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**Promoción y protección de todos los derechos humanos,
civiles, políticos, económicos, sociales y culturales,
incluido el derecho al desarrollo**

Informe del Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental, Anand Grover*

Adición

Misión a Australia**

Resumen

El Relator Especial sobre el derecho de toda persona al disfrute del más alto nivel posible de salud física y mental ("derecho a la salud") visitó Australia del 23 de noviembre al 4 de diciembre de 2009. El Relator Especial celebró reuniones con representantes del Gobierno, organizaciones de la sociedad civil y profesionales de la salud en Canberra, Sydney, Brisbane, Melbourne, Alice Springs y Darwin.

Aunque el nivel de vida y la calidad de la atención de salud en Australia son excelentes, durante su misión el Relator Especial le preocupó especialmente la prestación de servicios de salud a los aborígenes y los isleños del Estrecho de Torres, así como a las personas privadas de libertad, tanto en prisiones como centros de internamiento de inmigrantes.

En la sección II del presente informe se examina el marco jurídico internacional y nacional en el que se inscribe el derecho a la salud en Australia y se estudia el reconocimiento de los derechos humanos internacionales en el derecho australiano.

* Documento presentado con retraso.

** El resumen del presente informe se distribuye en todos los idiomas oficiales. El informe propiamente dicho figura en el anexo al resumen y se distribuye únicamente en el idioma en que se presentó.

En la sección III se analizan cuestiones relacionadas con la salud de los indígenas, incluido el contexto histórico que generó las dificultades que enfrentan actualmente esas comunidades. En gran parte, esas dificultades tienen que ver con las deficientes condiciones socioeconómicas que repercuten negativamente en los factores sociales determinantes de la salud, y hasta hace poco, el descuido y la insuficiencia de recursos de este sector. El Relator Especial examina varias cuestiones, como el éxito educativo, el acceso a los servicios básicos, el personal de salud y la participación política, así como las últimas iniciativas oficiales en materia de servicios sociales para los indígenas.

La sección IV se centra en el derecho a la salud de las personas privadas de libertad en Australia, en concreto en las prisiones y los centros de internamiento para los inmigrantes ilegales. El Relator Especial observó algunas incongruencias en el trato y el acceso a los servicios entre los distintos centros y consideró particularmente preocupante el efecto desproporcionado de la encarcelación en las poblaciones indígenas, así como en los enfermos mentales. También observó que la persistencia de la política australiana del internamiento obligatorio de las personas en situación irregular llegadas por vía marítima obstaculiza el ejercicio efectivo del derecho a la salud por los solicitantes de asilo en Australia.

En la sección V, el Relator Especial expone sus conclusiones y recomendaciones en relación con cada una de las esferas examinadas durante la misión.

Anexo

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his mission to Australia (23 November to 4 December 2009)

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I. Introduction

1. At the invitation of the Government, the Special Rapporteur visited Australia from 22 November to 4 December 2009. The purpose of the mission was to understand, in a spirit of co-operation and dialogue, how Australia endeavours to implement the right to health, the measures taken for its successful realization and the obstacles encountered both at the national and international level.

2. The key themes of the mission were the impact of poverty and discrimination, including inequalities, on the enjoyment of the right to health, and in particular in the context of indigenous health, and health care in detention establishments, including those for asylum-seekers, refugees and prisoners. During the twelve-day mission, the Special Rapporteur travelled to Canberra, Sydney, Melbourne, Brisbane, Alice Springs, Darwin and North Stradbroke Island and had the opportunity to visit Indigenous communities and meet with their representatives.

3. Throughout the mission, all levels of Government and other relevant actors were open and constructive. The Special Rapporteur had the pleasure of meeting the Minister for Health and Ageing, Nicola Roxon, MP, the Minister for Immigration and Citizenship, Senator Chris Evans, the Minister for Indigenous Health, Rural and Regional Health and Regional Services Delivery, Warren Snowdon, MP, and the Parliamentary Secretary for Disabilities and Children's Services, Bill Shorten, MP, as well as a number of senior Government officials.

4. The Special Rapporteur also had the opportunity to meet with representatives of civil society organizations and communities, academics and health professionals, and would like to thank all those who have given their time and extended co-operation to him. In particular, he would like to acknowledge the valuable contribution and insights of Dr. Ngaire Brown, Mr. Michael Levy, Professor Ian Anderson and Justice Elizabeth Evatt.

5. The Special Rapporteur would like to thank all those who he met throughout the mission for their cooperation, and their commitment to realization of the right to health.

II. International and national legal framework

6. Australia has ratified several international human rights treaty recognizing the enjoyment of the right to health, including the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

7. Australia, being a dualist nation, needs to incorporate rights encompassed by those treaties into domestic law to make them directly justiciable. Currently, none of the aforementioned treaties has been entirely legislatively incorporated into Australian law. The Special Rapporteur regrets that there is no such formal recognition of the right to health in Australia. Australia's obligations to respect and protect human rights derives from its adherence to the core international human rights treaties and ratification of these treaties gives rise to binding obligations under international law, to ensure the enjoyment of the right to health of every person within its jurisdiction as outlined within these international instruments.

8. The Special Rapporteur welcomes the Australian government's support for the United Nations Declaration on the Rights of Indigenous Peoples. Through its endorsement of the Declaration, Australia reaffirms the right of Indigenous peoples to access all social and health services without discrimination. Australia is also committed to improvement of economic and social conditions of Indigenous peoples including education, employment and housing, and their right to the enjoyment of the highest attainable standard of physical and mental health, and commits itself to take the necessary steps with a view to progressively achieving full realization of these rights.¹

9. All rights enshrined within the International Covenant on Economic, Social and Cultural Rights are to be applied without discrimination.² States should refrain from denying or limiting equal access for all persons, including minorities, to preventive, curative and palliative health services.³ Indigenous peoples have the right to specific measures to improve their access to health services⁴ that are culturally appropriate, taking into account traditional practices and medicines. The Committee on Economic, Social and Cultural Rights notes that, in indigenous communities, individual health is often linked to the health of the society as a whole, and has a collective dimension.⁵

10. The enjoyment of the right to health of persons in detention is protected by a number of international treaties to which Australia is party. All persons deprived of their liberty are entitled to be treated with humanity and respect for the inherent dignity of the human person.⁶ States should refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.⁷ Furthermore, health professionals should provide incarcerated individuals with the same quality and standard of care as those who are not imprisoned.⁸ States are also urged to ensure that individuals in detention have access to information and effective legal means enabling them to ensure that their humanity and dignity are respected, to complain if these rules are ignored, and to obtain adequate compensation in the event of a violation.⁹

11. The principle of equivalence, as stipulated in the Basic Principles for the Treatment of Prisoners, indicates that 'except for those limitation that are demonstrably necessary by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights as well as the rights as are set out in other United Nations conventions. Prisoners shall have access to the health services available in the country, without discrimination on the grounds of their legal situation.¹⁰ Where facilities are provided within an institution, they should be proper for the medical care of sick

¹ Articles 21 and 24 of the Declaration on the Rights of Indigenous Peoples.

² ICESCR, Article 2(2); E/C.12/2000/4, para. 12.

³ E/C.12/2000/4, para. 34.

⁴ Ibid., para. 27.

⁵ Idem.

⁶ ICCPR, Article 10(1).

⁷ E/C.12/2000/4, para. 34.

⁸ United Nations Principles of Medical Ethics relevant to the Role of Health Personnel, Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Res. 37/194, principle 1.

⁹ General comment 21, art. 10, para. 7; see HRI/GEN/1/Rev.1, para. 7.

¹⁰ Basic Principles for the Treatment of Prisoners, adopted December 14, 1990, A/45/111 (A/45/49 (1990), art. 9); United Nations Human Rights Committee (HRC), "Replaces general comment 9 concerning humane treatment of persons deprived of liberty," A/47/40 (1992), para. 3.

prisoners and trained staff available¹¹ who are under the obligation to care for their physical and mental health.

Recognition of international human rights under Australian Law

12. Recently, the Government of Australia took the commendable step of commissioning a national human rights consultation, whose objectives were, inter alia, to determine which human rights should be protected and promoted within Australia, and assess the viability of the introduction of a national instrument enshrining human rights.

13. The Special Rapporteur welcomes the extensive consultation that took place over 10 months, including community consultation through public hearings along with written submissions. The National Human Rights Consultation rightly noted a lack of awareness of human rights generally throughout Australia, and a need to address this issue. The Special Rapporteur commends the recommendation that the Federal Government develop a national plan to implement a comprehensive educational framework for human rights¹² that will increase awareness of human rights throughout Australia.

14. However, the Special Rapporteur is concerned that the outcome document of the consultation did not recommend the constitutional protection of human rights. He is concerned that, should a Human Rights Act lack such protection, it is liable to be repealed or altered at will. This concern was highlighted in the recent suspension of the Racial Discrimination Act 1975 (Cth) vis-à-vis its application in the Northern Territory (see Chapter III).

15. Furthermore, the Special Rapporteur is particularly concerned by the Consultation's recommendation that, irrespective of whichever model of domestic incorporation is selected, economic and social rights should not be justiciable, and that complaints should instead be heard by the Australian Human Rights Commission.¹³ The Special Rapporteur believes that it is only through making these rights justiciable that effective protection and redress are guaranteed.

16. There is also no national framework for inclusion of human rights training in educational curricula of health professionals, although ethics training is a core component of each of the programmes assessed during the mission. As health professionals throughout the world are often the first to witness the effects of torture, trauma and substance use, and are required to document and monitor human rights abuses, it is regrettable that such training is not mandatory for health professionals.

III. Indigenous health

17. Indigenous peoples have the right to specific, culturally appropriate measures to improve their access to health services and care, and States should provide resources for indigenous peoples to design, deliver and control such services.¹⁴ Unfortunately, Australia's first people have, in the past, consistently been excluded from participation and determination of their rights. To provide a context for this situation, it is necessary to examine the history of Anglo-Australian settlement and its impact on the Indigenous people.

¹¹ Basic Principles for the Treatment of Prisoners, Rule 22(2) and 25(1)

¹² National Human Rights Consultation Report (2009), p. xxix.

¹³ National Human Rights Consultation Report (2009), Recommendations, p. xxxv.

¹⁴ E/C.12/2000/4, para. 27.

A. Background to Aboriginal and Torres Strait Islander inhabitation

18. Australia's first inhabitants were the Aboriginal and Torres Strait Islander peoples, who settled the land at least 40,000 years ago. When the first European settlers arrived in 1788, around 700 languages and dialects were spoken by Indigenous Australians.¹⁵ Along with appropriation of land and water resources, European settlement had a catastrophic impact on indigenous health: widespread, if variable, population decline through influenza, TB and smallpox epidemics occurred.¹⁶ This occurred in addition to instances of targeted violence, which, although responsible for fewer deaths than illness, were deplorable.

19. Since European settlement, Aboriginal and Torres Strait Islanders have endured repeated periods of upheaval and forced movement. In 1897, legislation allowed the government to shift Indigenous people onto designated reserves, resulting in forced removal from traditional lands, and family separation. The policy of assimilation introduced in the early 20th century, now known as the "Stolen Generations", also resulted in the forced removal of Indigenous children from their parents.¹⁷

20. The introduction of equal wages in the pastoral industry in 1968, although an important advancement in the struggle for equal rights for Aboriginal and Torres Strait Islanders, resulted in unemployment for many indigenous workers, and whole communities were compelled to leave the land for urban areas. A lack of urban accommodation resulted in mass migration to areas such as the Alice Springs Town Camps, which significantly strained existing resources in these places.

21. Since the 1960s, significant progress has been made towards realizing basic rights of Indigenous peoples. Following the instatement of the right to vote in 1962, a national referendum in 1967 gave the Federal Government the power to pass legislation on behalf of Indigenous Australians, and include the population in censuses.

22. In 1992, the High Court of Australia recognized rights and interests to land held by Aboriginal and Torres Strait Islander people under their traditional laws and customs, rejecting the doctrine of *terra nullius*, which had provided that Australia was uninhabited at the time of European settlement.¹⁸ Following the judgment, the Native Title Act 1993 (Cth) was passed, providing for the determination of native title in Australia.

23. In 1999, the Australian Parliament passed a Motion of Reconciliation, although without a formal apology to indigenous populations. In February 2008, the government formally apologized to them for the laws and policies of successive parliaments and governments that had inflicted profound grief, suffering and loss; specifically with regard to the Stolen Generations, which the Special Rapporteur welcomes as an important symbolic gesture.

24. Following centuries of racial discrimination, loss of land, identity and culture, lack of self-determination and comprehensive disadvantage, the Aboriginal and Torres Strait Islander peoples have faced significant disempowerment over generations. Throughout the mission, the Special Rapporteur witnessed the impact this legacy has had on Indigenous persons, particularly on their collective and individual self-esteem, and confidence in being

¹⁵ Department of Immigration and Citizenship, *Life in Australia*, (Canberra, Australian Government, Department of Immigration and Citizenship, 2007).

¹⁶ Jupp, J., ed.. *The Australian people: An encyclopedia of the nation, its people and their origins*, (Cambridge University Press, 2002)

¹⁷ National Enquiry into the Separation of ATSI children from their families, *Bringing them home*, Commonwealth of Australia, 1997

¹⁸ *Mabo v Queensland (No 2)* (1992) 175 CLR 1.

able to control their own future. The Special Rapporteur notes that understanding the past and ongoing impact of colonization on Indigenous people is central to addressing the inequalities in health, as well as the underlying social determinants impacting upon health.

25. A corollary of loss of land over the years has been migration, particularly to urban centres, resulting in psychological and material stress from unfamiliar environments, poor housing, low wages and unemployment.¹⁹ All of these have heavily influenced Indigenous peoples' poor health,²⁰ not only through the direct impact on the loss of control of livelihoods, but also through deterioration of self-esteem and autonomy.²¹

26. The importance of the connection to traditional lands has been confirmed by CESC, which states that development-related activities leading to the displacement of indigenous peoples against their will from traditional territories has a deleterious impact upon health.²² In contrast, indigenous groups who regain ownership of their traditional lands, and exercise genuine control over their affairs, enjoy improved health.²³

27. Disconnection from community, as well as social exclusion generally – not only from mainstream society, but also from cultural practices and heritage²⁴ – has been shown to predispose to mortality and morbidity.²⁵ This prevents people from participating in education or training, gaining access to services and citizenship activities, and is socially and psychologically damaging, materially costly, and harmful to health.²⁶

28. While the Special Rapporteur commends the Government's apology in February 2008 to the Indigenous people of Australia, as the impact of these symbolic gestures cannot be underestimated, he reaffirms that they must be accompanied by concrete efforts to enable healing. The Special Rapporteur welcomes the establishment of the Aboriginal and Torres Strait Islander Healing Foundation with its focus on funding grassroots healing initiatives, building capacity for the prevention and treatment of trauma and building an evidence base of best practice healing.

29. The Special Rapporteur also welcomes the recent establishment of the National Congress of Australia's First Peoples, which will serve as the national representative indigenous body. Since the abolishment of the Aboriginal and Torres Strait Islander Commission in March 2005, indigenous people had not been represented through a national body.

30. The Special Rapporteur also urges the Government to consider implementation of relevant initiatives in the mainstream community to raise the knowledge and understanding of Aboriginal and Torres Strait Islander culture; for instance, through inclusion of material

¹⁹ World Health Organization (WHO), *Social Determinants and indigenous health: The International experience and its policy implications* - Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on Social Determinants of Health (CSDH) (WHO, 2007)

²⁰ Idem.

²¹ Marmot, M., 'Self-esteem and health' *British Medical Journal* vol. 327, pp. 574-575 (2003).

²² E/C.12/2000/4, para. 27.

²³ Watson, N. L. 'Implications of land rights reform for indigenous health' 186 (10) *Medical Journal of Australia*, pp. 534-536 (2007).

²⁴ WHO, *Social Determinants and indigenous health: The International experience and its policy implications* - Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on Social Determinants of Health (CSDH) (WHO, 2007).

²⁵ WHO, *Social Determinants of health – the solid facts*. Eds: Wilkinson, R. and Marmot, M. (2nd ed.), 16 (2003).

²⁶ Idem.

relating to Indigenous culture, languages, history and the legacy of injustice in school curricula.

B. Health status of Aboriginal and Torres Strait Islander populations

31. Limited access to the basic socio-economic and environmental conditions necessary for good health, inadequate health services and infrastructure, a history of under-resourcing in indigenous health and, until recently, a lack of strong political commitment at a national level, have all contributed to a disturbing picture of health conditions and outcomes among indigenous people in Australia.²⁷

32. Life expectancy for indigenous Australians is 67.2 years for males and 72.9 years for females, compared with 78.7 and 82.6 years respectively for all males and females.²⁸ The five leading causes of death for Indigenous peoples are currently: diseases of the circulatory system; injury; cancers; endocrine, metabolic and nutritional disorders (including diabetes); and respiratory diseases.²⁹

33. Chronic health conditions responsible for much of the ill-health experienced by Indigenous people include circulatory diseases, diabetes, respiratory diseases, musculoskeletal conditions, kidney disease and eye and ear problems. Indigenous people are hospitalized at 14 times the rate of non-Indigenous people for renal dialysis, and at three times the rate for endocrine, nutritional and metabolic diseases.³⁰ They are twice as likely as non-Indigenous Australians to report high or very high levels of psychological distress, and are hospitalized for mental or behavioural disorders at twice the expected rate, as compared to the general population.³¹

34. Injury and poisoning are large contributors to indigenous morbidity, especially for younger people. Widespread hurt, loss, and suffering in Indigenous communities also leads to an increase in incidence of intentional injury – hospitalizations for injury due to assault are 8 and 35 times higher for Indigenous males and females respectively.³²

35. Indigenous child mortality and disease also contribute to the gap in life expectancy. Although it has declined significantly in certain states,³³ it continues to be disproportionately higher across a range of causes, including respiratory-related mortality, nutritional anaemia, infectious and parasitic diseases, and emotional and behavioural difficulties.³⁴

C. Underlying determinants of health

36. Article 12 of the International Covenant on Economic, Social and Cultural Rights acknowledges that the enjoyment of the right to health embraces a wide range of socio-

²⁷ The disparity in key health indicators between indigenous and non-indigenous peoples has been previously noted with concern by the Committee on the Rights of the Child (CRC/C/153), the Committee on the Elimination of Racial Discrimination (CERD/C/AUS/CO/14) and the Committee on Economic, Social and Cultural Rights (E/C.12/AUS/CO/4).

²⁸ Australian Government Closing the Gap: Prime Minister's Report 2010, p. 13 (2010).

²⁹ Australian Bureau of Statistics. *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*. (Canberra, Australian Institute of Health and Welfare 2009) xxii.

³⁰ Ibid., 107.

³¹ Ibid., 108, 110.

³² Ibid., para. 126.

³³ Australian Government Closing the Gap: Prime Minister's Report 2010, p. 18 (2010).

³⁴ Aboriginal and Torres Strait Islander Health Performance Framework Report (2008), 29.

economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, adequate food and housing and healthy occupational and environmental conditions.³⁵ The Special Rapporteur closely considered these issues during his visit, and notes with regret that the inadequacy in securing these conditions negatively affects of the enjoyment of the right to health of many indigenous Australians.

37. The Special Rapporteur was moved by the stories told by members of Indigenous communities, the living conditions witnessed, and the extent of preventable disease and health-related disability demonstrated during the mission. The gap between the everyday lives of mainstream and Indigenous Australia, the latter being affected heavily by ill-health, disability and death, was striking and confirmed the existence of stark inequalities.

38. The Special Rapporteur on adequate housing as a component of the right to an adequate standard of living has already raised concerns about the housing conditions of Indigenous people.³⁶ Overcrowding and poor quality housing have been identified as major factors affecting Indigenous peoples' health, through facilitating spread of diseases such as skin and respiratory infections, eye and ear infections, diarrhoeal diseases and rheumatic fever.³⁷ In 2006, 27 per cent of Australia's Indigenous people were reported to be living in overcrowded conditions, and 51 permanent dwellings had no organized sewerage supply.³⁸

39. The National Partnership Agreement on Indigenous Housing provides a ten-year funding strategy to address overcrowding, homelessness, poor conditions and severe housing shortage in remote Indigenous communities. Allocation of A\$1.94 billion through this agreement, as part of a total A\$5.5 billion allocation, is a welcome initiative.³⁹ However, the Special Rapporteur was concerned by stakeholder reports that these additional resources were, thus far, not reaching communities, and bottlenecks in State and Territory governments prevented rapid improvements in the situation.

40. While educational attainment of Indigenous Australians continues to improve, indicators of numeracy, literacy and reading skills, as well as school retention, are all considerably lower among indigenous children compared to mainstream Australians. More than one-third of Australia's indigenous 15-year-old students have been assessed to "not have the adequate skills and knowledge in reading literacy to meet real-life challenges and remain at a substantial disadvantage in their lives beyond school".⁴⁰ Post-secondary education levels also remain lower among indigenous Australians.⁴¹

41. Education impacts on the health outcomes of individuals directly, through improvement of health-related knowledge and ability to utilize that knowledge, and indirectly, through increasing employment prospects and income, facilitating access to health services.⁴² Higher levels of educational attainment are also associated with higher

³⁵ E/C.12/2000/4, para. 4.

³⁶ A/HRC/4/18/Add.2

³⁷ Australian Bureau of Statistics, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*, (Canberra, Australian Institute of Health and Welfare, 2009) 39.

³⁸ Ibid., 40, 44.

³⁹ Coalition of Australian Governments, (2008). National Partnership Agreement on Remote Indigenous Housing. National Indigenous Reform Agreement.

⁴⁰ De Bortoli, L. and Thomson, S., *The achievement of Australia's indigenous students in PISA 2000-2006, OECD Programme for International Assessment (PISA)*, (ACER Press, 2009).

⁴¹ Australian Bureau of Statistics, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Canberra, Australian Institute of Health and Welfare, 2009).

⁴² Ibid., 15.

levels of self-reported good health, lower rates of self-reported psychological distress and a reduction in rates of chronic health conditions.⁴³

42. Higher education also increases the likelihood of full-time employment. The unemployment rate for Indigenous people is three times the rate for non-Indigenous people (15.6 per cent and 5.1 per cent, respectively); this has a direct impact on the household income level for Indigenous people, which equates to 63 per cent of the income level of non-Indigenous households.⁴⁴

43. The Special Rapporteur welcomes the Government's commitment to halving the gap in literacy and numeracy outcomes between Indigenous and non-Indigenous Australians within a decade from 2008. As lack of education is a significant structural issue impeding empowerment and equality of indigenous people; improving this determinant needs to be a priority. Schooling must be culturally inclusive, including the teaching of indigenous languages, and schools should build partnerships with communities to ensure educational relevance, supportive school environments⁴⁵ and a greater understanding of cultural factors.⁴⁶ This will require flexible financial support that allows schools to tailor their approaches to the local context.

(a) Access to health services

44. The federal Government's spending on health care amounted to A\$40.1 billion (approximately US\$30 billion) in 2006/07, or 18.2 per cent of total government spending. State governments are responsible for the operation and financing of public hospitals, but rely on funding from the federal Government. Medicare entitles all Australians to free health care in public hospitals and to at least a partial refund of the cost of visits to private medical practitioners, and the Pharmaceutical Benefits Scheme allows for subsidized access to certain medications.⁴⁷

45. In addition to these national programmes, Aboriginal health services are an important provider of comprehensive primary health services for indigenous Australians, particularly in more remote areas. These services receive funding from state and federal governments to operate over 130 Aboriginal Community Controlled Health Services/Aboriginal Medical Services (ACCHs/AMSs). The integrated primary health care model adopted by ACCHs/AMSs is in keeping with the philosophy of Aboriginal community control and the holistic view of health.⁴⁸

46. Guided by the Statement of Intent between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, the Government has set six key targets to address indigenous disadvantage under the 'Closing the Gap' initiative. These include closing the life expectancy gap within a generation, halving the gap in mortality rates for indigenous children under five within a decade, and other targets relating to early childhood education, educational and literacy outcomes and employment. The initiative has resulted in an unprecedented investment in indigenous health of A\$1.57 billion to reduce

⁴³ Ibid., 24-25.

⁴⁴ Aboriginal and Torres Strait Islander Health Performance Framework – 2008 Report, pp. 97-98.

⁴⁵ Aboriginal and Torres Strait Islander Social Justice Commissioner, "Remote indigenous education", Chap. 3, Social Justice Report 2008, (Sydney, Australian Human Rights Commission, 2009)

⁴⁶ Kral, I., The literacy question in remote indigenous Australia, CAEPR Topical Issue No. 06/2009, Centre for Aboriginal Economic Policy research, Australian National University (2009).

⁴⁷ Australian Government, 'About Medicare Australia', Department of Health and Ageing, <http://www.medicareaustralia.gov.au/>

⁴⁸ <http://www.naccho.org.au/aboutus/aboutus.html>

major risk factors (such as smoking), improve chronic disease management and follow-up, and expand health workforce capacity in the Indigenous population.⁴⁹

47. The Special Rapporteur welcomes this commendable political and financial commitment. However, he is concerned by the lack of a comprehensive national plan to achieve the targets to close the gap. Through the Statement of Intent, Governments committed to the development of a ‘comprehensive, long-term plan of action that is targeted to need, evidence-based and capable of addressing the existing inequities in health services’.⁵⁰

48. During his mission, the Special Rapporteur visited various health facilities providing care to indigenous people, from ACCHS to tertiary facilities. The Special Rapporteur noted the high quality of care provided to patients, and commends the outstanding efforts of individuals working in these settings.

49. Average expenditure on health goods and services per person for Aboriginal and Torres Strait Islander people is 17 per cent higher than the expenditure for non-Indigenous people. Considering the high level of morbidity among indigenous Australians, and mortality rates that are more than twice those for other Australians, these figures suggest that expenditures for Aboriginal and Torres Strait Islander people are insufficient to meet current needs.⁵¹

50. Throughout the mission, the Special Rapporteur was provided with evidence that Indigenous peoples encounter a number of obstacles to access to health services, which the Government has noted. These obstacles include language and cultural barriers, distance to services, lack of transportation, high service costs, and Western-dominated models of care.

(b) Primary health care

51. Indigenous Australians are hospitalized for potentially preventable conditions at five times the rate of other Australians⁵² as a result of lack of access to preventive health measures such as vaccination, health promotion, early screening and diagnosis. Simple screening, prevention and treatment programmes can reduce deaths due to heart disease and limit progression to end-stage renal failure significantly, and result in considerable savings in tertiary care expenditures.⁵³ The Special Rapporteur was informed that current efforts in maternal, newborn and child health are not managed comprehensively, and are often limited to acute medical interventions on a needs basis. This is illustrated by the decline in neonatal and infant mortality, without an accompanying decrease in child morbidity due to malnutrition and infectious diseases.

52. Given the challenges in making services appropriate and accessible to indigenous communities, the Special Rapporteur emphasizes the need for greater political support and investment for targeted primary health care with a comprehensive approach, which includes not only clinical care, but prevention programmes, health promotion, rehabilitation, public

⁴⁹ Commonwealth of Australia, *Closing the Gap on indigenous disadvantage: the challenge for Australia*, an Australian government Initiative. (2009).

⁵⁰ Indigenous Health Equality Summit ‘Statement of Intent’ Close the Gap, 1 (Canberra, 2008).

⁵¹ Australian Bureau of Statistics, *The health and welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2008*, (Canberra, Australian Institute of Health and Welfare, 2009).

⁵² Idem.

⁵³ Hoy, W. et al.. ‘Reducing premature death and renal failure in Australian Aboriginals’. *Medical Journal of Australia*, vol. 172, 473-478 (2000).

health measures, advocacy on health-related matters⁵⁴ and capacity-building of individuals and communities.

(c) Hospital care

53. Indigenous people are twice as likely as other Australians to be hospitalized. The Special Rapporteur witnessed this during his visit to Alice Springs Hospital where, although the Northern Territory population is 30 per cent indigenous, over 90 per cent of inpatients were of indigenous descent.

54. Challenges faced by the hospital in meeting the needs of renal dialysis patients raised the question as to whether sufficient resources for tertiary care are being allocated to adequately address the needs of indigenous peoples. Many of the dialysis patients in the care of the hospital did not have permanent accommodation in Alice Springs, as they travel from their communities to access care. The Special Rapporteur commends the efforts of civil society organizations, such as the Purple House in Alice Springs, in providing temporary accommodation to patients, training community members to administer dialysis and setting up mobile dialysis for more remote communities.

55. The Special Rapporteur was informed that ensuring follow-up care for patients with chronic illnesses after discharge was a significant challenge. Existing outreach specialist and follow-up services are not meeting demand, and require further investment to ensure sustainable implementation. As witnessed during the mission, indigenous communities face significant challenges to ensuring continuity of care, including lack of, or frequent changes of, residence, lack of public transportation from their area into city centres, and lack of access to telephones (29 per cent of indigenous people over 15 years of age do not have a working telephone at home⁵⁵).

56. An accessible and competent health workforce is vital to ensure that the health system can provide services that meet the needs of Aboriginal and Torres Strait Islander people and improve their health outcomes. To achieve this, the number and capacity of Aboriginal and Torres Strait Islander people entering into and working in the health workforce must be increased.⁵⁶ Only 1 per cent of the current health workforce is Indigenous, although increases have been seen recently. The Special Rapporteur welcomes, in particular, efforts by civil society organizations such as ACCHS and the Australian Indigenous Doctors' Association to build and strengthen the Aboriginal medical workforce. Further improvements will require greater investment in education, as well as quotas in medical training facilities, targeted support for indigenous students through financial assistance and role model and mentoring programmes, and community engagement to ensure acceptability of schools and training institutions.

57. The Special Rapporteur was also informed that hospital managements not only failed to take into account the particular needs of indigenous patients and their families, but even reinforced stereotypes and prejudice; for instance, by installing screens and walkways to allow non-indigenous people to access hospitals without seeing indigenous families sitting at the entrance.

⁵⁴ The Fred Hollows Foundation. "Prevention is better than cure - Comprehensive Primary Health Care", Indigenous Health in Australia (no date), www.eniar.org/pdf/7_primary_health.pdf

⁵⁵ Australian Bureau of Statistics, *The health and welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008* (Canberra, Australian Institute of Health and Welfare, 2009).

⁵⁶ National Aboriginal and Torres Strait Islander Health Council, *A blueprint for action: pathways into the health workforce for Aboriginal and Torres Strait Islander people*. Canberra, National Aboriginal and Torres Strait Islander Health Council (2008).

(d) Participation

58. Informed participation at community, national and international levels in health-related decision making is a key component of the enjoyment of the right to health.⁵⁷ In this context, the Special Rapporteur welcomes the new co-operative framework between community-controlled health services and the Federal and Territory governments that aims to increase indigenous peoples' control over planning, development and delivery of primary health care.

59. The Special Rapporteur noted apprehension throughout the mission regarding the proposal to direct significant resources to mainstream health services under the "Closing the Gap" initiative. The Special Rapporteur acknowledges the need for mainstream services to be upgraded to adequately service the needs of Aboriginal and Torres Strait Islanders, and supports this initiative. However, any major diversion of resources away from community-controlled services towards mainstream primary care providers, if it occurs, is concerning.

60. Although Government data indicates that up to 70 per cent of indigenous people have been noted to utilize mainstream primary health services,⁵⁸ there does not appear to be any data demonstrating that this is the *preference* of indigenous people. Various data indicate that 30 to 50 per cent of indigenous people use Aboriginal medical services (including the ACCHSs)⁵⁹ despite these services being small in number. ACCHSs provide comprehensive primary health care in a way that mainstream services generally cannot, and have guarantees to ensure accountability to the communities they serve, through the role of elected members;⁶⁰ and as such, they were consistently cited during the mission as the preferred model of care.

(e) Northern Territory Emergency Response

61. During the mission, the Special Rapporteur received information from a number of individuals and groups on the topic of the Northern Territory Emergency Response (NTER), instituted by the previous Australian Government in 2007 to address concerns regarding the wellbeing of Indigenous peoples in the Territory. He was informed that, although certain aspects of the intervention have been considered beneficial, the manner in which the Emergency Response was initially conducted significantly undermined the efforts of existing health agencies working in these communities. For instance, the view was expressed that Government-appointed practitioners unknown to communities, who were brought in to complete child health checks, created fear amongst clients and sometimes duplicated services already being provided.⁶¹ Medical practitioners who had devoted significant time to establishing relationships and building trust within these communities, often for decades, expressed their feelings of disappointment and powerlessness arising from not being consulted prior to implementation of this aspect of the Intervention.

62. Furthermore, the Special Rapporteur was concerned by the failure of the NTER, as initially implemented, to meet basic standards of a right-to-health approach. Such an

⁵⁷ E/C.12/2000/4, para. 11.

⁵⁸ *National Aboriginal and Torres Strait Islander Health Survey*, 2004-05

⁵⁹ For more detailed analysis, see Aboriginal and Torres Strait Islander Social Justice Commissioner and Race Discrimination Commissioner Submission to the National Health and Hospitals Reform Commission by the Close the Gap Steering Committee, March 2009, pp. 6-8.

⁶⁰ *Ibid.*, 3.

⁶¹ Australian Indigenous Doctors' Association Submission to the Northern Territory Emergency Response Review Board (2008), http://www.aida.org.au/pdf/submissions/Submission_8.pdf

approach should have included implementation of a transparent plan with clear benchmarks and indicators, monitoring and accountability, developed with the meaningful engagement and participation of communities. The Special Rapporteur commends the Government's decision to undertake redesign consultations with affected communities.⁶²

63. The Special Rapporteur is concerned that absolute prohibitions on alcohol consumption, as part of the intervention, result in a shifting of risk rather than global risk reduction. Although many communities and individuals support the alcohol-related restrictions, particularly in light of reduced violence within communities since the measures were implemented, others found the measures restrictive and paternalistic.⁶³ Binge drinking on community borders has increased, along with drink driving and "grog running", and a shift of people to 'Long Grass' communities such as those in Darwin.⁶⁴ The risks associated with alcohol consumption will never be totally eliminated; however, the Special Rapporteur is concerned that measures restricting alcohol supply, creating permit systems, or designating drinking areas temporarily address secondary problems arising from excessive alcohol consumption but fail in the long-term to address the relevant causal factors associated with alcohol abuse in these populations. The Special Rapporteur emphasizes that the primary goal of any intervention should be to reduce the incidence of alcoholism and alcohol-related violence through appropriate temporary measures, in addition to long-term strategies designed to address underlying contributing factors.

64. The Special Rapporteur was also concerned that the Emergency Response exposed a clear lack of constitutional protection of the rights of Australian citizens, irrespective of any perceived or actual benefit flowing from the intervention. The ability of the Government to suspend the application of the *Racial Discrimination Act* (Cth) and subsequently implement policies that were clearly discriminatory vis-à-vis Aboriginal and Torres Strait Islander people, was of great concern to the Special Rapporteur. This highlighted the need for constitutional entrenchment of fundamental rights, including the right to health, for both Indigenous and non-Indigenous Australians. It is also concerning that the *Racial Discrimination Act* has yet to be reinstated, despite the Government undertaking to restore operation of the Act as soon as possible.

IV. Health care in detention

65. The right to the highest attainable standard of health is to be enjoyed without discrimination. It is especially important for vulnerable persons, such as asylum-seekers and persons in detention. CESCR stipulates that States are obliged to respect the right to health by refraining from denying or limiting equal access for all persons, including asylum-seekers and illegal immigrants, to preventive, palliative and curative services,⁶⁵ subsequently reinforced by the Committee on the Elimination of Racial Discrimination in 2004.⁶⁶ Pursuant to the Standard Minimum Rules for Treatment of Prisoners, sick prisoners requiring medical treatment are entitled, inter alia, to transfer to specialized institutions where appropriate, to psychiatric services, and to daily monitoring when ill.⁶⁷

⁶² Australian Government (2009) *Report on the Northern Territory Emergency Response Redesign Consultations*.

⁶³ Ibid., 30-38.

⁶⁴ Ibid., 34.

⁶⁵ E/C.12/2000/4, para. 34.

⁶⁶ HRI/GEN/1/Rev.7/Add.1, para. 36.

⁶⁷ Rules 22, 25.

A. Prisons

66. The Special Rapporteur noted with approval the high standard of specialized health care within prisons, such as Long Bay Prison. Whilst he supports establishment of such excellent facilities, he is concerned about the inadequacy of primary health care resourcing throughout the sector in Australia. Delays in accessing primary health care were noted in both correctional centres visited during the mission, and concerns were raised regarding the capacity of primary health services to manage complex chronic diseases.

67. Moreover, within these institutions, there are insufficient preventive health, or health promotion, programmes in place. Given high drug use rates, as well as complex issues concerning Indigenous inmates in particular,⁶⁸ time spent in detention should be better utilized to effect long-term behavioural change in relation to health.

68. The Special Rapporteur was also informed that detainees cannot access Medicare or the Pharmaceutical Benefits Scheme, as health services in prisons are provided by private health providers. This existence of an effectively separate health system within prisons, and the need to reapply for a Medicare number upon release, is challenging for some detainees and creates problems with information exchange between prisons and community health services. Evidence collected throughout the mission suggested that prisoners often do not readily form relationships with community General Practitioners; discharge summaries are often lost, and issues of continuity of care arise.

(a) Mental illness

69. Under the Standard Minimum Rules for the Treatment of Prisoners, every institution is required to include a psychiatric service for the diagnosis of mental diseases, and prisons in Australia appear to comply with this requirement. However, it seems that current services are insufficient to treat the number of inmates who suffer from mental illness.

70. Individuals with mental illness are significantly overrepresented within the prison system in Australia. In New South Wales, 43 per cent of prisoners met the diagnostic criteria for at least one mental illness, in comparison to a 15 per cent 12-month prevalence rate of mental illness in the wider community.⁶⁹ Psychosis is at least 10 times more prevalent in prisons than in the community.⁷⁰

71. Since the commendable process of deinstitutionalization of mental health care services has occurred throughout Australia, there has been insufficient provision of replacement community-based treatment options, particularly in light of population increases.⁷¹ This has resulted in prisons becoming de facto mental institutions,⁷² which invariably increases pressure on existing prison mental health services. This has the potential to result in poor long-term mental health outcomes for detainees.

⁶⁸ National Indigenous Drug and Alcohol Committee, *Bridges and Barriers - addressing Indigenous incarceration and health*, 6 (2009).

⁶⁹ Butler, T. et al. 'Mental Disorder in the New South Wales prisoner population' *Australian and New Zealand Journal of Psychiatry* Vol 39. pp. 407, 409 (2005).

⁷⁰ White, P. and Whiteford H., 'Prisons: mental health institutions of the 21st century?' *Medical Journal of Australia* vol. 185(6), pp. 302-303 (2006).

⁷¹ Whiteford, H. and Buckingham W., 'Ten years of mental health service reform in Australia: are we getting it right?' *Medical Journal of Australia* vol. 182(8) pp. 396-397 (2005).

⁷² Australian Capital Territory Human Rights Commission, *Human rights audit on the operation of ACT correctional facilities under corrections legislation*, p. 32; Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living – Mission to Australia (11 May 2007) see A/HRC/4/18/add.2, para. 121 (2007).

72. Time spent in custody represents a unique opportunity for psychiatric diagnosis and intervention for persons who may have difficulty accessing services outside of prison, particularly because they frequently experience periods of incarceration interspersed with time in the community. Although prison is by definition an unsatisfactory place in which to treat the mentally ill, the prevalence of mental illness is noted to be lower within the sentenced prison population than at reception into imprisonment.⁷³ The exact reasons for this are uncertain, but it is likely that treatment within these facilities is a factor in decreasing the prevalence recorded.

73. Despite this, resourcing of mental health diagnosis and treatment within prisons, particularly for chronic illnesses, remains inadequate.⁷⁴ Although funding for generic mental health initiatives has increased (particularly in light of the Council of Australian Governments' National Action Plan on Mental Health), more needs to be done in relation to provision of services to specific groups such as prison populations.⁷⁵

(b) Incarceration of Aboriginal and Torres Strait Islanders

74. People of Aboriginal and Torres Strait Islander descent are also overrepresented in Australian prisons. As of September 2009, indigenous prisoners represented 26 per cent of the prison population in Australia, despite the country's total Indigenous population remaining at only 2 per cent.⁷⁶ Annually, up to 25 per cent of young Aboriginal men are estimated to have direct involvement with correctional services.⁷⁷

75. Various reasons for the overrepresentation of Indigenous peoples among the prison population have been cited, such as historical cultural displacement, trauma and disadvantage, lower levels of educational attainment, higher rates of unemployment, and alcohol and drug misuse.⁷⁸ Certainly, a complex interaction of these factors has led to the current situation. Nevertheless, imprisonment poses risks to all prisoners, including transmission of blood-borne viruses, possible sexual assault and mental illness, among others.

76. The Special Rapporteur strongly recommends that further steps be taken, in addition to existing initiatives, to reduce rates and lengths of Indigenous incarceration; specifically, through diversion programmes, reconsideration of relevant criminal laws, and assessment of sentencing policies.

77. Throughout the mission, the Special Rapporteur observed a triad of vulnerability factors consisting of incarceration, mental illness, and being of Aboriginal or Torres Strait Islander descent. All prisoners have higher rates of serious mental illness and substance use than the general population.⁷⁹ Despite the fact that incarceration is noted to be particularly

⁷³ Butler, T. et al., 'Mental Disorder in the New South Wales prisoner population' *Australian and New Zealand Journal of Psychiatry* Vol. 39 (5) pp. 407 and 410 (2005).

⁷⁴ Human Rights and Equal Opportunity Commission *Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin Report) Chap.30 (1993).

⁷⁵ Senate Standing Committee on Community Affairs *Towards recovery: mental health services in Australia*, Chap. 9, paras. 9.69-9.72 (2008).

⁷⁶ Australian Bureau of Statistics, *Corrective Services Issue 4512.0 6* (2009).

⁷⁷ Krieg, A. 'Aboriginal incarceration: health and social impacts' *Medical Journal of Australia*, vol. 184 (10) p. 534 (2006).

⁷⁸ National Indigenous Drug and Alcohol Committee, *Bridges and Barriers: addressing Indigenous incarceration and health*, 6 (2009).

⁷⁹ *Ibid.*, para. 1.

damaging to the mental health of Indigenous peoples, forensic mental health services nevertheless systematically fail to meet their needs.⁸⁰

78. These issues are exacerbated by high rates of dual diagnosis – that is, the coexistence of mental illness with substance abuse. Indigenous drug and alcohol abuse was initially hypothesized to have occurred in response to colonization and dispossession, but has since evolved into a cause of indigenous disadvantage; specifically, in terms of over-representation in prison.⁸¹ The coexistence of these issues with mental illness poses a significant challenge in terms of rehabilitation and effectiveness of health-related interventions.

79. High levels of illiteracy were also observed in Aboriginal prisoner populations, particularly in the Northern Territory. In this context, the Special Rapporteur was concerned that issues may arise vis-à-vis gaining informed consent for treatment, and implementing effective health promotion projects.

80. Additionally, there is currently a paucity of research which differentiates between indigenous and non-indigenous prisoners, despite their significant overrepresentation within the prison population.

81. Given the high rate of incarceration of indigenous persons, the Special Rapporteur was concerned to find that very few prison staff of Aboriginal and Torres Strait Islander descent work in Australia's correctional facilities. Obstacles in recruitment were conveyed to the Special Rapporteur, such as the low proportion of indigenous individuals in Australia generally. Irrespective of these factors, the importance of recruitment of such staff should be recognized, particularly in facilities where Indigenous inmates comprise a majority of the prison population.

B. Detention centres

82. In Australia, the Migration Act 1958 (Cth) ("Migration Act") regulates the entry into, and presence in, Australia of non-citizens. In accordance with the Act, non-citizens within the migration zone who do not hold a valid visa are required to be detained, and unless they are granted permission to remain in Australia, they must be removed as soon as reasonably practicable.

83. Those subject to mandatory detention include 1) all unauthorized arrivals, for management of health, identity and security checks; 2) unlawful non-citizens who present unacceptable risks to the community; and 3) unlawful non-citizens who repeatedly refuse to comply with their visa conditions.⁸² Detainees are placed in immigration detention centres, community detention, immigration residential housing, immigration transit accommodation or alternative temporary detention in the community.

84. In July 2008, the current government announced its seven 'Key Immigration Detention Values' which utilize a risk-based approach to immigration detention and seek a prompt resolution of cases, but maintain mandatory detention as an essential component of Australia's border control. The Department of Immigration and Citizenship has stated its

⁸⁰ Human Rights and Equal Opportunity Commission, Report of the National Inquiry into the Human Rights of People with Mental Illness (Burdekin Report) Chapter 30 (1993); this situation does not appear to have improved substantially since publication of this report.

⁸¹ Weatherburn, D. 'The role of drug and alcohol policy in reducing Indigenous over-representation in prison', Drug and Alcohol Review, vol. 27 (1), pp. 91-92 (2008).

⁸² Department of Immigration and Citizenship, 'Key Immigration Detention Values' (2008), www.immi.gov.au/managing-australias-borders/detention/about/key-values.htm

commitment to detention as a last resort, to avoid detention of children in immigration detention centres, to review the length and conditions of detention regularly, and to treat people in detention fairly, reasonably within the law, and with respect of their inherent dignity.⁸³

85. While the Special Rapporteur welcomes the fundamental shift in immigration detention policy presented by the new Values, and the decrease in detainee numbers and detention time that have resulted, he notes with concern that mandatory immigration detention remains a central feature of immigration policy in Australia, and the additional freeze imposed on processing of new claims by Sri Lankan and Afghan nationals.⁸⁴ Repeal of mandatory detention has been recommended by CESCR, and reiterates the concerns of Australia's National Human Rights Commission.⁸⁵ There is no evidence to suggest that immigration detention acts as a deterrent to illegal non-citizens entering Australia.⁸⁶ Indeed, over 90 per cent of asylum seekers that arrive in Australia by boat are later recognized as refugees and granted permanent protection visas.⁸⁷

86. The Special Rapporteur underlines that the seven key values are not legally binding, and welcomes the draft legislation designed to amend the Migration Act to include the Values. However, he notes with concern that the proposed Bill fails to apply the new detention values to offshore excised territory, and specify a maximum detention period.

87. The government of Australia's delivery of health care to people in immigration detention is guided by its Detention Health Framework,⁸⁸ which is designed to ensure that the quality of health services provided in detention is comparable to that available to the Australian population. The Department of Immigration and Citizenship's goal for health service delivery is "to ensure that the only change to an individual's well-being as a result of being in detention is the restriction of freedom of movement".⁸⁹

88. The Department of Immigration and Citizenship (DIAC) has a duty of care towards those whom it detains to provide accessible, appropriate, and good quality health care services. Primary health care in immigration detention centres is provided by a private company selected through a tendering process conducted by the DIAC, who are contractually bound to deliver agreed services in the relevant settings. All detainees undergo a health check on entry, and primary health care services are provided in mainland immigration detention centres (IDCs) through nurses' clinics, general practitioners and mental health professionals, who are on site for set clinic sessions. Access to emergency and specialist care is available through on-site specialist visits, or referrals to community providers. As detainees cannot access Medicare, the DIAC pays for health services through fee arrangements with the private provider (which, for example, covers on-site health staffing costs) and pays other expenses such as specialist care on a cost-recovery basis.

89. The Special Rapporteur visited Villawood Immigration Detention Centre, Maribyrnong Immigration Detention Centre and the Brisbane Immigration Transit

⁸³ New Directions in Detention – Restoring Integrity to Australia's Immigration System, speech by Senator Chris Evans, Minister for Immigration and Citizenship, July 2008

⁸⁴ Department of Immigration and Citizenship 'Immediate changes to Australia's refugee processing' (media release, 6 May 2010).

⁸⁵ E/C.12/AUS/CO/4

⁸⁶ A Just Australia 'Myths and facts about asylum seekers' (2009), www.tsjc.org/uploads/media/AJA_Myths_Facts.pdf

⁸⁷ Amnesty International, A short stay on Christmas Island, 22 December 2009, www.amnesty.org.au/refugees/comments/22308 (2009).

⁸⁸ Department of Immigration and Citizenship (2007), Detention Health Framework

⁸⁹ Ibid., p. 34.

Accommodation and commends the provision of health care services in these facilities. Overall, the services provided met the needs of the detainees; however, the Special Rapporteur notes with concern the prevalence of mental health issues among detainees, particularly those detained for lengthy periods.

90. Although it appears that health services of acceptable quality are currently being provided, the Special Rapporteur regrets that there is no specific independent monitoring and accountability mechanism in place for health services provision. The obligation to ensure enjoyment of the right to health includes the adoption of legislation or other administrative measures ensuring equal access to health care and health-related services provided by third parties, and ensuring that third parties do not limit people's access to health-related information and services.⁹⁰ Detainees highlighted some concerns relating to inefficient exchange of medical information between various elements of the health care system: for instance, those detained under Section 501 of the Migration Act noted problems with medical records transfer between prisons and IDCs, which poses challenges for continuity of care.

91. The health care service provider in IDCs faces particular challenges in meeting the cultural needs of detainees. Medical staff and detainees reported that telephone interpretation services were used for most interactions if translation was needed. In the context of such language barriers, ensuring informed consent poses a challenge for medical professionals. Whilst telephone interpretation services may provide some support, on-site interpreters would improve information exchange and ensure that detainees are fully supported to provide informed consent. As almost 50 per cent of detainees of Maribyrnong IDC come mainly from only four different countries, providing on-site part-time interpreters for the main languages represented in the centre would not be particularly onerous.

(a) Mental health

92. A correlation between length of stay in immigration detention and mental health issues has been established through various studies,⁹¹ including a large-scale review of health in Australian immigration detention centres.⁹² The results indicate that those detained for longer periods of time (greater than 24 months) had particularly poor health, both mental and physical. Significantly, people detained for over 24 months had rates of new mental illness 3.6 times higher than for those released within 3 months.⁹³ The mental health of detainees reportedly deteriorates significantly during immigration detention, and numerous instances of self-harming behaviour have been documented, including among children.⁹⁴

93. Although it is commendable that the current Government has taken significant steps to reduce lengths of stay in detention, as of 23 October 2009, 30 per cent of the detainees in Australia's IDCs were detained for more than 3 months. As such, length of detention remains an area of concern for the Special Rapporteur. Depressive, anxiety and post-

⁹⁰ E/C.12/2000/4, para. 35.

⁹¹ See e.g. Keller, A. S., Rosenfeld, B., Trinh-Shevrin, C., et al. 'Mental health of detained asylum seekers' *The Lancet*, vol. 362, Issue 9397, pp. 1721-1723 (2003); Ichikawa M., Nakahara S. & Wakai, S. 'Effect of post-migration detention on mental health among Afghan asylum seekers in Japan' *Australian and New Zealand Journal of Psychiatry*, vol. 40, Issue 4, pp. 341-346 (2006).

⁹² Green, J. P. and Eagar, K., 'The health of people in Australian immigration detention centres', *Medical Journal of Australia*, 192(2) p. 65 (2009).

⁹³ *Ibid.*, p. 68.

⁹⁴ Australian Human Rights and Equal Opportunity Commission, *A Last Resort? The National Inquiry into Children in Immigration Detention* (2004).

traumatic stress disorders are common psychological sequelae of torture and trauma, which are well-documented among refugee and asylum seekers.⁹⁵ Under conditions of detention or prolonged uncertainty about the future, the negative psychological impact of previous experiences of trauma is exacerbated.

94. During his mission, the Special Rapporteur was impressed by the standard of mental health services provided in the IDCs by specialist nurses, counsellors, psychologists and psychiatrists. However, he notes with some concern the role of the centre's security services in facilitating access to mental health and other health services. Detainees generally communicate their need for medical care to security officers, who then facilitate access to services. Detainees who are at risk of suicide and self-harm (SASH) are identified by security services personnel; their behaviour is monitored once they have been placed in SASH rooms, and security personnel can make decisions regarding the detainees' placement back into the regular facilities. The Special Rapporteur is concerned about the lack of support and specialized training provided to security personnel to adequately fill these roles.

(b) Excised offshore places

95. In September 2001, the Migration Amendment (Excision from Migration Zone) Act 2001 (Cth) was enacted, with the effect that non-citizens who first enter Australia at an excised offshore place without a valid visa are, in effect, prohibited from applying for visas on arrival or during their stay in Australia, unless the Minister determines it is in the public interest to lift the ban prohibiting them from doing so. Furthermore, offshore entry persons are barred from initiating certain legal proceedings in Australian courts, including in relation to the lawfulness of their detention. Under the current government's policy, all people who arrive by boat without a valid visa are taken into immigration detention on Christmas Island.⁹⁶ The excised offshore places, which include the Territory of Christmas Island, remain under Australian jurisdiction and the Act applies to these places in all respects, other than extending the visa application process to unauthorized arrivals. Since 2001, Christmas Island also hosts an Immigration Detention Centre.

96. While the Special Rapporteur was unable to visit Christmas Island and the immigration detention centre there due to time constraints, he notes with concern information provided to him during his mission; in particular, the fact that children continue to be detained on Christmas Island, albeit in community detention. As at 5 March 2010, there were 1,808 people in immigration detention on Christmas Island.⁹⁷ Conditions in the immigration detention centre have been described as cramped and the temporary accommodation of tents and converted classrooms as "unacceptable".⁹⁸

97. The remoteness of the island (2,650 km northwest of Perth) poses significant challenges regarding service provision – legal aid, community advocacy and support networks, care and support by non-governmental organizations, are particularly compromised due to the limited charter flights available, and expense associated with

⁹⁵ Foundation House - The Victorian Foundation for Survivors of Torture Inc (Foundation House) to the Senate Legal and Constitutional Committee Inquiry into the Migration Amendment (Designated Unauthorised Arrivals) Bill 2006.

⁹⁶ Australian Human Rights Commission, *Immigration detention and offshore processing on Christmas Island* (2009)

⁹⁷ Department of Immigration and Citizenship, 'Immigration Detention Statistics Summary' 5 March 2010, Australian Government, 1 (2010).

⁹⁸ Amnesty International, 'A short stay on Christmas Island', 22 December 2009, Amnesty International, 2009) (see <http://www.amnesty.org.au/refugees/comments/22308>)

reaching the island.⁹⁹ Although it was noted that the island is no more remote than certain parts of mainland Australia, and provides medical services at least equivalent to those of remote communities, the utility of locating the facility in such an inaccessible place has to be questioned.

98. The lack of specialist mental health and psychiatric services on the island is of particular concern, in light of the vulnerable population detained there. In conjunction with the reported “prison-like”, high security environment,¹⁰⁰ the shortage of community-based accommodation – leading to detainees with mental health concerns or a background of torture and trauma being held in closed detention facilities – the lack of local mental health services¹⁰¹ presents exacerbating factors for poor mental health.

99. The Special Rapporteur also notes with concern the non-statutory refugee status assessment process, which applies only to those who arrive in excised offshore places and is not governed by the Migration Act. It removes the right to submit an application for any visa (including a protection visa) unless the Minister determines it is in the public interest for the ban to be lifted, bars access to independent merits review by the Refugee Review Tribunal or Administrative Appeals Tribunal, and provides only limited access to judicial review of decisions regarding refugee status. This arbitrary distinction between mainland and non-mainland arrivals increases the risk of refoulement, and potentially violates Australia’s obligations under the 1951 Refugee Convention, which prohibits State parties from penalizing asylum seekers on account of their unlawful entry where they are coming directly from a territory where their life or freedom was threatened.¹⁰²

V. Conclusions and recommendations

100. The Special Rapporteur calls upon the Government of Australia to:

- Take steps to enshrine human rights, including the right to the enjoyment of the highest attainable standard of health, within the Constitution of Australia;
- Ratify the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment, and establish an independent national preventive mechanism to conduct regular inspections of all places of detention, including those for immigration detainees;
- Pass legislation restoring the *Racial Discrimination Act vis-à-vis the Northern Territory* as a matter of priority, and introduce constitutional protection of the rights of Indigenous peoples;
- Develop a national health policy which includes a detailed plan for the full realization of the right to health;

⁹⁹ Immigration detention and offshore processing on Christmas Island, Australian Human Rights Commission (2009); Refugee Council of Australia (2008), Joint letter concerning Christmas Island Immigration Detention Centre: “NEW high security detention centre unsuitable for asylum seekers”.

¹⁰⁰ Refugee Council of Australia (2008), Joint letter concerning Christmas Island Immigration Detention Centre: New high security detention centre unsuitable for asylum seekers”.

¹⁰¹ Immigration detention and offshore processing on Christmas Island, (Australian Human Rights Commission, 2009)

¹⁰² Article 31.

- Implement legislative or other guarantees to ensure that the opinions of national representative indigenous bodies, such as the National Congress of Australia's First Peoples, are taken into account;
- Give priority to education in human rights throughout the country, particularly in respect of education for health professionals, and ensure that progress is made through the engagement of relevant national monitoring bodies;
- Address, as a matter of urgency, the qualitative and quantitative inadequacy of educational services for remote communities, in light of the adverse impact of this on the enjoyment of the right to health;
- To ensure that Indigenous communities have control over allocation of resources, by providing local governance monitoring structures which would include representatives of Indigenous peoples thus granting that decisions meet community-specific needs;
- To allocate additional funding to health promotion programmes concerning responsible alcohol use, and to support, counselling and rehabilitation services, as suggested throughout the Northern Territory Emergency Response redesign consultations;
- To review practices in relation to health information exchange within the prison system, as well as between prisons and the community health providers;
- To increase engagement with community health providers by prisons, which would improve continuity of care and facilitate reintegration into the community;
- To increase resource allocation for diagnosis, treatment and prevention of mental illnesses within prisons, and conduct research into the morbidity of mental illness within incarcerated populations;
- To consider renewed assessment of, and investment in, the primary health care sector throughout the prison system, particularly in respect of health promotion activities;
- To undertake research regarding indigenous incarceration issues as a matter of urgency, and ensure that new interventions concerning prevention of incarceration and treatment during incarceration are evidence-based and appropriately evaluated. Particular attention should be given to research concerning mental illness and substance abuse, as well as literacy issues;
- To investigate new methods for recruitment and retention of correctional services staff of Aboriginal and Torres Strait Islander descent;
- To reconsider the policy of mandatory detention of irregular arrivals;
- To assess the viability of providing on-site interpreters in immigration detention facilities, at least for frequently spoken languages, which would render health services more accessible and appropriate for detainees lacking English language skills;
- To place detainees with a history of torture and trauma in community detention, or arrange a bridging visa upon diagnosis, and develop a consistent policy to this effect;

- To ensure appropriate further training is provided to non-medical personnel who are involved in identifying or referring immigration detainees with potential mental health issues, or develop different mechanisms for detainees to access necessary services;
 - To reconsider the appropriateness of detention facilities continuing to operate on Christmas Island, and assess provision of mental health services to this population as a matter of priority.
-