

Immigration detention and HIV

Advice for healthcare
and operational staff



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Disclaimer

By producing this resource, NAT and BHIVA are not endorsing the policies of detention or removal from the UK of people living with HIV. Our aim is to ensure that the needs of people in immigration detention living with or at risk of acquiring HIV are taken fully into account and the best possible care is provided if detention or removal occurs.

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Foreword

People held in immigration detention are entitled to the same level of healthcare and patient rights as those in wider society.

It is crucial that all people living with HIV have consistent access to good quality treatment and care for their own health. And given that approximately half the people leaving immigration detention remain in the UK, at least temporarily, there are also considerable public health benefits associated with ensuring access to appropriate HIV-related care for those that need it.

Moreover, for stigmatised conditions such as HIV, it is important that good quality healthcare is matched by non-stigmatising attitudes and respect for confidentiality.

This guide brings together current Home Office rules and guidance, with guidelines on HIV prevention, treatment and care, and relevant wider healthcare standards. It provides the information and advice that will enable staff in Immigration Removal Centres, Short-term Holding Facilities and HIV services to meet their obligations and ensure that people living with HIV in immigration detention receive the best possible treatment and care.

We are all committed to ensuring that the needs of people living with HIV are met, and we are delighted to jointly commend this guidance as a vital tool for securing that outcome.

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Key changes since 2009

This guidance incorporates a number of developments since publication of its 2009 edition (see [Appendix A](#) for associated documentation). The key changes covered are:

Organisational changes

- The UK Border Agency (UKBA) no longer exists. The Home Office is now directly responsible for managing immigration detention.
- NHS England Health and Justice commissions healthcare in Immigration Removal Centres (IRCs) and Short-term Holding Facilities (STHFs) in England. The Home Office commissions healthcare in the one IRC in Scotland.

Home Office policy and legislation

- In 2016, the Home Office issued guidance on *Adults at risk in immigration detention* (updated in 2018) with the intention of reducing the number of vulnerable people detained.
- *The Short-term Holding Facility Rules*, updated in 2018, now detail what medical services people detained in STHFs can expect.

HIV prevention and testing guidelines

- The PARTNER study established that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load do not pass the virus on to their sexual partners.
- In December 2016, NICE published *HIV testing: increasing uptake among people who may have undiagnosed HIV* (NG60).
- The *Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England 2018-21*, updated in February 2018, commits to implementing 'opt-out' testing for blood-borne viruses (BBVs) and development of care pathways in immigration detention.

HIV treatment and care guidance

- *BHIVA guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy* have been updated and commencement of ART is recommended immediately after diagnosis with HIV.
- New *BHIVA Standards of Care for People Living with HIV* were published in 2018.



The detention pathway: Quick checklist

Prior to detention (see [Section 3.4](#))

If an HIV clinician believes that their patient might be at risk of immigration detention, they should:

- Discuss with the person what to do in the event of detention
- Reassure them that their HIV status will not affect the outcome of any immigration applications
- Provide them with a contact card and list of their prescribed medications
- Be prepared to respond to requests for information from healthcare staff in immigration detention facilities
- Be prepared to discuss their patient's fitness to travel
- Be prepared to provide treatment summaries and adequate supplies of ART.

Arrival

IRC / STHF (see [Section 3.1.1](#))

- Provide a supply of ART for those who have been prescribed it prior to detention within 24 hours of disclosure of HIV status.
- For new arrivals who are living with HIV, ensure access to the local HIV service as soon as possible.
- With the person's consent, access health records from their previous HIV specialist as soon as possible after arrival.
- Maintain patient confidentiality.
- At the initial medical examination, offer opt-out testing for BBVs and provide sexual health information.
- Consider whether the detained person may be at risk of harm in detention.

HIV SERVICES (see [Section 3.1.2](#))

- Respond immediately to urgent requests from IRC / STHF staff for ART for a detained person.
- Be prepared to provide appointments at short notice to people in immigration detention facilities.
- Respond quickly to requests from other clinics or IRCs / STHFs for treatment summaries and other information.
- Maintain patient confidentiality as normal.

Detention and transfer

IRC / STHF (see [Section 3.2.1](#))

- Support treatment adherence.
- Ensure attendance at HIV service appointments, as determined by an HIV specialist.
- Continue to evaluate whether a detained person may be at risk of harm in detention.
- Repeat sexual health promotion and offer of BBV testing.
- For people newly diagnosed with HIV, ensure quick linkage into an HIV service and other relevant care.
- Offer counselling and support, especially for the newly diagnosed.
- Continue to maintain patient confidentiality.
- If a detained person is being transferred, inform the HIV service well in advance, and arrange for adequate supplies of ART and treatment summaries to be provided.

HIV SERVICES (see [Section 3.2.2](#))

- Provide IRC healthcare staff with a copy of the patient's treatment plan if consent has been given.
- Be prepared to advocate for patients: if necessary request removal of handcuffs and that escorts leave the exam room unless the person poses a risk to themselves or others.
- Raise concerns about a person's risk of harm in detention with the IRC GP.
- Be prepared for transfers: ensure treatment summaries are readily available and that patients have good supplies of ART at all times.

Removal or release

IRC / STHF (see [Section 3.3.1](#))

- Inform the HIV clinician in good time if their patient is being removed or released.
- Arrange adequate supplies of ART and treatment summaries for those who are being removed or released.
- Consult with the HIV specialist before determining fitness to travel.
- Support detained people who are departing with information about HIV treatment and support organisations available in their destination.

HIV SERVICES (see [Section 3.3.2](#))

- Be prepared to respond urgently and comprehensively to inquiries from IRC GPs about fitness to travel.
- Be prepared for removal or release of patients: ensure that they have good supplies of ART at all times and that treatment summaries are readily available.
- Provide people who are being removed with a letter for the clinician in their destination country, and discuss the contents of the letter with them.
- Assist IRC / STHF staff to supply information about HIV treatment and support organisations available in the person's destination.

1. Introduction

HIV can be well managed with treatment, but it is a serious long-term condition and people living with HIV can have complex needs relating to their health and care. For those in or at risk of immigration detention, it is essential that HIV-related needs are met.

HIV is a significant public health inequality in the UK. It disproportionately affects certain groups, including migrant populations. In 2017, 1 in 5 people entering immigration detention were from Africa, the region with the highest HIV prevalence.¹ There are also increasing numbers of people in detention who originate from Eastern Europe where the HIV epidemic continues to rise rapidly. Therefore, there is a need to consider HIV-related health and social care needs when developing policy and practice that may impact on healthcare provision for those in immigration detention.

This guide explains how current policy and guidance should be implemented to ensure that the HIV-related needs of people in immigration detention are met.

1.1 Navigating this guide

This guide is a practical resource for healthcare and operational staff in IRCs and residential STHFs, and for HIV clinicians whose patients are in or at risk of immigration detention.

The information provided may also be useful for staff in non-residential STHFs and in prisons, and for others who work with or support people living with HIV in immigration detention such as third sector organisations.

There are two main sections in this guide:

- **Part 2** outlines and explains current policy and the practices that establish good and effective HIV prevention, treatment and care in immigration detention. Key points are summarised in the **HEADLINES**.

- **Part 3** outlines the specific responsibilities of different stakeholders at three points in the detention pathway: arrival, detention and removal or release. There are separate sections for healthcare and operational staff in detention facilities and for HIV services that have patients who are in immigration detention or are at risk of detention. Key points are summarised in the **Responsibilities** text boxes and can also be found in a quick checklist on [pages 6-7](#).

The [appendices](#) contain details of where to get further information, key policy and guidance, and contact details for immigration detention facilities and their local HIV services.

1.2 HIV: the basics

Human Immunodeficiency Virus (HIV) is a virus which attacks the immune system. If a person's immune system has been damaged by HIV to the extent that they acquire certain infections and cancers that the body is unable to fight off, they are said to have Acquired Immune Deficiency Syndrome (AIDS). However, given outstanding advances in treatment, people who are diagnosed with HIV now can anticipate a normal life expectancy if they have prompt access to treatment and take it as prescribed.

HIV can be transmitted through semen, vaginal fluids, blood and breast milk. Transmission can occur through sex without a condom or by sharing drug injecting equipment. HIV can be passed to a baby during pregnancy, birth or breastfeeding, although this is almost entirely preventable with the right treatment and care before, during, and after birth.

Over 100,000 people in the UK are living with HIV, but 1 in 8 of those do not know that they have the virus. It is vital that people who may have been at risk of acquiring HIV get tested. People experience better health outcomes when they are diagnosed promptly and start treatment immediately. They are also much less likely to pass on the virus when

¹ Home Office, 2018a, *Detention data tables*, Table dt_04 [<https://www.gov.uk/government/statistics/immigration-statistics-year-ending-june-2018-data-tables>]

they are aware of their HIV status. Therefore, effective testing is crucial for individual and public health. HIV can be diagnosed by a blood or saliva test. There is a four-week ‘window period’ after infection, when tests may not provide accurate results.

Treatment for HIV involves taking antiretroviral therapy (ART). The medication works by stopping the virus from reproducing, and restoring the immune system so that it can fight infection. It is important that people adhere to their prescribed regimen to avoid developing drug resistance.

With proper adherence, ART reduces the HIV viral load in a person’s body to such a low level that it can’t be detected.² This is commonly referred to as having an undetectable viral load or ‘being undetectable’. In England in 2017, 98% of people with an HIV diagnosis were receiving treatment and 97% of people receiving treatment were virally suppressed.³

People living with HIV are protected by the Equality Act 2010, and discrimination against someone living with HIV is unlawful. However, HIV-related stigma remains a problem for people living with HIV, and fear of discrimination is known to prevent people from getting tested and accessing treatment. Stigma often results from ignorance around transmission risk, and prejudice against groups predominantly affected by HIV.

1.3 Detention, removal and the immigration estate

People who are subject to immigration control may be held in immigration detention, either while their applications to enter or remain in the UK are being processed, or while they are awaiting removal

from the UK. It is an administrative, rather than a criminal justice procedure.

The Home Office has overall responsibility for the detention estate. The immigration detention service has largely been outsourced to private operators although Her Majesty’s Prison and Probation Service (HMPPS) provides the service at Morton Hall IRC. Immigration detainees are normally held in one of eight Immigration Removal Centres (IRCs) across the UK.⁴ They can also be held for up to 7 days in residential Short-term Holding Facilities (STHFs), usually en route to an IRC or while awaiting removal.

According to Home Office guidance, “Detention must be used sparingly, and for the shortest period necessary”.⁵ However, being held in detention is not the same as receiving a sentence, so there is not a pre-determined limit for how long someone may be held. Of those leaving immigration detention in the year ending June 2018, approximately two-thirds had been held for less than a month. Although only occurring in a minority of cases, some people are held for a year or more.⁶

Of the 27,348 people who entered immigration detention in the UK in 2017, 85% were men and 15% were women.⁷ 46% had made a claim for asylum.⁸ Of the 28,256 people who left detention in 2017, 47% were removed from the UK and 53% were released and entered the community. The majority of those entering the community were granted immigration bail, while others were granted leave to enter or to remain.⁹ 2,226 people were being held in immigration detention at the end of June 2018.¹⁰

Children should not be held in immigration detention unless there are exceptional circumstances, although 63 children were

2 World Health Organization (WHO), 2012, *Antiretroviral treatment as prevention (TASP) of HIV and TB*

3 Public Health England, 2018, *Progress towards ending the HIV epidemic in the United Kingdom*, p17 [<https://www.gov.uk/government/publications/hiv-in-the-united-kingdom>]

4 See Appendix B for more details on the immigration estate.

5 Home Office, 2017a, *Offender management guidance: Detention and temporary release*, Chapter 55.1.3 [<https://www.gov.uk/government/publications/offender-management>]

6 Home Office, 2018b *How many people are detained or returned?* [<https://www.gov.uk/government/publications/immigration-statistics-year-ending-june-2018/how-many-people-are-detained-or-returned>]

7 Home Office, 2018a, *op. cit.* Table dt_04

8 *Ibid.* Table dt_04

9 *Ibid.* Table dt_05

10 Home Office, 2018b, *op. cit.* This figure cannot be compared with the previous year because the data now includes people held in immigration detention in prisons, whereas they had previously been excluded. Comparing like-for-like data, there was a 36% reduction in people held in immigration detention in June 2018 compared with the figure for June 2017.

detained in 2017.¹¹ When children are held, it is mainly in pre-departure accommodation or family accommodation at Tinsley House, as part of the Family Returns Process. These stays are limited to 72 hours although they can be extended up to seven days with Ministerial approval.¹² However, age-disputed minors can be held in IRCs while awaiting an age assessment, which is organised in conjunction with local social services.

Non-residential STHFs and prisons

Immigration detainees can also be held for up to 24 hours in non-residential STHFs. These take the form of approximately 30 holding rooms, housed in Home Office reporting centres, at airports or ports. Non-residential STHFs are subject to modified rules around access to medical care and, generally, do not have on-site healthcare provision.¹³

Although this guidance pertains to people held in IRCs and residential STHFs, it is also a useful guide for those managing non-residential STHFs. Staff in non-residential STHFs should have training and awareness sufficient to know how to support people living with HIV within the facility, particularly in relation to managing access to medication and liaising with primary and specialist care providers.

At the end of June 2018, there were also 321 immigration detainees in prisons.¹⁴ Their access to HIV prevention, treatment and care should follow the protocols established for prisons.¹⁵

1.4 Healthcare services in immigration detention

Healthcare services in IRCs and STHFs in England are commissioned by NHS England Health and Justice. At Dungavel, the one IRC in Scotland, they are commissioned directly by the Home Office. Healthcare is provided either by NHS Trusts or by

private contractors. It must comply with the NHS England service specification.¹⁶

In 2002 the Home Office published standards stating that “*All detainees must have available to them the same range and quality of services as the general public receives from the National Health Service*”.¹⁷ This principle, known as ‘equivalence of care’, has since been refined by the Royal College of General Practitioners Secure Environments Group to recognise that the expectation of ‘equivalence’ means that services must be “consistent in range and quality (availability, accessibility and acceptability)”.¹⁸

People being held in immigration detention hold these rights regardless of the setting in which they are being held, although the ways of achieving equivalence of care may differ between detention facilities. For example, given the short amount of time spent in STHFs, it might be more reasonable for some routine secondary care to be arranged on transfer to an IRC. However, a short stay is no justification for avoiding attention to immediate needs. Some secondary care requirements, such as access to medication, are more urgent and cannot be delayed for the seven days that a person may be held in an STHF.

11 Home Office, 2018a, *op. cit.* Table dt_04

12 Home Office, 2017a, *op. cit.* Chapter 55.9.4; see also Home Office, 2017b, *Family Returns Process* [<https://www.gov.uk/government/publications/returns-preparation>]

13 See Rules 6 and 31 of *The Short-term Holding Facility Rules 2018*, SI 2018/409 [<http://www.legislation.gov.uk/ukxi/2018/409/contents/made>]

14 Home Office, 2018b, *op. cit.*

15 See NAT, 2017, *Tackling Blood-Borne Viruses: A Framework for Prisons in the UK* [https://www.nat.org.uk/sites/default/files/tackling_BBVS_in_prison2017.pdf]

16 The service specification is currently under revision at time of publication of this guide. It is available from NHS England Health and Justice. [<https://www.england.nhs.uk/commissioning/health-just/contacts/>]

17 Home Office, 2002, *Detention Services Operating Standards Manual for Immigration Removal Centres*. [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257352/operatingstandards_manual.pdf]

18 Royal College of General Practitioners Secure Environments Group, 2018 *Equivalence of care in Secure Environments in the UK*, p.5

HEADLINES

HIV and healthcare in immigration detention

- Prompt diagnosis and access to treatment provides the best health outcomes for people living with HIV. It is vital that people who have been prescribed ART are able to take their medication as directed by their clinician.
- With good treatment adherence, the HIV virus becomes undetectable in a person's body and they are not able to pass it on.
- 1 in 8 people living with HIV in the UK do not know that they have the virus. Effective testing is crucial for reducing the numbers of undiagnosed people.
- HIV-related stigma and fear of stigma can prevent people from getting an HIV test and accessing treatment, so measures to prevent stigma are vitally important.
- People held in immigration detention are entitled to the same level of healthcare as anyone else in the UK.
- People can be held in immigration detention for long periods. Healthcare provision must be premised on this assumption.
- Although rare, children and age-disputed minors are sometimes held in detention. Unlikely though the need may be, healthcare staff need to be prepared to provide paediatric HIV care.
- Over half the people leaving detention in 2017 were released into the community. Any health risks among the detained population are, therefore, wider public health risks.



2. HIV prevention, treatment and care in immigration detention

It is vital that people living with HIV who are being held in immigration detention receive good quality HIV treatment and care. HIV prevention should also be promoted in detention facilities, via opt-out testing and access to sexual health information.

People held in immigration detention are entitled to the same level of care as the general population, including rights around confidentiality and involvement in their own care. A person who is being detained also has additional rights concerning vulnerability.

To be as effective as possible, prevention, treatment and care must be offered in a stigma-free environment. It is incumbent upon all staff to understand stigma and discrimination, and work to combat it in detention facilities.

2.1 Managing HIV treatment and care

With access to treatment and support, people can live well with HIV. Still, some who were diagnosed late or have not been able to maintain treatment, for example, may not be doing so well. Regardless of their state of health, any person living with HIV in immigration detention needs to be able to access good treatment and care.

2.1.1 Access to medication

HIV medication, or ART, offers lifesaving treatment, but some people who have been prescribed ART can find the regimen demanding and may require support to maintain good adherence.

Drugs must be taken at the same time every day, according to specific instructions. Some ART drugs must be taken with food, others at night before going to bed. At least 95% adherence to treatment is required. This means missing no more than one dose a month for someone taking once-daily therapy, or two doses a month with

twice-daily therapy. Missed doses compromise the efficacy of therapy and can lead to drug resistance which limits future treatment options.

It is essential that reception screening and the initial medical examination in IRCs (and comparable healthcare provisions in STHFs) prioritise continuity of ART for people who have already been prescribed HIV treatment.

Clinical guidelines state that people who receive an HIV diagnosis should start treatment immediately.¹⁹ Being diagnosed with HIV can be distressing. If a person is diagnosed with HIV after arriving in immigration detention and their clinician prescribes ART, IRC healthcare staff must ensure that measures are taken to support the person to adjust to their diagnosis and to adhere to therapy.

Protocol for access to ART

Every IRC and STHF should have in place a clinical protocol for the management of newly arrived HIV-positive detainees who have been prescribed ART. The protocol in IRCs should also consider those who are diagnosed in detention. This protocol must be agreed with the local HIV service.

In particular, an on-call system must be in place between the IRC or STHF and the local HIV service, including outside clinic hours and at weekends, in case a person living with HIV in immigration detention finds themselves without a supply of medication for whatever reason. The HIV service should provide the appropriate ART within 24 hours of the health screening and will usually be able to respond more quickly.

If a detained person states that they have been prescribed ART but cannot provide information about their previous HIV service, within 24 hours of the reception health screening healthcare staff in the detention facility and the local HIV service healthcare team should between them identify a course of action to enable assessment of HIV-

¹⁹ BHIVA, 2016, *British HIV Association guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy* (2016 interim update) [<https://www.bhiva.org/HIV-1-treatment-guidelines>]

related needs and to meet them as clinically appropriate.

2.1.2 Other HIV-related care

People living with HIV must be able to access high-quality, confidential clinical primary care services alongside secondary care from HIV specialists that is consistent with current UK and BHIVA standards.²⁰ To foster good communication and co-operation, IRC and STHF healthcare staff and HIV specialists should discuss how medical care is provided in their respective facilities.

Continuity in access to treatment, care and support is crucial for people living with HIV. Care is disrupted if appointments in the HIV service are cancelled frequently, at short notice, or for operational reasons. Cancellation of appointments must be avoided unless absolutely necessary.

Sudden changes, such as being detained, transferred between facilities, or removed at short notice can interrupt ongoing clinical care, compromise drug adherence, and risk the loss of medical records and clinical support. Appropriate handover between all clinical services must be in place to ensure continuity of care whenever people living with HIV arrive into, or leave immigration detention.

People living with HIV can have multiple and complex health and social care needs. Given their compromised immune system, it is particularly important that they take good care of their general health.

Good nutrition is particularly important for people living with HIV, in order to support the immune system, maintain good health, counteract any side effects of ART, and enhance its effectiveness.

2.2 HIV prevention and testing

People experience better health outcomes when they are diagnosed promptly and start treatment immediately. In addition, those who are aware of their HIV status are far less likely to transmit the virus than those who are undiagnosed. Given that

half the people held in IRCs enter the community, at least temporarily, the benefits of prevention go beyond the IRC. Therefore, there are individual and public health-based incentives to support HIV testing, prevention and treatment.

2.2.1 Sexual health promotion

The time spent in detention presents an opportunity to raise awareness about sexual health and to promote HIV testing.

The initial medical examination provides a good opportunity to inform new arrivals, without creating unnecessary alarm and in a culturally sensitive manner, about ways to prevent HIV transmission and how they can access HIV testing, treatment, care and support. Healthcare staff should also identify the most effective way, on a confidential basis, to provide accessible condoms and lubricant to those who need to reduce the risk of HIV or other sexually transmitted infections.

Sexual health promotion materials should be made available in key languages. NAM provides translations of their HIV information resources.²¹ Basic information about HIV and sexual health should be followed-up with more in-depth education and individualised support, as required.

Some people held in immigration detention may be using PrEP (pre-exposure prophylaxis) as a method of HIV prevention. There should be a protocol in place determining what should happen if a person reports that they are using PrEP. For example, IRC staff should be able to link people to sexual health services that can provide PrEP.²²

If a person is taking ART as prescribed, their HIV viral load will become undetectable. If a person is virally suppressed their health will be improved, and it also means they cannot transmit HIV to other people. In other words, treatment is a prevention method. To sustain viral suppression, it is crucial that IRC and STHF healthcare staff support people living with HIV to adhere to their prescribed treatment regimen and to maintain regular attendance for monitoring from HIV clinicians.

²⁰ BHIVA, 2018, *Standards of Care for People Living with HIV* [<https://www.bhiva.org/standards-of-care-2018>]; MEDFASH, 2011, *Standards for psychological support for adults living with HIV* [<http://www.medfash.org.uk/publications>]

²¹ <http://www.aidsmap.com/translations>

²² At the time of publication, PrEP is available via the NHS in Wales and Scotland and through the IMPACT trial in England. Some sexual health clinics also provide PrEP off-trial, at a cost to the patient.

2.2.2 HIV testing

Opt-out HIV testing should be part of routine screening for blood-borne viruses (BBVs) at the initial medical examination, at any time if a person requests an HIV test or indicates that there may have been risk of exposure, or if it is clinically indicated.²³ Tests should be conducted in private settings, and confidentiality must be maintained. The patient's right to confidentiality must be explained to allay any fears a person may have about their privacy being breached.

People may spend only a limited time in IRCs, which can present real challenges for HIV testing and follow-up. One solution is to offer a rapid 'Point-of-Care' test (POCT), which provides instant results.²⁴

If reactive, a POCT should be followed by a confirmatory laboratory analysed test in line with current UK testing guidelines.²⁵ If a person receives an HIV diagnosis within the IRC, they should have access to appropriate post-test counselling, referral to an HIV specialist as soon as possible, and a baseline assessment to clarify their clinical condition. The decision on whether to start treatment should be determined by an HIV clinician in association with the patient, and in line with current UK treatment guidelines.²⁶ A newly diagnosed person must see an HIV specialist before a date is set for removal.

If a person receives a negative test result they should be advised about the 'window period' which follows an infection, during which time HIV may not be detected by a test. If risk of exposure to HIV in the four weeks preceding the test is identified, then the test should be repeated after another four weeks.

2.3 Assessing vulnerability

In 2016, Stephen Shaw published a review into the welfare in detention of vulnerable persons, concluding that while all people in detention have some degree of vulnerability, there are certain characteristics which make individuals more likely to be vulnerable.²⁷

The Government's response to the Shaw Review included publication of the *Adults at risk in immigration detention* (AAR) guidance, which has been subject to subsequent revision. The guidance identifies certain indicators of risk, and presumes that detention is not appropriate for those at risk of harm in detention, unless outweighed by immigration factors.²⁸

The indicators include people with mental health conditions; victims of torture, sexual and gender-based violence; those who are pregnant; people with serious physical health conditions or illness; those aged over 70; and transgender people. The guidance also recognises that there may be other conditions "which may render an individual particularly vulnerable to harm if they are placed in detention or remain in detention... [and that] the nature and severity of a condition... can change over time".²⁹

Some people living with HIV, especially those who were diagnosed late, may present with HIV-related illnesses which require specialist in-patient care. People living with HIV also have an increased risk of mental health conditions. Therefore, HIV status may be one of a number of factors, including co-morbidities, mental health difficulties and experience of stigma which, in combination, render a person vulnerable to harm.

It is vital that people living with HIV receive an assessment for vulnerability, including a mental health assessment, to identify whether they may be at increased risk of harm in detention. HIV is a

23 NICE, 2016, *HIV testing: increasing uptake among people who may have undiagnosed HIV* (guideline NG60). [<https://www.nice.org.uk/guidance/ng60>] The guidelines include a list of clinical indicators for HIV testing in adults. See also the commitment to implementing opt-out testing in the Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England 2018-21.

24 *Ibid.*

25 *Ibid.*

26 BHIVA, 2016, *British HIV Association guidelines for the treatment of HIV positive adults with antiretroviral therapy* (2016 interim update). [<http://www.bhiva.org/guidelines.aspx>]

27 Stephen Shaw, 2016, *Review into the Welfare in Detention of Vulnerable Persons: A report to the Home Office*. [<https://www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons>]

28 Home Office, 2018c, *Adults at risk in immigration detention*, Version 3.0 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721603/adults-at-risk-policy-guidance_v3.pdf]

29 *Ibid.*

fluctuating condition, and it may be necessary to initiate an assessment of vulnerability even if one has previously been conducted.

The AAR guidance establishes weighting criteria for the evidence that can support an assessment that there is likely to be risk of harm to the individual if they are detained. Level 1 is a self-declaration from the detainee, and level 2 requires professional evidence that an individual may be an adult at risk. Level 3 evidence requires professional evidence that the individual is at risk and that a period of detention is likely to cause harm.

It is important that clinicians consider whether their patients are at risk of harm in detention and, if so, that this is raised. Healthcare staff in IRCs and STHFs must report cases to the manager of the facility where they believe that the health of the patient will be affected by continued detention or conditions of detention.³⁰ HIV clinicians should flag any concerns with IRC doctors and their patient's case worker.

Pregnant women

Pregnancy is an indicator of risk within the AAR guidance. In addition, there is specific legislative provision concerning immigration detention for pregnant women which states that they may only be detained if they will shortly be removed from the UK, or under exceptional circumstances. In either case, they may not be detained for longer than 72 hours, although this can be extended up to a week with Ministerial approval. There is a duty to have regard to the woman's welfare when determining whether to authorise detention.³¹

BHIVA Guidelines on the management of HIV infection in pregnant women, under review at time of publication, recognise that some pregnant women living with HIV will have specific psychosocial challenges during pregnancy requiring management from a specialised multidisciplinary team. Continuity of care and uninterrupted access to treatment for pregnant women living with HIV are vital for the health of both the mother and child.³² Both of these factors must be taken into

consideration if a pregnant woman living with HIV is detained.

Should someone receive notification of removal when pregnant, with patient consent the HIV specialist should contact the person's case owner to request a delay in removal while the medical implications of the situation are considered.

Children

Since 2010, children are no longer detained in IRCs, although families with children may be detained in pre-departure accommodation as part of the Family Returns Process.³³ Every year since 2010 some children have been detained, including age-disputed minors.

Paediatric HIV treatment and care is highly specialised and a child who is living with HIV must have access to that care to avoid their health being severely compromised. A child diagnosed with HIV whilst in detention will also need to be accommodated in an environment that supports the improvement of their health. Preserving confidentiality is particularly important where the patient is a child, as they may not have been told their HIV status.

There is no specific age for transfer from paediatric to adult HIV care, and some young people remain within the paediatric service into early adulthood. This should be taken into account during the referral into secondary care services.

2.4 Eliminating HIV-related stigma

HIV-related stigma is a barrier to prevention, testing and treatment that must be challenged. Awareness of stigma and discrimination, and the implementation of mitigating actions are crucial for the promotion of effective HIV treatment and prevention in immigration detention.

Stigma and discrimination are a significant issue for many people in the UK who are affected by HIV. Moreover, people in immigration detention

30 Rule 35 of *The Detention Centre Rules* 2001, SI 2001/238 as amended by *The Detention Centre (Amendment) Rules* 2018, SI 2018/411 [<http://www.legislation.gov.uk/uksi/2001/238/contents/made> and <http://www.legislation.gov.uk/uksi/2018/411/made>]; and Rule 32 of *The Short-term Holding Facility Rules* 2018, SI 2018/409 [<http://www.legislation.gov.uk/uksi/2018/409/contents/made>]

31 *Immigration Act* 2016, s.60 [<http://www.legislation.gov.uk/ukpga/2016/19/contents/enacted/data.htm>] See also guidance: Home Office, 2016, *Detention of pregnant women* [<https://www.gov.uk/government/publications/offender-management>]

32 BHIVA, 2018, *Management of HIV infection in pregnant women* (consultation version) [<http://www.bhiva.org/guidelines.aspx>]

33 Home Office, 2017c, *Family Returns Process* [<https://www.gov.uk/government/publications/returns-preparation>]

may come from countries or communities where there are particularly high levels of stigma, including internalised stigma. Therefore, cultural sensitivity must be applied when dealing with detainees who are living with HIV.

Discrimination based on HIV status is illegal under the Equality Act 2010, and has no place in immigration detention. Bullying and intimidation between detainees, unprofessional behaviour from staff, and breaches in medical confidentiality are all examples of unacceptable, discriminatory behaviour.

Stigma and discrimination are not easily tackled but concrete actions can make a difference.³⁴ Stigma is often based on ignorance about how HIV is transmitted and prejudice against the groups most affected. The provision of good quality sexual health information that dispels misunderstandings about HIV transmission and discusses prevention in an open and non-judgmental way is a proactive method for tackling stigma.

Policies that address equality and diversity and access to healthcare must be in place and must incorporate information about HIV and health-related discrimination. These policies should be well understood by all staff in immigration detention facilities, and should be prominently displayed. Staff and detainees should understand the measures they can take if they believe HIV-related stigma or discrimination has occurred.

2.5 Patient rights

Healthcare for patients in immigration detention comes with the same level of rights that are available to the general population.

2.5.1 Confidentiality

People held in immigration detention have the right to decide when and with whom their health information is shared. Many people living with HIV fear the discrimination that may follow disclosure of their status and are concerned about breaches of confidentiality. Detained people may be even

more concerned than the general population if they believe, incorrectly, that their HIV status may affect their immigration applications.

Staff in detention facilities and in the HIV service should all be aware of their duty to preserve and maintain confidentiality.³⁵ This involves not sharing health-related information without securing consent from the patient, as well as ensuring privacy for assessments, HIV tests, appointments, appointment booking and collecting medication.

At the initial medical examination, healthcare staff should make patients aware of their right to confidentiality, and any circumstances under which their health-related information might be shared without their consent. Information about confidentiality should be prominently displayed in the IRC and STHF healthcare area.

Operational and escorting staff do not need to be informed about a detainee's HIV status. However, it may become obvious if they are involved in transferring a patient to the HIV service. Therefore, all staff, including contractors, must be made fully aware of their responsibility to maintain confidentiality, and the consequences of sharing private, sensitive information. In order to preserve patient privacy, escorting staff should not be present during medical appointments unless in exceptional circumstances and where it is requested by clinical staff.

2.5.2 Patient involvement

The Health and Social Care Act 2012 includes new rights for patients to be engaged in their own health, care and treatment. The principles of patient involvement, access to good quality health information, and shared decision making should be applied, as far as possible, in order that patients are supported to engage in condition self-management.

Social prescribing into sources of non-clinical, community support may be particularly valuable to those in detention who want to be actively engaged in their own care. Therefore, the presence of voluntary and community sector services in IRCs

34 See NAT, 2016 *Tackling HIV Stigma: What works?* [https://www.nat.org.uk/sites/default/files/publications/Jun_16_Tackling_HIV_Stigma.pdf]

35 See Home Office, 2016 *The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers Detention Services Order 01/2016* [<https://www.gov.uk/government/publications/medical-information-sharing>]; and Department of Health, 20016 *Confidentiality* [<https://www.england.nhs.uk/publication/confidentiality-policy/>]

and STHFs should be welcomed and encouraged.

2.5.3 Interpreters

Interpretation services should be available for people who do not speak sufficient English to communicate with healthcare staff and to understand the process of assessment and available services, support and rights. Given confidentiality requirements and potential difficulties in sharing sensitive information, family members or other detainees should not be used as interpreters except in an emergency situation. An independent interpreter or telephone interpreting service should be used.

2.6 Staff training

It is recommended that all staff working in IRCs and STHFs, including contractors, receive HIV training so that they understand the facility's policies and their obligations concerning equality, confidentiality, the need to facilitate treatment adherence, appropriate conduct during a medical escort, and so forth.

Training should also enable staff to identify and manage transmission-related risk, and to understand the experience of living with HIV, particularly with regard to the stigma and discrimination faced by people with HIV. Voluntary sector and community-based organisations may be well placed to provide part of this training.

HEADLINES

HIV prevention, treatment and care in immigration detention

- **All IRCs and STHFs should have a protocol, agreed with their local HIV service, to ensure swift access to ART for any person held in immigration detention who needs medication. Entering detention should not mean that people living with HIV have to miss ART doses.**
- **People in immigration detention are entitled to the same level of care that is available to the general public.**
- **Good communication between the local HIV service and the detention facility is vital for ensuring complete and continuous care for people living with HIV in immigration detention.**
- **Opt-out HIV testing should be part of routine screening during the initial medical examination. Point of care HIV tests (POCT) can give immediate results.**
- **Anyone who is diagnosed with HIV while in immigration detention should immediately be referred to HIV care.**
- **Detainees living with HIV should have a risk assessment for vulnerability which considers the combined impact of their HIV-status and other risk indicators.**
- **HIV-related stigma and fear of stigma can prevent people from getting an HIV test and accessing treatment, so measures to prevent stigma in immigration detention are vitally important.**
- **In line with NHS guidelines, confidentiality must be maintained concerning a person's HIV status and other health information.**
- **All staff in detention facilities should receive appropriate training so that they understand their obligations towards people living with HIV, especially in relation to confidentiality.**

3. Key responsibilities during arrival, detention, and removal or release

There are three key stages that map out a person's experience in immigration detention: **arrival, detention, and removal or release**. At each of these stages, there are clear responsibilities for staff in the detention facility and in the local HIV service. By meeting these responsibilities staff can go some way to ensuring that the standards of good HIV prevention, treatment and care set out in Part 2 are achieved. Where relevant, reference has been made to sections in Part 2 that relate to responsibilities discussed in this section.

Key responsibilities for healthcare staff in IRCs and STHFs include identifying a person's HIV status, providing confidential primary care, ensuring access to HIV treatment and specialist care, making decisions regarding fitness to travel, and ensuring continuity of care when a person departs from the facility.

Operational and escorting staff working in detention facilities also have obligations towards people in their care who are living with HIV, including maintaining non-discriminatory conduct, preserving patient confidentiality, and supporting adherence to prescribed treatment regimens.

It is important that staff in the local HIV service (and previous clinicians where relevant) communicate well with the IRC or STHF healthcare team, the case owner and other Home Office personnel, while at the same time preserving patient confidentiality and securing their patient's consent before sharing their health information. HIV specialists who are new to work with IRCs and STHFs may find it useful if their local facility can provide an introduction to the process of providing medical care in immigration detention.

3.1 Arrival

3.1.1 IRC and STHF

Every detainee should be medically screened within two hours of arrival at an IRC or STHF. In IRCs this is followed up with a more comprehensive medical examination within 24 hours of arrival. Often people are only held in STHFs for a day or less either en route to or from an IRC, although they can be held there for up to seven days. For those in STHFs, a more comprehensive medical examination beyond the reception screening is not mandated but, on request, a detained person should be seen by a healthcare practitioner as soon as practicable.³⁶

Given that people living with HIV may arrive in an STHF with significant healthcare needs which should be met through ongoing secondary care, best practice is to ensure that people living with HIV are swiftly moved on to less temporary accommodation.

Reception screening

Reception at an immigration facility can be a time of heightened vulnerability for detainees, and the reception health screen may not be the best time to begin complex HIV-related work. However, it does present a critical moment for identifying people who are already being treated for HIV.

Those who disclose their HIV status on arrival at an IRC or STHF may have information with them from their previous HIV service or specialist. This may include a letter or contacts card, or a 'blue book' which provides an overview of their medical history including information on sexual health. The nurse should ask for this information during the screening of anyone indicating that they are living with HIV. The patient may be able to provide contact information even if they do not have formal correspondence from a previous HIV service.

³⁶ *The Detention Centre Rules 2001*, SI 2001/238 [<http://www.legislation.gov.uk/ukxi/2001/238/contents/made>]; *The Short-term Holding Facility Rules 2018*, SI 2018/409 [<http://www.legislation.gov.uk/ukxi/2018/409/article/32/made>]
Home Office, 2011, *Detention Services Operating Standards Manual for immigration service removal centres*. [<https://www.gov.uk/government/publications/detention-services-operating-standards-manual>]

The nurse should ascertain from any person living with HIV if they are taking ART, and if they have brought medication with them. People who have been detained without warning are unlikely to be carrying a supply of medication. It is of paramount importance that people are maintained on their existing therapy regimen. Immediate contact with the previous HIV service should be made to confirm the prescribed medications and to discuss the patient's medical history and healthcare needs.

For those who have arrived without medication, access to the appropriate ART must be arranged immediately. To facilitate this access there should be protocols in place between the IRC or STHF and the local HIV service (see [section 2.1.1](#))

If a detained person states that they have been prescribed ART but cannot provide information about their previous HIV service, healthcare staff in the detention facility should contact the local HIV service within 24 hours to identify a course of action to enable assessment of HIV-related needs and to meet them as clinically appropriate.

Initial medical examination

The medical examination which takes place within 24 hours of a person's arrival in an IRC is more comprehensive than the reception screening. Those who are held in STHFs can access a healthcare professional on request.

The initial medical examination should include the offer of routine BBV screening, including for HIV. Some people may find it difficult to discuss a stigmatised condition such as HIV. They may also believe that diagnosis of a BBV or disclosing their status will threaten their immigration application. Therefore, some may opt-out of BBV tests and some people who are living with HIV may not feel comfortable talking about this.

To mitigate these difficulties, the initial medical examination should include clear information reassuring the person that:

- Confidentiality of healthcare information will be fully respected and protected
- Discrimination is not tolerated in the facility, including discrimination on grounds of HIV status or any other health condition

- They have full entitlement to high-quality NHS equivalent care for all health conditions.

The medical examination also includes identification of mental health history. The assessor should be aware that people living with HIV have a higher prevalence of mental health and cognitive difficulties.

The examination should also consider whether people are at risk of harm in detention according to the *Adults at risk in immigration detention* guidance (see [section 2.3](#)) and, if so, the assessor must raise this matter with the IRC or STHF manager and the detainee's caseworker.

Arrangements should be made for anyone living with HIV to see a local HIV specialist as soon as possible after arrival in an IRC, unless they can stay under the care of their existing specialist. If an individual's passage through the IRC from reception to planned removal is too swift to allow for transfer of care to the local HIV service, then the person's previous HIV clinician should be consulted, especially regarding fitness to travel.

For those being held in STHFs, it may be more appropriate to wait until transfer to an IRC has taken place before secondary care arrangements are made. It is important that the person's needs are considered on a case-by-case basis, and that every reasonable effort is made to expedite the transfer and to convey to the receiving IRC information about their healthcare requirements.

Copies of relevant health documentation should be requested from the previous HIV service at the earliest opportunity, as long as the patient gives consent.

Sexual health promotion

Sexual health information should be included in the initial medical examination and should be available throughout the detention period (see [section 2.2.1](#)). Healthcare staff should provide comprehensive and non-discriminatory sexual health advice. This should include information on transmission risk, testing and prevention methods available, as well as the supply of condoms and lubricant. A protocol should be in place to ensure that support is available for people who are using PrEP for HIV prevention. IRC healthcare staff should be able to link people to sexual health services that can provide PrEP (see [section 2.2.1](#)).

Responsibilities for IRC / STHF staff during arrival

- Provide a supply of ART for those who have been prescribed it prior to detention within 24 hours of disclosure of HIV status.
- For new arrivals who are living with HIV, ensure access to the local HIV service as soon as possible.
- With the person's consent, access health records from their previous HIV specialist as soon as possible after arrival.
- Maintain patient confidentiality.
- At the initial medical examination, offer opt-out testing for BBVs and provide sexual health information.
- Consider whether the detained person may be at risk of harm in detention.

3.1.2 HIV services

HIV clinicians who work in the catchment area of an IRC or STHF must agree a protocol for arranging immediate access to appropriate ART should a person arrive without treatment (see 2.1.1). Staff in the HIV service should expect to make appointments for detained people promptly.

IRC staff will contact the HIV service if a detained person states that they have been prescribed

ART but cannot provide information about their previous service. HIV services local to IRCs should be prepared to respond urgently to this contact. They should work in collaboration with the IRC to identify a course of action to enable assessment of HIV-related needs and to meet them as clinically appropriate.

Responsibilities for HIV services during arrival

- Respond immediately to urgent requests from IRC / STHF staff for ART for a detained person.
- Be prepared to provide appointments at short notice to people in immigration detention facilities.
- Respond quickly to requests from IRCs / STHFs for treatment summaries and other information.
- Maintain patient confidentiality as normal.

3.2 Detention

The length of time that a person will remain in detention is unknown. Despite this uncertainty, the aims of healthcare staff in both the detention facility

and the HIV service must be to meet the person's HIV-related treatment, care and support needs and to be prepared to support continuity of care when they leave the facility.

3.2.1 IRC and STHF

IRC or STHF staff should ensure that every person living with HIV who is in immigration detention is under the care of a specialist consultant in an HIV service (this may be the local service or, if feasible, the service the person was attending before they were detained), to facilitate either unbroken access to existing treatment or, for the newly diagnosed, appropriate baseline investigations and treatment commencement.

More involved interventions, such as counselling and psychosocial support, should be offered for those who need help in coming to terms with an HIV diagnosis and in preparing for removal. Local support services can assist in meeting these needs, and detention facilities should encourage their involvement in providing support for people living with HIV in immigration detention.

Given that HIV is a fluctuating condition, healthcare staff should continue to evaluate the risk of harm in detention throughout the time a person living with HIV is detained.

Access to medication

Guidance states that, if they want to, people in secure environments should be allowed to keep their medications with them.³⁷ If there is some reason why a person living with HIV is not keeping possession of their medication and they must visit the medical facility for their ART, healthcare staff must ensure the person can take the medication exactly as prescribed.

Adherence is vital to protect the health of the individual and to reduce transmission risk. If the person living with HIV does not attend the medical facility at the expected time to take their medication, healthcare staff should proactively seek them out.

Arrangements should be in place to support confidentiality and treatment adherence. This could include ensuring that a person living with HIV has private accommodation, or that they have access to a space to take their medication in privacy.

Appointments with the HIV service

Every effort should be made to ensure that people can attend their appointments at the HIV service. It is not appropriate for appointments to be cancelled for operational reasons, such as a lack of escorts, unless in exceptional circumstances. Detainees should be put on 'medical hold' prior to their appointment, to avoid transfer to another IRC and the inevitable delays while medical records are forwarded and new appointments are made.

People should not be routinely handcuffed during transport to medical appointments. Restraints should only be applied if a risk assessment indicates a specific risk of escape or threat to safety for staff or the public. To preserve patient confidentiality and the individual's confidence in their patient rights, handcuffs should be removed during appointments and the guard should leave the room. Any exceptions to this protocol must be justifiable under Home Office policy on the use of restraints.³⁸

Transfers

Transfers between facilities can occur at short notice. A person's HIV-related needs must be integrated into planning for a transfer, and they must be reassured that this is the case.

The IRC GP should be informed in advance of the intention to move a person living with HIV so that they can establish whether transfer should be delayed due to ill-health or upcoming medical appointments (a 'medical hold'), and so that they can ensure appropriate arrangements are in place to avoid treatment interruption and for the timely transfer of medical records.

The IRC GP should contact the detained person's HIV specialist in advance of a transfer, to ensure that the patient has an adequate supply of ART and to arrange for a treatment summary that they can carry with them. This will minimise difficulties for the patient and healthcare providers at the destination IRC.

³⁷ Royal Pharmaceutical Society, 2017 *Professional standards for optimising medicines for people in secure environments*. [<https://www.rpharms.com/resources/professional-standards/optimising-medicines-in-secure-environments>]

³⁸ Home Office, 2016 *Use of restraints(s) for escorted moves – all staff*, Detention Services Order 07/2016 [<https://www.gov.uk/government/collections/detention-service-orders>]

Responsibilities for IRC / STHF staff during detention

- Support treatment adherence.
- Ensure attendance at HIV service appointments, as determined by an HIV clinician.
- Continue to evaluate whether a detained person may be at risk of harm in detention.
- Repeat sexual health promotion and offer of BBV testing.
- For people newly diagnosed with HIV, ensure quick linkage into an HIV service and other relevant care.
- Offer counselling and support, especially for the newly diagnosed.
- Continue to maintain patient confidentiality.
- If a detained person is being transferred, inform the HIV service well in advance, and arrange for adequate supplies of ART and treatment summaries to be provided.

3.2.2 HIV services

The clinician's objective is to act in the interest of their patient's welfare, and they should speak out against any inappropriate practices that they witness. For example, if a person's handcuffs are not removed automatically during the appointment the clinician should request their removal unless the person poses a serious risk to themselves or to others. Similarly, if the escort does not leave the examination room, the clinician should request that they do so to ensure confidentiality for the patient.

HIV clinicians should provide healthcare staff in the detention facility with a written record of a patient's treatment and care plan, and should ensure that their specific requirements are understood. These requirements may include provisions such as an individual rather than shared room, or specific times for meals.

The HIV clinician should also ensure that their patient understands the principles of confidentiality, and obtain appropriate consent before information is shared. The person living with HIV should be made aware of what private information will be shared with healthcare staff in the detention facility and why.

HIV clinicians should be aware of the *Adults at risk in immigration detention* guidance (see [section 2.3](#)). If they consider that their patient may be at

risk of harm in detention, they should raise this matter with healthcare staff in the detention facility and the caseworker.

During detention a person can be transferred between IRCs at short notice. HIV clinicians should be prepared in advance to provide treatment summaries and ART supplies, and to support the IRC GP's efforts to minimise disruption to the person during transfer. Best practice is to ensure that the person living with HIV has good supplies of ART at all times so that there is no risk of interrupting the treatment regimen.

Responsibilities for HIV services during detention

- Provide IRC healthcare staff with a copy of the patient's treatment plan if consent has been given.
- Be prepared to advocate for patients: if necessary, request removal of handcuffs and that escorts leave the exam room unless the person poses a risk to themselves or others.
- Raise concerns about a person's risk of harm in detention with the IRC GP.
- Be prepared for transfers: ensure treatment summaries are readily available and that patients have good supplies of ART at all times.

3.3 Removal or release

3.3.1 IRC and STHF

IRC healthcare staff should inform the HIV specialist in good time if their patient is being removed or released. The HIV service can then provide a treatment summary and ensure that six months' supply of HIV medication is available for the person to take with them to ensure continuity of care prior to establishing contact with a treating clinician in their destination.

If a person is being removed, they may not be aware of the system for treatment, care and support that they will experience on return to their home country. Most countries have organisations that can support a returning individual to access HIV care. In collaboration with the HIV specialist, IRC healthcare staff should identify such organisations in the destination country and enable the person living with HIV to contact them prior to departure if they so wish.

Fitness to travel

The decision to remove a detainee is made by Home Office personnel who will presume the person is fit to travel unless they are informed otherwise.

A person should not be removed if their condition is not stable. Operational staff should inform the GP of a detainee's intended removal with sufficient time that the GP can communicate with the HIV specialist, conduct an examination if necessary, and raise any concerns identified about the fitness

to travel of a person living with HIV.

The final judgement regarding whether a person living with HIV is medically stable and fit to travel rests with the IRC GP in consultation with the individual's HIV specialist. If an individual's passage through the IRC from reception to planned removal is too swift to allow for transfer of care to the local HIV service, then the person's previous HIV clinician should be consulted. All advice and documentation provided by an HIV specialist to the IRC GP should be recorded, as good practice and in order to provide an audit trail.

It is important that the IRC GP makes their patient aware that refusing consent for a fitness to travel assessment will not prevent their removal as the Home Office will assume that the detainee is fit to travel unless an assessment from the GP finds otherwise. However, it is equally important that the patient gives consent for the assessment and understands that their information will be shared with the Home Office.

While not an exhaustive list, a decision on fitness to travel should take into account if the person living with HIV is:

- Awaiting an HIV test result or appropriate post-test counselling and a baseline assessment to clarify their clinical condition
- In receipt of a recent HIV diagnosis, or has just started ART or a new drug regimen
- Co-infected with another sexually transmitted infection or tuberculosis

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- Experiencing mental health issues
- Pregnant or has given birth within the last six months
- Experiencing any ongoing medical complications, including where in-patient care has been required.

Medical opinions are independent from the Home

Office process, and do not reflect an endorsement of the decision to remove an individual. Any advice provided by an HIV specialist on whether a person living with HIV is stable is entirely separate from advice they might be asked to provide in relation to legal cases concerning the person's removal. By providing advice on the stability of a patient's condition to an IRC GP considering fitness to travel, the HIV specialist is not consenting to removal.

Responsibilities for IRC / STHF staff during removal or release

- **Inform the HIV clinician in good time if their patient is being removed or released.**
- **Arrange adequate supplies of ART and treatment summaries for those who are being removed or released.**
- **Consult with the HIV specialist before determining fitness to travel.**
- **Support detained people who are departing with information about HIV treatment and support organisations available in their destination.**

3.3.2 HIV services

A person may be released at short notice and may not have good knowledge of the healthcare services available in their destination. The HIV service must be prepared to provide a treatment summary and ensure that six months' supply of HIV medication is available for the patient to take with them to ensure continuity of care. It is also good practice to provide contact information for the local HIV service and any available voluntary and community services that will be able to support the newly-released person.

If a person living with HIV is to be removed from the UK, their HIV specialist should be asked for advice by the IRC GP prior to the removal. Providing a quick, comprehensive response on requests for information regarding fitness to travel, or for treatment summaries, ART supplies, and information on HIV support in the destination country will have a significant impact on the patient's experience of removal and their longer-term health.

HIV clinicians should be aware that offering a medical opinion regarding their patient's health condition and fitness to travel does not constitute

an endorsement of decisions made by the Home Office to remove a person from the UK.

Responses to requests for information concerning fitness for travel should include:

- A brief medical history, including care for all conditions and a full history of ART treatment, including possible resistance and treatment failure.
- Details of all services involved in the care of the patient, such as HIV specialist, specialist nurse, hepatologist, thoracic and other medical specialists, paediatrician, mental health professionals, and any voluntary sector or peer support organisations.
- An opinion about the impact that travel may have on the patient's physical and mental health, and whether they are medically stable.

Where individuals have been notified that they will be removed, as soon as possible the HIV clinician should provide the patient with a letter for their future clinicians in their country of repatriation, even if the date for travel is not yet set. This should include reference to their HIV status, a treatment

summary and contact telephone numbers of current and previous clinicians.

The letter should be discussed with the patient so that they are fully aware of its contents and of the need to keep it safe until they have established a relationship with a new treating clinician in their destination country. The letter should be sealed and marked 'private and confidential.' HIV clinicians can also support their patient by linking them with trusted HIV-support organisations in the destination country.

Local HIV specialists should also provide their patient (either directly or via IRC healthcare staff) with a supply of ART in preparation for removal. Normal NHS clinical practice is to dispense ART medication for six months, and it is best practice to keep ART supplies topped up in case of swift removals. This will allow the person living with HIV to maintain their treatment regimen during the removal process and for the initial period in their destination country.

Responsibilities for HIV services during removal or release

- **Be prepared to respond urgently and comprehensively to inquiries from IRC GPs about fitness to travel.**
- **Be prepared for removal or release of patients: ensure that they have good supplies of ART at all times and that treatment summaries are readily available.**
- **Provide people who are being removed with a letter for the clinician in their destination country, and discuss the contents of the letter with them.**
- **Assist IRC / STHF staff to supply information about HIV treatment and support organisations available in the person's destination.**

3.4 HIV services with patients at risk of detention

HIV specialists who are aware that their patients could be detained (i.e. if they are on immigration bail, or an asylum applicant or otherwise subject to immigration control) should discuss with them what to do in the event of detention. The clinician should reassure patients that disclosure of their HIV status to IRC and STHF healthcare staff or case owners will not affect their immigration status or the outcome of their immigration application.

The clinician should provide a contact card with their name and contact details and a list of any medications prescribed.³⁹ The person living with HIV should carry this information in the event they are detained.

All HIV clinicians should be prepared to receive and give high priority to calls from IRC and STHF

healthcare staff, HIV specialists local to detention facilities, and their patient's case owner to update them on the health of the patient, as long as consent has been given. Input from the HIV specialist who knows the patient well will ensure that appropriate medication is dispensed and may influence the longer-term outcome for that individual.

If removal of a person living with HIV is proposed before their care has transferred to an HIV clinician local to the IRC, the pre-detention clinician will need to be involved in the fitness to travel assessment and the preparation for transfer including provision of a treatment summary and an adequate supply of ART. If at all possible, the clinician should be prepared for this development.

³⁹ i-base offers a useful resource called the 'Treatment Passport' where medications, CD4 count, viral load and other important information can be recorded easily in one place. Further information on how to order this resource is available at www.i-base.info.

Responsibilities for HIV services with patients at risk of detention

If an HIV clinician believes that their patient might be at risk of immigration detention, they should:

- Discuss with the person what to do in the event of detention
- Reassure them that their HIV status will not affect the outcome of any immigration applications
- Provide them with a contact card and list of their prescribed medications
- Be prepared to respond to requests for information from healthcare staff in immigration detention facilities
- Be prepared to discuss their patient's fitness to travel
- Be prepared to provide treatment summaries and adequate supplies of ART.



Appendix A: Key resources

Standards governing immigration detention, including healthcare

- *The Detention Centre Rules 2001*, SI 2001/238 [<http://www.legislation.gov.uk/uksi/2001/238/contents/made>]
- Home Office, 2002, *Detention Services Operating Standards Manual for Immigration Removal Centres* [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257352/operatingstandards_manual.pdf]
- *The Short-term Holding Facility Rules 2018*, SI 2018/409 [<http://www.legislation.gov.uk/uksi/2018/409/article/32/made>]
- Home Office, 2018, *Adults at risk in immigration detention*, Version 3.0 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721603/adults-at-risk-policy-guidance_v3.pdf]
- Royal College of General Practitioners Secure Environments Group, 2018, *Equivalence of care in Secure Environments in the UK* [<http://www.rcgp.org.uk/about-us/news/2018/july/prison-health-is-public-health.aspx>]
- *Partnership Agreement between Home Office Immigration Enforcement, NHS England and Public Health England 2018-21*, updated in February 2018, (which commits to implementing 'opt-out' testing for blood-borne viruses (BBVs) and development of care pathways) [<https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf>]
- Home Office, 2016, *The Protection, Use and Sharing of Medical Information Relating to People Detained Under Immigration Powers* Detention Services Order 01/2016 [<https://www.gov.uk/government/collections/detention-service-orders>]
- Home Office, 2016, *Use of restraints(s) for escorted moves – all staff*, Detention Services Order 07/2016 [<https://www.gov.uk/government/collections/detention-service-orders>]
- NAT, 2017, *Tackling Blood-Borne Viruses: A Framework for Prisons in the UK* [https://www.nat.org.uk/sites/default/files/tackling_BBVS_in_prison2017.pdf]

Health and wellbeing in immigration detention

- Stephen Shaw, 2016, *Review into the Welfare in Detention of Vulnerable Persons: A report to the Home Office* [<https://www.gov.uk/government/publications/review-into-the-welfare-in-detention-of-vulnerable-persons>]
- Stephen Shaw, 2018, *Welfare in detention of vulnerable persons review: progress report* [<https://www.gov.uk/government/publications/welfare-in-detention-of-vulnerable-persons-review-progress-report>]
- Medical Justice, 2011, *Detained and Denied: The clinical care of immigration detainees living with HIV* [<http://www.medicaljustice.org.uk/wp-content/uploads/2016/03/detained-and-denied.pdf>]
- BMA, 2017, *Locked up, locked out: health and human rights in immigration detention* [<https://www.bma.org.uk/collective-voice/policy-and-research/ethics/health-and-human-rights-in-immigration-detention>]

Standards for HIV testing, treatment and care

- BHIVA, 2017, Endorsement of the Prevention Access Campaign U=U consensus statement [<https://www.bhiva.org/BHIVA-endorses-U-U-consensus-statement>]

- NICE, 2016, *HIV testing: increasing uptake among people who may have undiagnosed HIV* [NG60] [<https://www.nice.org.uk/guidance/NG60>]
- BHIVA, 2008, *UK National Guidelines for HIV Testing* (under revision at the time of publication) [<https://www.bhiva.org/HIV-testing-guidelines>]
- BHIVA, 2016, *British HIV Association guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy* (interim update), August 2016 [<https://www.bhiva.org/HIV-1-treatment-guidelines>]
- MEDFASH, 2011, *Standards for psychological support for adults living with HIV* [<http://www.medfash.org.uk/publications>]
- BHIVA, 2018, *Standards of Care for People Living with HIV* [<https://www.bhiva.org/standards-of-care-2018>]
- BHIVA, 2018, *Management of HIV infection in pregnant women* (consultation version) [<http://www.bhiva.org/guidelines.aspx>]
- NAM has an online search facility for HIV services and support organisations and information about HIV [www.aidsmap.com]
- Department of Health and Social Care, 2012, *HIV Outpatient Clinical Care Pathway* [<https://www.gov.uk/government/publications/hiv-outpatient-pathway-updated-guidance>]

Support for immigration detainees

- Medical Justice offers medical help to those held in immigration detention in the UK [www.medicaljustice.org.uk]
- Hibiscus Initiatives supports foreign nationals and black, minority ethnic and refugee individuals involved in the criminal justice system in the UK and provides some services for people leaving immigration detention [<http://hibiscusinitiatives.org.uk>]
- The Refugee Council supports refugees and asylum seekers [www.refugeecouncil.org.uk]

Guidance on health-care related rights

- NHS England, 2016, *Confidentiality Policy* [<https://www.england.nhs.uk/publication/confidentiality-policy/>]
- NAT, 2014, *Confidentiality in the NHS: Your Information, Your Rights* [https://www.nat.org.uk/sites/default/files/publications/Confidentiality-July-2014_FINAL-2.pdf]
- NAT, 2016, *Tackling HIV Stigma: What works?* [https://www.nat.org.uk/sites/default/files/publications/Jun_16_Tackling_HIV_Stigma.pdf]

Further information on HIV

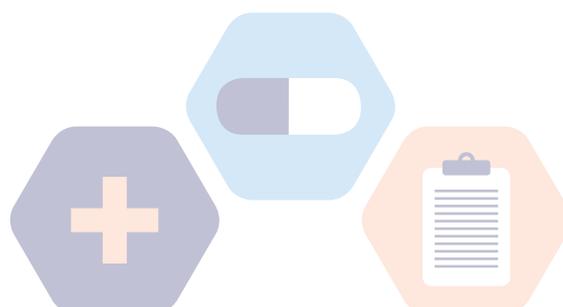
- HIV i-base provides information about HIV and hosts the 'HIV Treatment Passport' where people can hold all the treatment information in one place [i-base.info]

Appendix B: IRC, STHF and local HIV clinic contacts

There are eight Immigration Removal Centres and three Short-term Holding Facilities in the UK.

IRC / STHF	Contact details	Local HIV service
Brook House	Perimeter Road South Gatwick Airport West Sussex RH6 0PQ Tel: 01293 566500	Sexual Health Clinic Crawley Hospital West Green Drive Crawley West Sussex RH11 7DH Tel: 01293 600459
Campsfield House	Langford Lane Kidlington Oxfordshire OX5 1RE Tel: 01865 233600	Oxfordshire Sexual Health Service Churchill Hospital Old Road Headington Oxfordshire OX3 7LE Tel: 01865 231231
Colnbrook IRC (also used as an STHF facility)	Colnbrook Bypass Harmondsworth West Drayton Middlesex UB7 0FX Tel: 020 8607 5200	GUM / HIV Department 1st Floor Northwick Park Hospital Watford Road Harrow Middlesex HA1 3UJ Tel: 020 8869 3142
Dungavel House	Strathaven South Lanarkshire ML10 6RF Tel: 01698 395000	Monklands BBV Service Monklands Hospital Monkscourt Avenue Airdrie ML6 0JS Tel: 01236 712247
Harmondsworth	Colnbrook Bypass Harmondsworth West Drayton Middlesex UB7 0HB Tel: 020 8283 3850	GUM / HIV Department 1st Floor Northwick Park Hospital Watford Road Harrow Middlesex HA1 3UJ Tel: 020 8869 3142

IRC / SHTF	Contact details	Local HIV service
Larne House STHF	2 Hope Street Larne Antrim BT40 1UR Tel: 028 2826 2070	GUM Clinic Level 3 Outpatients Department Royal Victoria Hospital Grosvenor Road Belfast BT12 6BA Tel: 028 9063 6477 028 9063 6483
Manchester STHF	Building 302 Argosy Drive World Freight Terminal Manchester Airport M90 5PD Tel: 0161 509 2015	South Manchester Sexual Health Centre 1st Floor Withington Community Hospital Nell Lane Manchester M20 2LR Tel: 0161 217 4939
Morton Hall	Swinderby Lincolnshire LN6 9PT Tel: 01522 666700	GUM Department Lindon House 134 Dixon Street Lincoln Tel: 01522 309309
Tinsley House (also has Pre-Departure Accommodation for families)	Perimeter Road South Gatwick Airport Gatwick West Sussex RH6 0PQ Tel: 01293 434800	Sexual Health Clinic Crawley Hospital West Green Drive Crawley West Sussex RH11 7DH Tel: 01293 600459
Yarl's Wood	Twinwoods Business Park Thurleigh Road Milton Ernest Bedfordshire MK44 2FQ Tel: 01234 821000	Bridge House GUM Clinic Bedford Hospital Brittania Road Bedford Bedfordshire MK42 9DJ Tel: 01234 792 146





Feedback and further copies

NAT and BHIVA welcome feedback on this guidance, including any suggestions on improvements that could be made. Please email: info@nat.org.uk with comments, or to request additional copies of the booklet.

A PDF version can also be downloaded by visiting www.nat.org.uk/publications

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BHIVA is the leading UK association representing professionals in HIV care. Since 1995, we have been committed to providing excellent care for people living with and affected by HIV. BHIVA is a national advisory body on all aspects of HIV care and we provide a national platform for HIV care issues. Our representatives contribute to international, national and local committees dealing with HIV care. In addition, we promote undergraduate, postgraduate and continuing medical education within HIV care.

For further information, please visit: www.bhiva.org,
email: bhiva@bhiva.org or telephone: 01462 530070.

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