difficulties sleeping and suffer from nightmares should be provided with their own bedroom.

39. In the section Role of a dispersal accommodation provider we should ask that the text refer to a 'wheelchair user' (as it does elsewhere) rather than to be a person 'confined to a wheelchair'.

40. It is unclear from the instruction how medical practitioners will be able to claim the costs of a medical certificate relevant to the question of return or to the location/type of accommodation required by the applicant, directly from the Agency or, in appropriate cases, from the One Stop Service. This should be set out clearly in the instruction.

ILPA
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