About the Refugee Health Network at Medact

1. Medact's Refugee health network is a group of clinicians, academics and representatives of NGOs sharing information and working on issues of health for refugees and asylum seekers.

2. We welcome new comprehensive guidance on dispersal of asylum seekers with healthcare needs. Efforts to ensure continuity of care for those with recognised health needs after dispersal are especially welcome. However, concerns remain. Those concerns are outlined below.

GENERAL COMMENTS

3. Much depends on the qualifications and expertise of the health care staff involved in assessing the health status of applicants to be dispersed. Many asylum seekers are vulnerable and often confused regarding their situation. Good health care by experienced and qualified nurses and doctors is of paramount importance to ensure that health issues--including mental health --are adequately dealt with. In view of their particular vulnerabilities and the health risks involved, quality assurances systems which are transparent and subject to regular audit are essential. Health care providers involved in this process should all be subject to transparency standards at the level of that required in NHS primary and secondary care. Contracts between UKBA and all service providers, as well as providers' internal arrangements including business targets should be public, with a view to assessing their potential impact on patient care.

SPECIFIC COMMENTS

Difficulties registering with a GP

4. We remain concerned that issues of barriers to access for asylum seekers are not adequately recognised and dealt with in the guidance. There is evidence to show that confusion remains on the part of clinicians about the entitlement of asylum seekers to healthcare in the UK. This has resulted in those with entitlement being refused care. The current guidance states that the accommodation provider should take the supported person to a GP within 1 day of his arrival at the dispersal address. This does not go far enough. The guidance should require accommodation providers should ensure that those with health needs are *registered* with a GP within this timeframe. This may include providing evidence of entitlement to NHS services to the GP.

Confidentiality

5. We believe that further clarification of confidentiality obligations is needed. The current draft guidance states in the section entitled, "Registering an asylum claim (Port/Local enforcement office/Asylum screening unit action)" that "Any medical evidence or notes must be kept confidential and records must be kept according to best practice". The current guidance does not go far enough.

   a. Confidentiality should apply to *any* medical information;
   b. Patient consent needs to be obtained before sharing information;
   c. Patients need to be informed about their rights as regards their medical information

   A clear standard of confidentiality needs to be established in the guidance. As the Refugee Council has argued previously, this standard should mirror that of the Department of Health (2003) *Confidentality: NHS Code of practice*, London, TSO.

Informing clinicians of dispersal action

6. We welcome the fact that in cases where there are complex health needs, the guidance requires that treating clinicians must be informed of the dispersal action. However, it is vital that a reasonable timeframe should be set out for delivering the treating clinician's notification. Optimally, this should be at the first knowledge of dispersal destination and should allow for sufficient time for consultation with the clinician, transfer of medical records and gaining the clinicians opinion on what treatment is needed in the dispersal area. Research from the National AIDS trust has found that insufficient notice periods can have a detrimental effect on continuity of treatment.[1]

Children

7. With regard to children, we recommend that all children are seen by a health visitor (HV), or school nurse (SN) as HVs and SNs visitors have the appropriate training and expertise to assess children's physical, developmental, social and mental condition. Though problems may sometimes be obvious, this is often not the case and early identification of problems that asylum seeking children may have is vital. The current draft guidance states that children under 5 are seen by a Health Visitor "where there is clinical need". HVs (and for older children, SNs) are in the best position to identify such need. We believe that that age limit for IA health checks be raised to 12 and should be carried out for all children. Because of the importance of this issue, the Royal College of Paediatrics and Child Health should be consulted on any policy or guidance relating to the health of children.

[1] NAT, *Dispersal of Asylum Seekers with HIV*, accessed at http://www.areyouhivprejudiced.org/Media%20library/Files/PDF%20documents/NAT-Dispersal-Of-Asylum-Seekers.pdf on 27 October 2010

Medical evidence

8. The draft guidance states that where the applicant has submitted medical evidence that may impact on the dispersal location or the nature of the property allocated, caseworkers can if required, request advice from the Asylum support medical adviser (ASMA) about the general availability of treatment in particular regions. Establishing the general availability of treatment does not go far enough in ensuring continuity of an adequate level of care in complex cases. In cases where there are severe or complex health needs, the guidance should reflect these needs by requiring the ASMA to establish that the treatment the particular applicant requires is available to him/her in the accommodation destination and that there are no barriers to him/her receiving this treatment.

9. The section of the draft guidance on dispersal states that where an applicant has provided medical evidence that is older than two months old, unless it is clear that this information is still relevant, the s/he must obtain updated information from a treating clinician. Unless there is a compelling reason to impose this timeframe, it should be extended. Any medical evidence should be submitted for screening by the Medical Adviser or another appropriate medical professional to determine whether more recent information is necessary.

Delaying or deferring dispersal

10. We welcome a statement of cases where deferring dispersal may be appropriate. While it is recognised that this list is not exhaustive, a standard or statement should be set out which recognises that this should be considered where, “the health or well-being of the applicant may be put at risk is dispersed.” This would ensure that the guidance adequately covers the range of situations where the need for delay, deferral or cancellation of dispersal may arise.

11. The criteria for deferral or selective dispersal on health grounds includes where “invasive surgery is booked to take place in a month”. This section should be extended to include should cases where surgery is scheduled for longer than a month in the future where there is evidence of possible delay in rebooking and this delay would have an adverse health impact on the applicant.

Mental health

12. The guidance section entitled Mental Health- Dispersal Guidelines recognises that asylum seekers may have a higher risk of PTSD or co-morbid disorders. This statement could go further in recognising that many mental health issues may arise out of the treatment of asylum seekers in their home countries.

While the guidance recognises that cessation of mental health treatment with a trusted clinician may be detrimental to the capacity for recovery in the long term, consideration should be given to exempting applicants with such mental health issues from dispersal. This is especially the case where the applicant has support networks in place from which s/he would be removed if dispersed.

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