



Reducing Barriers for People with Precarious Immigration Status in Ottawa Community Health Centres

Preliminary Report

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This report was written by Dr. Jennifer Ridgley, Department of Geography and Environmental Studies, Carleton University. Research for this report was conducted in partnership with the Ottawa Sanctuary City Network, the Pinecrest Queensway Community Health Centre (PQCHC) and the Somerset West Community Health Centre (SWCHC). Views and opinions expressed in this document are those of the author and study participants, and do not necessarily reflect those of PQCHC, SWCHC, the Ottawa Sanctuary City Network, or Carleton University.

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Introduction

Many frontline organizations in Ottawa are working hard to overcome barriers and to ensure immigrants and refugees in Ottawa have access to the services and supports that they need in order to live healthy and secure lives. Residents with precarious immigration status face specific barriers related to the threat of detention and deportation, as well as the stress produced by living without permanent status in Canada. Some of these barriers are created by federal, provincial, and municipal policy, and systems level changes are necessary to overcome them. In the meantime, there are concrete steps that local organizations like Community Health Centres (CHCs) can take to improve access and reduce risks for people with precarious immigration status who live, work, and raise their families in Ottawa.

This report presents the preliminary findings of a research project designed to:

- 1) Identify the barriers and risks that people with precarious immigration status might face in accessing programs and services at Ottawa CHCs.
- 2) Develop best practices and guiding principles to help reduce those barriers and risks.

People with precarious immigration status face the same familiar barriers to health and equity as many newcomers (including those related to language, employment, housing, discrimination, and a lack of culturally appropriate care), and more research needs to be done on the way that immigration status intersects with and amplifies these barriers. The purpose of this initial project, however, was to concentrate on the specific barriers and risks that exist for people who live under threat of detention and deportation because they do not have permission to stay permanently in Canada. Recognizing that policy changes at the federal, provincial, or municipal level will take time, the focus of this report is on the way that barriers and risks may be exacerbated or reduced in the everyday interactions between clients and frontline staff. This report also focuses on the concrete steps the CHCs can take to help build a culture of “Access Without Fear” in Ottawa.

The research project emerged out of a partnership with the Ottawa Sanctuary City Network, the Somerset West and Pinecrest Queensway Community Health Centres, and Dr. Jennifer Ridgley at Carleton University. It involved in-depth interviews with frontline staff at two CHCs (Pinecrest-Queensway and Somerset West), an analysis of registration, intake, and assessment processes in these organizations, and a review of existing literature on precarious immigration status and access to health and social services in Canadian cities.

Although this particular project did not involve interviews with residents living with precarious status, research from other cities with undocumented or out of status people identified fear as

a significant factor that shapes access to services and supports, particularly if people avoid community agencies for fear that their personal or medical information will be shared with immigration authorities. For this reason, this project paid a significant amount of attention to the practices in Ottawa CHCs that might exacerbate or alleviate these fears.

A Note on “Precarious Immigration Status”

Precarious immigration status refers to a broad category of immigration situations experienced by people who are living without permission to stay permanently in Canada (Goldring & Landolt, 2013). It includes temporary foreign workers, refugees, asylum seekers, international students, people with expired visas, and people who have entered or stayed in the country without authorization. These groups have vastly different legal and policy contexts which shape their experiences in Canada and their access to healthcare, but they share forms of vulnerability that are created by federal immigration law, and their lack of permanent status means that they live under threat of detention and deportation.

In Canada, advocates, policy makers, and researchers have adopted the use of this term because it captures the non-linear nature of the migration process for many marginalized groups, in which people tend to move in and out of various “statuses” over time (for example, a refugee claimant who has their application denied, and is living in the country awaiting an appeal). Immigration scholars Goldring and Landolt (2013) use the idea of “chutes and ladders” to highlight the paths within and across different legal status categories, referencing the popular board game where players advance but also fall back in often dramatic ways over the course of play. The realities of immigration status in the Canadian context are not reflected in public outcry about alleged “illegal” border crossings or in media representations that draw distinctions between “legal” and “illegal” immigration. Because these distinctions are sometimes used to justify inequitable access to rights and services – including health care – it is important not to reproduce them.

Summary of Findings

What creates or exacerbates barriers for people with precarious immigration status?

- When clients are asked about their immigration status.
- A lack of awareness in the city about what services are available to residents with precarious immigration status, particularly those who do not have insurance.
- Fears that the CHCs are connected to and share information with the immigration authorities or government.
- Judgement and prejudice about clients' migration decisions, or their entitlement to support.
- The collection of sociodemographic and household information.
- Requests for documents and identification.
- Ineligibility for some services and programs.

What creates or exacerbates risks for people with precarious immigration status?

- The storage of identifiable immigration and sociodemographic information.
- A lack of clarity about how client data is being used.
- Sharing client information with organizations that do not have "Access Without Fear" or sanctuary policies.
- Contact with the police, who sometimes share information with the immigration authorities.
- When residents access services and programs that might jeopardize their immigration applications.

What can CHCs do to reduce barriers and risks?

- Develop and publicize strong “Access Without Fear” or sanctuary policies and protocols to prevent the collection, storage, and sharing of identifiable immigration information.
- Publicize services and supports that are available to people without insurance (especially within immigrant, refugee, and newcomer communities).
- Further incorporate an awareness of precarious immigration status into health equity work.
- Review and revise existing policies on the collection, storage, and sharing of client data to reflect the sensitive nature of immigration status.
- Increase awareness within the organization about how client data is being used.
- Consult with community partners about client data storage and sharing practices.
- Strengthen staff training on precarious immigration status and barriers to access.

Background: Living with Precarious Immigration Status

The complexities of Canada's immigration system and the vulnerability of some newcomer populations make it difficult to assess the numbers and needs of people with precarious immigration status in Ottawa, particularly those who are undocumented or out of status. We do know that changes in federal immigration policy over the course of several decades have led to an increase in the number of people living in Canada without permanent status. These changes include a policy shift away from permanent settlement and towards the expansion of temporary worker programs to fulfil labour market needs, as well as the introduction of barriers to permanent status such as rising application fees, lengthy processing times, and language tests (IRCC, 2016; Sharma, 2006; Valiani, 2013). More recently, the political climate in the United States and the end of Temporary Protected Status (TPS) for some have led thousands of people to cross the border into Canada seeking asylum. Many of these have made their way to Ottawa to live, and some will eventually have their asylum claims rejected and be pushed out of status. Given national and international policy contexts, it is safe to assume that there are growing numbers of people living in Ottawa for extended periods of time under conditions of immigration precariousness and uncertainty.

Living with precarious immigration status often means being subject to strict conditions. This might include reporting requirements or regular contact with Canada Border Services Agency (CBSA) and Immigration, Refugees, and Citizenship Canada (IRCC), employment and travel restrictions, a lack of access to public services, or even just living one's life in a way that demonstrates – to the Canadian immigration authorities – a commitment to settle in Canada. Federal immigration policy also creates situations where people are dependent on others (eg. employers or family members) for their status and permission to stay in Canada, and women are more represented in these dependent immigration categories than men (Oxman-Martinez et al., 2005). People with precarious status often become permanent residents or citizens in time, but until this happens, detention, deportation, or being ordered to leave the country is always a possibility. Living under threat of detention or deportation leaves people vulnerable to exploitation and abuse by employers, "immigration consultants," sponsors, family, or community members. It also structures access to health care in complex ways (Bernhard, Goldring, Young, Berinstein, & Wilson, 2007; Oxman-Martinez et al., 2005; Saad, 2013; Simich, Wu, & Nerad, 2007).

Existing research suggests that fear is a significant factor shaping access to services and supports for people with precarious immigration status, including access to healthcare

(Goldring & Landolt, 2013; Saad, 2013). People at risk of detention or deportation may not go to community agencies or health centres for fear that their personal or medical information will be shared with the immigration authorities. They may also fear that accessing services will jeopardize their immigration applications and their efforts to achieve more permanent status in Canada. Frontline service providers are not required to report people who are present in the country without authorization or to share client information with the immigration authorities, but many organizations do not have formal policies or protocols in place about immigration status to guide staff or to reassure clients.

Changes at the federal and provincial level are critical to improving access to health insurance and permanent status in a timely manner, but until that happens, local organizations can focus on building strong “Access Without Fear” or sanctuary policies to help ensure all residents have access to the services and supports they need, regardless of their immigration status.

Methodology and Approach

The analysis and recommendations in this report are based on a total of 26 interviews with frontline staff at CHCs (the majority of these taking place at Pinecrest-Queensway and Somerset West), an analysis of registration, intake, and assessment processes and forms used by CHC staff, and a review of existing literature on precarious immigration status and access to health and social services in Canada. Interviews with CHC staff represent a subset of 52 interviews conducted with frontline service providers in Ottawa as part of a larger research project, and data from this larger pool was included in this report where there was direct discussion of community health centres (for example, when participants from other organizations recounted their experiences with CHCs).

Interview participants spanned a wide range of roles, programs, and services. They included doctors, nurse practitioners, medical receptionists, health navigators, and staff involved in various programs that support children, families, and youth. Interviews lasted between 45 and 90 minutes and were audio-recorded, transcribed, and coded for analysis. The interview excerpts included in this report are representative of sentiments shared by a significant number of people interviewed, and some have been edited for brevity or to protect the identity of participants.

Importantly, this project is preliminary because it does not include the voices of residents in Ottawa who are living with precarious immigration status. The ethical issues of conducting research with people facing the threat of detention and deportation are significant, but may be worthy of future consideration, particularly if this research became a part of concrete efforts to empower residents and improve health access and equity.

Findings: What is happening in the CHCs?

Frontline staff reported that they work with people with precarious immigration status on a regular basis, although it is much less common for them to encounter people who are known to be undocumented or out of status compared to refugees and asylum seekers. It is, however, common for staff to be working with clients or families who have their status change over the course of their participation in CHC programs or services (eg. a refugee whose claim is eventually rejected). Compared to people interviewed in other sectors, staff at the CHCs demonstrated stronger commitments to serving people with precarious immigration status and overcoming barriers put in place for people who are out of status. A significant number of staff spoke of their experiences responding to the arrival of Syrian refugees, and their desire to mobilize the knowledge they had developed during this response in the service of other groups of people living in Ottawa. The following section summarizes what researchers learned about what is happening in the CHCs. In particular, it focuses on the everyday practices of staff and on their interactions with clients.

Immigration questions and client data

Direct questions about immigration status are not included on the general registration forms for either Somerset West or Pinecrest-Queensway CHC, but staff frequently ask clients about their immigration status in order to determine eligibility for various supports and programs, or as a proxy method for assessing a client's needs.

Although there is a commitment to protecting client privacy within the CHCs and to following existing policies and protocols regarding client information (particularly client medical information), there is less awareness about how immigration situations and statuses are sensitive or risky for clients. Staff witnessed fear and anxiety in clients when discussing immigration issues and they described a “pulling back” when clients were questioned about status.

I had one woman, she said “If I give you my information, will they use that information to deport me?” I was so shocked....She showed me an original document which was her ID, and I had made a copy of it. They she asked me these questions, and I said, “why don’t you take this back? I cannot serve you. I am sorry.”

Without exception, staff demonstrated a commitment to protecting client information and data, and many discussed their organization's privacy policies (including the process of getting consent to share client information). For the most part, however, frontline staff have not received in-depth information about what happens to client information and case notes once

they are entered into the various databases or client management systems used by the CHCs and affiliated programs. There is uncertainty about who has access to the data (inside and outside their organization or program) and what it is used for (eg. reports to funders, strategic planning, program evaluation, etc.). Frontline staff are also unsure about when, and under which circumstances, health centres might be compelled to share client immigration information with the IRCC or law enforcement (by subpoena or a court order). This raises questions about whether staff have adequate training to provide clients with sufficient information when they are asking clients for consent to share information, or when asking clients for sensitive information.

There are situations where staff from other organizations are working on site at a CHC (the presence of a settlement worker at SWCHC is an example of this), or when CHCs are delivering programs in partnership with other organizations (for example, the City of Ottawa or CMHA). These organizations and programs have their own databases and case management systems, and may have data practices and policies that are different from the CHCs. For example, interview participants from other organizations in Ottawa (outside of the CHCs) suggested that IRCC has access to client databases used by settlement organizations. At least one CHC staff person who was interviewed said that all their client data goes to CMHA. If overcoming barriers to access necessitates changing the way client immigration information is collected and handled, then engaging with partner organizations will be an important part of this process.

“All sociodemographic information is immigration information”

In addition to information about the immigration status of clients, the CHCs collect and store a significant amount of sociodemographic information about clients during registration, intake, and assessment processes. This can include data about income, household composition, marital status, place of birth, date of arrival in Canada, etc. In many cases, clients are asked to provide the same information several times. A client may fill out a general registration form during their first encounter with the CHC, then another for a specific program they are accessing. They may then be asked for yet more sociodemographic information during intake or assessment processes. Interview participants suggested that this data is stored in NOD, or other client management systems and databases, and some believe that it is used for research and reporting purposes. However, as mentioned above, there is a significant amount of confusion about how client data is handled within and outside of the CHCs, and what it is used for.

For some people with precarious immigration status, the collection and storage of identifiable sociodemographic and medical information creates added fear and risk. Immigration applications can be rejected if minor information about the household is recorded incorrectly, or changes are not reported properly. People's lives often shift over the course of lengthy immigration processes (eg. family members move in and out of the household, incomes change, people leave their spouses, etc.), and some people find it difficult to update applications, particularly if there are language or financial barriers. Medical information can also be used as grounds for inadmissibility. Information on an immigration application may not align exactly with what a client would consider revealing to a social worker or health care provider who is trying to assist them.

We do chart every single thing, and we do have [database] and we have [assessment tool], and I know that every quarter there is some data they are collecting and sharing it with the City of Ottawa about how many families we serve, how many of them were immigrants, all of those things. How many children. And if there is some specific cases that we have some challenges with, we usually report that to the city and to our Director.... We just make sure that we chart everything. Because that could be something being asked by a court to be released for some cases. We had that before so we make sure that we document everything.

People with precarious immigration status may not access services where they know they will be asked questions that feel sensitive or complicated to answer. Some clients see the CHCs as linked to the "government," and thus may be concerned about how answers to sociodemographic questions will impact their immigration applications. For these reasons, when it comes to increasing access for people with precarious immigration status, *all sociodemographic information should be considered immigration information.*

It is worth noting here that it is well recognized in the sector that sociodemographic and health questions can be sensitive for clients, and can thus present a barrier to access. In Ottawa, there is also increased interest in the potential of using sociodemographic data to meet important health equity goals and to overcome barriers. Asking good questions and protecting client data is an ongoing challenge throughout the sector, and the specificity of risks for people with precarious immigration status should be incorporated into all discussions about data collection and analysis.

Access for people without insurance

Residents of Ottawa who are living with precarious status do not always have health insurance, and CHCs are one of the few places people without insurance can go to receive care. There is not a lot of public awareness about this, and so people without insurance usually hear about

CHCs through other organizations or community members who are “in the know.” This raises significant access and equity issues.

Most (but not all) CHC staff were aware that their organizations can provide healthcare to people without insurance. Those involved in primary care were more likely to discuss the limitations of what they are able to provide. Staff outside of primary care expressed concerns about the burden of serving the uninsured: the limited funds

I talk to my other family physician colleagues and they don't even know about CHCs. They don't know. They're, like, "Oh, my patient has a family member who doesn't have OHIP and I've told them I don't know what to do." I am, like, "What do you mean you don't know what to do? I work in a CHC! You are looking at it!"

available to provide care and fears about the clinics being overwhelmed. Several staff mentioned the ongoing issues with IFHP in Ottawa, including providers who still refuse to accept IFHP, and a lack of understanding about the IFHP system. Several staff feel problems with IFHP are creating major issues for clients and healthcare providers in Ottawa.

Several interview participants from other organizations in the city (legal clinics, settlement organizations, and shelters) reported incidents of phoning CHCs (including Somerset West and Pinecrest-Queensway) and being told the CHC wouldn't serve their clients because they didn't have insurance and/or status.

An incident that comes to mind is where a client needed to access healthcare, and was not yet insured. In trying to locate a CHC that would let them in based on the catchment area, I called a few of the CHCs. First, I looked on their websites. None of the CHCs had on their website that they would take in clients who are uninsured, so I called. Neither of them would confirm on the phone that they would take in a client without insurance. And I KNOW that they provide healthcare to people without insurance, so it was very frustrating to have that conversation.

I sent the client there anyway, and as far as I know they got the healthcare they needed. And I imagine that any other agency, and any other legal clinic who wasn't sure already that the health centres provide for people without insurance...they might have ended the situation there. Just told the client, "I am sorry, you are just not going to receive healthcare."

I've worked in another CHC... very similar patient population...and rules are always changing as to who we'll accept, who we won't accept, so I'm sure the medical receptionists' heads are spinning.

I don't know who we're accepting, who we're not accepting. And so unless you say the right exact words on the phone when you call to get your kid in with a sore ear, they're probably getting told no, we're not going to see that person because they didn't say the magic word that needed to be said for them to be seen.

Knowledge about the immigration system and precarious status

In interviews, staff demonstrated an awareness of the way that language, transportation, cultural background, employment, housing, etc. impact people's access to health in the city. They have received less guidance, however, on the way that immigration status impacts access outside of formal eligibility requirements. Many expressed a desire for more training and information. This was particularly true for those who are asked to write letters in support of refugee claims or other immigration applications. Some staff identified immigration precariousness as a significant health issue in itself, specifically the stress associated with living under threat of detention and deportation, or possible family separation.

Informal networks and supports

Many staff spoke of their reliance on informal networks and mechanisms to serve residents who have precarious immigration status, particularly people who are in an emergency situations, people with ID issues, and people who have been denied various forms of support by the city. Interview participants brought up the importance of knowing who to call for help, and of developing relationships with people who would go out of their way to serve people in difficult situations. Clients may get access to informal support because a staff person feels compelled by a difficult situation or feels an affinity for a client or family because of a shared language or cultural background; this raises significant access and equity issues. Staff also talked about how important informal networks are for newcomers who use social media and social connections to share information about what services are available and share experiences with specific organizations or service providers in the city. This means that stories about uncomfortable experiences at local organizations spread quickly in the community (for

It all kind of relies on the kindness of "angels" who will serve people....

example, experiences of being asked about immigration status) and can shape residents' decisions about whether to access particular programs or services.

Staff also raised concerns about the lack of support for people who didn't fit into the neat "boxes" that determined eligibility for various programs and subsidies run or funded by the city, and how CHC staff often took on additional responsibilities in order to assist these clients. This is related to the workload issue discussed below. Many staff spoke of the piecemeal nature of support for people without status, and the lack of a systematic approach to people falling through the cracks. This echoes research in other cities, which has discussed the pros and cons of uneven and informal approaches to service provision that often develop to compensate for systemic barriers to access.

We all have our people we can call if we can't get help anywhere else. People we know who will go out of their way to help. But, you know, you don't want to pick up that phone too many times! You have to make choices about when to call on people.

Discrimination, racism, and judgement

The barriers created by discrimination, racism, and judgement came up during research interviews in a number of different ways. Several staff acknowledged that their clients faced these barriers in their everyday lives, and that this may shape their willingness to access services, particularly if they are in precarious immigration situations and are forced to rely on the discretion of frontline staff to receive services. Two staff who were interviewed also provided accounts of racism and discrimination within the CHCs, specifically directed at clients from other staff members. These accounts included comments made about clients, and subtle racist, disrespectful, or dismissive behaviour.

A small number of interviewees expressed judgements about different groups of newcomers, and about whether they deserved various services and supports (eg. contrasting refugees arriving under private sponsorship or government assisted programs to so called "illegal" migrants, or asylum seekers crossing the border from the United States). To the extent that judgements about deservingness might impact whether clients get access to supports and services, these attitudes represent a barrier to people who already face significant access issues. Staff suggested that hiring more staff with personal immigration experiences, or from immigrant communities, could help address these issues, as would a greater understanding of the challenges inherent in the immigration process.

Workload

Many CHC staff spend a significant amount of time trying to resolve access problems for clients that are directly related to immigration issues. This includes work done to overcome barriers that exist outside of the CHCs, so that clients can get access to programs and supports they are entitled to. For example, staff spoke of the work they do to help clients resolve problems with identification and documents, most notably correcting information that was recorded wrong by the CBSA at point of entry (the spelling of names, marital status, date of birth, etc.). Staff described how this was necessary in order for clients to prove eligibility for services and income supports. They also talked about the hours they spent on the phone trying to get answers from the city in the service of their clients, and the heavy workload involved in maintaining ad hoc service provision and support in the absence of a more systemic approach.

Conclusions

Many barriers to access are created at the federal and provincial levels of government through immigration, refugee, and health systems that create precariousness and insecurity for residents in Ottawa. Granting full and formal status to immigrants and refugees quickly and unconditionally would address these barriers, and improve the health and wellbeing of Ottawa residents. In the meantime, local organizations like CHCs can work to reduce the barriers and risks that exist for people with precarious status in the everyday work of their organizations.

Some of these barriers and risks relate to the collection and storage of immigration and personal information. This research revealed that clients are often asked immigration questions. This usually occurs as part of assessment or intake processes, to determine eligibility for programs, or in casual conversation to develop rapport. Staff record immigration and sociodemographic information in case notes and various client data management systems used by the CHCs and affiliated programs, but many staff are unclear about what happens to that information or how it is used. The CHCs have strong privacy policies that protect immigration status, but the storage of identifiable immigration, sociodemographic, and household information can still create risks for clients. Even where clients are not being asked immigration questions, fears that the CHCs are connected to and share information with the immigration authorities or government may keep people away. Strong “Access without Fear” or sanctuary policies may help alleviate these issues, particularly if they are accompanied by staff training, public outreach, and regular review.

CHC staff are in a challenging situation when they are asked to help clients navigate the complex immigration, refugee, health, and social service systems that produce precariousness and uncertainty. Some staff suggested that their own lack of understanding of the immigration

process may be creating barriers for clients; they said that they would welcome opportunities to learn more. A lack of understanding may also fuel judgements and discrimination based on a person's immigration situation, and thus create further barriers to access.

The lack of awareness in the city about what services are available to residents with precarious immigration status, particularly those who do not have insurance, also creates barriers. It is not widely known that the CHCs can serve people without insurance, including among other health professionals and community organizations. There are indications that even staff who work in the health centres are sometimes unclear about eligibility, or may turn people away based on immigration status. As discussed in the recommendations, CHCs could remove these barriers by publicizing the services, programs, and supports available to people without insurance, and by working with community partners to develop a greater awareness of available supports city-wide.

Staff Suggestions for Improving Access

When asked what would help reduce barriers and increase the health outcomes for people with precarious immigration status, staff had numerous suggestions, listed below. All of the responses are included, although not all of them relate to changes that could be made within the CHCs.

- More language and translation or interpretation supports.
- Access to subsidized housing.
- Lower caseloads in programs with a high percentage of newcomers.
- Less data collection and paperwork, not just within the CHCs, but at the city level.
- Increased awareness among policy makers about how immigration and refugee application processes create stress and health problems.
- Workshops or “brown bag lunches” to learn about the immigration system, particularly for primary care people who are asked to write letters in support of immigration applications.
- A pool of flexible and easy to access funds that staff could access to help clients with emergencies and exceptional circumstances.
- Changes at the city so there are fewer barriers to accessing social assistance and housing supports.
- More staff who come from racialized and immigrant communities and/or who have direct experience with immigration challenges.
- A resource guide for frontline service providers that lists where clients who are out of status can go for help.
- Shorter wait times for processing applications and asylum claims.
- Financial support for clients to cover application costs.
- More education among health care professionals about IFHP because specialists do not know how to process these claims.
- Ways to keep up on policies and practices that keep changing.
- Earlier access to OHIP and an end to the wait times before OHIP kicks in.

Recommendations for Ottawa CHCs

1. CHCs in Ottawa should establish and publicize clear and robust policies that would eliminate or reduce questions about immigration status and that would restrict the sharing of immigration information. A plan for staff training, discussions with partner organizations, public outreach, and periodic reviews of the policies should be incorporated into these efforts.
2. CHCs should broadly publicize their mandate to serve people who do not have insurance, including on websites, on social media, in sector meetings, and with partner organizations. They should specifically focus on the CHCs as places where people without status can receive healthcare and support. Careful consideration should be given to reaching people who are not otherwise connected to service providers and the healthcare system. Increased awareness among frontline staff about the services available to the uninsured and people who are out of status would also be useful (particularly those who are the first point of contact on the telephone or in person). CHCs may also want to explore whether increases in the discretionary funding available for CHCs to serve people without insurance would improve access for people with precarious immigration status.
3. A review of how client information is collected and stored should take place. Client information that is collected and stored for reporting, funding, or strategic planning purposes should be stored separately from all identifying client information. Greater staff awareness of how client data is stored and used would strengthen consent protocols and allow staff to be clear with clients about why they are asking sensitive questions.
4. The sensitive nature of immigration status should be a more explicit component of training and policies regarding client privacy.
5. CHCs should explore opportunities for research that directly engages people in the community who are living with precarious immigration status in order to develop a more in-depth understanding of the way immigration status structures access to CHC programs and services. Although the CHCs may not have the capacity to do this themselves, exploring partnerships with researchers and organizations in the city that serve people who are out of status may open up opportunities for this kind of work.
6. Immigration status should continue to be incorporated into ongoing equity work within the CHCs.

Guiding Principles for Frontline Staff

These guidelines were developed as a resource to help frontline CHC staff navigate the collection, storage, and sharing of sensitive immigration information, and to help eliminate the barriers and risks that can be created through everyday interactions with clients who face immigration challenges. These guidelines are also outlined in a one-page, stand alone resource that is available at: <https://ottawasanctuarycity.ca/wp-content/uploads/2017/03/Guiding-Principles-for-CHC-Staff.pdf>.

1. Do not ask about immigration status.

Frontline service providers often ask clients about their immigration status in order to determine eligibility for various supports and programs, or as a proxy method to assess a client's needs. Research suggests that people with precarious immigration status may not access services that they are entitled to if they believe that they will be questioned about their immigration status (particularly if they are at risk of detention or deportation). Where possible, try to ask questions about *eligibility* and *need*, rather than status. If questions about immigration status are necessary in order to facilitate access to services, ask only after trust has been established, rather than during the first few encounters with a client. Questions about immigration status should not be included on registration, intake, or assessment forms.

2. Reduce the storage of immigration information.

The storage of immigration information in databases and client files creates risks for people with precarious immigration status. It is possible for Immigration, Refugees, and Citizenship Canada (IRCC) to subpoena or get a court order for client files, and information stored within the CHC for other purposes might end up jeopardizing a client's immigration application. The police or courts may seek access to client files in relation to a legal or criminal matter, and inadvertently gain access to unrelated immigration information that would put the client or their family members at risk of detention or deportation. The security of databases, particularly online databases, is an ongoing issue for organizations involved in health and social services. The best way to protect a client's immigration information is to not store it in the first place. If immigration data must be collected for funding reports or planning purposes, it should be stored separately from any identifying client information.

3. Treat all sociodemographic and personal information as immigration information.

For some people with precarious status, the collection of sociodemographic information also creates fear and risk. Immigration applications can be rejected if there are minor errors in details such as household composition, income, marital status, travel history, etc. People's lives often shift over the course of lengthy immigration processes, and it is difficult to update applications, particularly where there are language or financial barriers. Some clients view CHCs and other public service providers as linked to the government and therefore to immigration authorities. For this reason, they will be concerned about how answers to sociodemographic questions might impact their immigration applications. Where possible, reduce the collection of sociodemographic information unless it is necessary to serve the client. If you must collect it, explain exactly how the information will be stored and used.

4. Immigration enforcement is the responsibility of the federal government.

Immigration law is extremely complex, and enforcement is the responsibility of the federal government. People fall out of status for complex reasons, and often have to make difficult decisions about the immigration process in order to protect themselves and their family members. Barrier free access requires that CHCs are seen to be spaces free of judgement – separate and distinct from government and law enforcement. Personal opinions about a client's migration decisions or their entitlement to support should never shape service provision. Local police regularly communicate and collaborate with immigration enforcement. Under no circumstances should healthcare professionals or frontline service providers report immigration information to the police, or the immigration authorities.

5. Check with community partners about data storage and sharing practices.

Immigration information should be treated as extremely sensitive and should be protected by all the privacy protocols that surround the collection and sharing of confidential health information. Not all organizations in Ottawa treat immigration information this way. Before making referrals and sharing client information outside of the CHC, check with partner organizations about their specific practices and protocols. Do they have "Access Without Fear" policies and protocols in place? Getting consent from clients to share information with other

organizations should involve clear communication about exactly what happens to the information once it leaves the CHC. Immigration information that is irrelevant to service delivery should always be omitted when communicating with other organizations and community partners. CHCs that are committed to instituting “Access Without Fear” principles in their service delivery can play an important role in educating and encouraging their community partners to do the same.

6. Increase public awareness about available supports.

It is difficult for residents with precarious immigration status to find reliable information about where they can go for services and supports, particularly those who do not have health insurance. This is particularly true for people who are not already connected to community services and supports. CHCs are some of the few places where people without insurance can access healthcare. In order for these services to be equitably accessible, they must be well known to all who may need them. CHCs should publicize available services to residents and community partners.

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