Chapter 5

Australia's court and tribunal procedures

5.1 In considering the laws and practices of relevant Australian courts and tribunals, the committee took as its starting point Australia's commitment under its reservation to the UN Convention on the Rights of Persons with Disabilities. This commitment requires Australian governments to ensure that substituted decision-making occurs only as a last resort and only with all necessary safeguards. As noted in chapter 4, the committee considers that courts and tribunals must have robust laws and procedures in place for the defence of the rights of persons with disabilities. Submitters identified several areas where safeguards are reportedly lacking or are in need of improvement. Some areas are common across jurisdictions, whereas others are specific to children's cases conducted under Commonwealth law. Issues specific to the exercise of Commonwealth law by the Family Court of Australia will be considered in the next chapter.

Representation and participation in proceedings before courts and tribunals

5.2 A number of concerns raised were relevant to both Commonwealth and State and Territory procedures. Notably, submitters questioned whether the processes used across jurisdictions ensured that the opinions of the disabled person were sought and given full weight. Access to legal representation and medical opinion were key aspects of this discussion.

Participation in proceedings – adults with disabilities

5.3 For adults with disabilities, arrangements for their participation in sterilisation proceedings differ across the States and Territories. Legislative requirements can also differ from procedures under the Australian Guardianship and Administration Council (AGAC) *Protocol for Special Medical Procedures (Sterilisation).*

Capacity to consent

5.4 In three jurisdictions, relevant legislation permits the court or tribunal to hear an application for an order authorising a sterilisation procedure if there is an existing guardianship order in place. In these jurisdictions, namely, the Australian Capital Territory (ACT), South Australia and Western Australia, analysis of whether the person has the capacity to consent to the contemplated medical procedure is not a prerequisite for determining whether the court has standing to hear the matter.[1]

5.5 In contrast, in New South Wales, Queensland, Tasmania and Victoria, the fact that a guardianship order is in place does not necessarily give a court or tribunal authority to hear a sterilisation case. Under the relevant State and Territory legislation,

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1 *Guardianship and Management of Property Act 1991* (ACT), s. 69; *Guardianship and Administration Act 1993* (SA), s. 61; *Guardianship and Administration Act 1990* (WA), s. 13; s. 56A.

a court or tribunal may hear a sterilisation case only if the person is considered incapable of giving, or refusing, consent to the proposed procedure. The person's capacity to understand the nature and effect of the proposed procedure is considered on a case-by-case basis.[2] In these jurisdictions it appears that there is a two-stage process to determine whether to make a sterilisation order. First, it must be ascertained whether the person has the capacity to consent to the procedure. Second, if the person is found to be without capacity, the court or tribunal is to determine whether to authorise the proposed sterilisation procedure.

5.6 In the Northern Territory, relevant legislation adopts a hybrid approach. The *Adult Guardianship Act* authorises the local courts to hear a sterilisation case where there is an existing guardianship order in place. However, the court must ascertain whether the person has capacity to consent to, or to refuse, the proposed procedure. If the person has capacity, the court must give effect to the person's wishes.[3]

5.7 The AGAC's *Protocol for Special Medical Procedures (Sterilisation)* requires tribunals to adopt a two-stage inquiry process. As a starting point, the tribunal must consider whether a person has the capacity to consent to the proposed treatment.[4] The protocol defines 'capacity' to mean capable of:

- understanding the nature and effect of their decisions about the proposed sterilisation;
- freely and voluntarily making decisions about the proposed sterilisation; and
- communicating their decisions in some way.[5]

5.8 Specific direction is given to tribunal officers regarding the steps needed to determine whether a person has capacity. In particular, the protocol advises that neither an adult nor child will be able to give valid consent if he or she is unable to understand the nature and significance of the treatment and associated risks.[6] The protocol also draws attention to the need to consider if the person is, or may be, affected or influenced by the differing views of his or her carers.[7] However, while requiring tribunals to consider capacity to consent as a threshold question, the protocol

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2 *Guardianship Act 1987* (NSW), ss. 33–34; *Adult Guardianship Act* (NT), s.21; *Guardianship and Administration Act 2000* (QLD), s. 70; *Guardianship and Administration Act 1995* (Tas); *Guardianship and Administration Act 1986* (VIC), s. 36, s. 39.

3 *Adult Guardianship Act*, s.21.

4 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 3.2.

5 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.11.

6 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.13.

7 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.14.

does not expressly prohibit tribunals from hearing a case where it is determined that a person has capacity.

Legal representation and participation in hearing

5.9 Arrangements for the person's participation in proceedings differ across the states and territories. An outline of the procedures under the *Protocol for Special Medical Procedures (Sterilisation)*, the protocol as applied by the Queensland Civil and Administrative Tribunal, and ACT legislation and practice, illustrate the various procedures that may be adopted.

5.10 Under the protocol, tribunals are directed to first determine the question of capacity. To address this issue, the protocol encourages tribunals to hold a preliminary hearing.[8] However, the protocol does not expressly require the tribunal to consider whether it is practicable to speak directly with the person. Rather, the protocol states that the tribunal may obtain an independent, that is, a third party, assessment of the person's capacity. Once the tribunal has considered the question of capacity, the protocol contemplates that the tribunal may make orders, known as directions, about how the hearing will be conducted.[9] Directions can include orders for a third party, such as a 'next friend', 'separate representative' or the person's 'legal guardian', to represent the person.[10] The protocol does not expressly encourage or require tribunals to consider the potential for the person to directly engage with the hearing process.

5.11 The Queensland Civil and Administrative Tribunal provided an explanation of the tribunal's application of the protocol. The tribunal noted that a third party may be appointed to represent the adult. The committee was advised that representatives are appointed to ensure that the tribunal can 'obtain a more robust analysis of the adult's capacity to give consent than would be obtained via an applicant whose interests may not always fully align with the interests of the adult.' The committee was further advised that tribunal members may directly engage with the adult, as 'a member of the tribunal can speak to the adult (if possible).'[11]

5.12 In the ACT, the *Guardianship and Management of Property Act 1991* provides two relevant procedural directions for the tribunal to follow in sterilisation cases. The tribunal must obtain the person's wishes, and give effect to the person's wishes to the extent that to do so would be consistent with the person's interests.[12] The tribunal must appoint a third party to represent the person. Section 70 of the Act

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8 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.8; 5.15.

9 Clause 5.21 of the Protocol states 'When the tribunal is satisfied on the two crucial questions, the Tribunal may give any or all of the following directions'. The two threshold questions are 'Does the person has capacity' (cl. 5.8–5.15) and 'Is sterilisation required' (cl. 5.16–5.20).

10 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.21.

11 Correspondence received from the Queensland Civil and Administrative Tribunal, 3 May 2013, p. 3.

12 *Guardianship and Management of Property Act 1991* (ACT), s.4.

directs the tribunal to appoint the person's guardian, the Public Advocate, or some other independent person. The committee was advised that, generally, orders are made to appoint the Public Advocate of the ACT.[13] The committee was advised that the tribunal typically requests the Public Advocate to report on the views of the person, to the extent that the person's views can be ascertained.[14] Additionally, the tribunal must consult the person's carers, unless this would adversely affect the person's interests.[15]

5.13 Advice provided by the General President of the Australian Capital Territory Civil and Administrative Tribunal indicated that the tribunal may adopt procedures in addition to those contemplated by the Act. In particular, the committee was advised that the tribunal will seek the person's views in each case. To do so, the tribunal may speak directly to the person during the hearing. Additionally, if requested or appropriate in the circumstances, tribunal members may separately meet with the person. [16]

5.14 Accordingly, a person's access and entitlements to legal representation can vary according to the jurisdiction in which they reside.

Stakeholder views – capacity to consent

5.15 Similar to the views of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, as explored in chapter 3, submitters warned against practices that could deny the legal capacity of persons with disabilities. The central importance of capacity was noted by private individuals, Public Advocates, and disability and human rights advocates.[17] As the Adult Guardian of Queensland and the Public Advocate of Queensland advised, it cannot be presumed that persons with disabilities are unable to exercise their legal autonomy:

> Many people have various forms of disability that in no way impact upon their capacity to exercise their legal rights or make decisions about themselves or their bodies.[18]

5.16 Family Planning New South Wales also noted that disability should not be equated with an inability to make decisions about personal health matters:

> Too often people with disability are presumed not to have the ability to make their own decisions because they have a disability. Many people who

13 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, p. 2.

14 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, p. 3.

15 *Guardianship and Management of Property Act 1991*, s. 4.

16 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, pp. 4–5.

17 See, for example, Adults Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 1; Professor John Carter, private capacity, *Committee Hansard*, 27 March 2013, p. 48; Janine Truter, *Submission 18*, p. 1.

18 Adults Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 1.

> have an intellectual disability can make decisions about their reproductive and sexual health.[19]

5.17 There was a general theme throughout submissions to the inquiry that persons with disabilities should receive appropriate support to exercise their legal capacity.[20] As the New South Wales Council for Intellectual Disability submitted, the starting point should be consideration of whether there are appropriate support mechanisms in place:

> [T]he really big important bit in the middle there is whether the people themselves are able to make the decision. While there need to be really good practical safeguards to ensure that that really is an informed and free choice, our aim should be that as much as possible, at the end of the day, it is people with disability themselves who are making their own choices about whether or not they have any form of contraception or menstrual management.[21]

5.18 Accordingly, there was strong consensus that consent and support for legal capacity are paramount. Determining capacity to consent was, therefore, considered to be a threshold issue to be settled before any third-party involvement in the decision-making process.[22] However, views were divided on whether the legal or medical community has a legitimate role to play in the absence of capacity to consent.

5.19 Two arguments were put forward in support of the view that third parties, such as courts and tribunals, have no role to play in the decision-making process for the non-therapeutic sterilisation of persons with disabilities. As noted in chapter 3, disability and human rights advocates argued that there are no legitimate grounds on which a sterilisation may be performed without the person's consent. As further noted in chapter 3, this view was challenged on the basis that this approach does not cater for persons without decision-making capacity.

5.20 Additionally, it was intimated that substituted decision-making is prohibited under international law. Notwithstanding Australia's caveat to this Article, which asserts that substituted decision-making may be appropriate in certain circumstances,[23] it was submitted that Australia's obligations under Article 12 of the Convention on the Rights of Persons with Disabilities require the provision of support

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19 Dr Deborah Bateson, Medical Director, Family Planning New South Wales, *Committee Hansard*, 27 March 2013, p. 10.

20 See, for example, Name Withheld, *Submission 63*, p. 1. This issue is further explored below.

21 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 10.

22 See, for example, Family Planning Victoria, *Submission 58*, p. 4.

23 United Nations, *United Nations Treaty Collection*, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en#EndDec (accessed 3 May 2013).

for persons with disabilities to exercise their legal capacity.[24] As People with Disability Australia (PWDA) submitted:

> Implementation of article 12 requires establishing supported decision-making alternatives to substitute decision-making regimes. It will also require effective safeguards to be introduced in relation to supportted decision-making arrangements to prevent abuse in accordance with international human rights law.[25]

5.21 PWDA further commented that the successful implementation of Article 12 will require 'fundamental reforms':

> Implementation of article 12 is critical for people with disability to achieve many of the rights contained in the CRPD, and it will require 'fundamental reform in the current legal, administrative and service arrangements that regulate legal capacity of people with disability so that supported decision-making can be recognised, developed and promoted'. In this context, the legal prohibition of voluntary or coerced sterilisation must be complemented by the fundamental reforms required for the development of a comprehensive supported decision-making system that contains appropriate and effective safeguards.[26]

5.22 Such statements reflect comments by United Nations' committees and officials, for example the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, that Article 12 requires 'the replacement of substituted decision-making regimes with supported decision-making'.[27] As the statement of Dr Deborah Bateson, Medical Director, Family Planning New South Wales, indicates, supported decision-making was equated with protection against coercion:

> It is important to say from the outset that we support the rights of people with disability to make decisions about their reproductive and sexual health and we strongly oppose involuntary or coerced sterilisation of people with disability.[28]

5.23 Therefore, it was questioned whether courts and tribunals have a recognised role for sterilisation matters within the international law framework. This is reflected in assertions that a sterilisation procedure may be involuntary or coerced despite being

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24 See, for example, People with Disability Australia, *Submission 50*, p. 18.

25 People with Disability Australia, *Submission 50*, p. 18.

26 People with Disability Australia, *Submission 50*, p. 18; citing Disability Representative, Advocacy, Legal and Human Rights Organisations, *Disability Rights Now – Civil Society Report to the United Nations Committee on the Rights of persons with Disabilities*, August 2012, p. 187.

27 Mendez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, A/HRC/22/53, p. 7.

28 Dr Bateson, Family Planning New South Wales, *Committee Hansard*, 27 March 2013, p. 10.

authorised by a court or tribunal.[29] This view was encapsulated in the submission by Ms Linda Steele, Lecturer, Faculty of Law, University of Wollongong:

> It also follows from the current legal framework for sterilisation that involuntary sterilisation pursuant to a court or tribunal order is not only a form of violence but is specifically a form of *legal violence*. Legal violence is violence that is specifically made possible by and authorised by the law. Sterilisation is legal violence because without the court or tribunal order (under legislation giving jurisdiction to a court and tribunal to make such an order), the involuntary sterilisation of people with disability is not lawfully possible and if committed could be unlawful and attract a criminal penalty.[30]

5.24 Accordingly, Ms Steele concluded that 'the current legal framework requires broad scale reform to shift from the legal framework of *regulation* to a framework of complete prohibition'.[31] Similarly, People with Disability Australia argued:

> [A]uthorisation of sterilisation by a court or tribunal on behalf of an adult with disability in the absence of serious risk to life or health constitutes involuntary or coerced sterilisation.[32]

5.25 Conversely, other submitters argued that in the absence of capacity it is appropriate for courts and tribunals to make decisions affecting a person with a disability. As the statement by Family Planning Victoria makes clear, there was a view that third parties may properly make decisions for persons without the capacity to decide for themselves:

> FPV considers that there are two broad groups of people with a disability who are affected by the practice of involuntary or coerced sterilisation and that these two groups, and those who support them, require different elements of support, education, and protection. These two groups [include] people with a disability who lack capacity to consent and require a substitute decision–maker.[33]

5.26 This was reiterated by the disability advocacy service Intellectual Disability Rights Service Inc., which held that 'if a person cannot understand sufficiently to make their own decisions then it is important that the decision go before a court or a tribunal.'[34] Catholic Social Services Victoria also contended that determinations by 'decision-making bodies' may be appropriate where a person is without capacity to

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29 See, for example, Mr Graeme Innes, Disability Discrimination Commissioner, Australian Human Rights Commission, *Committee Hansard,* 27 March 2013, p. 10; People with Disability Australia, *Submission 50,* p. 6.

30 Ms Linda Steele, *Submission 44,* p. 8.

31 Ms Linda Steele, *Submission 44,* p. 6.

32 People with Disabilities Australia, *Submission 50,* p. 14.

33 Family Planning Victoria, *Submission 58,* p. 4.

34 Ms Janene Cootes, Executive Officer, Intellectual Disability Rights Service Inc, *Committee Hansard,* 27 March 2013, p. 18.

consent, particularly in situations where caregivers are unable to provide 'all reasonable care'.[35] Further, the committee was offered an alternative interpretation of the scope and effect of Article 12 of the Convention on the Rights of Persons with Disabilities. The Australian Human Rights Commission concluded that Article 12 allows for appropriate substituted decision-making:

> Article 12 of the CRPD requires States Parties to support persons with disability to exercise their own legal capacity, and to ensure that any measures which allow for legal capacity to be exercised on behalf of a person with a disability are checked by adequate safeguards to prevent abuse, and particularly 'are free of conflict of interest'.[36]

5.27 On this basis, substituted decision-making by courts and tribunals was held to serve a legitimate purpose. However, the role of courts and tribunals was seen as limited to instances where persons are without the capacity to give, or to withhold, consent. It was argued that third parties cannot legitimately assume the decision-making powers of persons who are capable of deciding for themselves. As the Office of the Adult Guardian stated, '[i]t is only where the person lacks the necessary cognitive capacity that society has the right to intervene in relation to that person's decision-making.'[37] For persons with disabilities who are nonetheless able to exercise legal capacity, the Office of the Adult Guardian held that 'they should be treated in exactly the same way as any member of the Australian community'.[38] Similarly, the Adult Guardian of Queensland and the Public Advocate of Queensland submitted:

> [i]t is only where an individual lacks capacity to exercise those rights and make those decisions that there is any justification for intervention in their lives.[39]

5.28 There appeared to be a one possible exception to this view. Australian Lawyers for Human Rights submitted that compliance with international recommendations and best practice requires both the individual's consent and court authorisation:

> ALHR believes that the only way to improve laws and practices governing sterilisation is to comply with the…recommendations made by the CEDAW Committee, CRC Committee and the UPR (Universal Periodic Review) process. This requires legislative prohibition of the sterilisation of children, particularly girls, regardless of whether they have a disability, and adults without free and informed consent *and an order from a competent court or tribunal* [emphasis added].[40]

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35 Catholic Social Services Victoria, *Submission 39*, p. 3.

36 Australian Human Rights Commission, *Submission 5*, p. 10.

37 Mr Kevin Martin, Adult Guardian, Office of the Adult Guardian, *Committee Hansard*, 27 March 2013, p. 28.

38 Mr Martin, Office of the Adult Guardian, *Committee Hansard*, 27 March 2013, p. 28.

39 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 1.

40 Australian Lawyers for Human Rights, *Submission 41*, p.7.

5.29 When the committee spoke to women with disabilities, some questioned whether there were situations where substituted decision-making was legitimate:

> I think the reason I am here is that when I was involved with the advocacy movement there were a lot of things about women with disabilities being sterilised…my biggest problem is that I cannot see where a support worker or parent can make a decision for a woman with a disability.[41]

Views on consent, wishes and tribunal procedure

5.30 One submitter, Professor Susan Hayes, Professor of Behavioural Sciences in Medicine, Sydney Medical School, University of Sydney, noted with approval current steps taken by courts and tribunals to determine the wishes and capacity of persons with disabilities.[42] However, this view was not commonly shared by submitters to the inquiry. Accordingly, several recommendations were made to improve court and tribunal practice.

5.31 Submitters identified a need for greater awareness and recognition of the reality that capacity can develop over time with appropriate support. Indeed, it was submitted that there is a clear link between capacity and the degree and nature of support provided. A lack of support can be mistakenly correlated with a lack of capacity. For example, Women with Disabilities Australia (WWDA) criticised an approach that fails to recognise, or to consider, that capacity may change with time and circumstance:

> One of the other things is a problem around the notion that she will never have capacity, as if 'capacity' is a fixed state, and that she will never be able to handle her menstruation or that there will never be any kind of thing that will work…So when it comes to women and girls with disabilities, there is this weird notion of capacity as a fixed state and also that there will be no other options in the future.[43]

5.32 WWDA warned that the view of capacity as a fixed state can deny legal autonomy on the basis of a stereotypical, discriminatory understanding of disability, instead of an individual's circumstances or potential:

> Views such as these fail to acknowledge the fact that 'incapacity' can very often be a function of the environment and more often than not, a lack of support for the individual concerned.[44]

5.33 The link between capacity and support services was highlighted by other submitters to the inquiry. Family Planning New South Wales also recognised that '[m]any people who have an intellectual disability can make decisions about their reproductive and sexual health but may need support in the decision-making

41 Donna, *Committee Hansard*, 30 January 2013, p. 2.

42 Professor Susan Hayes, *Submission 47*, p. 3.

43 Ms Frohmader, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 14.

44 Women With Disabilities Australia, *Submission 49*, p. 38.

process.'[45] Similarly, Family Planning Victoria, while maintaining that there may be a segment of Australians with disabilities without legal capacity, noted the relevance of support services:

> [P]eople with a disability need age-appropriate information and education delivered in a developmentally-appropriate way, and support so that they can make their own choices.[46]

5.34 Sexual Health and Family Planning Australia concurred:

> Many people who have a disability, including those with intellectual disabilities, are capable of making decisions about their sexual and reproductive health, *if provided with developmentally appropriate information and unbiased guidance*.[47]

5.35 The National Council on Intellectual Disability (NCID) spoke not only of the relevance of appropriate support services but also of societal attitudes:

> NCID believes in the developmental model, which means having high expectations for each person. To achieve this we must provide support education based on individual needs and learning style of each person. We know that people with intellectual disability can and do grow and develop through life's ages and stages when given access to powerful, potent and precise intervention when appropriate in their lives.[48]

5.36 Sexual Health and Family Planning Australia further argued that steps to determine capacity are based on the assumption that a person with a disability receives appropriate support:

> The steps to determine free and informed consent and "best interest" are broadly based on the following assumed abilities of the disabled individual and/or their guardian to understand the facts involved, understand the choices, weigh up the consequences of the choices, understand how the consequences affect them [and] communicate their decision.[49]

5.37 Sexual Health and Family Planning Australia pointed out that the kinds of support services that may assist a person with a disability to understand the facts involved, the options available, and the consequences of their choices may not be provided:

> SH&FPA is concerned that these steps [to determine capacity] are predicated on there being adequate active support and education services to allow individuals to fully understand the connections between fertility, menstruation management, sexual activity, pregnancy, parenting with a disability and the full range of available options. It is our view that at

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45 Dr Bateson, Family Planning New South Wales, *Committee Hansard,* 27 March 2013, p. 10.

46 Family Planning Victoria, *Submission 58,* p. 4.

47 Sexual Health and Family Planning Australia, *Submission 52,* p. 3.

48 National Council on Intellectual Disability, *Submission 77*, p. 9.

49 Sexual Health and Family Planning Australia, *Submission 52,* p. 3.

> present, there are insufficient support structures to help individuals, their carers, the courts and the state to make these decisions in a fully informed way.[50]

5.38 It was further submitted that greater awareness of the nature of capacity requires courts and tribunals, and other relevant third parties, to be alert to subtle forms of coercion. Some people with an intellectual disability have been trained to be so compliant and acquiescent by carers and service providers that they need to be taught the concept of independent decision-making. Catholic Women's League Australia supported 'the promotion of the idea of informed consent, even when the person concerned has some experience of disability'. However, the organisation was concerned that 'the principles of informed consent, which include freedom from fear and all those other factors, are not being respected when it comes to the carers of disabled people or the disabled people themselves.'[51] The New South Wales Council for Intellectual Disability advised that subtle forms of 'coercion' can include a desire on the part of an individual with disability to obtain their carers' approval:

> [W]hen we talk about free and informed consent, it is the really tricky area with a lot of people with intellectual disability who are just used to doing whatever it takes to please.[52]

5.39 PWDA submitted that the circumstances in which an individual provides consent, or otherwise exercises their legal capacity, must be carefully and critically considered:

> Ostensibly it might appear as if a person is consenting but in fact we know from the stories from the women and the men we talk to that they have been coerced into it. So, it is not their informed choice to have this occur.[53]

5.40 The Office of the Adult Guardian advised that great care needs to be taken when assessing an individual's legal capacity:

> When it comes to consider the role of that particular individual in exercising the right that everyone else in the community possesses, there is a necessity for great care to be taken to ensure that the inability of that person to properly express and display decision in relation to them is indeed a decision.[54]

5.41 Accordingly, the quality of capacity assessments was questioned. The New South Wales Council for Intellectual Disability advised that there is a lack of

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50 Sexual Health and Family Planning Australia, *Submission 52*, p. 3.

51 Mrs Anna Maria Krohn, Bioethics Convenor, Catholic Women's League Australia, *Committee Hansard*, 27 March 2013, p. 44.

52 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 20.

53 Ms Therese Sands, Co-Chief Executive Officer, People with Disability Australia, *Committee Hansard*, 11 December 2012, p. 4.

54 Mr Martin, Office of the Adult Guardian, *Committee Hansard*, 27 March 2013, p. 28.

uniformity in the procedures adopted by State and Territory tribunals, and the quality of assessments is variable:

> I think just about all the legislation in some way calls for the views of the person to be obtained but what that means in practice would be a variable issue. Similarly, with capacity assessments, the quality of assessments that someone lacks capacity may vary. I think it is only in New South Wales that the legislation requires that there be a written statement of reasons explaining why the tribunal is satisfied that the person lacks capacity and the sterilisation should be approved.[55]

5.42 Ms Colleen Pearce, Public Advocate, Office of the Public Advocate, Victoria, also questioned whether safeguards that apply in one jurisdiction apply across the board, commenting that 'safeguards that exist in Victoria are one thing, and there are concerns…that the kinds of safeguards we have in place here are not replicated elsewhere.'[56]

5.43 Differences in tribunal practice have been noted in previous inquiries. Reporting in 2001 to the Australian Human Rights Commission, Susan Brady, John Britton, and Sonia Grover noted with approval the practice existing in some state and territory jurisdictions of providing a questionnaire to expert medical witnesses to clarify the information the court is seeking.[57] Evidence presented to this inquiry was silent on whether this practice is currently in use by all tribunals or the Family Court.

5.44 These concerns with tribunal procedures were, unsurprisingly, not shared by participants in the tribunal process. The Office of the Public Advocate (OPA) provided a detailed overview of the measures taken to minimise the risk of coercion and to maximise the level of support provided. The OPA advised that officers seek to develop a relationship with the person with a disability independent of the person's carers, family or friends. To avoid the risk of pressure or influence, OPA officers attempt to meet individually with the person. The committee was further informed that OPA officers also meet with medical advisers, social workers and others involved in the application to obtain information about the person's wishes. It was put to the committee that:

> the process will never be perfect, but there is a definite activity taken by [the OPA] office and by the tribunal itself to ascertain the real wishes of the individual as best we possibly can.[58]

5.45 The Northern Territory Government advised that section 7 of the *Mental Health and Related Services Act* directs that the person receive information and advice

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55 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 2.

56 Ms Colleen Pearce, Public Advocate, Office of the Public Advocate, Victoria, *Committee Hansard*, 11 December 2012, p. 6.

57 Susan Brady, John Britton, Sonia Grover, *The sterilisation of girls and young women in Australia: issues and progress*, p. 44.

58 Mr Martin, Office of the Adult Guardian, *Committee Hansard*, 27 March 2013, p. 30.

about the proposed treatment and adequate time to consider the information provided.[59] The New South Wales Government advised that it approves the procedures applied by the Guardianship and Administration Board to ascertain the person's wishes and capacity to consent. Such procedures reportedly include independent investigations by the Public Guardian and reports by health care providers.[60] The Adult Guardian of Queensland and the Public Advocate of Queensland supported procedures adopted by the Queensland Civil and Administrative Tribunal (QCAT) to ascertain the person's wishes.[61]

5.46 It was also questioned whether procedures to obtain medical advice are adequate. The committee was advised that ascertaining whether a person has capacity to provide or withhold consent can be quite an involved process. It is not a process to be rushed. As the Intellectual Disability Rights Service Inc. advised:

> Consent on decisions about sterilisation procedures should be made by the woman herself where ever possible…[T]hat involves usually a lengthy procedure of doctors liaising with the person to gauge their understanding, hopefully increasing their understanding of the decision that they need to make. I think it is a real misnomer that it is a one-off interaction between a doctor and patient and that the doctor can then decide that this person cannot make a decision for themselves. It needs to be a fairly in-depth process the doctor would go through to make that judgement. It also needs to be based on full information and information about alternatives for the person to weigh up if they are able to weigh up those options…Coercion can be very subtle.[62]

5.47 It was submitted that the process by which medical practitioners evaluate capacity to consent is subjective. The committee was informed that there is no widely accepted, easily administered standardised assessment of capacity to provide free and informed consent.[63] Based on their experience providing training programs to health professionals, Family Planning Victoria questioned whether there is sufficient expertise within the medical profession to properly ascertain wishes or capacity to consent:

> [D]uring our experience training health professionals and offering secondary consultation, it has become evident that many health professionals do not feel confident communicating with people with disabilities, particularly around sexual and reproductive health issues. It also appears that many health professionals do not consider, and in some

59 Northern Territory Government, *Submission 34*, p. 5.

60 New South Wales Government, *Submission 57*, pp. 2–3.

61 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 7.

62 Ms Cootes, Intellectual Disability Rights Service Inc, *Committee Hansard*, 27 March 2013, p. 18.

63 Family Planning Victoria, *Submission 58*, p. 6.

> cases do not respect, the sexual and reproductive health rights of people with disabilities.[64]

5.48 Other submitters also questioned whether there is sufficient expertise within the medical community to advise on proposed sterilisation procedures. The Office of the Public Advocate, Victoria argued that there is a need for greater disability awareness and understanding among the medical profession:

> We think that an important topic is educating medical professionals. We do a lot of it already but we would love to do more of it, and we would love for medical professionals to be required to do some of it. We are really keen to hear any suggestions you have at the national level by which we can encourage this to occur.[65]

5.49 This view was shared by Family Planning Victoria:

> [M]any people with disability who fit into the first category [of having the capacity or potential capacity to consent] are treated as if they fall into the second [of lacking capacity to consent and therefore requiring a substitute decision–maker]. Medical practitioners require more specific support regarding the assessment of a person's capacity to consent to determine which of these categories accurately describes an individual's level of capacity.[66]

5.50 In response to these and related concerns, Sexual Health and Family Planning Australia argued that a comprehensive education strategy is required:

> Therefore steps to determine capacity (both for individuals with a disability as well as their carers) must include a nationally endorsed, up-to-date set of education strategies, tools and resources which can be freely and easily accessed and used by health professionals, parents, support workers, and other relevant stakeholders.[67]

5.51 The New South Wales Centre for Disability questioned not only medical expertise but also the extent of disability awareness and the influence of personal values:

> I am a little bit sceptical about the list [of experts] that medical colleges can come up with, because the fact that someone does a lot of this kind of work does not necessarily mean that their values are appropriate.[68]

5.52 Evidence from the medical community was provided by the Australian Medical Association, the Royal Australian College of Physicians, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the

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64 Family Planning Victoria, *Submission 58,* p. 5.

65 Dr Chesterman, Office of the Public Advocate, Victoria, *Proof Committee Hansard,* 11 December 2013, p. 14.

66 Family Planning Victoria, *Submission 58,* p. 4.

67 Sexual Health and Family Planning Australia, *Submission 52,* p. 3.

68 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard,* 11 December 2012, p. 12.

Australian Association of Developmental Disability Medicine Inc. (the AADDM), and the Royal Children's Hospital, as well as individual medical practitioners. Of these, the Australian Medical Association, the Royal Australian College of Physicians and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists did not comment on the expertise or training of doctors and other relevant medical staff in disability matters. In contrast, the AADDM noted that expertise among general practitioners may be lacking, stating that '[m]any GPs do not feel comfortable relating to a female with ID (intellectual disability) who has difficulty communicating or is prone to aggressive outbursts'.[69] Both the Royal Children's Hospital and the AADDM concluded that there is a need for increased training of medical professionals.[70] This issue was considered in chapter 2.

5.53 Evidence provided by the medical community shed further light on the procedures used to determine a person's legal capacity. The Royal Children's Hospital advised that there are extensive guidelines provided by medical boards and medical training programs. Accordingly, it was submitted that '[f]rom our perspective, there is no need for a legal framework that reiterates' these guidelines.[71] The Royal Children's Hospital also noted that '[c]linicians with some experience in working with young women with disability are well aware of the need to try to establish the wishes of the young woman herself'.[72] However, it was further noted that this is not required by medical policy but rather by ethical principle. The hospital's evidence brought into question whether the steps taken by the medical community to ascertain the person's wishes are adequate. The hospital noted that '[a]t RHC, the young women with disabilities tend to be in the more severely disabled spectrum with limited capacity for medication and limited self-care abilities'.[73] The committee was not provided information about the steps taken to ascertain the wishes of these women. Rather, the committee was advised that steps are taken to try to establish factors relevant to the women's quality of life.[74]

5.54 The Australian Medical Association noted that decision making capacity is not static and can be subject to change. The Association also commented that where a person is considered to lack decision-making capacity, 'the patient should be encouraged to participate in the decision-making process as much as possible'. However, the committee was not provided advice about procedures and protocols in place to help facilitate the person's involvement or the doctor's assessment of capacity.[75]

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69 Australian Association of Developmental Disability Medicine Inc., *Submission 59*, p. 3.

70 Australian Association of Developmental Disability Medicine Inc., *Submission 59*, pp. 3–4; Royal Children's Hospital, *Submission 69*, p. 2.

71 Royal Children's Hospital, *Submission 69*, p. 6.

72 Royal Children's Hospital, *Submission 69*, p. 6.

73 Royal Children's Hospital, *Submission 69*, p. 6.

74 Royal Children's Hospital, *Submission 69*, p. 6.

75 Australian Medical Association, *Submission 53*, p. 2.

5.55 Submitters also questioned whether the courts and tribunals are appropriately scrutinising and evaluating the medical evidence received. Reporting in 1997, the Australian Human Rights Commission commented on an apparent trend among Australian courts to 'uncritically accept medical evidence to the exclusion of other relevant expertise'.[76] Similar concerns were raised with the committee. Ms Linda Steele advised that 'the medicalisation of sterilisation has ramifications for evidence and procedure'.[77] It was argued that the consideration by a court or tribunal of whether sterilisation is medically necessary leads to a general acceptance of medical advice.[78] WWDA agreed:

> The propensity of Courts and parents to value medical opinion above all else–and in many cases elevating opinions and assertions to the status of fact–has the effect of reducing the 'best interests' of disabled women and girls to the 'best [and easiest, quickest and cheapest] ways' of controlling and managing their unruly bodies and 'behaviour'.[79]

5.56 It was also questioned whether courts and tribunals have access to a sufficient breadth of medical advice. Mr Simpson observed that:

> To me the other issue that comes with the tribunal—or should come with the tribunal one way or the other, whether it is through the tribunal's own initiative or through involving a public advocate—is ensuring that there is balanced evidence in front of the tribunal and, unless the case is extremely clear, ensuring that a second opinion is obtained from Dr Grover or the like—someone who is known to the public advocate or the tribunal as having the relevant expertise.[80]

5.57 Submitters also argued that there are further measures that could be taken to ensure that the person's wishes are before the tribunal and are given due weight. Access to legal representation was a key feature of this debate. Similar issues arose in relation to children's proceedings.

Participation and legal representation – adults and children

5.58 As noted in chapter 3, the United Nations' Human Rights Committee has concluded that legal representation is a crucial and necessary part of court or tribunal hearings to determine a person's capacity. Commenting in particular on the situation in Lithuania, the committee recommended that:

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76 Australian Human Rights Commission, *The sterilisation of girls and young women in* Australia, 1997, p. 17; citing G. Carlson, M. Taylor, J. Wilson, and J. Griffen, *Menstrual Management and Fertility Management for Women who have Intellectual Disability and High Support Needs: Analysis of Australian Policy*, (2nd ed), 1994, Department of Social Work and Social Policy , University of Queensland.

77 Ms Linda Steele, *Submission 44*, pp. 11–12.

78 Ms Linda Steele, *Submission 44*, pp. 11–12.

79 Women With Disabilities Australia, *Submission 49*, p. 47.

80 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 12.

> [t]he State party should ensure free and effective legal representation to individuals in all proceedings regarding their legal capacity, including actions to have their legal capacity reviewed. It also should take appropriate measures to facilitate legal support to persons with disabilities in all matters impacting on their physical and mental health.[81]

5.59 Evidence before the committee indicated that procedures for legal representation differ across the jurisdictions. The AGAC advised that the *Protocol for Special Medical Procedures (Sterilisation)* provides guidance for tribunals considering the appointment of representation for the person.[82] Specifically, clause 5.21 advises that tribunals may consider appointing a representative, known as a separate representative. The protocol does not specify the intended role of the separate representative. Nor does it state that a separate representative is to be a legal representative.[83]

5.60 For proceedings concerning adults with disabilities, practices vary across the states and territories. For example, in the ACT the tribunal must appoint a representative.[84] However, this is not necessarily a legal role.[85] In contrast, the Northern Territory Government advised that there two options for legal representation, namely, the appointment of a legal representative or legal counsel. Both are government funded positions. The committee was further advised that legal counsel operate similarly to the Independent Children's Lawyers appointed in Family Court proceedings.[86]

5.61 The New South Wales Government advised that separate legal representation, provided by Legal Aid New South Wales, will be appointed for both adult and child sterilisation cases. The separate representative's role is to meet with the person to obtain their views and wishes, to the extent this is possible; review the evidence available and obtain any further relevant evidence; and present their independent conclusion to the tribunal about whether the application should be granted.[87] The Adult Guardian of Queensland and the Public Advocate of Queensland advised that the appointment of a legal representative for a child who is the subject of a sterilisation application is mandatory. A legal representative must be appointed in each case. The representative is to act in the child's best interests; have regard to any

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81 Human Rights Committee, *Consideration of reports submitted by States Parties under article 40 of the Covenant, Concluding observations adopted by the Human Rights Committee at its 150 session, 9–27 July 2012–Lithuania*, p. 4, http://www2.ohchr.org/english/bodies/hrc/hrcs105.htm (accessed 7 May 2013).

82 Australian Guardianship and Administration Council, *Submission 28*, p. 4.

83 Australian Guardianship and Administration Council, *Submission 28*, Attachment 1, *Protocol for Special Medical Procedures (Sterilisation)*, cl. 5.21.

84 *Guardianship and Management of Property Act 1991* (ACT), s. 70(2).

85 Correspondence received from the Australian Capital Territory Civil and Administrative Tribunal, 12 May 2013, p. 2.

86 Northern Territory Government, *Submission 34*, pp. 3, 5.

87 New South Wales Government, *Submission 57*, p. 5.

expressed views or wishes of the child; and, to the greatest extent practicable, present the child's views and wishes to the tribunal.[88] The committee was informed that the tribunal has the authority to order that all parties provide information to the child's representative, thus making clear Parliament's intention for the child representative, and by extension the tribunal, to have complete access to all necessary information concerning the child.[89]

5.62 For children's cases, submitters focused on procedures for the appointment of an Independent Children's Lawyer in the Family Court of Australia. The role of an Independent Children's Lawyer (an ICL) is specified in Division 10, Part 7 of the *Family Law Act 1975*. As noted in chapter 3, an ICL does not represent the children's views but forms an independent opinion of what is in the child's best interests.[90] Section 68L of the Act states that the court may appoint an ICL if it appears to the court that the child's interests ought to be independently legally represented. The Family Court confirmed that, in accordance with section 68L, the appointment of an ICL is at the court's discretion.[91] In *Re K* (1994) FLC 92-461, the Full Court of the Family Court held that the circumstances in which it would be appropriate for an ICL to be appointed include:

> [a]pplications in the court's welfare jurisdiction relating in particular to the medical treatment of children where the child's interests are not adequately represented by one of the parties.[92]

5.63 Submitters were critical of the courts' discretion, arguing that it undermines a safeguard that should be available in each case.[93] Academics, disability advocates, and members of the medical profession were united in the view that an ICL should be appointed for every application for court approval of a proposed child sterilisation procedure. Dr Wendy Bonython, Assistant Professor, School of Law, University of Canberra, submitted that an ICL is an essential part of identifying 'the fine-grained details' of a child's best interests:

> There is a very real risk that, if you do not have an independent lawyer whose job is specifically to assess what the best interests of the child are, evidence that is important may simply be missed or left out. If judges do not have access to information they cannot make the best decision possible under the circumstances. I would say that they do need independent representation–not just somebody acting in the role of the contradictor like a Human Rights Commission or someone from the Public Advocate–an

88 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 7.

89 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 7.

90 *Family Law Act 1975*, s. 68LA.

91 Attorney–General's Department, answer to question on notice, 19 April 2013 (received 14 May 2013).

92 Attorney–General's Department, answer to question on notice, 19 April 2013 (received 14 May 2013).

93 See, for example, Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 2.

> independent legal adviser who is applying the best interest tests, considering them in the context of the facts, and is completely divorced from any other confounding factors based on family dynamics and relationships that may be present.[94]

5.64 Representatives of the Royal Children's Hospital also submitted that there is a need for independent legal representation for children, noting with concern that an ICL was not appointed in the family law case *Re Angela*.[95] Accordingly, it was recommended that the court's discretion to appoint an ICL in child sterilisation cases should be removed. Appointment should be mandatory.[96] Australian Lawyers for Human Rights linked the failure to provide an ICL with a failure to ensure that the child 'has a voice' in proceedings that impact their welfare.[97]

5.65 Additionally, while highlighting the importance of legal representation for children, the expertise of Independent Children's Lawyers was questioned. Dr Susan Hayes identified a need for 'more thorough and extensive' training for lawyers who represent adults or children in sterilisation cases.[98] The Queensland Centre for Intellectual and Development Disability, the Queenslanders with Disabilities Network and Queensland Advocacy Inc. submitted that legal representatives should receive training in disability matters, including alternatives to sterilisation.[99] The New South Wales Council for Intellectual Disability commented:

> In relation to ensuring that there is another voice for the child or for the person with a disability, if the Public Advocate is involved you have an expert rights based body. If you are relying on separate representative lawyers from Legal Aid, as I think may happen in other parts of Australia, you are not necessarily getting anybody who has the expertise.[100]

5.66 The committee sought, but did not receive information concerning the qualifications of persons appointed to act as an ICL.[101] In contrast, the committee was informed that a child's legal representative for proceedings before QCAT 'must be a lawyer with experience in dealing with children with impairment'.[102]

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94 Dr Wendy Bonython, Assistant Professor, School of Law, University of Canberra, *Committee Hansard*, 27 March 2013, p. 63.

95 Royal Children's Hospital, *Submission 69*, p. 6.

96 See, for example, Dr Wendy Bonython, *Submission 22*, Recommendation 6, p. 4.

97 Australian Lawyers for Human Rights, *Submission 41*, p. 3.

98 Professor Susan Hayes, *Submission 47*, p. 4.

99 Qld Centre for Intellectual and Developmental Disability, Queenslanders with Disabilities Network, and Qld Advocacy Inc, *Submission 37*, p. 3.

100 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 11.

101 Attorney–General's Department, answer to question on notice, 19 April 2013 (received 14 May 2013).

102 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 7.

5.67 In response to these concerns, Chief Justice Diana Bryant of the Family Court of Australia advised that the appointment of an ICL may not be appropriate in every case. The Chief Justice considered that despite the title of 'Independent' Children's Lawyer, an ICL 'is not going to necessarily be giving an objective view'.[103] The Chief Justice advised that in considering what is in the best interests of the child, an ICL may concur with the views of a party to the proceedings. The Chief Justice agreed with the proposition that a child's voice can be represented by a third party, such as a contradictor.[104] However, the committee notes that there is a legislative requirement under the *Family Law Act 1975* (Cth) for ICLs to act independently. Objectivity and impartiality appear to be an implicit part of their duties as specified under section 68LA of the Act.

5.68 In addition to the legal representation of children, it was further put to the committee that adults should also be provided representation.[105] However, some submitters, such as the Royal Children's Hospital, were silent on the issue of whether this representative should be a legal representative.[106]

5.69 Alternatively, it was submitted that it would be appropriate to include disability advocates in child and adult sterilisation cases. The Queensland Centre for Intellectual and Development Disability, the Queenslanders with Disabilities Network and Queensland Advocacy Inc. argued that it would be appropriate for disability advocates to be parties to sterilisation cases to 'provide informed and independent representation'. The organisations advised that additional resources would be required for disability advocacy services to undertake this role.[107] The Chief Justice of the Family Court advised that 'it would not be appropriate for rights–based organisations to be involved'.

> The information regarding rights and so forth should inform other people in making decisions. We get ultimately the evidence that comes from doctors, parents, psychiatrists and psychologists who have thought about all of these issues at an earlier stage. So one would have hoped that all of the issues about rights, difficulties and problems would have been considered—particularly where hospitals are involved.[108]

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103 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Proof Committee Hansard*, 27 March 2013, p. 60.

104 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Proof Committee Hansard*, 27 March 2013, p. 61.

105 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard*, 11 December 2012, p. 11.

106 Royal Children's Hospital, *Submission 69*, p. 2; Associate Professor Sonia Grover, Gynaecologist, Royal Children's Hospital, *Committee Hansard*, 11 December 2012, p. 11.

107 Qld Centre for Intellectual and Developmental Disability, Queenslanders with Disabilities Network, and Qld Advocacy Inc., *Submission 37*, p. 3.

108 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Proof Committee Hansard*, 27 March 2013, p. 60.

The 'best interests' test

5.70 The use and application of the 'best interests' test was a key topic for submitters to the inquiry. Currently, the best interest test is not in use in every jurisdiction. In jurisdictions where a best interest test is in use, there are variations in the criteria to determine whether a sterilisation procedure would be in a person's best interests. As one submitter noted:

> The very fragmented nature of the legislative and common law system that we have at the moment means that you could have different tests being applied all over the place.[109]

5.71 Of the four jurisdictions that have legislated for child sterilisation procedures, New South Wales has not adopted a best interests test. However, Dr Bonython, University of Canberra, advised that there have been cases in New South Wales where the tribunal has taken a broad view of the legislation and, accordingly, applied a best interests test.[110] In the remaining jurisdictions, Queensland, Tasmania and the Commonwealth (including Western Australia operating under Commonwealth law), sterilisation may be authorised if in the child's best interests. However, while these three jurisdictions all use a best interests test, the criteria that define best interests differ. For adults, a best interests test applies in five jurisdictions. However, again the criteria used to determine whether this test is satisfied differ throughout the jurisdictions.

The best interests of the child - definition

5.72 For Commonwealth cases, 'child's best interests' is defined by section 60CC of the Family Law Act. However, the definition relates to family arrangements such as who the child is to live with and spend time with. The court is also to consider factors outlined in *Re Marion (No. 2)* (1994) FLC 92–448 and Division 4.2.3 of the Family Law Rules. The criteria that apply for Commonwealth cases are outlined in detail in chapter 3.

5.73 In Queensland, sterilisation is taken to be in the child's best interest if one or more of the following applies:[111]

- The sterilisation is medically necessary;
- The child is, or is likely to be, sexually active and there is no method of contraception that could reasonably be expected to be successfully applied; or
- If the child is female, the child has problems with menstruation and cessation of menstruation by sterilisation is the only practicable way of overcoming the problems.

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109 Dr Bonython, School of Law, University of Canberra, *Committee Hansard*, 27 March 2013, p. 65.

110 Dr Bonython, School of Law, University of Canberra, *Committee Hansard*, 27 March 2013, p. 65.

111 *Guardianship and Administration Act 2000* (QLD), ss 80D(1)(a).

5.74 Additionally, the court must be satisfied that all of the following criteria apply:[112]

- The child's impairment results in a substantial reduction of the child's capacity for communication, social interaction and learning; and
- The child's impairment is, or is likely to be, permanent and there is a reasonable likelihood, when the child turns 18, the child will have impaired capacity for consenting to sterilisation; and
- The sterilisation cannot reasonably be postponed; and
- The sterilisation is otherwise in the child's best interests.

5.75 In contrast, in Tasmania 'best interest of the child' is determined according to the following factors:[113]

- The wishes of that person, so far as they can be ascertained; and
- The consequences to that person if the proposed treatment is not carried out; and any alternative treatment available to that person; and
- Whether the proposed treatment can be postponed on the ground that better treatment may become available and whether that person is likely to become capable of consenting to the treatment.

Criteria to determine whether a procedure would be in the best interests of the adult

5.76 For sterilisation cases involving adults, a best interests test is used in the Australian Capital Territory, the Northern Territory, Tasmania, Victoria, and Western Australia. In New South Wales, sterilisation may only be approved if the tribunal is satisfied that the treatment is necessary to save the adult's life or to prevent serious damage to the person's health.[114] In Queensland, the legislation does not include a best interests test. However, the list of factors that the tribunal is to consider share elements of the best interests test used in children's cases. Factors include whether the procedure is medically necessary; whether the person is, or is likely to be, sexually active; whether there are other methods of contraception that could reasonably be expected to be successfully applied; and whether the sterilisation cannot reasonably be postponed.[115] South Australia adopts a hybrid approach, whereby sterilisation may be authorised if therapeutically necessary or if certain other factors are satisfied.[116]

5.77 In the remaining jurisdictions, the best interest tests are not uniform but are defined differently throughout the relevant State and Territory legislation. Details of ACT, Northern Territory and Victorian legislation are provided by way of contrast. In

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112 *Guardianship and Administration Act 2000* (QLD), ss 80D(1)(b)–(e).

113 *Guardianship and Administration Act 1995* (Tas), s. 45.

114 *Guardianship Act 1987* (NSW), s. 45.

115 *Guardianship and Administration Act 2000* (QLD), s. 70.

116 *Guardianship and Administration Act 1993* (SA), s. 61.

the Australian Capital Territory, to determine whether a procedure is in the adult's best interests, the tribunal must consider the person's wishes, insofar as they can be ascertained; the likely consequences if the procedure is not carried out; the availability of alternative treatments; and whether the treatment can be postponed as better treatments may become available.[117] In the Northern Territory, while a threshold for authorising a procedure is whether the procedure is in the person's best interests, 'best interests' is not explicitly defined the legislation.[118] In Victoria, to determine whether sterilisation would be in the person's best interests, the tribunal is to consider the person's wishes and the wishes of any relative; the consequences if treatment is not carried out; the nature and degree of any risks associated with the treatment; and whether the treatment is to be carried out only to promote and maintain the person's health and well-being.[119] By considering the views of relatives, the Victorian legislation explicitly incorporates the opinions, and potentially the needs and circumstances, of carers and family members.

Criticisms of the best interests test

5.78 The merits of the best interests test as the basis for authorising a sterilisation procedure were strongly debated. Opinion was divided on whether the best interests test is not only appropriate for sterilisation cases but suitably defends a person's human rights.[120] The strong opposition to the use of the best interest test is evident in WWDA's statement that the test has been 'successively used to justify the torture of women and girls with disabilities' and to 'perpetuate discriminatory attitudes'.[121] Best interests tests were criticised on two grounds.

International law

5.79 First, it was submitted that use of a best interests test is prohibited under international law. WWDA contended that the international human rights framework is 'very clear that best interests can no longer be used as an argument'.[122] People with Disability Australia likewise commented that due to the presence of best interests tests in Commonwealth, state and territory legislation 'there is no synergy' between Australia's domestic law and international law.[123]

5.80 As explored in chapter 3, the committee was advised of comments by United Nations' committees regarding best interests tests. This included the advice of the Australian Women Against Violence Alliance that the United Nations' Committee

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117 *Guardianship and Management of Property Act 1991* (ACT), s. 70.

118 *Adult Guardianship Act* (NT), s. 21.

119 *Guardianship and Administration Act 1986* (VIC), s. 38.

120 See, for example, Ms Cootes, Intellectual Disability Rights Service Inc, *Committee Hansard*, 27 March 2013, p. 18.

121 Women With Disabilities Australia, *Submission 49*, p. 44.

122 Ms Frohmader, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 27.

123 Ms Sands, People with Disability Australia, *Committee Hansard*, 11 December 2012, p. 6.

on the Rights of the Child has stated that 'the interpretation of the child's interests must be consistent with the whole Convention, including the obligation to protect children from all forms of violence.'[124] Similarly, WWDA submitted:

> The committee on the rights of the child has spelt out that you cannot sterilise a child with a disability using the language of 'best interest'—it is not in their best interest.[125]

5.81 The Human Rights Committee has questioned the use of 'best interests' tests, advising that 'international human rights standards…prohibit the coerced treatment of people suffering from intellectual disabilities, regardless of arguments of their "best interests"'.[126] Such statements formed the basis of the argument that the best interest test is prohibited under international law.[127]

5.82 Amnesty International Australia also submitted that a best interest test is contrary to international law, reporting that:

> [c]laims that forcing or coercing women and girls into sterilisation is in their best interests contradict the general principles of respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons set out in Article 3(a) of the CRDP [Convention on the Rights of Persons with Disabilities].[128]

5.83 People with Disability Australia argued that Australia's interpretation of the best interests test differs from what was intended under the Convention:

> So under the convention, if the concept of involuntary or coerced sterilisation is a form of violence, then how could it ever be in the best interests of a child to authorise it? So the concept of involuntary and coerced sterilisation is different according to our obligations under international human rights and often the best interests, as applied here, actually allows for the authorisation of what we would call 'legal violence'—and it has been called that in some other submissions as well.[129]

5.84 However, the recommendations of United Nation's committees, and the resulting interpretation of Australia's international law obligations, were not supported by all submitters to the inquiry. The Commonwealth Attorney–General's Department advised that the use of the best interest test is, in the Government's view, consistent

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124 Australian Women Against Violence Alliance, *Submission 49*, pp. 1–2.

125 Ms Frohmader, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 6.

126 Office of the United Nations High Commissioner for Human Rights, *Thematic study on the issue of violence against women and girls and disability*, 30 March 2012, p. 10.

127 See, for example, Ms Frohmader, Women With Disabilities Australia, *Committee Hansard*, 11 December 2012, p. 6.

128 Amnesty International Australia, *Submission 48*, p. 44.

129 Ms Sands, People with Disability Australia, *Committee Hansard*, 11 December 2012, p. 6.

with Australia's international obligations.[130] The scope and effect of international law is considered in chapter 4 of this report.

5.85 Dr Wendy Bonython provided a counterpoint to the view that a best interests test is contrary to human rights principles. Dr Bonython noted that Article 7 of the Convention on the Rights of the Child requires the child's best interests to be a primary consideration in all actions concerning children with disabilities.[131] Dr Bonython further argued that sterilisation may be necessary to protect a person's rights:

> Sterilisation of people lacking capacity should be extremely rare; however, there may be some circumstances under which it is in the best interests of the person concerned, and, rather than denying that person their best chance of living a life of dignity and meaning by categorically banning the procedure, this submission instead argues that appropriate safeguards should be put in place to ensure that it truly is in their best interests.[132]

5.86 The Adult Guardian of Queensland and the Public Advocate of Queensland made a similar point, stating:

> It would seem that society has a tendency to assume that an individual would not choose sterilisation rather than applying an equilateral perspective that considers that both choices are ones that may be rightly made by an individual if they are in a situation where such a decision is being considered. The right to choose as well as the best interests of the person (taking into account all short and long term circumstances) must both be considered.[133]

5.87 In contrast with the concerns with the use of a best interests test, a number of submitters supported its use. In particular, the best interests test was supported by members of the judiciary and the legal profession, the medical profession, and carers of persons with disabilities. Dr Bonython submitted:

> [l]egislation should, at a minimum, contain a 'best interests' test based on Nicholson CJ's guidelines, considering not just the person's medical welfare, but also their psychological, educational, and social best interests.[134]

5.88 This view was endorsed by the Chief Justice of the Family Court, who noted that consideration of a particular child's best interests can differ from a broader rights-based discussion:

> I would only add that our role is to make a decision that is in the best interests of the child in a particular case, and that is what we do. Rights

130 Attorney–General's Department, answer to question on notice, 19 April 2013 (received 14 May 2013).

131 Dr Wendy Bonython, *Submission 22*, p. 22.

132 Dr Wendy Bonython, *Submission 22*, p. 2.

133 Adult Guardian of Queensland and the Public Advocate of Queensland, *Submission 19*, p. 2.

134 Dr Wendy Bonython, *Submission 22*, Recommendation 5, p. 37.

> based issues, as I say, are separate. They sometimes coincide but sometimes they do not. I do not think I can say any more than that.[135]

5.89 This emphasis on the circumstances of the particular child was also cited by members of the medical profession in support of the use of the best interests test. Dr Irwin Farris commented:

> I would argue that taking into consideration the whole context of the patient and her situation it should be possible for an independent authority such as a Guardianship Board, to conclude that it is the best interests of the patient that a sterilisation procedure be performed.[136]

5.90 Similarly, Ms Janine Truter, private capacity, submitted that is the best interest test promotes equality and equal access to medical treatment:

> [A] person who is not disabled, or a disabled person with some decision-making ability can consent to their sterilisation in their own best interests. Those who can't give valid consent would lose this option, or the option to have someone make the decision on their behalf, under any proposed laws to make sterilisation illegal.[137]

5.91 The best interests test was contrasted with the criteria used in New South Wales. Carers, for example Professor John and Mrs Merran Carter, expressed concern with the New South Wales framework, arguing that it has led to unfair and overly restrictive outcomes. Accordingly, the Carters recommended the New South Wales legislation be amended to introduce a best interests test. Such a test, it was submitted, should consider factors such as the person's quality of life, ability to be independent, medical reasons for the proposed procedure and the suitability and availability of any alternatives.[138]

5.92 There was, however, a limit to the support for the use of the best interests tests. Dr Bonython was critical of Family Court decisions that have authorised sterilisation of a minor before menstruation:

> To pre-emptively authorise sterilisation of a minor before menstruation begins is inconsistent with the concept of it being a 'step of last resort'. The risk that a girl might be traumatised, as a consequence of being exposed to a phenomenon that she is yet to encounter is too remote to justify the procedure. Furthermore, it prematurely deprives her of the right to attempt to manage any issues which may- not necessarily will- manifest in a less invasive way.[139]

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135 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Committee Hansard*, 27 March 2013, p. 61.

136 Dr Irwin Faris, *Submission 8*, p. 1. See also Royal Australian College of Physicians, *Submission 17*, p. 2.

137 Ms Janine Truter, *Submission 18*, p. 4.

138 Professor John and Mrs Merren Carter, *Supplementary Submission*, p. 1.

139 Dr Wendy Bonython, *Submission 22*, p. 37.

Amorphous, undefined and slanted to give weight to the views and needs of carers

5.93 Submitters also argued that the best interest test is a malleable concept that can fail to address the needs and human rights of persons with disabilities. There appeared to be widespread concern that best interests tests are amorphous, and therefore do not provide adequate safeguards. The Intellectual Disability Rights Service Inc. characterised the best interests test as 'very loose'.[140] People with Disability Australia agreed with comments by former justice of the High Court of Australia, Brennan J, that 'in the absence of legal rules or a hierarchy of values' the best interests test is discretionary and flexible, being subject to the values and experiences of the decision-maker.[141] A similar point was made by the OPA, Victoria and the New South Wales Council for Intellectual Disability.[142] Mr Simpson, New South Wales Council for Intellectual Disability commented:

> [a] lot of the trouble is that the combination of the best interests test is so much in the eye of the beholder, with the beholder perhaps being an elderly judge. I think that is problematic.[143]

5.94 Several submitters argued that best interests tests have been used to justify decisions based on inappropriate considerations such as preventing pregnancies resulting from sexual abuse, notions that persons with disabilities are incapable of parenting, eugenic arguments and arguments that sterilisation would benefit the state, the community, and the family.[144] Analysis by WWDA was commonly cited in support of these concerns.[145] Predominantly, it was argued that a best interests test may allow the courts and tribunals to elevate the needs of the carer above the needs, wishes and interests of the person with disability. This view was held by a broad spectrum of submitters to the inquiry, including disability advocates and the Australian Human Right Commission. Disability Discrimination Commissioner Mr Graeme Innes considered best interests tests to be susceptible to a 'slewed' interpretation, one that prioritises the interest of parents and carers:

> The justification for the views that you talked about is based on a slewed interpretation of best interests. It is really based on the assertion that the best interests of children or adults with disability and the best interests of

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140 Ms Janene Cootes, Executive Officer, Intellectual Disability Rights Service Inc., *Committee Hansard,* 27 March 2013, p. 18.

141 People with Disabilities Australia, *Submission 50,* p. 15.

142 Dr Chesterman, Office of the Public Advocate, Victoria, *Committee Hansard,* 11 December 2013, p. 14; Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard,* 11 December 2012, p. 14.

143 Mr Simpson, New South Wales Council for Intellectual Disability, *Committee Hansard,* 11 December 2012, p. 14.

144 See, for example, Ms Sands, People with Disability Australia, *Committee Hansard,* 11 December 2012, p. 3.

145 See, for example, Australian Lawyers for Human Rights, *Submission 41,* p. 4; Australian Women's Health Network, *Submission* 44, p. 2; Catholic Women's League Australia Inc., *Submission 32,* p. 5.

> parents and carers can be weighed on an equal footing. International human rights law makes it clear that that is just not the case and that the primary issue to take into account is the best interests of the adult or child with a disability. Whilst the interests of parents and carers are important they do not rate at the level of the best interests of the child or adult with disability. There is an obvious reason for that—that is, the person whose bodily integrity is being impacted upon is an adult or child with a disability so of course their best interests would have to be paramount.[146]

5.95 The Queensland Centre for Intellectual and Developmental Disabilities concurred:

> Leaving decision-making in the hands of professionals—be it the Family Court of Australia or guardianship boards, who have little experience or knowledge of living with disability and whose framework derives from a utilitarian perspective—will only result in the decisions we see occurring today: that 'therapeutic' is defined as being in the best interests of a triangle of stakeholders—family, medical profession and care organisations—rather than the individual.[147]

5.96 While supporting a best interests approach, Dr Bonython cautioned against considering the views, needs and wishes of parents and carers as a key factor when reaching a decision.[148] Queensland Advocacy Inc agreed:

> Therefore, the test of 'best interests' requires careful consideration and analysis. Frequently, there is a tendency to give substantial weight to the 'best interests' of other parties, particularly family members and services.[149]

5.97 It is notable that the AGAC's *Protocol for Special Medical Procedures (Sterilisation)* directs tribunals to distinguish between the best interests of the person and the interests of the person's carers.[150]

5.98 However, not all submitters to the inquiry took exception to the inclusion in a court or tribunal's deliberation of the needs and wishes of the carer. Ms Janine Truter, private capacity, submitted:

> The carer is crucial to the best interests of the person with a decision-making disability. To disregard their role and emotional investment, as well as the best interests of the decision-making disabled person, is astonishing.[151]

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146 Mr Graeme Innes, Disability Discrimination Commissioner, Australian Human Rights Commission, *Committee Hansard*, 27 March 2013, p. 37.

147 Ms Miriam Taylor Gomez, Education Coordinator, Queensland Centre for Intellectual and Developmental Disabilities, *Committee Hansard*, 11 December 2012, pp. 19–20.

148 Dr Wendy Bonython, *Submission 22*, pp. 10–11.

149 Queensland Advocacy Inc, *Submission 65*, p. 7.

150 Australian Guardianship and Administration Council, *Submission 28*, p. 1.

151 Ms Janine Truter, *Submission 18*, p. 3.

5.99 Ms Truter argued that calls for courts and tribunals to not consider the needs and wishes of parents are based on an unrealistic and inappropriate assumption that parents and guardians do not properly support the welfare of persons in their care. It was submitted that calls for sterilisation to be banned other than in circumstance where the person is capable of providing free and informed consent incorrectly assumes that a prohibition is needed to protect disabled persons from their carers or guardians.[152] Chief Justice Diana Bryant of the Family Court of Australia advised that it is legally permissible to consider the views and needs of parents and carers, if this would help inform the court of the overall circumstances and facts relevant to the child:

> It is important to remember that although the best interests of the child is the paramount consideration, it is not the sole determinant. It is well established at law that all relevant circumstances in each individual case should be taken into account in arriving an outcome that is in the child's best interests. In some sterilisation cases, the appreciable easing of the burden on the parents as primary carers has been found to be a relevant factor.[153]

The introduction of a 'but for' test

5.100 The 'but for' test was submitted as an alternative to a 'best interests' test. Ms Lesley Naik provided the following explanation of the purpose and practical application of a 'but for' test:

> The ‘but for’ test in the context of sterilisation recognises that a child’s intellectual disability often changes the equation that indicates a case for or against sterilisation. It therefore isolates the distinctive feature of these children, which is their intellectual disability, and compels the removal of that distinctive feature from the decision–making process. In practical terms, it asks ‘but for’ the child’s intellectual disability would the outcome of the clinical decision be any different?[154]

5.101 Various submitters advised that the United Nations special rapporteur on torture 'has recently reiterated that the law should never distinguish individuals on the basis of capacity or disability in order to permit sterilisation'.[155] It was argued that by removing any consideration of the presence and effects of disability, a 'but for' test complements this recommended approach. In short, submitters argued that a 'but for' test is a necessary safeguard to prevent discrimination.

5.102 In defence of the proposition that 'there is discrimination within the law itself that results in the delineation of people with disability as a distinct class of legal subjects', Ms Linda Steele submitted that to fail to adopt a 'but for' is to 'render an

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152 Ms Janine Truter, *Submission 18*, p. 3.

153 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Submission 36*, p. 4.

154 Ms Lesley Naik, *Submission 7*, p. 7.

155 Ms Linda Steele, *Submission 44*, p. 3; Women With Disabilities Australia, *Submission 49*, p. 39.

individual *fundamentally* different and *incomparable* to someone without a disability.'[156] Queensland Advocacy Inc similarly argued that a 'but for' test removes discrimination, and in doing so promotes equality before the law:

> As an option of last resort, it should not be offered on a discriminatory basis. Therefore, it is crucial to consider whether sterilisation would be offered to a person without a disability in the same circumstances or given the same medical indications.[157]

5.103 Associate Professor Sonia Grover, Gynaecologist, Royal Children's Hospital, agreed, stating '[w]e should not be doing a sterilising procedure if we would not be doing it on somebody who did not have a disability.'[158] People with Disability Australia also supported a 'but for' test on the grounds that it promotes human rights and equality:

> In making decisions about an application for authorisation of purported therapeutic sterilisation, PWDA argues that the "but for" criterion is the most protective of human rights. That is, in determining an application for authorisation of a procedure that will result, either directly or indirectly in sterilisation, the court or tribunal must determine if the procedure would be authorised in the same or similar circumstances in relation to a person without disability. If the procedure would not be authorised in relation to a person without disability, it ought not be authorised in relation to a person with disability.[159]

5.104 Further, Queensland Advocacy Inc argued that a 'but for' test is necessary to counter, and to expose, cultural prejudice:

> Sterilisation is currently performed on a discriminatory basis, in particular being performed on very young women and girls, men and boys, where the culturally valued norm is for young people never to be sterilised. Thus, it is important to ask whether sterilisation would be proposed "but for" the disability.[160]

Reported difficulties with a 'but for' test

5.105 However, difficulties were also identified with the use of a 'but for' test. Accordingly, the test was not supported by all submitters to the inquiry. Rather than promoting equality, it was submitted that the test actually diminishes access to legal and medical remedies that may have otherwise been available but for the use of the 'but for' test.

> [S]ome commentators and judges have taken the view that it is inappropriate to apply the comparator test - asking whether the same order

156 Ms Linda Steele, *Submission 44*, pp. 14–16.

157 Queensland Advocacy Inc, *Submission 65*, p. 6.

158 Associate Professor Sonia Grover, Gynaecologist, Royal Children's Hospital, *Committee Hansard*, 11 December 2012, p. 9.

159 People with Disabilities Australia, *Submission 50*, p. 17.

160 Queensland Advocacy Inc, *Submission 65*, p. 6.

> would be granted in respect of a person without a disability- because of the enormity of the disability affecting the people the orders are being sought.
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> In P v P (2), the Court rejected the use of the 'but for' or comparator, test in applications for authorisation, stating:
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> "In our view it is illusory and misleading to even attempt to equate her position and to do so entirely shifts the focus of the enquiry away from where it should be, i.e. whether it is in her best interests that the procedure be performed."[161]

5.106 The Chief Justice of the Family Court also noted the conclusions of the Full Court of the Family Court in *P & P & Legal Aid Commission of New South Wales & Human Rights and Equal Opportunity Commission*. Specifically, the court's concern that the 'but for' test is actually discriminatory was highlighted:

> [T]he test is whether or not it would be in the best interests of the child to have the procedure performed, taking into account all relevant facts and circumstances. Professor Grover is effectively advancing what has been described as the but for test. The test has been rejected by the Full Court of the Family Court…The Full Court said the following:
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> "We disagree with the concept of such a test in these cases. While it may be superficially attractive to impose this sort of test upon the basis that it is non-discriminatory and equates the intellectually handicapped person with the non-intellectual handicapped, upon analysis it has the opposite effect.
>
> To apply it is, in our view, conceptually incorrect. We consider it is both unrealistic and contrary to the intention of the majority judgement in Marion's case to deal with a particular aspect of the child's needs and capacities as though it existed in isolation from other needs and capacities."[162]

5.107 Implicit in this judicial reasoning is support for the view that a person with disabilities cannot be viewed as part of a larger class of persons, but must be considered with reference to their individual life circumstances. This is evident in a New South Wales case cited by WWDA, in which the tribunal held that:

> Ms BAH's disability is clearly central to the Tribunal's deliberations in this matter. But for Ms BAH's intellectual disability, the Tribunal would not have given consideration to the proposed treatment.[163]

5.108 However, there was a concern among some submitters that an individual focus legitimises discrimination and ill treatment. As Ms Linda Steele submitted:

> The absolute distinction made on the basis of disability between people with and without disability, and the additional characterisation of these in terms of normality and abnormality…means that individuals with disability

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161 Dr Wendy Bonython, *Submission 22*, p. 23.

162 The Hon. Diana Bryant, AO, Chief Justice, Family Court of Australia, *Submission 36*, p. 5.

163 *BAH* [2009] NSWGT 8 (28 July 2009), as cited in Women With Disabilities Australia, *Submission 49*, pp. 39–40.

> can be legitimately subject to a form of violence that would be incomprehensible to people without disability. Moreover, the focus on an individual's best interests isolates them from comparison.[164]

The 'but for' test and the medical profession

5.109 It was further suggested that a 'but for' test may be appropriate for use by the medical profession. Both the OPA and Ms Lesley Naik identified that the test could be used as a threshold consideration to determine whether it would be inappropriate to proceed with the proposed sterilisation procedure without court or tribunal approval. As the OPA submitted:

> When parents and professionals are considering the sterilisation of a child, they should ask themselves whether they are only considering this procedure because of the child's disability (the 'but for' test). If this procedure would not be considered for a child without a disability then judicial authority has to be obtained as it must be a non-therapeutic procedure that is being considered.[165]

5.110 In support of this proposal, the OPA cited the work of Ms Lesley Naik.[166] In evidence before this inquiry, Ms Naik reported that the '"but for" test may be a useful practical tool to assist medical practitioners to apply the legal test for determining whether sterilisation requires court authorisation'.[167]

Committee view

5.111 As the committee has recommended in the previous chapter, substituted decision-making must only occur where appropriate supported decision-making has not resulted in persons having the capacity to decide for themselves. The laws, practices and procedures of relevant courts and tribunals must recognise that they are a venue of last resort to be accessed only after all appropriate supported decision-making options have been explored. Accordingly, the courts and tribunals exist to serve persons without legal capacity, even with the assistance of supported decision-making. The committee's analysis has revealed that Australia is failing to ensure that substituted decision-making only occurs where appropriate, and with all necessary safeguards. More can, and must, be done to defend the rights of persons with disabilities.

5.112 Aspects of court and tribunal procedure must be changed. Giving effect to this change will require amendments to the Commonwealth, state and territory laws that regulate court procedure. Implementing the recommended changes in every jurisdiction will lead to greater uniformity in the laws, practices and procedures that regulate access to sterilisation procedures for persons with disabilities. In chapter 7,

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164 Ms Linda Steele, *Submission 44*, pp. 14–16.

165 Office of the Public Advocate, *Submission 14*, p. 7.

166 Office of the Public Advocate, *Submission 14*, p. 7.

167 Ms Lesley Naik, *Submission 7*, p. 6.

the committee will consider whether additional consistency and uniformity across jurisdictions is required.

Amend legislation to ensure that courts and tribunals do not interfere with a person's ability to decide for themselves

5.113 In the first instance, for cases concerning adults, state and territory legislation should be amended to explicitly state that it is presumed that persons with disabilities have the capacity to make their own decisions unless objectively assessed otherwise. The committee was particularly struck by the compelling evidence before this inquiry that capacity is not static. Capacity can evolve with time and support. Accordingly, incapacity cannot be assumed even where a guardianship order is in place. It must be tested in every instance when major or irreversible decisions, such as sterilisation, are being considered.

Recommendation 8

5.114 The committee recommends that state and territory legislation regulating the sterilisation of adults with disabilities be amended to explicitly state that it is presumed that persons with disabilities have the capacity to make their own decisions unless objectively assessed otherwise. The legislation should be amended to specify that it cannot be presumed that persons are without legal capacity in relation to the proposed special medical procedure, including a sterilisation procedure, even where there is an existing guardianship order in place.

Recommendation 9

5.115 The committee recommends that Commonwealth, state and territory legislation regulating the sterilisation of adults with disabilities be amended to explicitly state that a court or tribunal does not have authority to hear an application for an order approving a proposed special medical procedure, including a sterilisation procedure, where the person with a disability has legal capacity.

5.116 The committee considers that there is merit in introducing one definition of capacity to apply in every jurisdiction. A person's rights to autonomy and bodily integrity should not vary depending on the state or territory in which they live. The committee particularly recommends the definition of capacity under the Australian Guardianship and Administration Council's *Protocol for Special Medical Procedures (Sterilisation).*

Recommendation 10

5.117 The committee recommends that each Australian jurisdiction use the same definition of capacity, to ensure that a person's rights to autonomy and bodily integrity do not vary according to, and are not dependent on, the jurisdiction in which they live.

A best protection of rights test

5.118 The committee recognises that the application of a best interests test is a contentious subject. After careful consideration the committee reached three conclusions.

5.119 First, while a test that considers the person's interests is to be preferred over an outright ban on sterilisation, the test should be focussed on the protection of their rights, rather than on their 'best interests'. The main arguments regarding this issue were discussed in the previous chapter. The committee accepts the evidence that was provided by many submitters showing that, as currently applied, 'best interests' tests are currently at risk of 'a slewed interpretation'.[168]

5.120 The committee believes that the language of 'best interests' is not the most appropriate in this context. The committee believes that the appropriate test is of whether an action represents the best available protection and fulfilment of a person's rights. This should include recognition that a person with a disability should have the same right to access medical procedures in pursuit of quality of life as does a person without a disability.

5.121 Second, the committee concluded that a 'best protection of rights' test must be stringent – current criteria are insufficient to safeguard the rights of persons with disabilities as applied in some cases. Specifically, accounting for someone's best interests must include:

- Protection of their rights.
- Maximising future options and choices.
- Decisions to be made on the basis of the best support services available, not whatever services happen to have been provided in the past, which witnesses (including people with disabilities, their parents, and guardians) have frequently told the committee have been inadequate. This is particularly important in the context of the roll-out of Disability Care Australia services.

5.122 The committee urges jurisdictions, in adopting a best protection of rights test, to be vigilant and ensure it is not undermined by inappropriately broad interpretations of what constitute 'therapeutic' cases not requiring tribunal or court consideration. The problem of ambiguity in the interpretation of 'therapeutic' was discussed in an earlier chapter, and will be considered further by the committee in a later report on intersex issues.

5.123 The committee emphasises that, in moving away from the best interests test, it is still of the view that the procedural safeguards and considerations identified in the Australian Guardianship and Administration Council's 2009 *Protocol* (discussed in chapters 3 and 5) should be retained. Thus, for example, there should continue to be a requirement that less invasive procedures must have been considered and, where appropriate, tried, before more invasive or permanent procedures are undertaken.

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168 Mr Graeme Innes, Disability Discrimination Commissioner, Australian Human Rights Commission, *Committee Hansard*, 27 March 2013, p. 37.

5.124 Third, the committee agreed with the Full Court of the Family Court, that a 'but for' test should not be adopted by courts and tribunals. Committee members have been exposed to a wide range of issues in the context of disability, both within and beyond the current inquiry, and both within and outside their parliamentary responsibilities. That range of experience leads the committee to the view that a disability cannot be treated as an isolated feature of a person, which may be conceptually separated from the rest of their being. They are not defined by their disability, but neither is the disability a separable thing. Accordingly, courts should not construct tests as if it were possible to separate them. The committee is also concerned that a 'but for' test requires life without disability to be taken as the 'norm', and disability is then defined as deviance from that norm. Every person should be treated as equal, and the committee believes that a best protection of rights test, underpinned by a strong understanding and protection of equal rights, is the better approach.

5.125 The committee notes, however, that there is considerable merit in Ms Naik's suggestion that a 'but for' test could assist doctors to clarify their thinking about circumstances in which cases require court consideration, and this should be considered further by those responsible for training and development of medical professionals working in the field.

Recommendation 11

5.126 The committee recommends that all jurisdictions adopt in law a uniform 'best protection of rights' test, replacing current 'best interests' tests, that makes explicit reference to the protection of the individual's rights; and the maintenance of future options and choices.

Recommendation 12

5.127 The committee recommends that, in those cases where the need for supports has a bearing on the assessment of interests, regard should be had to best support services available, rather than the deficit in services provided in the past.

Recommended changes to court and tribunal procedures

5.128 An irreversible medical procedure should not be authorised on the basis of temporary circumstance. Similarly, an irreversible procedure should not be authorised due to a failure to provide a person with the support he or she needs to understand the proposed procedure and to convey their wishes. Sterilisation should not occur due to failure on the part of courts and tribunals to facilitate supported decision-making. Accordingly, consideration should be given to whether procedures have sufficient flexibility to accommodate individual needs.

5.129 In every case, consideration must be given to whether the court or tribunal has before it all necessary information. From the evidence provided to this inquiry, the committee considers that there are key parties that should be present in each case. These include the person, to the fullest extent that he or she is able to personally participate in proceedings; his or her parents, guardians or carers; independent representatives for the person with a disability; independent medical experts; and

independent expert advocates for the needs and rights of the individual who is the subject of the proceeding.

Independent representation

5.130 It is essential that, in proceedings to determine capacity, all appropriate support is given. Support should be free from conflicts of interest, assumptions and undue pressure. Family members or carers are essential to the process and should have a right to be heard, but they are not independent of their relative. An independent third party should be appointed in each case. Accordingly, the committee urges relevant courts and tribunals to carefully consider their procedures and practices. Courts and tribunals should facilitate the persons' participation in proceedings in a manner appropriate for that person.

5.131 None of the costs of this representation in court should be borne by the person or their family.

Recommendation 13

5.132 The committee recommends that the states and territories ensure that independent representation is provided for people with disabilities. Representation should be independent; while family or guardians should have a right to be involved, an independent representative should not be a member of the person's family or a caregiver.

Recommendation 14

5.133 The committee recommends that the costs of legal representation for adults should be covered by the relevant legal aid commission. state and territory governments should review legal aid funding arrangements to ensure that there are adequate funds to meet the costs of providing a legal representative for persons with disabilities in special medical procedure cases, including sterilisation cases.

5.134 For children's cases, the committee agrees with the opinions of several submitters to the inquiry that a legal representative must be appointed for each child in every child sterilisation case. While the focus of submitters was on the appointment of Independent Children's Lawyers in Commonwealth child sterilisation cases, the necessity of appointing a legal representative for children applies regardless of the jurisdiction in which the matter is heard. A legal representative tasked with conveying the child's wishes to the court and providing an independent assessment of the child's best interests must be appointed in every case. Independent Children's Lawyers are a critical part of ensuring a child's voice is heard. While parents are often the fiercest advocates for their children they are of necessity not independent, and the committee received evidence on a range of cases, both within and outside the legal system, where parents were not always able to advocate for, or were confused about, the best interests of their children. Consistent with the current duties of an Independent Children's Lawyer as specified in the Family Law Act, Independent Children's Lawyers should act independently and objectively, and convey to the court the child's views while providing an independent assessment of the child's best interests.

5.135 For Commonwealth cases, the committee understands that the Commonwealth government funds state and territory legal aid commissions to deliver legal aid services for Commonwealth cases in accordance with agreed principles and priorities.[169] Funding arrangements may need to be reviewed to ensure that there are sufficient funds to meet the costs of appointing an Independent Children's Lawyer in child sterilisation cases. State and Territory governments may likewise need to review funding arrangements to ensure that a legal representative can be appointed in state and territory child sterilisation proceedings.

Recommendation 15

5.136 The committee recommends that a legal representative be appointed in each child sterilisation case regardless of the jurisdiction in which the matter is heard. Commonwealth, state and territory legislation should be amended as necessary to ensure that the appointment of a legal representative of the child is mandatory in each sterilisation case.

Recommendation 16

5.137 The committee recommends that legal aid be provided to cover the costs incurred by the child's legal representative. The committee recognises that governments may need to revise current legal aid funding arrangements to ensure that there are sufficient funds to meet the costs of children's representatives in sterilisation cases.

5.138 The committee is particularly concerned with the lack of evidence regarding the training required to be appointed as an Independent Children's Lawyer. Appropriate training is a fundamental part of providing appropriate safeguards. An inadequate understanding of the nature and effects of disability compromises the legal representative's ability to make an informed decision in the case, and to work with the child to convey the child's wishes. A lack of understanding also has the potential to compromise the child's participation in proceedings.

5.139 Accordingly, the committee recommends that the Commonwealth and State and Territory governments work with legal aid commissions and relevant law societies to develop mandatory training courses for legal practitioners seeking to be appointed as a child representative in any case. As a necessity, training must include modules about children's capacity to communicate and to make decisions, and about disability awareness.

Recommendation 17

5.140 The committee recommends that Commonwealth, state and territory governments work with legal aid commissions and relevant law societies to develop training courses for legal practitioners about children's legal capacity,

169 See: Council of Australian Governments, N*ational partnership agreement on legal assistance services*, http://www.federalfinancialrelations.gov.au/content/npa/other/legal_assistance_services/national_partnership.pdf (accessed 9 July 2013).

techniques to communicate, and the varying effects and nature of disability. Successful completion of such courses should be mandatory before being appointed to represent a child.

Independent advocates

5.141 The committee considers that there is a role in both children's and adults' sterilisation proceedings for the court and tribunal to be assisted by persons who specialise in disability matters. In particular, the committee recognises the expertise of Public Advocates in communicating with persons with disabilities, and assessing the kinds of support needed to provide the person the best chance to develop capacity or to convey their wishes to the court. It is their expertise in all aspects of disability that separates disability advocates from members of the medical profession.

5.142 The committee notes the view of Chief Justice Diana Bryant that the courts would not be served by generic arguments about disability management or human rights. Courts and tribunals would be better served by advice that is tailored and specific to the individual. This approach also respects the person as an individual rather than as a stereotype or social or legal construct. However, the committee considers that a person skilled and experienced in working closely with persons with disabilities can provide a valuable support and advice to the court about the kind of procedures that the person needs in order to effectively engage with the court and tribunal, as well as the medical and legal support that may be of benefit to the person.

5.143 The committee recommends that Commonwealth, state and territory legislation be amended to provide the right for public advocates, such as the Office of the Public Advocate, to be a party to child or adult sterilisation cases. The Commonwealth and the state and territory governments should work with advocacy services to meet the advocate's costs. The cost should not be borne by the families in the proceedings.

Recommendation 18

5.144 The committee recommends that Commonwealth, state and territory legislation be amended to provide the right to public advocates, such as the Office of the Public Advocate, to be a party to child or adult sterilisation cases.

5.145 While mentioned only in passing, the committee is concerned by evidence provided by the Family Court of Australia that independent advocates or third parties, such as child welfare authorities, and the Australian Human Rights Commission, can (and do) decline the court's invitation to become a party to a child sterilisation case. In the committee's view, these agencies are ideally suited to the role of contradictor. Alternatively, where these agencies are in agreement with one or more of the parties, their involvement gives independent verification of the necessity, or lack of necessity, of the proposed procedure.

5.146 The committee understands that the Commonwealth Attorney–General's Department is currently considering whether Commonwealth laws and procedures provide appropriate support for persons in sterilisation cases. Evidence before the committee did not explain the apparent reluctance on the part of child welfare authorities, public advocates and agencies such as the Australian Human Rights

Commission to participate in child sterilisation proceedings. The committee considers that this matter is of primary importance. The Commonwealth Attorney–General's Department should consult with relevant agencies to determine the reasons for any reluctance and measures that can be taken to address identified concerns.

Medical advice

5.147 The committee particularly notes concerns that insufficient time may be allocated to medical practitioners to determine the person's capacity and what is medically necessary to safeguard and to improve the person's quality of life. The committee notes with approval practices existing in some jurisdictions of providing questionnaires to medical experts appearing in sterilisation cases. Questionnaires and information packs should be commonplace in each jurisdiction, and should seek the medical practitioner's advice about the processes the practitioner recommends in order to appropriately determine the capacity, wishes and medical needs of the person with a disability. In the interest of procedural fairness, sterilisation cases should be conducted without undue delay. However, courts and tribunal should be responsive to medical advice about what processes are appropriate in the particular case.

5.148 The committee recognises the concerns of a number of submitters that expertise in disability matters may be lacking among the medical professionals appointed in sterilisation cases. An appropriate response to this concern requires input not only from the medical profession but also the courts and tribunals. In the first instance, courts and tribunal should include in information packs and questionnaires details of the factors that the courts and tribunals are not authorised to consider, such as outdated and paternalistic attitudes to disability, eugenic arguments or assessments of the person's current or hypothetical future capacity to care for children. This material should present a factual up-to-date explanation of disability rights and of abilities. Additionally, legislation in each jurisdiction should be amended to require the input of more than one medical practitioner. Applicants should be required to provide reports from the person's treating doctor, but the court or tribunal should also have available to it the opinion of a specialist in the relevant area of medicine not involved in the person's care and with no interest in the outcome of the hearing. At least one of the medical practitioners must be independent, that is, the medical practitioner must not have any substantive previous involvement with the patient and the case.

Recommendation 19

5.149 The committee recommends courts and tribunals develop information packs and questionnaires to provide guidance for medical experts in sterilisation cases. The information packs should specify the factors that courts and tribunals consider under the relevant legislation, and should also note issues that the courts and tribunals are not authorised to consider such as outdated and paternalistic attitudes to disability, eugenic arguments or assessments of the person's current or hypothetical capacity to care for children. Questionnaires should seek the medical expert's advice about the procedures that could usefully be adopted in the particular case to facilitate both a robust medical assessment and the person's participation in proceedings.

5.150 As noted, to address concerns about the expertise of medical professionals, input will also be required from the medical community. The committee notes the advice provided by submitters to the inquiry that there is a need for additional training programs for medical professionals involved in child or adult sterilisation cases. The completion of training courses about the nature and effects of disability should be a prerequisite for medical practitioners providing evidence in adult or child sterilisation cases.