NAT submission to inquiry into the use of Immigration Detention

1. NAT (National AIDS Trust) welcomes the opportunity to submit evidence to this inquiry into the use of immigration detention.

2. NAT is the UK's HIV policy charity. We have been actively working on the issue of HIV treatment and care in immigration detention for the past decade. We have conducted two surveys (2004-5 and 2011-12) of the provision of HIV services in immigration removal centres (IRCs). NAT has also published, in collaborating with the British HIV Association (BHIVA), clinical best practice advice for healthcare teams working with HIV positive detainees (2009).

Executive summary

3. This submission provides evidence for the following areas of the call for evidence:
   - **How far does the current detention system support the needs of vulnerable detainees, including pregnant women, detainees with a disability and young adults?**
   - **What are your views on the current conditions within UK immigration detention centres, including detainees' access to advice and services?**
   - **What are the impacts of immigration detention on individuals, family and social networks, and wider communities?**

4. Survey data about HIV care in IRCs indicate that detainees are still not receiving their entitlement to healthcare equivalent to that provided by the NHS to the wider community.

5. People living with HIV in detention are not yet being adequately supported to adherence to their medication or to attend essential medical appointments off-site. This negatively affects their short-term clinical outcomes and longer-term health outcomes. Poor treatment adherence also increases the risk of onwards transmission of HIV. People who spend time immigration detention sometimes leave it with more illness than when they went in[1] - this is a serious failure of care.

6. Poor arrangements for continuity of care when leaving an IRC means that some detainee patients are lost to follow up and may not re-connect with HIV

[1] Medical Justice. 2010. Grave breaches: Failures to provide NHS equivalent clinical care to immigration detainees with HIV.

treatment services promptly (or at all). This has serious consequences for individual and public health.

7. NAT makes the following recommendations to this inquiry:

- **Detention of people living with HIV should be dependent upon the availability of treatment and care services equivalent to those provided by the NHS to the community. In the absence of such services, people with HIV should not be immigration detention.**

- **While detainees should hold their medication where possible, IRC healthcare teams still have a responsibility to provide support with adherence to all detainees who are taking antiretroviral treatment (ART), including making regular checks on their physical and mental health and wellbeing.**

- **IRC healthcare teams should be required to have a formal, written protocol with the local clinic which treats HIV positive detainees. This should include a commitment from the IRC healthcare team to contact the clinic immediately that they become aware that a detainee needs ART access, and a commitment from the clinic to provide ART within 24 hours of this request.**

- **Attendance at HIV clinical appointments must always be considered a priority for transport bookings.**

- **Detainees who are attending HIV clinic appointments should not routinely be restrained and the presence of security escorts should be proportionate and based on an individual risk assessment. Patients should never been handcuffed during consultations and tests and should not be accompanied into the consulting room by security escorts.**

- **IRC healthcare teams should be required to have a formal, written protocol on HIV testing, in line with existing clinical and public health guidelines produced by BHIVA/BASHH/BIS and NICE.**

- **All people living with HIV who are being released to the community should be provided with an adequate supply of ART to support unbroken access to medication and continuity of care.**

- **All providers of healthcare in IRCs must be required to keep a basic set of records about the treatment of detainees, kept in a retrievable format for seven years from the time that the patient leaves the IRC (or an appropriate time in line with NHS practice). This should include information on testing (if applicable), ART prescriptions and access, medical appointments made and kept, and preparations for release, transfer or removal.**

Contact details:

Sarah Radcliffe, Policy & Campaigns Manager, NAT
sarah.radcliffe@nat.org.uk; 0207814 6767.

Needs of people living with HIV in the detention system

8. In the UK, HIV is legally defined as a disability from the point of diagnosis.[2] With prompt and ongoing access to medication, treatment and care services, HIV can be considered a manageable long-term condition. Consistently taking HIV treatment can also reduce the likelihood of onwards transmission to an extremely low level.[3] Conversely, if someone's HIV remains undiagnosed and/or someone living with HIV is unable to access treatment when needed, their health will deteriorate and they will become vulnerable to a range of opportunistic infections. The key to successful HIV treatment is near-perfect (>95%) adherence to medication and regular monitoring from an HIV specialist clinical team.

9. Migrant and asylum seeking people in the UK, especially those born in sub-Saharan Africa, carry a disproportionately large burden of HIV.[4] African-born people are also more likely to be diagnosed late in their infection, at a point at which they should already have started treatment. This means that HIV will have already had an impact on their health and they may experience more HIV-related health problems in the future. Asylum seekers and refused asylum seekers who are being supported by the Home Office are frequently living in extreme poverty, often not able to pay for the food required to take their treatment as prescribed.[5] Even prior to entering detention, migrants and asylum seekers with HIV have greater vulnerabilities than that general HIV positive population.

10. People in detention are entitled to a range and quality of healthcare services equivalent to that provided by the NHS to the wider population. Research by NAT shows that this is not yet consistently happening in relation to HIV, despite the existence of best-practice clinical advice on the provision of HIV treatment and care in IRCs.[6]

11. NAT, with the support of BHIVA and Offender Health (now Public Health England Directorate of Health and Justice), surveyed Immigration Removal Centres (IRC) and HIV clinics local to these IRCs about the treatment and care of HIV positive detainees during 2011/12. NAT also gathered case study evidence from Medical Justice, who supported 27 detainees with HIV during the survey period. Our research revealed significant variation (and failures) in the quality of care provided to detainees with diagnosed HIV.

12. All 10 main IRCs responded to the survey (short-term holding facilities were not included). Seven HIV clinics responded. These clinics are local to nine of the 10 IRCs. The quality of information provided by the IRCs varied greatly, with the most significant gaps in data originating from the IRC which treated

---

[2] Equality Act 2010.
[3] BHIVA/EAGA. 2013. The use of antiretroviral therapy to reduce HIV transmission. https://www.gov.uk/government/publications/the-use-of-antiretroviral-therapy-to-reduce-hiv-transmission
[4] 65% of new HIV diagnosis in 2012 were in people born outside of UK (55% outside of Europe). African-born people represented 34% of new diagnoses in 2012.
PHE. National HIV surveillance data tables. https://www.gov.uk/government/statistics/hiv-data-tables
[5] NAT and THT. 2010. *Poverty and HIV: 2006-2009.* THT. 2013. *Poverty & HIV.*
[6] NAT and BHIVA. 2009. Detention, removal and people living with HIV. http://www.nat.org.uk/media/Files/Publications/June-2009-Detention-removal-and-PLWH.pdf

the largest single cohort of HIV positive detainees (Harmondsworth, which saw 34 HIV positive detainees).

13. 95 cases of HIV were identified, which NAT estimates to represent between 60 and 70 individual patients (the data did not track individual patients between IRCs). 67% of the reported cases were in the three largest IRCs (Harmondsworth, Yarl's Wood and Colnbrook).

14. Maintaining good adherence to HIV medication is challenging for all patients, but the detention environment creates additional barriers to good adherence. Our survey found that IRC healthcare teams are following best-practice by letting detainees hold their medication with them at all times (unless contraindicated by individual risk assessment). This is positive, but not in itself sufficient to support detainee adherence. Healthcare teams have a duty to support their patients to take their medication as prescribed, including by ensuring that detainees have access to mental health services as needed.

15. There were at least four (and as many as 12) cases of treatment interruption (not including additional interruptions associated with arrival at the IRC) during this time-period. IRC healthcare teams, HIV clinicians and voluntary sector organisations disagree in their respective records about how many of the detainees missed doses of ART while in detention.

Recommendations

16. **While detainees should hold their medication where possible, IRC healthcare teams still have a responsibility to provide support with adherence to all detainees who are taking ART, including making regular checks on their physical and mental health and wellbeing.**

Detainee access to services

17. Detainees with diagnosed HIV will be in the care of an NHS HIV clinic. Normally this is the clinic nearest to the IRC although sometimes the detainee will continue to visit a clinic where they were a patient prior to entering the IRC. The HIV specialised clinical team will need to see their patient at least every 3-6 months. These appointments are the only way of monitoring whether someone's HIV treatment is successfully controlling the virus.

18. Around 10% of patients who are on treatment arrived at the IRC without a supply of their antiretroviral medication. IRC healthcare teams should have an agreed protocol with the local HIV clinic to deal with medical emergencies such as this (e.g. an 'on call' system for urgent access to ART). Our survey showed, however that only one patient received a supply of the necessary medication within 24 hours, as recommended in the NAT/BHIVA advice.

19. NAT's research also found that detainees regularly miss their medical appointments. Only four of the 10 IRCs specified that medical appointments would be considered a priority for transport bookings. Another stated that if the patient needed urgent access to ART this would be considered a priority for booking transport.

20. One clinic (Tudor Wing) alone recorded 18 'did not attends' (DNAs) (from Harmondsworth and Colnbrook IRCs) during the period of the survey and stated that there is a "very high DNA rate for scheduled appointments" from the IRCs. Crawley Sexual Health Clinic stated that missing appointments was "the norm" for patients from nearby Brook and Tinsley IRCs.

21. Clinical teams expressed their alarm that patients from some IRCs are still attending HIV clinics in handcuffs and accompanied by more than one security escort. Four clinics stated that this was the norm when receiving patients from IRCs, despite clear advice to the contrary from the Home Office and NAT/BHIVA. In at least one location restraints are kept on and security escorts are present during consultations.

22. Given the high rates of undiagnosed HIV in the UK community generally, and within African-born populations in particular, there are likely to be significant numbers of HIV positive detainees who are not aware of their status and are not yet accessing medical treatment. Seven of the IRCs reported that they had in place a protocol for HIV testing. In one case this protocol was to not routinely offer tests but to provide on request. Another reported that they used existing NICE HIV testing guidance in place of an in-house protocol.

23. NAT is aware of at least one case of a detainee living with severe symptoms of (undiagnosed) advanced HIV infection. Despite extreme pain and problems with his eyes which nearly resulted in HIV-related blindness, he was refused an appointment with an NHS doctor. He told NAT that "when you are in detention you're not taken seriously when you are ill. They say 'he's trying to get out' - they think you are making it up."

Recommendations

24. IRC healthcare teams should be required to have a formal, written protocol with the local clinic which treats HIV positive detainees. This should include a commitment from the IRC healthcare team to contact the clinic immediately that they become aware that a detainee needs ART access, and a commitment from the clinic to provide ART within 24 hours of this request.

25. Attendance at HIV clinical appointments must always be considered a priority for transport bookings.

26. Detainees who are attending HIV clinic appointments should not routinely be restrained and the presence of security escorts should be proportionate and based on an individual risk assessment. Patients should never been handcuffed during consultations and tests and should not be accompanied into the consulting room by security escorts.

27. IRC healthcare teams should be required to have a formal, written protocol on HIV testing, in line with existing clinical and public health guidelines produced by BHIVA/BASHH/BIS and NICE.

Long-lasting impacts of detention on people living with HIV and their communities

28. Poor adherence to medication and missed medical appointments while in detention can have lifelong impacts on the health of detainees who are living with HIV. Put simply, detainees who do not receive their entitlement to HIV treatment and care will leave detention in poorer health than they would have been if they had remained in the community in the care of NHS HIV services. Poor adherence to HIV medication can have immediate short-term health impacts such as susceptibility to serious opportunistic infections and AIDS-defining conditions. These illnesses may have a lingering impact on someone's future health, even if they later achieve good adherence and treatment success.

29. Treatment interruption while in detention can also put a patient at risk of developing drug resistance. This means that they will have to switch the medication they are taking, and will have fewer treatment options available in future. Drug resistance can also be transmitted along with the virus. If someone is living with a type of HIV which is already resistant to a particular type of medication, their options for future treatment are even more limited.

30. NAT's survey showed that in 32% of cases detainees living with HIV returned to the community at the end of detention, and 7% were transferred to another IRC. This means that in nearly half of cases, detainees with HIV will continue to access NHS services on leaving the IRC. However, there is currently poor preparation for continuity of care prior to leaving detention.

31. The NAT/BHIVA advice outlines the importance of consulting with HIV clinicians prior to removing patients from the country or otherwise moving them from their current care arrangements. The advice states that all HIV positive detainees leaving an IRC should be provided with an adequate supply of medication (3 months' worth if leaving the UK), plus a letter from their treating clinician and information about HIV treatment services at their destination (if leaving the UK). HIV clinics responding to our survey said that while they were mostly notified of upcoming removal of their patients, but were not routinely notified or consulted about patients preparing for release to the community or transfer to another IRC. This means that the necessary ongoing care arrangements had not been made prior to the patient leaving the IRC, creating a serious risk that they will be lost to follow-up by NHS services.

32. Once a patient loses contact with their treating HIV clinic, it is up to them to either reconnect of their own initiative or seek care in an alternative clinic (who will then attempt to connect with their previous treating clinician). But in cases of former detainees, there is a real risk that they will avoid contact with any public services for fear of arrest or other negative consequences related to their immigration status.

33. Poor access to HIV treatment and care, whether due to failures of care in detention system or loss to follow-up on leaving detention, can also have serious public health consequences. Good adherence to HIV treatment suppresses the virus so that it becomes 'undetectable' in the blood. At this point, the person living with HIV can be considered virtually non-infection – that is, they will not transmit HIV to anyone else. By contrast, someone who

is not taking treatment consistently will be much more likely to pass on HIV sexually (if not using condoms) or though mother-to-child transmission.

Recommendations

34. **All people living with HIV who are being released to the community should be provided with an adequate supply of ART to support unbroken access to medication and continuity of care.**

35. **All providers of healthcare in IRCs must be required to keep a basic set of records about the treatment of detainees, kept in a retrievable format for seven years from the time that the patient leaves the IRC (or an appropriate time in line with NHS practice). This should include information on testing (if applicable), ART prescriptions and access, medical appointments made and kept, and preparations for release, transfer or removal.**

NAT
September 2014