

United Kingdom

Country statistics

The population of the country is 67,666,301. In 2018 the HIV prevalence was 103,800; the HBV prevalence was estimated at 180,000 chronic stage and 0.68 per 100,000 acute (2018). The HCV prevalence in the country was 143,000 and TB prevalence (for England only) was 8.3 per 100,000.

In 2018, 9.4% of adults between the age of 16-59 reported taking drugs in England and Wales; 37% of people in drug treatment services had injected (2018)

There were 11.2 deaths per 100,000 people (2018) by suicide. The prevalence of mental illness due to variability in definitions is difficult to estimate.

In 2018, there were 447,694 diagnoses of sexually transmitted infections (STIs) made in England.

Access in the general population

In the general population there is theoretical access to prevention services, methods and tools, but in practice service availability is limited.

Treatment is available for HIV, HBV, HCV, and TB.

Definition of closed setting – closed settings relevant in the national context

There is no definition for closed settings in the UK but they include prisons; pre-trial detention; police custody (after arrest); immigration detention centres where migrants are detained prior to deportation; and other settings including secure facilities for children and young people, and police and court Liaison and Diversion services

Difference of prevalence in closed settings vs general population

The estimated prevalence of HIV and other blood borne viruses (BBVs) is higher in closed settings as there is higher prevalence of other linked behaviours, particularly injecting drug use.

Funding for prevention and health interventions in closed settings

In England, NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities for children and young people, police and court Liaison and Diversion services and immigration removal centres. It is also responsible for sexual abuse/assault services.

The Health and Justice services are commissioned via 10 Health and Justice teams across 4 regions (North, Midlands, London and South). Central Government (Department for Health and Social Care) funds NHS England.

In Wales, Local Health Boards (LHBs) commission healthcare services in public sector prisons (including clinical drug treatment services), and are responsible for commissioning mainstream healthcare services which offenders in the community will access.

In Scotland, the responsibility for healthcare in the Scottish Prison Service (SPS) sits with local health boards. The commissioning guidelines place responsibility for healthcare costs on the health board of residence, not the situation of the prison. For the first six months of their custodial sentence, prisoners are considered to be resident in the area where they were ordinarily resident before they were sentenced, or the area in which the offence was committed if their ordinary residence cannot be determined. After a period of six months following conviction, a person held in prison is to be treated as ordinarily resident at the place where that person is held.

In Northern Ireland, Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Hydebank Wood College, and Magilligan and are managed by the South Eastern Health and Social Care Trust, which is the local HSCB (Health and Social Care Board).

People in prison across the UK are entitled to the same level of healthcare as those in the community. This is called 'equivalence of care'.

Prison statistics

The size of prison population was 83,430 in England and Wales (end of May 2018); 7,595 in Scotland (end of June 2018); and 1,475 in Northern Ireland (end of March 2018).

In the most recent estimates, approximately 1% of women and 0.3% of men in prison were living with HIV, but it is not clear when these estimates are from (they are from before 2017).

There are no official estimates for HBV prevalence; however, there are indicators that it is higher than among the general population.

13% of women prisoners and 7% of men are estimated to have HCV in prisons (pre 2017).

There are no official estimates of TB in prisons but it is considered to be higher than in the general population.

The prevalence of mental illness is unknown; there are indicators that it is higher than among the general population. The suicide rate was 1.1 per 1,000 prisoners in 2018. Suicide accounted for 92 of 325 deaths.

The prevalence of STIs is unknown in prisons.

Access and policies vs practice in prisons

Hepatitis vaccinations, information on BBVs and HIV, and prevention measures such as condoms and lubricants, Pre-Exposure Prophylaxis and Post-Exposure Prophylaxis, and needle and syringe exchange, opioid

substitution therapy and Naloxone are theoretically available, but in practice access is limited and highly variable between prisons.

BBV testing is supposed to be opt-out but in reality some prisons are better than others at implementing this policy. 34% of new arrivals in prison were tested for HIV in 2018. Rates of take up from BBV testing indicate that it is in fact opt-in in a lot of prisons and some have not implemented the policy fully at all. There are pressures on time but also communications - i.e. actually asking people to opt-in.

Access to healthcare should be equivalent to in the community but in reality we know that people struggle to access sexual health services and testing. There is not always clear information on how to access testing. Health checks and wider healthcare support is often inadequate.

Other issues in prisons

PLHIV, people with viral hepatitis and TB patients are detained together with the other detainees.

There is mixed practice whether HIV, viral hepatitis and TB specialists visit patients in the prison or whether they are transported to the specialist clinic or offices. The necessary transportation usually takes place, but not always.

Trans people can access hormonal therapy in theory but NAT (National AIDS Trust) is aware of issues with access in prisons.

Training for prison staff happens on an ad hoc basis, and rarely rather than regularly.

Medical information should always be confidential; however, there can be issues with prison staff sharing information if they learn about someone's status.

Other services for PLHIV are rarely available, and usually only if the specialist HIV clinic is able to provide them. Other services for patients with viral hepatitis or TB depend on the institution but are usually low level and not comprehensive.

Some of these services are sometimes provided by NGOs but also on a very ad hoc basis.

Pre-trial detention statistics

The pre-trial population was 9145 in June 2019. People are detained prior to their trials in the same facilities as those who have been sentenced. The data for those in pre-trial detention cannot be separated from that for prisons. Therefore, the following data is for the entire prison population, not just for those in pre-trial detention. In most recent estimates, approximately 1% of women and 0.3% of men in prison were diagnosed with HIV, but it is not clear when these data were collected (pre 2017). The prevalence of HBV is unknown, but there are indicators that it is much higher than among the general population. The prevalence of HCV is 13% of women prisoners and 7% of men (pre 2017 estimates). TB prevalence is unknown, but there are indicators that it is higher than among the general population.

The prevalence of mental illness is unknown. The suicide rate is 1.1 per 1,000 prisoners in 2018. The prevalence of STIs is unknown.

Access and policies vs practice in pre-trial detention

PLHIV, patients with viral hepatitis and TB are held together with the general prison population, therefore the information below describes prisons in general, rather than pre-trial detention specifically.

There is access to prevention tools and methods in theory, but in reality, there is limited access or none at all.

Treatment services for HIV, HBV, HCV, and TB are available.

BBV testing is supposed to be opt-out but in reality, some prisons are better than others at implementing this policy. Rates of take up indicated that it is in fact opt-in in a lot of prisons and some have not implemented the policy fully at all. There are pressures on time but also communications - i.e. actually asking people to opt-in. Some prisons are better than others at implementation of the opt-out policy.

Other issues in pre-trial detention

For specialist check-ups, people held in prisons are usually transported to the relevant specialist clinics.

NGOs are present in some of the facilities but they do not provide a standardised service, rather provision is on an ad hoc basis.

People in police custody statistics

There is no data available on police custody.

Access and policies vs practice for people in police custody

Treatment is available but there are no policies for testing and screening activities in police custody.

Testing tends only to be considered in police custody following incidents where there are concerns for officer safety. A law was considered to allow forced testing in these circumstances, which NAT successfully challenged.

If someone says, they need access to medication then the police should help them to access it but in reality, NAT is aware that people often go without while in custody. There are some better-informed custody nurses but experiences are very mixed.

Other issues for people in police custody

PLHIV, patients with viral hepatitis and TB are held together with other detained people.

In general, people can only be held in police custody for 24 hours. This is not long enough to be visited by specialists or to be transported to a specialist facility for their HIV, viral hepatitis or TB care and treatment. NGOs are present in some of the facilities but it is not a standardised service they provide, rather on an ad hoc basis.

Centres for refugees and migrants statistics

People who are subject to immigration controls can be held in immigration removal centres (IRCs) prior to deportation. There are no detention centres for those who have successfully claimed refugee status, but some people who have been detained may make an asylum claim. The size of the IRC population was 2,226 as at the end of June 2018; over the course of 2018, 27,348 entered these facilities.

Prevalence of communicable diseases or mental illnesses in IRCs is unknown.

36% of deaths in immigration detention were the result of suicide for the period of 2010-2015.

Access and policies vs practice in centres for refugees and migrants

In theory, the 'equivalence of care' principle extends to immigration detention. Therefore, anyone detained in an IRC should receive the same standard of care that is available to the general community.

Prevention tools and methods are theoretically available, but they are not commonly or universally available.

There is access to treatment. However, there are barriers to healthcare for individuals in immigration detention. Everyone should be able to access testing in immigration removal centres but in reality, there are many barriers in access to healthcare for people in IRCs

Other issues in centres for refugees and migrants

PLHIV, patients with viral hepatitis and TB are held together with other people in the centres.

For specialist check-ups, they are usually transported to the relevant specialist clinics, but there is good evidence that people miss appointments because of transport being unavailable

NGOs are present in some of the facilities but they do not provide a standardised service, rather their service provision is on an ad hoc basis and will vary.

Young people

Closed settings for young people include youth prison and correction (training) centres for young offenders in the UK.

The policy around opt-out BBV testing does not apply to youth detention settings. Young people in detained settings should have access to equivalence of care and should have condoms and other prevention tools made available. This is likely to vary between settings.