



**DISPERSAL OF
ASYLUM SEEKERS**

LIVING WITH HIV



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DISPERSAL OF ASYLUM SEEKERS LIVING WITH HIV

The National AIDS Trust (NAT) has expressed serious concerns about the impact of dispersal on asylum seekers living with HIV, and has taken a lead in engaging the National Asylum Support Service (NASS) on this issue.

A recent survey by NAT identified, amongst other issues:

- Dispersal at such short notice that HIV treatment was interrupted and health harmed
- Dispersal when asylum seekers with HIV were too ill or vulnerable to travel
- Dispersal without effective links made with health care providers to ensure continuity of care in the dispersal destination.

NASS published a new policy bulletin in December 2005 on dispersing asylum seekers with health care needs.

Amongst other policy changes, it states that from now on:

- If an asylum seeker is HIV positive, a delay to dispersal must be considered
- Dispersal can only take place when the treating clinician is satisfied that arrangements are in place for continuity of care in the dispersal destination
- The accommodation provider in the dispersal destination has an obligation to ensure asylum seekers living with HIV are registered with a GP.

This report looks at areas of concern in relation to past dispersal of asylum seekers living with HIV, and the extent to which new NASS policy will address these issues.

INTRODUCTION

The National AIDS Trust (NAT) is the UK's leading independent policy development and campaigning voice on HIV and AIDS and has as one of its key objectives a commitment to ensure equitable access to HIV treatment and care for all those living with HIV.

Recent years have witnessed increasing concern at failures to meet the HIV-related needs of migrants in the UK. In particular, the process of dispersal of asylum seekers from London and the south east of England has resulted in real difficulties for asylum seekers living with HIV.

This report outlines failings in the dispersal system as identified by stakeholders; considers how new policies and processes announced by the National Asylum Support Service (NASS) in December 2005 (Policy bulletin 85, *Dispersing asylum seekers with health care needs*)¹ will address these problems; and makes further recommendations for change.

WHAT IS DISPERSAL?

Dispersal is the process of moving an asylum seeker to a different area of residence, to share the call on resources and public services amongst a wider range of local authorities across the UK instead of one particular area of the country. Under the Immigration and Asylum Act 1999 and the Nationality and Asylum Act 2002, an asylum seeker requiring support and accommodation may be dispersed anywhere in the UK. NASS is part of the Home Office's Immigration and Nationality Directorate and provides support, while applications are being considered, to asylum seekers who would otherwise be destitute (asylum seekers are not permitted to work in the UK). NASS cannot take into account an applicant's preference for a particular area of dispersal. Claims for asylum are not processed by NASS - the Asylum Casework Directorate of the Immigration and Nationality Directorate does this.²

¹ http://www.nat.org.uk/documents/NASS_Policy_Bulletin_85.pdf

² For further information visit www.ind.homeoffice.gov.uk



ASYLUM SEEKERS AND HIV

There are over 40 million people currently living with HIV, and infection levels are increasing worldwide. The prevalence of HIV amongst asylum seekers in the UK is unknown, however some of the countries from which many asylum seekers originate have a high HIV prevalence. Zimbabwe, for instance, which accounted for the fourth highest number of asylum applications in 2004, has a prevalence rate of 23%. It may well be the case that HIV prevalence amongst asylum seekers is not as high as in their country of origin, however it is likely to be higher than that of the UK, which currently stands at 0.1%.³

The number of people living with HIV in the UK has been rising year on year and now stands at 58,300. Whilst men having sex with men still account for around 30% of new HIV diagnoses, three quarters of the 4,287 heterosexually acquired HIV infections diagnosed in 2004 were contracted in high-prevalence countries.⁴

HIV is known to thrive amongst vulnerable populations, and migrants are one such group. Indeed, the reasons individuals are claiming asylum may also have put them at risk of contracting HIV (for example, the use of rape as a weapon of war). People living with HIV have complex care needs. A compromised immune system means that it is particularly important for people living with HIV to take care of their general health and it is to the benefit of wider public health that an individual living with HIV is aware of their condition and has the means to prevent onward transmission of HIV. If taking antiretroviral (ARV) treatment, it is vital that a patient adheres strictly to the treatment regimen.

NAT is keen to ensure that asylum seekers living with HIV have access to adequate and ongoing HIV treatment and care, and that no harm should be caused to asylum seekers – or to wider public health – as a result of dispersal to new areas of residence.

CONCERNS ABOUT DISPERSAL OF ASYLUM SEEKERS LIVING WITH HIV

Concerns have been expressed in the past by several organisations and individuals – including politicians, clinicians and the voluntary sector – about the impact of dispersal on asylum seekers living with HIV.

In July 2003 the House of Commons All Party Parliamentary Group on AIDS (APPGA) published *Migration and HIV: Improving Lives in Britain*, resulting from its inquiry into the impact of the UK nationality and immigration system on people living with HIV.⁵ The following year, research was published in the *British Medical Journal* identifying potential barriers to the safe dispersal of asylum seekers living with HIV⁶, and the report *Treat with respect - HIV, public health and immigration* by four leading HIV physicians was published in 2005.⁷

All these documents identified problems with the dispersal of HIV positive asylum seekers. The issues of concern included, amongst others, short notice periods prior to dispersal leaving asylum seekers without sufficient time to arrange medication for the journey and arrival in the new area of residence; not knowing where to obtain HIV medication on their arrival; lack of handover of medical details from one area to another; problems with confidentiality; and being dispersed when unwell.

REVIEW OF NASS POLICY

In 2004 NASS commissioned an independent review of its dispersal policies and practices in relation to asylum seekers' health care. The purpose of the review was "to ensure that NASS dispersal policies and practices are based on a widely understood framework that takes applicants' health needs into account while remaining focussed on the requirement for dispersal; draws on the experience and knowledge of informed stakeholders; [and] draws on contemporary evidence and information about health needs and health services".⁸ The review was conducted by Hilary Scott.

³ UNAIDS/World Health Organisation - AIDS epidemic update, December 2005

⁴ Health Protection Agency http://www.hpa.org.uk/hpa/publications/hiv_sti_2005/pdf/Mtl_BW_Part_1_HIV.pdf

⁵ Migration and HIV: Improving Lives in Britain - An Inquiry into the Impact of the UK Nationality and Immigration System on People Living with HIV, ISBN 0 9534418 22. For details on obtaining the report, see <http://www.appg-aids.org.uk/publications.htm>

⁶ Dispersal of HIV positive asylum seekers: national survey of UK healthcare providers, S Creighton, G Sethi, S G Edwards and R Miller, *British Medical Journal* August 2004; 329: 322-323.

⁷ http://www.ukcoalition.org/migration/HIV-Treat_With_Respect1.pdf

⁸ http://www.nat.org.uk/documents/hilary_scott_review.htm (executive summary, paragraph iii)



Whilst the resulting NASS report, *Meeting the health care needs of people seeking asylum - a review* was not produced specifically in response to the particular problems occurring with HIV positive asylum seekers, it did acknowledge some of the problems they had faced - confidentiality and consent to disclose health-related information, for example.⁹ Several references to HIV were made and one of the report's recommendations was to produce a comprehensive policy bulletin dedicated to the way NASS approaches health care issues, including the care of asylum seekers who are HIV positive.

We also note the independent report commissioned by the Research Development and Statistics Directorate of the Home Office in December 2005, *An exploration of factors affecting the successful dispersal of asylum seekers*¹⁰ which made reference to some of the issues explored in NAT's research.

▶ NAT'S INTERVENTION

At NAT's request, a meeting was held with NASS in May 2005 and we were pleased by the willingness of NASS staff to discuss the health care needs during dispersal of asylum seekers living with HIV. At the same time, NASS were considering how to implement the recommendations of the Hilary Scott review.

NASS held a meeting with health care professionals and voluntary sector representatives in July 2005, which NAT representatives attended, and later that month NASS produced a draft policy bulletin, 'Dispersing Asylum Seekers with Health Care Needs'. NAT submitted a response to the consultation on this draft, focussing on the sections applicable to asylum seekers living with HIV, based on our knowledge and experience as a charity working on a range of HIV-related issues and stemming from the concerns expressed in publications listed above.¹¹

Whilst NASS consulted upon and revised its draft policy bulletin, NAT sought to investigate further some of the issues of concern related to dispersal of asylum seekers living with HIV. We approached people directly involved in the dispersal process to gain an understanding of the experience of these stakeholders,

with a view to providing recommendations to NASS that would help to achieve continuity of HIV care and treatment during the dispersal process.

The final bulletin on *Dispersing Asylum Seekers with Health Care Needs* was published in December 2005.¹² The bulletin includes a commitment from NASS to review its content and implementation in 12 months' time.

▶ NEW NAT RESEARCH

NAT's research took the form of questionnaires distributed amongst clinicians and discussions with staff members of HIV and asylum seekers' support organisations, with NASS staff members and with some clinicians. Additional written information was also received from a number of HIV and asylum support organisations. Sixty four questionnaires from clinicians were analysed. Both quantitative and qualitative information was sought, so that clinicians were able to provide comprehensive comment on key issues. The results of NAT's research in no way claim to be a comprehensive overview of the opinions of all support organisations or of clinicians treating asylum seekers living with HIV, but do illustrate some of the concerns around dispersal. Further details of the research methods are enclosed at Annex 1, followed by a series of data tables.

The findings from NAT's research are presented over the following pages, and we then assess whether the concerns we have identified will be addressed by the policies outlined in the new NASS policy bulletin. Our findings form the basis of suggested further policy changes where necessary. NAT's research gathered clinicians' experience of the dispersal process over the last 12 months. Significant changes are taking place in NASS accommodation provision, and the majority of asylum seekers are now housed in initial accommodation centres rather than emergency accommodation. However, asylum seekers living with HIV have particular needs, irrespective of where they are dispersed from. As a result of this research, NAT considers itself well placed as a policy organisation to contribute to the debate on how the new bulletin is implemented and the processes that will result from it, based on the reported experience of some of those involved in the dispersal process.

⁹ http://www.nat.org.uk/documents/hilary_scott_review.htm (paragraph 25)

¹⁰ <http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr5005.pdf>

¹¹ See <http://www.nat.org.uk>

¹² See footnote 1 on page 3

2 RESEARCH FINDINGS

▶ INAPPROPRIATE DISPERSAL

NAT does not have a position on the merits or otherwise of dispersal as a policy in general. We do believe, however, that dispersal should not take place when an asylum seeker could be harmed as a result. The results of our survey confirmed that asylum seekers have been dispersed when it would have been better for their health for dispersal to be delayed.

We asked clinicians in areas from which asylum seekers had been dispersed whether, over the last 12 months, they felt it was **safe and appropriate to disperse their patient(s)**. Overall, 22% thought it had never been safe or appropriate, and 51% thought it had been safe only in up to 25% of cases. Sixteen percent of clinicians questioned felt it had been safe and appropriate to disperse in between 26 and 50% of the cases they had dealt with. Only 3% said it had always been safe and appropriate to disperse their patients (see table 16). Taking into account answers to this question from clinicians in areas both from and to which asylum seekers were dispersed (tables 16 and 20), 15% thought it was never safe and appropriate, 3% answered always, with the highest number of responses (36%) indicating it was safe and appropriate in up to 25% of cases.

We asked clinicians in areas to which asylum seekers had been dispersed, to list the proportion of cases over the last twelve months in which **dispersal has had a detrimental impact to their patients' health** (table 42). We were encouraged by the clinicians who indicated that in the majority of cases, this did not happen, with none of the clinicians reporting that dispersal had always had a detrimental impact, and none indicating a detrimental effect in either 76 - 100% or 51 - 75% of cases they had worked with. However only 21% of clinicians said that dispersal never had a detrimental effect. Thirty seven percent considered that dispersal had had a detrimental impact in 26 - 50% of the cases they had worked with, and 42% thought this was the case in up to 25% of cases they had worked on.

Of particular concern were the cases in which interruption to antiretroviral therapy had occurred for example:

“Missed drugs; abnormal blood results; HIV not followed up; developments of viral resistance not detected until late due to missed blood tests.”

Whilst no clinicians thought that **interruption to a patient's antiretroviral therapy** as a result of being dispersed was always the case, NAT is concerned that 57% of clinicians believed that this had occurred in up to a quarter of their patients (table 41).

The psychological impact of dispersal on asylum seekers was also of concern to many clinicians, for example:

“Some of my patients have been subjected to, or allege that they have been tortured. This causes additional problems and following dispersal frequently need to relate incidents of torture again to doctors or solicitors. This is not helpful to their psychological well-being.”

When to delay dispersal?

NAT has argued from the outset that, in addition to cases involving children or pregnant women with HIV - which were identified in the NASS draft policy bulletin as needing consideration - there would be other circumstances in which a delay to dispersal of an asylum seeker living with HIV might be appropriate. We sought to ascertain which medical conditions might require dispersal of asylum seekers living with HIV to be delayed, according to the views of clinicians (tables 8 to 15, and 21 to 28). Data from these tables were aggregated, so that the responses of clinicians in areas where asylum seekers were dispersed both to (tables 21 to 28) and from (tables 8 to 15) were combined.



The results of our questionnaire to clinicians showed strong views on a number of issues. A clear majority (83%) thought that dispersal should be delayed when HIV had recently been diagnosed – 25% agreed and 58% strongly agreed with this statement. A similar view was expressed in the case of a patient being diagnosed with AIDS within the past 3 months, with 78% agreeing (61% strongly) that dispersal should be delayed.

In cases of asymptomatic HIV when the patient was not on antiretroviral therapy, however, less than a quarter of clinicians thought that dispersal should be delayed. Indeed 43% thought it should not be, and a third neither agreed nor disagreed with this proposal.

In cases where a patient is new to antiretroviral therapy, 65% thought that dispersal should be delayed. This compares with 19% who thought it should not be, and 16% without strong views on the issue.

Co-infection with a sexually transmitted infection was a key concern, with two thirds of clinicians questioned expressing the view that dispersal should be delayed under such circumstances. Seventeen percent disagreed.

When an asylum seeker with HIV has co-existing mental health problems, 78% thought that dispersal should be delayed. Fourteen percent thought that it should not be delayed; 8% neither agreed nor disagreed. One clinician commented:

“HIV is still stigmatised and the mental health impact of dispersing such patients needs to be considered as well. However, for patients who are stable either on or off treatment, dispersal is appropriate, provided adequate notice is given for preparation.”

In cases of pregnancy, or where an HIV positive woman has a child under the age of three months, 84% strongly agreed or agreed that this was cause for delay. Fourteen percent disagreed with this statement, and 2% had no strong opinion. One clinician stated that:

“Dispersing pregnant women against their will should become impossible. The risk of mother to child transmission is too high!”

Further reasons to delay dispersal

Clinicians identified a number of additional circumstances under which delays to dispersal should be considered. A **complicated treatment history, problems with adherence to treatment and resistance to particular drugs** were suggested. Successful treatment of HIV is heavily dependent on strict adherence to a treatment regimen and non-adherence can not only cause serious risks to a patient's health, but also increase susceptibility to resistance to medication. In light of the relatively limited choice of HIV drugs available, becoming resistant to a particular type of drug and limiting the range of options available to a patient for treatment is clearly very serious. One clinician concluded that patients with significant resistance problems *“need to be treated in centres of excellence”*.

A number of other **co-existing conditions** (other than NAT's questionnaire categories of a sexually transmitted infection or mental health problems) were also identified as reasons for potential delay to dispersal. Patients receiving tuberculosis treatment or prophylaxis were mentioned in particular, as well as those with any other serious co-condition. In addition, patients who had undergone a **recent change to their HIV treatment** were identified in this category.

Several clinicians considered issues relating to family as a reason to consider delaying dispersal, such as:

“If a near family member fits one of the categories [listed in the survey] and is dependent on the person who is to be dispersed.”

Some went further still:

“There is little experience in much of the country of treating HIV positive children - I am not sure it is appropriate to disperse children at all.”

When asked whether there are *“any elements of care you are particularly concerned about”*, paediatric HIV was mentioned by several clinicians. One commented,



“Care of children. [It is] particularly concerning given there are fewer services set up to meet the needs of children. The mental health issues for children who have to keep moving home, nursery, school etc. We have had problems with drug resistance in children, most likely as a result of the distress and difficult circumstances endured by their parents when they keep being moved on - sometimes within a very short period of time.”

One of the key concerns expressed by clinicians working in areas asylum seekers were dispersed from related to the availability of **support networks** in the new areas of residence. This is covered in a separate section.

► **CONSULTATION WITH CLINICIANS PRIOR TO DISPERSAL**

It is clear that there are several circumstances under which clinicians would recommend a delay to dispersal. The following section considers contact between NASS and treating clinicians regarding the suitability of dispersal for an asylum seeker living with HIV, and ease of communication with NASS from the point of view of clinicians and support organisations.

Consideration by NASS of advice from treating clinicians

In our questionnaire to clinicians, NAT asked, *“In cases where you provided expert medical advice over the last twelve months, due consideration was given to this advice before dispersal in the following proportion of cases”* (table 17).

It should be pointed out that some clinicians did not answer this question, for example stating that the question was *“not answered as I have no follow up data”*, or *“not sure whether my advice made any difference – no feedback from dispersal agencies”*.

However the majority of those clinicians who answered the question felt that their views were frequently not taken into account by NASS prior to dispersal.

Only 21% of clinicians questioned thought that their views had been given due consideration in over half of the cases in which they provided medical advice (i.e. in

51–75% of cases, 76 – 100% of cases, or always).

However, 79% of those questioned stated that in less than half of the cases in which they provided medical advice (26–50% of cases, 0–25% of cases or never), had their views been given due consideration. The majority of responses to this question (41%) were that clinicians' views had been taken into account in 0–25% of the cases in which they had given expert medical advice.

Typical comments from clinicians were that:

“Medical comments never seem to be taken into consideration.”

“More liaison [is] needed with clinician, and clinician's views [should be] taken into consideration.”

“I wrote two strongly worded letters against dispersal on medical grounds and made numerous phone calls - all were ignored. I know of only one case where dispersal has been delayed - this patient was actually receiving chemotherapy.”

Several clinicians commented on the fact they would welcome contact from NASS regarding their patients prior to dispersal taking place. There was no specific question in the NAT questionnaire on this point, but it was mentioned numerous times under 'any further comments':

“We generally hear just via the grapevine that patients have been dispersed. There is no liaison with us before it happens.”

“No consultation of our service before decision – need to write supporting letters at extremely short notice.”

We appreciate that for reasons of confidentiality, NASS has a duty to give information about dispersal only to the asylum seeker. But there is clearly a question of how the asylum seeker can be supported in involving his or her treating clinician as soon as possible in preparations for dispersal.



Communication

Communication with NASS was an issue raised by clinicians and support organisations alike, and some frustration was expressed about reportedly not being able to contact NASS. Comments from clinicians and support organisations included:

“Very difficult to contact NASS to give medical advice – no key worker name, phone number constantly engaged or not answered and very difficult to obtain in the first place.” (Clinician)

“Helping to make representation for the parent takes hours of clinician’s time and very difficult to access NASS. No feedback ever from NASS.” (Clinician treating an asylum seeker’s child with HIV)

“The system is fractured and cumbersome. It is rarely clear where complaints (or any form of communication) should be addressed to. [Examples of] good practice [are] very rare. Often this is one person prepared to help and be positive within the NASS bureaucracy.” (HIV support organisation)

“A key point would be the ability to directly contact whomsoever is making the NASS medical assessment.” (Clinician)

NASS has given assurances to NAT that all correspondence they receive is acknowledged; therefore steps clearly need to be taken to address this perceived gap. This will be addressed in section 3 on page 17 under 'communication'.

▶ NOTICE PERIOD

Moving to a different area of the country can be a significant upheaval for anybody. For an asylum seeker who has been diagnosed with HIV and is already accessing clinical care, the need for reasonable notice is essential. Our questionnaire confirmed that the notice period for such people is inadequate.

It was widely reported by clinicians that notice periods prior to dispersal were insufficient for asylum seekers to arrange adequate supplies of medication for the journey and arrival period, and arrange appropriate medical care in the new area. Short notice periods did

not leave time for transfer of medical records, and we also noted the burden on clinics in dispersal areas, which might be able to prepare better in advance for new patients if a longer notice period were given - for instance providing extra consultation time for patients and arranging suitable interpretation where necessary.

All of the asylum and HIV organisations we spoke to said that the notice period given to HIV positive asylum seekers prior to dispersal was too short. One HIV positive asylum seeker, asked how he could have been helped to prepare for dispersal, answered *“give people enough time to prepare”*. He had not had sufficient time to arrange medication for his journey or to arrange medical care in advance of arriving in the dispersal area, and also stated that he was not given medical records to take with him to the new area.

The impact of an insufficient notice period on arranging appropriate transfer of care can be serious:

“Lack of advance notice can lead to a break in treatment and problems with resistance.” (Clinician)

Another clinician stated, *“the system is chaotic and dangerous”*, although one comment was received in support of current procedures:

“I think there has been an improvement unless [asylum seekers] are being deported or moved prior to expected deportation.”

Typical comments from clinicians in relation to notice however, were:

“Always very short notice – a few days.”

“Ridiculous for two patients – a few days only.”

“In my personal experience patients are given 1 – 2 days notice of the final decision to disperse them. This is definitely inadequate, particularly for those with complex medical issues.”

The responses to the NAT questionnaire suggested that clinicians in areas both from and to which asylum seekers were dispersed felt that more time to prepare for dispersal would have been beneficial.



Over two thirds of clinicians in areas from which asylum seekers had been dispersed disagreed or strongly disagreed that the notice period for dispersal of asylum seekers living with HIV was adequate (table 3).

Eighty one percent of those clinicians disagreed or strongly disagreed that the notice period provided them and their patients adequate time to arrange medication for the journey and arrival in the new area. Two percent strongly agreed that notice was adequate, 7% agreed and 10% neither agreed nor disagreed (table 4). Eighty five percent disagreed or strongly disagreed that there was adequate time to arrange treatment and care in the dispersal area, with no respondents strongly agreeing with this statement (table 5).

To allow for adequate handover of medical records to the dispersal area, 86% of clinicians questioned in areas from which asylum seekers were dispersed disagreed or strongly disagreed that the notice period was adequate, again with no respondents strongly agreeing. Seven percent of clinicians agreed with the statement, and a further 7% neither agreed nor disagreed (table 6).

The views of clinicians in areas to which asylum seekers living with HIV were dispersed are covered in the 'handover of care' section on page 17.

Late representation

NAT recognises that, in some cases, asylum seekers have not contacted their clinician immediately on receipt of notice of dispersal, which may affect perceptions of the length of the notice period. We are concerned that some asylum seekers may contact their clinician only at the very last moment to present their concerns about being dispersed. This can leave very little time for the clinician to contact NASS to advise them (with the asylum seeker's consent) of particular health care needs that need to be taken into account in arranging a dispersal area, or if necessary recommend that dispersal be delayed.

Again, NAT appreciates that for reasons of confidentiality, NASS has a duty to give information about dispersal only to the asylum seeker. However it

seems that asylum seekers and clinicians could benefit from increased co-ordination in this area. This is addressed in section three.

Extension to notice period

Of the clinicians who thought an extension to the notice period is required, the range of notice stated was two weeks to five months. The notice period most frequently suggested was four weeks (table 7).

There was clear consensus amongst HIV and asylum support organisations that the notice period is too short. One clinician declined to give a specific length of time for notice prior to dispersal, suggesting that *"notice period extension does not help and instead close liaison is required"*.

HANDOVER OF CARE

Many of the comments received from clinicians about the length of the notice period related to the consequent difficulty in preparing for the handover of care of an asylum seeker prior to dispersal to a new area of residence. The importance of ensuring arrangements are in place before dispersal was outlined in the following comments from three clinicians:

"A child with post traumatic stress disorder was seeing intensive counselling [services] in London but lost [this] care on dispersal."

"It seems to us that patients with a booked appointment in a new area – before travelling – are more likely to continue care after moving at a time when they are subject to stress and depression."

"I must emphasise that prior communications between clinics is vital in order to facilitate and improve patient management and dispersal."

Suitable arrangements for handover of care from one clinician to another are key to the wellbeing of an asylum seeker being dispersed to another area of residence. Referring to their experience over the past twelve months, two clinicians stated:



“Handover is impossible due to lack of notice”, and

“Need details of dispersal as soon as possible. Often asylum seekers know a little but not enough for medical transfer to be arranged.”

One clinician recommended:

“Information [should be] shared with dispersal area (local hospital which will take over care) before patient arrives. Delay in sharing information causes initial problems with care.”

This is supported by the following response:

“If dispersal has to happen in any of these circumstances [i.e. the conditions suggested by NAT in the questionnaire] then accurate medical records and access to previous records are a must”.

NAT’s view that the notice period prior to dispersal for asylum seekers living with HIV should be sufficient to arrange adequate handover of care is also borne out in responses from clinicians in areas to which asylum seekers have been dispersed. The majority of clinicians questioned indicated that further notice prior to dispersal would have been beneficial to themselves, their medical practice and consequently to asylum seekers living with HIV.

For clinicians practising in these areas, more notice prior to the arrival of these new patients would have been beneficial in terms of asylum seekers’ clinical care in 91% of responses (with 23% agreeing and 68% strongly agreeing). Nine percent neither agreed nor disagreed but no clinicians disagreed with the statement that more notice prior to dispersal would have been useful (table 34).

The results were similar for administration issues: again, 91% strongly agreed or agreed that more notice would have been beneficial (table 35). In terms of arranging interpretation services, 86% would have preferred more notice (27% agreed, 59% strongly agreed). Five percent disagreed, and 9% expressed no preference in line with the answers above (table 36).

It is clear from these figures that the need for adequate handover of care is a key concern amongst both clinicians and support workers involved with asylum seekers living with HIV. One comment from a support organisation representative on this issue was the need to:

“Raise awareness of immigration and [raise awareness among] NASS officers of the needs of HIV positive asylum seekers. Establish a referral and handover system between authorities.”

Particularly challenging situations were also described, for instance from a clinician about:

“Asylum seekers relocated at 4pm on Christmas Eve without any medication.”

NAT recognises the challenge that inadequate preparation can pose to clinicians in terms of registering and assessing newly dispersed HIV positive asylum seekers. In our questionnaire, we asked whether clinicians had been fully informed about their new patient, and whether more information would have been beneficial.

A third of respondents said that they were never fully informed about the medical history of their HIV positive asylum seeker patients at the time of arrival. None of the clinicians questioned said they had always been informed (table 29).

In addition to issues related to the notice period referred to above, clinicians agreed that more information or medical history prior to arrival would have been beneficial. In terms of clinical care, 23% agreed and 73% strongly agreed - 96% overall in favour (table 37). Ninety five percent agreed or strongly agreed that more information or medical history would be beneficial for administration reasons (table 38), with 85% agreeing or strongly agreeing it would have helped with interpreting and translation (table 39).

Language issues were again a matter of concern. Several clinicians expressed the need for *“translators who can cope with the subject area”*, and support organisations made it clear that provision of adequate interpretation is not simply a case of translating the words between a patient and a doctor. Asylum seekers



may have concerns about stigma if, as may be the case, an interpreter is part of the same ethnic community. There may be embarrassment, or fears around confidentiality, which could restrict the information given by the patient to the clinician, which could ultimately impact on a patient's health.

Patient held records

A patient held medical record ('hand held record') is an NHS booklet in which information provided by an asylum seeker to health care workers in initial accommodation centres is noted. In briefings given at initial accommodation centres prior to dispersal, asylum seekers are reminded to take their medical record with them to the new area of residence.

The majority of clinicians who responded to NAT's survey were in favour of hand held records, with 82% agreeing or strongly agreeing that a hand held record *"would be useful in registering and treating dispersed HIV positive asylum seeker patients"* (table 30).

Whilst such records are intended to be confidential and are the property of an individual asylum seeker (or their parent or guardian, in the case of children) the possibility exists for the record to be read by someone other than the patient or clinician. It is the choice of an individual whether to disclose their HIV status and a partner, for example, may not have been told about a positive HIV diagnosis. NAT therefore supports the principle that HIV status should not be explicitly recorded in these hand held notes. However, we acknowledge the importance of including some reference, recognisable to clinicians and GPs, which can act as a 'pointer' to a positive HIV diagnosis.

Registering for clinical care after dispersal

Hand held records should be taken by a dispersed asylum seeker to their first appointment with their GP following dispersal. NAT recognises the importance of accessing health care immediately after being dispersed - given the need for continual adherence to antiretroviral treatment, for example - and asked clinicians to state in what proportion of cases they agreed with the following statement: "My HIV positive asylum seeker patients registered for care within a

reasonable period upon their arrival in my area in the following proportion of cases" (table 31).

None of the clinicians questioned answered never, but only 5% answered always, with the highest number (37% of clinicians) ticking the '26-50% of cases' box.

Comments received on this point included:

"Most patients do eventually access care once they are aware of where it is and what services are offered."

"Patients don't know how/where to access treatment."

This highlights the importance of support from accommodation providers following dispersal, and also underlines how vital it is that the briefings and other information prior to being dispersed are provided in a way that can be understood by asylum seekers.

Rather than asylum seekers having to make their own arrangements for medical care in a new area, we asked clinicians whether NASS should require individual housing providers either to accompany dispersed asylum seekers to a GP for registration within a defined period, or otherwise ensure that registration with a GP takes place. Seventy nine percent agreed or strongly agreed this should be the case. Sixteen percent neither agreed nor disagreed, and just 5% disagreed (table 40).

One clinician added a comment about *"Assuring [asylum seekers living with HIV] have HIV care as well as GP care at new destination, with same facilities."*

Accessing care

It is a NASS principle for dispersed asylum seekers with health care needs to be able to access appropriate medical care and any special facilities they may need. NAT asked clinicians in areas to which asylum seekers had been dispersed, in what proportion of cases this principle was met for HIV positive asylum seeker patients arriving in their area. Fifteen percent felt it had not happened in any cases but, equally 15% felt it had happened for all of their cases. Forty five percent of clinicians stated it happened in between 0% and 50% of cases, and 25% in 50-100% of cases (table 32).



An example of special facilities not being available following dispersal was given by a clinician who reported that for their asylum seeker patients who had been victims of torture:

“We have no specialist torture counsellors. [It is] traumatic to go through history again. [Asylum seekers] often don’t speak English [and it is] traumatic for interpreters.”

We note that NASS does have a policy on victims of torture, which is outlined in NASS policy bulletin number 19.¹³

Being able to access appropriate medical care and any special facilities should relate not only to particular health services being available, but also to whether an asylum seeker has been adequately informed of how to access these services.

For instance, cultural differences can sometimes lead to confusion and difficulty - an example reported to NAT was a new mother who had an appointment for her baby with the local health visitor. The appointment was missed because the woman waited at home all day under the mistaken impression that a health ‘visitor’ would ‘visit’ her, rather than her having to take the baby to see the health visitor at the local GP surgery’s baby clinic.

Such linguistic misunderstandings emphasise the importance of clear and understandable information being provided to dispersed asylum seekers about what to expect of the UK health system, and what their own responsibilities are. This is also an area where support services can be beneficial, with people who have already been through similar experiences being well placed to give advice.

► HIV SUPPORT SERVICES

Throughout NAT’s research, the importance of social and psychosocial support was emphasised by clinicians, asylum support services and HIV support services.

Several references were made in the section of NAT’s questionnaire to clinicians covering potential reasons to delay dispersal:

“I feel that dispersal shouldn’t take place when individuals have family members or support networks nearby. A lack of support can lead to profound problems in child care, isolation, mental health difficulties and adherence.”

“There is a great need for social networks - details of patient groups in other areas might be a small psychological support.”

When asked if anything could be done “to improve your experience of receiving dispersed asylum seekers”, responses included social support, for instance:

“Informal social support - asylum seekers [are] often lonely.”

Provision of support networks was an issue that was also raised by asylum and HIV support organisations. As this is within their direct area of experience, they were understandably concerned about the level of support available to asylum seekers following dispersal to a new area:

“Dispersal of HIV positive people needs to be planned and a support system put in place with a proper handover.” (Asylum seekers support organisation)

“Provision of support groups/organisations who can assist clients varies dependent on city or town. As dispersal is mainly done by language, clients can often be dispersed to an area where there is no adequate support for those clients with AIDS. This is of particular concern when clients are dispersed to largely rural areas which do not have the same health provision as larger cities or towns. The worry is they will not receive the same amount of support or that health care professionals will not be as knowledgeable as workers in the larger cities will.” (Asylum seekers support organisation)

Support networks were important where children are concerned too - without them, health may suffer, as outlined by a clinician:

13 <http://www.asylumsupport.info/bulletin19.htm>



“Families where a child or children have HIV have even more complex medical and social needs. Children’s successful adherence to medication is strongly associated with a stable home environment, and good support networks. Many HIV-infected children have complex medical and learning problems, and stable schooling is very important. Children will be on lifelong ARV drugs, dispersal often affects adherence and may result in resistance. There are only a limited number of drug combinations available. This may result in failure of ARV drugs and deterioration in the child’s health and reduced life expectancy.”

▶ EFFECT OF DISPERSAL ON PATIENT HEALTH

NAT has argued consistently that an overriding principle of the dispersal process is that no harm should come to an asylum seeker living with HIV as a result of being dispersed.

We asked clinicians in areas from which asylum seekers had been dispersed whether they considered that their patients would receive an equivalent standard of care in the area to which they had been dispersed.

We recognise that this is a subjective question, and we did receive responses from some clinicians saying that they had no information about the sort of care their former patient was receiving in the new area of residence, or even where their patient had been dispersed to. They therefore felt unable to answer this question. However, of the clinicians who responded, 55% indicated that in over half of cases, their dispersed patients would have received equivalent care, but 45% thought equivalent care had been provided in less than half of cases (**table 18**).

NAT believes that the ability to access an equivalent standard of care in the new area of residence has a significant impact on whether **continuity of treatment** occurs during and following dispersal. We were concerned to learn that for the majority of clinicians this had not been the case. Thirty eight percent felt continuity of care had occurred in over half of the cases they had dealt with, and 62% in less than half of the cases they dealt with (**table 33**).

HAVE CONCERNS RELATED TO DISPERSAL OF ASYLUM SEEKERS LIVING WITH HIV BEEN ADDRESSED IN THE NEW NASS POLICY BULLETIN?

As outlined on page 4 of this report, NASS has taken steps to find out what the issues of concern are in relation to the health care of asylum seekers, and tried to address these concerns. NASS Policy Bulletin 85 on *Dispersing Asylum Seekers with Health Care Needs*¹⁴ was published in December 2005. The bulletin had been significantly strengthened in relation to people living with HIV compared with the draft bulletin, and we were pleased that many of NAT's recommendations made during the consultation were included.

If implemented effectively, the policy changes that NASS has proposed in the bulletin could improve the experience of the dispersal process for asylum seekers and clinicians. Listed below are NASS policy changes (**paragraph references shown in bold**) that will relate to asylum seekers living with HIV, which NAT hopes will address some of the concerns identified by our research. We have also indicated where we believe further progress is needed.

HIV information for NASS caseworkers

The new NASS policy bulletin, *Dispersing Asylum Seekers with Health Care Needs* includes an annex dealing specifically with HIV. NAT welcomes this guidance that NASS staff must take into consideration when arranging dispersal. **(Paragraph 9.7 and Annex D) NAT recommends that, in the next edition of the policy bulletin, NASS makes reference to the importance of continuity of statutory, voluntary, social and other support networks, to ensure the physical and psychological wellbeing of dispersed asylum seekers living with HIV.**

Furthermore, NASS should make information, in an accessible format, available to key stakeholders, including NASS caseworkers dealing with dispersal, on the new dispersal process of HIV positive asylum seekers.

Application for NASS support

On arrival at an Initial Accommodation Centre, asylum seekers are asked to complete an application for accommodation and financial support from NASS (the NASS 1 form). The form enables NASS to assess eligibility for support depending on personal circumstances, as well as capture relevant information that should be taken into account, including health care needs, when arranging dispersal.

As proposed by NAT, NASS now acknowledges in the policy bulletin that asylum seekers may be fearful of disclosing health care needs. NASS now recommends that people assisting asylum seekers to complete the NASS 1 form (usually voluntary sector support organisation staff) should give reassurance that asylum claims are considered separately from applications for NASS support and that being HIV positive will not affect an application for asylum.

(4.1, 4.2, 9.5)

Late notification of health care needs

Early notification of any health needs will better enable NASS to select an appropriate area for dispersal and suitable accommodation. However it is likely to remain the case that some asylum seekers will continue to delay disclosure of their HIV positive status. **NASS must therefore be prepared for cases in which disclosure of HIV status may be made at a late stage.**

The timing in the dispersal process when an asylum seeker discloses their positive HIV status should not be detrimental to the level of support or standard of accommodation they receive in comparison with those who have disclosed early.

¹⁴ See footnote 1 on page 3.



Confidentiality

It is essential that medical information provided on the NASS 1 form is treated sensitively and confidentially by those processing the forms.

Increasing the confidence of those completing the forms that information they have provided will be treated confidentially may provide reassurance and consequently increase the likelihood of vital information being captured at an earlier stage, ultimately facilitating the work of the NASS dispersal team. **Reference to confidentiality should be made on the NASS 1 form itself, in addition to being mentioned in the guidelines to completing the form.**

In order to provide applicants with a degree of reassurance that information they provide to NASS will be treated in confidence, **measures to protect confidentiality at the processing stage should include ensuring that application forms and other correspondence (both hard copy and electronic) are stored securely - for instance by keeping application forms locked away when not in direct use, and ensuring that screen savers and access passwords are used on staff computers when staff members working on these forms are away from their desks.**

HIV testing

NASS policy bulletin paragraph 5.1 states that HIV testing is offered, "Where there is reason for concern". NAT would go further: our discussions with clinicians and support organisations indicated that information on availability of an HIV test may encourage people to take one - either at that time, or in the future. We therefore recommend that **information about the opportunity to have an HIV test, the circumstances in which a test is advisable, and about the implications of being HIV positive in the UK compared with some other countries (such as access to treatment), should be made readily but confidentially available in initial accommodation centres.**

Delays to dispersal

NAT recognises that for some asylum seekers it is better to be dispersed as soon as possible after their arrival in an initial accommodation centre, in order that they can quickly begin to settle into a new area of residence in the UK. Registration with health care providers can take place once they have arrived in the

new area. However **if an asylum seeker's health may be put at risk as a result of dispersal from an initial accommodation centre, it would be appropriate for dispersal to be delayed.**

As recommended by NAT, the list of conditions in the NASS policy bulletin under which a delay to dispersal might be considered has been extended and now includes HIV. **(6.1)**

Many clinicians were concerned that dispersal should be delayed in cases of co-infection with tuberculosis. This appears to be addressed by the policy bulletin: "where active TB is detected, dispersal should be delayed and treatment commenced locally under the supervision of a TB specialist". **(10.3)**

We also welcome the reference in the policy bulletin that, "where issues of delayed dispersal/continuity of care arise in respect of an asylum seeker who is in initial accommodation, the site health team will liaise with the relevant clinician(s) and the local NASS initial accommodation team about dispersal timing" **(7.1)**, and liaison with clinicians will be with the Complex Casework Team (CCT) in non-initial accommodation cases. **(7.2)**

Dispersal notice

NAT recognises that even if NASS has been notified of the HIV positive status of an asylum seeker, individual dispersal notices sent to asylum seekers cannot make explicit reference to the person's HIV status, to protect the individual's confidentiality in the event of the letter being seen by someone else.

In addition, NASS will be unaware of some asylum seekers' positive HIV status. **The notice of dispersal should therefore always state that the decision to disperse has been made on the basis that an asylum seeker is fit to travel, and that if the applicant has any concerns regarding their health, they must immediately contact their doctor.** This could in fact be beneficial for all asylum seekers with health care needs, not just those with HIV.

There should also be advice on all dispersal notices (in line with the point made above) that **asylum seekers should contact the current voluntary sector support worker to obtain information about support services in the dispersal area.**



In order to maximise the time to prepare for dispersal, or to begin to make arrangements for recommending a delay to dispersal if appropriate, it is important that asylum seekers inform their clinician and/or voluntary sector support worker as soon as possible on receipt of their dispersal notice. NAT would therefore recommend that **clinicians who are treating asylum seekers should be aware of the likelihood of dispersal taking place and, at an early stage, advise their asylum seeker patient to inform them as soon as they have received their dispersal notice.**

Notice period and consultation with clinicians prior to dispersal

In line with NAT's recommendations, the new NASS policy bulletin acknowledges that the notice period should allow for effective preparation for dispersal, and recognises the importance of consultation with treating clinicians prior to dispersal. The bulletin states that dispersal should take place following expert clinical advice from the treating clinician, when asylum seekers and clinicians have had time to adequately prepare for dispersal and have confirmed arrangements with NASS. The arrangements could take four to six weeks to be completed, though in many instances will be done more quickly (9.2). NAT welcomes this progress, and will remain in contact with asylum and HIV support organisations to confirm that this new policy improves the experience of dispersal of asylum seekers living with HIV.

Handover of care

NAT welcomes the recognition in the policy bulletin of the measures that must be in place to ensure necessary handover of care, and the requirement that clinicians are satisfied that the following measures are in place:

"When dispersal is considered possible, NASS caseworkers will not move the asylum seeker until the treating clinician is:

- notified of the asylum seeker's new address;
- satisfied that there are appropriate facilities, (including suitable accommodation facilities) to ensure continuity of care;

- ready to discharge and transfer the asylum seeker's treatment to the receiving Primary Care Trust; and
- able to provide the asylum seeker with sufficient medication to cover them so that the receiving clinician has sufficient time to assess the treatment. This is to ensure that there is no interruption or change of the treatment without sufficient time to properly review the current treatment regime." (9.3)

Clinicians further commented that **in order to save time when trying to trace medical history, a patient is provided with the name, telephone number and/or e-mail address of a nurse or doctor they have seen for care before being dispersed, in order that health staff in the new area of residence can contact them on the asylum seeker's arrival.** NAT would support this recommendation.

NAT also welcomes the fact that NASS is planning to implement a pilot scheme on improving the timeliness, quality and relevance of information provided to PCTs about asylum seekers prior to dispersal. (16)

Communication

NAT welcomes the policy that letters to NASS from clinicians, whether sent directly or through an asylum seeker's representative, must be acknowledged, and NASS contact details provided. **NAT recommends that this should be extended to other forms of communication, such as e-mail.** It should be taken into account also that many clinicians prefer to communicate by telephone and discuss a particular case in confidence, rather than risking breaches of confidentiality by putting details in writing in an e-mail message.

To facilitate communication from clinicians to NASS, **the contact details of NASS regional health contacts provided in the policy bulletin should be publicised to clinicians.**



Children living with HIV

NAT welcomes the policy bulletin references to taking extra care when finding accommodation for families with children living with HIV; that NASS caseworkers will need to satisfy themselves that any accommodation is located where there are appropriate facilities for treating children with HIV and AIDS; and that the NASS Medical Adviser should be asked to provide advice about specific locations. **NAT recommends that the NASS Medical Adviser consults the Children's HIV Association of UK and Ireland (CHIVA) in order to give this advice.**

Furthermore, in line with the recommendation of a clinician who responded to our questionnaire, **cases of dispersal of children with HIV and their families will require a prolonged notice period, to arrange for appropriate multidisciplinary care and education needs.**

Pregnancy

The new policy bulletin states that "When the asylum seeker is pregnant and HIV positive, additional care is required and the case **must** be transferred to the Complex Casework Team (CCT)" (9.4). NAT welcomes this policy, though we stress **the importance of consultation with clinicians before a decision to disperse is made (in line with policy bulletin paragraphs 9.2 and 9.3).**

Registering for health care in new area of residence

As NAT recommended, in cases where the accommodation provider is notified that an asylum seeker has an existing medical condition (although not the nature of the condition), they must take the asylum seeker to register with a GP within five working days. If the asylum seeker is in urgent need of prescribed medication, the timescale will be one working day. (15.8, 15.9)

Arrival briefing

These must be carried out by the accommodation provider within one working day of an asylum seeker's arrival, in a language that can be understood, and include information about registering with a GP and NHS appointments systems. (15.11) NAT welcomes this guidance, but **recommends that recorded information in an understood language, and provision for playing**

it, is also made available where necessary, to enable the asylum seeker to easily refer back to this information. This is in recognition of the fact some individuals may not be able to understand written information even when provided in their own language.

Social and psychosocial support

NAT recommends that **the NASS principles of equivalent standard of care, and ability to access appropriate medical care and special facilities, should include the provision of suitable social and psychosocial support in the areas to which asylum seekers living with HIV are dispersed.**

We would also suggest, as stated above, that **on dispersal notices, asylum seekers are urged to contact their voluntary sector support worker to obtain information about support services in the dispersal area.**

GPs should also be provided with details of local HIV support services to pass on to their patients when they register in their new area of residence.

Paragraph 11.5 of the bulletin (in the mental health section) recognises that "the disruption of therapy with a trusted clinician may be detrimental to an individual's mental health and compromise their capacity for recovery in the long term". **NAT believes that in some cases, effective treatment and care for HIV can be enhanced by a relationship with a particular clinician, and recommends that this is acknowledged by NASS in the next edition of the policy bulletin.**

Feedback from clinicians

In line with the new guidelines on consultation with clinicians (9.2), **NAT recommends that clinicians are surveyed prior to the 12 monthly review of the policy bulletin.** This should ascertain whether they are satisfied that their recommendations have been taken into account when dispersal is being arranged and that the health of their patient did not suffer as a result of dispersal. **Clinicians should also be provided with a way to give evidence and feedback to NASS in an ongoing manner if they wish.**



▶ NEXT STEPS

NAT welcomes the progress that NASS has made in addressing concerns around dispersal of asylum seekers living with HIV. We appreciate that policy and practice around dispersal is undergoing change, and our interest in this issue is ongoing. NAT will remain in contact with relevant stakeholders regarding the impact of the new NASS policies and practices on asylum seekers living with HIV, in preparation for the review of the NASS policy bulletin planned for 12 months' time. We would therefore urge clinicians and support organisations with an interest in this issue to keep a brief record of positive or negative occurrences in relation to dispersal of asylum seekers living with HIV that could help to inform that review.

▶ ACKNOWLEDGEMENTS

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▶ ABOUT THE NATIONAL AIDS TRUST

NAT is the leading independent policy development and campaigning voice on HIV and AIDS. A registered charity, we develop policies and campaign to halt the spread of HIV, and improve the quality of life of people affected by HIV, both in the UK and internationally.

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January 2006

▶ QUANTITATIVE RESULTS OF QUESTIONNAIRES TO CLINICIANS

The questionnaire was developed by NAT staff with advice from an experienced HIV clinician and was distributed via a British HIV Association (BHIVA) members mailing. A reference to the questionnaire was also included in HIV Treatment Bulletin², with a link to the questionnaire on the NAT web site for clinicians to complete. To ensure that the surveys downloaded from the internet were indeed completed by clinicians, only those which included contact details were used. Everyone who completed the survey remains anonymous.

Seventy nine completed or partially completed questionnaires were returned to NAT, and 64 were suitable for analysis. The results of NAT's questionnaires in no way claim to be a comprehensive overview of the opinions of all support organisations or of clinicians treating asylum seekers living with HIV. Firstly, the responses to our questionnaire and comments made in one-to-one discussions are based on personal views. Secondly, changes are taking place in NASS accommodation provision and we recognise that data in this report may relate to systems that are in the process of being changed or will be changing². **(see 2.4 of new policy bulletin).**

In some cases, percentages have been rounded up or down by a fraction of a percentage point for ease of reporting, but actual numbers of responses received are shown. A copy of the questionnaire can be found at annex 2.

HEALTH PROFESSIONALS IN AREAS FROM WHICH ASYLUM SEEKERS HAVE BEEN DISPERSED

TABLE 1

Q1 How many HIV positive asylum seekers have you treated over the past 12 months?

RESPONSES: 36

4	had fewer than 10 new patients in a year
11	had between 10 and 20 new patients in a year
21	had over 20 new patients in a year
5	did not provide actual numbers

Highest number of new patients: 150

Lowest number of new patients: 1

¹ HIV Treatment Bulletin is a not-for-profit community publication that aims to provide a review of the most important medical advances related to clinical management of HIV and its related conditions as well as access to treatments. It is produced by HIV i-Base, an HIV positive-led activist group that produces treatment information for positive people and health care professionals. See <http://www.i-base.org.uk/htb/index.html>

² See paragraph 2.4 of NASS policy bulletin 85, Dispersing asylum seekers with health care needs

**TABLE 2****Q2 How many of your HIV positive asylum seeker patients have NASS wished to disperse in the past 12 months?**

RESPONSES: 32

21	Under 10
11	10 or more
9	did not provide actual numbers

TABLE 3**Q3 The current notice period for dispersal of HIV positive asylum seekers is adequate**

RESPONSES: 41

1	strongly agree	2	5%
2	agree	3	7%
3	neither	8	19%
4	disagree	6	15%
5	strongly disagree	22	54%

To what extent do you agree with the following statements? Please circle:

1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree, 5=strongly disagree

TABLE 4**Q4a The notice period provided my patients and me adequate time to arrange medication for the journey and arrival in the new area**

RESPONSES: 41

1	strongly agree	1	2%
2	agree	3	7%
3	neither	4	10%
4	disagree	11	27%
5	strongly disagree	22	54%

TABLE 5**Q4b The notice period provided my patients and me adequate time to identify an appropriate clinic and arrange treatment and care in new area**

RESPONSES: 41

1	strongly agree	0	0%
2	agree	2	5%
3	neither	4	10%
4	disagree	9	22%
5	strongly disagree	26	63%

**TABLE 6****Q4c The notice period provided my patients and me time for adequate handover of medical records to the dispersal area**

RESPONSES: 41

1	strongly agree	0	0%
2	agree	3	7%
3	neither	3	7%
4	disagree	6	15%
5	strongly disagree	29	71%

TABLE 7**Q5 If you believe that an extension to this notice period is required, how long should this be?**

RESPONSES: 32

Should not be dispersed	2
2 weeks	2
At least 3 weeks	1
4 weeks	10
At least 4 weeks	4
At least 6 weeks	4
At least 1 - 2 months	1
1 - 3 months	1
3 months	3
Over 4 months	1
5 months	1
As long as necessary	1

Plus 'Notice period extension does not help. It requires close liaison'.

TABLE 8**Q6a Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has a recent, new HIV diagnosis**

RESPONSES: 41

1	strongly agree	22	54%
2	agree	13	32%
3	neither	3	7%
4	disagree	3	7%
5	strongly disagree	0	0%

**TABLE 9**

Q6b Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has asymptomatic HIV and is not on antiretroviral therapy

RESPONSES: 41

1	strongly agree	7	17%
2	agree	4	10%
3	neither	12	29%
4	disagree	14	34%
5	strongly disagree	4	10%

TABLE 10

Q6c Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has a current or recent (within three months) AIDS diagnosis

RESPONSES: 41

1	strongly agree	26	63%
2	agree	7	17%
3	neither	4	10%
4	disagree	3	7%
5	strongly disagree	1	3%

TABLE 11

Q6d Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has co-infection with a sexually transmitted infection

RESPONSES: 41

1	strongly agree	13	32%
2	agree	12	29%
3	neither	7	17%
4	disagree	7	17%
5	strongly disagree	2	5%

TABLE 12

Q6e Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has coexisting mental health problems

RESPONSES: 41

1	strongly agree	25	61%
2	agree	8	20%
3	neither	3	7%
4	disagree	1	2%
5	strongly disagree	4	10%

**TABLE 13**

Q6f Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient is a woman who is pregnant or has given birth less than three months previously

RESPONSES: 41

1	strongly agree	33	81%
2	agree	2	5%
3	neither	1	2%
4	disagree	3	7%
5	strongly disagree	2	5%

TABLE 14

Q6g Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has just initiated antiretroviral therapy

RESPONSES: 41

1	strongly agree	33	81%
2	agree	4	10%
3	neither	1	2%
4	disagree	0	0%
5	strongly disagree	3	7%

TABLE 15

Q6h Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has been on antiretroviral therapy up to three months

RESPONSES: 41

1	strongly agree	11	27%
2	agree	18	44%
3	neither	5	12%
4	disagree	6	15%
5	strongly disagree	1	2%

TABLE 16

Q7 In your experience over the last 12 months, dispersal of HIV positive asylum seekers was safe and appropriate in the following proportion of cases

RESPONSES: 37

Never	8	22%
0-25%	19	51%
26-50%	6	16%
51-75%	2	5%
76-100%	1	3%
Always	1	3%

**TABLE 17**

Q8 In cases where you provided expert medical advice over the last 12 months, due consideration was given to this advice before dispersal in the following proportion of cases

RESPONSES: 29

Never	6	21%
0–25%	12	41%
26–50%	5	17%
51–75%	4	14%
76–100%	1	3.5%
Always	1	3.5%

TABLE 18

Q9a It is my view that HIV positive asylum seekers dispersed from my care in the past 12 months received an equivalent standard of care in the area they were dispersed to in the following proportion of cases

RESPONSES: 22

Never	1	4%
0–25%	6	27%
26–50%	3	14%
51–75%	5	23%
76–100%	4	18%
Always	3	14%

HEALTH PROFESSIONALS IN AREAS TO WHICH ASYLUM SEEKERS HAVE BEEN DISPERSED

TABLE 19

Q1 How many HIV positive asylum seekers have joined your clinical service over the past 12 months?

RESPONSES: 19

7	had under 10 new patients in a year
6	had between 10 and 20
6	had over 20
4	did not provide actual numbers

Highest number of new patients: 50

Lowest number of new patients: 2

**TABLE 20**

Q2 It was safe and appropriate to disperse the HIV positive asylum seekers who have arrived in my area over the last 12 months in the following proportion of cases

RESPONSES: 22

Never	1	5%
0-25%	2	9%
26-50%	4	18%
51-75%	6	27%
76-100%	8	36%
Always	1	5%

TABLE 21

Q3a Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has a recent, new HIV diagnosis

RESPONSES: 23

1	strongly agree	15	65%
2	agree	3	13%
3	neither	1	4%
4	disagree	2	9%
5	strongly disagree	2	9%

TABLE 22

Q3b Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has asymptomatic HIV and is not on antiretroviral therapy

RESPONSES: 23

1	strongly agree	3	13%
2	agree	2	9%
3	neither	9	39%
4	disagree	5	22%
5	strongly disagree	4	17%

**TABLE 23**

Q3c Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has a current or recent (within three months) AIDS diagnosis

RESPONSES: 23

1	strongly agree	13	56%
2	agree	4	17%
3	neither	2	9%
4	disagree	2	9%
5	strongly disagree	2	9%

TABLE 24

Q3d Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has co-infection with a sexually transmitted infection

RESPONSES: 23

1	strongly agree	10	44%
2	agree	7	30%
3	neither	4	17%
4	disagree	0	0%
5	strongly disagree	2	9%

TABLE 25

Q3e Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has coexisting mental health problems

RESPONSES: 23

1	strongly agree	15	65%
2	agree	2	9%
3	neither	2	9%
4	disagree	0	0%
5	strongly disagree	4	17%

TABLE 26

Q3f Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient is a woman who is pregnant or has given birth less than three months previously

RESPONSES: 23

1	strongly agree	15	65%
2	agree	4	17.5%
3	neither	0	0%
4	disagree	0	0%
5	strongly disagree	4	17.5%

**TABLE 27**

Q3g Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has just initiated antiretroviral therapy

RESPONSES: 23

1	strongly agree	15	65%
2	agree	4	17.5%
3	neither	0	0%
4	disagree	0	0%
5	strongly disagree	4	17.5%

TABLE 28

Q3h Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient has been on antiretroviral therapy up to three months

RESPONSES: 23

1	strongly agree	6	26%
2	agree	7	30%
3	neither	5	22%
4	disagree	3	13%
5	strongly disagree	2	9%

TABLE 29

Q4 Over the past 12 months I was fully informed about the medical history of my HIV positive asylum seeker patients at the time of their arrival in the following proportion of cases

RESPONSES: 22

Never	7	33%
0-25%	9	43%
26-50%	2	9.5%
51-75%	1	5%
76-100%	2	9.5%
Always	0	0%

**TABLE 30**

Q5 Hand held medical records would be useful in registering and treating dispersed HIV positive asylum seeker patients

RESPONSES: 22

1	strongly agree	11	50%
2	agree	7	32%
3	neither	1	4.5%
4	disagree	2	9%
5	strongly disagree	1	4.5%

TABLE 31

Q6 My HIV positive asylum seeker patients registered for care within a reasonable period upon their arrival in my area in the following proportion of cases

RESPONSES: 19

Never	0	0%
0-25%	5	26.5%
26-50%	7	37%
51-75%	1	5%
76-100%	5	26.5%
Always	1	5%

TABLE 32

Q7a A NASS principle is for dispersed asylum seekers with health care needs to be able to access appropriate medical care and any special facilities they may need. In my opinion, this principle was met for those HIV positive asylum seekers dispersed to my area over the past 12 months in the following proportion of cases

RESPONSES: 20

Never	3	15%
0-25%	4	20%
26-50%	5	25%
51-75%	2	10%
76-100%	3	15%
Always	3	15%

**TABLE 33**

Q7b A further NASS principle is for continuity of treatment to be arranged when dispersal is taking place. In my opinion, this principle was met for those HIV positive asylum seekers dispersed to my area over the past 12 months in the following proportion of cases

RESPONSES: 21

Never	5	24%
0-25%	5	24%
26-50%	3	14%
51-75%	3	14%
76-100%	3	14%
Always	2	10%

TABLE 34

Q8a More notice prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of clinical care

RESPONSES: 22

1	strongly agree	15	68%
2	agree	5	23%
3	neither	2	9%
4	disagree	0	0%
5	strongly disagree	0	0%

TABLE 35

Q8b More notice prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of administration

RESPONSES: 22

1	strongly agree	11	50%
2	agree	9	41%
3	neither	2	9%
4	disagree	0	0%
5	strongly disagree	0	0%

**TABLE 36**

Q8c More notice prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of interpreting/translation

RESPONSES: 22

1	strongly agree	13	59%
2	agree	6	27%
3	neither	2	9%
4	disagree	1	5%
5	strongly disagree	0	0%

TABLE 37

Q9a More information/medical history prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of clinical care

RESPONSES: 22

1	strongly agree	16	73%
2	agree	5	23%
3	neither	0	0%
4	disagree	0	0%
5	strongly disagree	1	4%

TABLE 38

Q9b More information/medical history prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of administration

RESPONSES: 21

1	strongly agree	12	57%
2	agree	8	38%
3	neither	0	0%
4	disagree	1	5%
5	strongly disagree	0	0%

TABLE 39

Q9c More information/medical history prior to arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of interpreting/translation

RESPONSES: 20

1	strongly agree	12	60%
2	agree	5	25%
3	neither	2	10%
4	disagree	1	5%
5	strongly disagree	0	0%

**TABLE 40**

Q10 NASS should require individual housing providers either to accompany dispersed asylum seekers to a GP for registration within a defined period, or otherwise ensure that registration with a GP takes place

RESPONSES: 19

1	strongly agree	9	47%
2	agree	6	32%
3	neither	3	16%
4	disagree	1	5%
5	strongly disagree	0	0%

TABLE 41

Q11 My HIV positive asylum seeker patients have experienced interruption to their antiretroviral therapy as a result of being dispersed in the following proportion of cases

RESPONSES: 21

Never	2	10%
0-25%	12	57%
26-50%	3	14%
51-75%	3	14%
76-100%	1	5%
Always	0	0%

TABLE 42

Q12 Over the past 12 months, dispersal to this area has had a detrimental impact on my HIV positive patients' health in the following proportion of cases

RESPONSES: 19

Never	4	21%
0-25%	8	42%
26-50%	7	37%
51-75%	0	0%
76-100%	0	0%
Always	0	0%



SAMPLE QUESTIONNAIRE

NATIONAL AIDS TRUST QUESTIONNAIRE DISPERSAL OF ASYLUM SEEKERS LIVING WITH HIV

▶ SECTION 1

Please tick appropriate box:

- A. I practice in an area where asylum seekers have been dispersed from
If you have ticked box A, please complete section 2 (below).
- B. I practice in an area where asylum seekers have been dispersed to
If you have ticked box B, please complete section 3 (on page 5).

▶ SECTION 2

For health professionals in areas where asylum seekers have been dispersed from

- Q1.** How many HIV positive asylum seekers have you treated over the past 12 months?
- Q2.** How many of your HIV positive asylum seeker patients have NASS wished to disperse in the past 12 months?

To what extent do you agree with the following statements?

Please circle:

1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree, 5=strongly disagree

- Q3.** The current notice period for dispersal of HIV positive asylum seekers is adequate 1 2 3 4 5
- Q4.** The notice period provided my patients and me adequate time:
- | | |
|---|-------------------|
| a) to arrange medication for the journey and arrival in new area | 1 2 3 4 5 |
| b) to identify an appropriate clinic and arrange treatment and care in new area | 1 2 3 4 5 |
| c) for adequate hand over of medical records to the dispersal area | 1 2 3 4 5 |

Any further comments/suggestions?

- Q5.** If you believe that an extension to this notice period is required, how long should this be?



Q6. Please consider the following medical situations and give your responses 1–5 as above

Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient:					
a) has a recent, new HIV diagnosis	1	2	3	4	5
b) has asymptomatic HIV and is not on antiretroviral therapy	1	2	3	4	5
c) has a current or recent (within three months) AIDS diagnosis	1	2	3	4	5
d) has co-infection with a sexually transmitted infection	1	2	3	4	5
e) has coexisting mental health problems	1	2	3	4	5
f) is a woman who is pregnant or has given birth less than three months previously	1	2	3	4	5
g) has just initiated antiretroviral therapy	1	2	3	4	5
h) has been on antiretroviral therapy up to three months	1	2	3	4	5
i) Please add any other particular medical situations that you feel should be considered.	1	2	3	4	5

Any further comments/suggestions?

Q7. In your experience over the last twelve months, dispersal of HIV positive asylum seekers was safe and appropriate in the following proportion of cases:

Never	0-25%	26-50%	51-75%	76-100%	Always
-------	-------	--------	--------	---------	--------

Q8. In cases where you provided expert medical advice over the last twelve months, due consideration was given to this advice before dispersal in the following proportion of cases:

Never	0-25%	26-50%	51-75%	76-100%	Always
-------	-------	--------	--------	---------	--------

Any further comments/suggestions?

Q9. a) It is my view that HIV positive asylum seekers dispersed from my care in the past twelve months received an equivalent standard of care in the area they were dispersed to in the following proportion of cases:

Never	0-25%	26-50%	51-75%	76-100%	Always
-------	-------	--------	--------	---------	--------

b) Are there any elements of care you are particularly concerned about?

Q10. Could anything be done to improve the experience of HIV positive asylum seekers being dispersed?

Please use this space to provide any further information you believe to be relevant (and continue on a separate sheet if necessary). We would be very grateful for examples of good practice and also issues of concern, with anonymised cases to illustrate the points you are making. Any recommendations for improvement to the dispersal process would also be very useful. The remaining questions are for clinicians in areas where asylum seekers have been dispersed to. Thank you for completing this questionnaire.



SECTION 3

For health professionals in areas where asylum seekers have been dispersed to

- Q1.** How many HIV positive asylum seekers have joined your clinical service over the past 12 months?
- Q2.** It was safe and appropriate to disperse the HIV positive asylum seekers who have arrived in my area over the last 12 months, in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|

To what extent do you agree with the following statements?

Please circle:

1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree, 5=strongly disagree

- Q3.** Dispersal of an asylum seeker with HIV should be delayed for medical reasons if the patient:
- | | | | | | |
|---|---|---|---|---|---|
| a) has a recent, new HIV diagnosis | 1 | 2 | 3 | 4 | 5 |
| b) has asymptomatic HIV and is not on antiretroviral therapy | 1 | 2 | 3 | 4 | 5 |
| c) has a current or recent (within three months) AIDS diagnosis | 1 | 2 | 3 | 4 | 5 |
| d) has co-infection with a sexually transmitted infection | 1 | 2 | 3 | 4 | 5 |
| e) has coexisting mental health problems | 1 | 2 | 3 | 4 | 5 |
| f) is a woman who is pregnant or has given birth less than three months previously | 1 | 2 | 3 | 4 | 5 |
| g) has just initiated antiretroviral therapy | 1 | 2 | 3 | 4 | 5 |
| h) has been on antiretroviral therapy up to three months | 1 | 2 | 3 | 4 | 5 |
| i) Please add any other particular medical situations that you feel should be considered. | 1 | 2 | 3 | 4 | 5 |

Any further comments/suggestions?

- Q4.** Over the past 12 months, I was fully informed about the medical history of my HIV positive asylum seeker patients at the time of their arrival in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|
- Q5.** Hand held medical records would be useful in registering and treating dispersed HIV positive asylum seeker patients (please give your responses 1-5 as above):
- 1 2 3 4 5
- Q6.** My HIV positive asylum seeker patients registered for care within a reasonable period upon their arrival in my area in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|
- Q7.** a) A NASS principle is for dispersed asylum seekers with healthcare needs to be able to access appropriate medical care and any special facilities they may need. In my opinion, this principle was met for those HIV positive asylum seekers dispersed to my area over the past twelve months in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|
- b) Are there any elements of care you are particularly concerned about?
- c) A further NASS principle is for continuity of treatment to be arranged when dispersal is taking place. In my opinion, this principle was met for HIV positive asylum seekers dispersed to my area over the past twelve months in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|



To what extent do you agree with the following statements?

Please circle:

1=strongly agree, 2=agree, 3=neither agree nor disagree, 4=disagree, 5=strongly disagree

- Q8.** More notice prior to the arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of:
- | | | | | | |
|----------------------------------|---|---|---|---|---|
| a) clinical care | 1 | 2 | 3 | 4 | 5 |
| b) administration | 1 | 2 | 3 | 4 | 5 |
| c) interpreting/translation | 1 | 2 | 3 | 4 | 5 |
| d) other issues - please specify | 1 | 2 | 3 | 4 | 5 |
- Q9.** More information/medical history prior to the arrival of HIV positive dispersed asylum seekers would have been beneficial in terms of:
- | | | | | | |
|----------------------------------|---|---|---|---|---|
| a) clinical care | 1 | 2 | 3 | 4 | 5 |
| b) administration | 1 | 2 | 3 | 4 | 5 |
| c) interpreting/translation | 1 | 2 | 3 | 4 | 5 |
| d) other issues - please specify | 1 | 2 | 3 | 4 | 5 |
- Q10.** NASS should require individual housing providers either to accompany dispersed asylum seekers to a GP for registration within a defined period, or otherwise ensure that registration with a GP takes place
- 1 2 3 4 5
- Q11.** My HIV positive asylum seeker patients have experienced interruption to their antiretroviral therapy as a result of being dispersed in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|
- Q12.** Over the past 12 months, dispersal to this area has had a detrimental impact on my HIV positive patients' health in the following proportion of cases:
- | | | | | | |
|-------|-------|--------|--------|---------|--------|
| Never | 0-25% | 26-50% | 51-75% | 76-100% | Always |
|-------|-------|--------|--------|---------|--------|
- Please give examples
- Q13.** Could anything be done to improve your experience of receiving dispersed asylum seekers?

Please use this space to provide any further information you believe to be relevant (and continue on a separate sheet if necessary). We would be very grateful for examples of good practice and also of issues of concern, with anonymised cases to illustrate the points you are making. Any recommendations for improvement to the dispersal process would also be very useful. Thank you for taking the time to complete this questionnaire.