Sterilisation of Children with Intellectual Disabilities

Nick O'Neill[1]

Introduction

The sterilisation of children with an intellectual disability remains controversial.

The issue became controversial partly because of the strong lobbying from individuals and disability groups concerned that young women, both children and adults, with an intellectual disability were being sterilised as a means of contraception and in order to free them from the need to deal with menstruation. That lobbying led to changes in the statute law of some of the Australian States. The lobbying has also informed some of the submissions put to courts and tribunals dealing with applications for consent to the carrying out of sterilising treatment on children. It has also contributed to submissions made to bodies such as the Family Law Council reporting to government on sterilisation procedures on children.[2]

The controversy has been recently revived by the Full Court of the Family Court of Australia which chose in its judgment in *P v P* to criticise recommendations made by the Family Law Council in its report on sterilisation procedures on children referred to above.[3] In that report the Council recommended that there should be a new Division of the *Family Law Act* 1975 (Cth) to regulate the sterilisation of children under 18 years of age. This article discusses some of the issues raised by the controversy and the struggle for the role of law maker in this field. It notes the apparent loosening both by interpretation and by the outcome of cases of the "best interests but treatment of last resort test" developed by the High Court of Australia. The article also suggests that sterilising procedures on children should occur only where a medical need requiring surgical action is demonstrated.

Family Law Council recommendations

The Family Law Council proposed that the legislation should indicate four situations in which sterilisation could never be authorised. These are:

- sterilisation for eugenic reasons;
- sterilisation purely for contraceptive purposes;
- sterilisation as a means of masking or avoiding the consequences of sexual abuse; or

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1 President, Guardianship Board of New South Wales

2 Family Law Council, *Sterilisation and other medical treatment of children* (AGPS, Canberra, 1994).

3 (1994) 19 Fam LR 1.

- sterilisations performed on young women prior to the onset of menstruation, based on predictions about future problems that might be encountered with menstruation.

The Council recommended that the legislation should provide that no person under the age of 18 should be sterilised unless the procedure was necessary to save life or to prevent serious damage to the person's physical or psychological health.

It also recommended that in deciding whether there was serious danger to a person's physical or psychological health the decision maker must have regard to whether the feasibility of less permanent means of contraception has been explored, where relevant; and an evaluation of the person's response to training in menstrual management; and finally, if, at this stage, a decision maker is inclined to approve the application, she or he must not do so unless performance of the procedure would be in the child's best interests.

The Council recommended that the Family Court of Australia should be given power to hear all applications for sterilisation relating to children under 18 years of age. This recommendation was contrary to the advice of the Council's Medical Powers Committee which proposed a co-operative model under which federal legislation containing limitations and criteria set out above would apply to children under the age of 18 years. However, if State or Territory tribunals applied the same or similar criteria to that contained in the federal legislation, they could also deal with applications for sterilising treatment.[4] This proposal is similar to the co-operative arrangements which apply in relation to Commonwealth, State and Territory anti-discrimination legislation.

The full recommendations of the Family Law Council on this matter are set out in the appendix to this article.

Some considerations of principle

Judges in the United States, Canada, the United Kingdom and Australia, as well as in many other countries, have been called upon to look at the issue of the sterilisation of children with intellectual disabilities. In the process they have made a number of statements of principle. In a leading United States case *In Re Grady*,[5] Handler J speaking for six of the seven judges sitting on the case in the Supreme Court of New Jersey said:

> Sterilisation may be said to destroy an important part of a person's social and biological identity — the ability to reproduce. It affects not only the health and welfare of the individual but the well-being of all society. Any legal discussion of sterilisation must begin with an acknowledgment that the right to procreate is fundamental to the very existence and survival of the race.

4 Family Law Council, op cit at 59.
5 426 A 2d 467 at 472 (1981).

Later he referred to a particular United States concern:

> Sterilisation has a sordid past in this country — especially from the viewpoint of the mentally retarded. In the early part of this century, many States enacted compulsory sterilisation laws as an easy answer to the problems and costs of caring for the misfortunate of society. Law makers may have sincerely believed that the social welfare would improve if fewer handicapped people were born, but they were too quick to accept unproven scientific theories of eugenics.

and concluded:

> Half a century later, we have serious doubts about the scientific validity of eugenic sterilisation.

In 1994, Brennan J, now the Chief Justice of the High Court of Australia, said:[6]

> The starting point has to be the "fundamental principle, plain and incontestable" that every person's body is inviolate.

In Australia's leading case on sterilisation, generally known as *Marion's Case*, Brennan J had more to say:[7]

> Sterilisation of an intellectually disabled child requires justification of a compelling kind, for involuntary sterilisation is a serious invasion of that child's personal integrity and a grave impairment of that child's human dignity.

Further on he said:[8]

> Each of us perceives his or her own identity and personality in terms which reflect the subjective appreciation of his or her own body, its attributes and functions. We may not see ourselves as others see us but our own perception of ourselves is entirely valid. The right to physical integrity protects a person's self-estimate. The law can reasonably assume that a person who is sui juris and who consents to the application of force to his or her body can adjust his or her self-estimate to comprehend an invasion of physical integrity. But such an assumption cannot be made in a case where a child who is intellectually disabled to a significant degree is subjected to a substantial invasion of his or her physical integrity. In the world in which that child perceives himself or herself to be living, the child's self-estimate is entirely valid, however defective or limited that estimate may appear to an observer to be. Moreover, that world and that self-estimate live in the mind of the child to which the outside world, even loving parents, have only limited access. The more profound the intellectual

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6 *P v P* (1994) 181 CLR 583 at 611.

7 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 267.

8 Ibid at 268.

> disability, the more limited the access. Yet, if a third party is to be empowered to authorise the compulsory sterilisation of an intellectually disabled child, the third party must be able to take account of the degree of impairment of the child's dignity entailed by the sterilising procedure. It follows that no authority for sterilisation should be given unless some compelling justification is identified and demonstrated. A substituted "consent" does not provide its own justification. In that case, the High Court held that although parents may consent to medical treatment of their children, this authority did not extend to treatment that would not be in the child's interests. The Court also ruled that parents cannot consent on behalf of their child to medical treatment which has sterilisation as its primary objective.

Brennan J's views are consistent with those set out in the Convention on the Rights of the Child which came into force for Australia in 1991. Article 23.1 of the Convention states:

> States Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

The United Nations Declaration on the Rights of Mentally Retarded Persons made in 1971 is more particular. It proclaims that:

> The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential.

The elements of the controversy

The question of the sterilisation of children with intellectual disabilities remains controversial for a number of reasons.

Parents cannot make the decision

Some parents of children with intellectual disabilities are affronted by the fact they cannot make the decision to have their child, usually a daughter, sterilised. They are expected to take the major responsibility for either providing directly or arranging for the care of their child. They know that this responsibility will be with them for the rest of their lives, even when their child has become a mature adult and they have become old. They are also concerned about the consequences if their intellectually disabled daughter became pregnant. Some of the professional carers of intellectually disabled children and health professionals working with them support the right of parents to have their children sterilised.

The High Court, however, has insisted in *Marion's Case* that the decision to authorise sterilisation is a special case which requires the authorisation of a court (or tribunal). The majority of the High Court said that such authorisation was required:[9]

> . . . first, because of the significant risk of making the wrong decision, either as to a child's present or future capacity to consent or about what are the best interests of a child who cannot consent, and secondly, because the consequences of a wrong decision are particularly grave. They went on to discuss the factors which contribute to a significant risk of a wrong decision being made.[10]

As a result of the High Court's decision in *P v P*, which confirmed Marion's Case, it is clear that the Family Court of Australia has jurisdiction to authorise the sterilisation of children of a marriage and whilst that person remains a child.[11]

Not a childhood issue?

The question arises, why should this matter be rushed into. Sterilisation is a question for adulthood not childhood. The Family Law Council reported that as an overwhelming response to its discussion paper on sterilisation and other medical procedures in children was an endorsement of the view that sterilisation of a child must be confined to exceptional circumstances or a last resort.[12]

Menstrual management

A major reason why parents wish to press on with applications for authorisation to carry out sterilising treatment is the onset of menstruation. Sometimes authorisation is sought before menstruation occurs. The Family Law Council reported that several of the earlier Family Court decisions approved the performance of sterilisations prior to the onset of menstruation.[13] Hillyer J of the High Court of New Zealand approved a sterilisation in 1991 based on evidence predicting the future should the girl the subject of the application commence to menstruate.[14] The Family Law Council received a number of submissions suggesting that sterilisation should not be performed on young women prior to the onset of menstruation based on predictions of future problems that might arise with menstruation.[15] The Council recommended that sterilisations should never be authorised on this basis.[16]

Ms J Wilson, who has researched the question of menstrual and fertility management for women with an intellectual disability, has set out some of the reasons why

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9 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 250.

10 Ibid at 250-253.

11 *P v P* (1994) 181 CLR 583.

12 Family Law Council, op cit at 5-7.

13 Ibid at 47-48.

14 *Re X* [1991] 2 NZLR 365.

15 Family Law Council, op cit at 47-48.

16 Ibid at 52.

sterilisation is sought as a means of disposing of the need for menstrual management. She suggested a more appropriate approach to this matter. She states:[17]

> Menstruation is often regarded negatively. That is, as uncomfortable, debilitating, and unclean. This is reflected by the fact that menstruation is rarely discussed openly, and women are pressured to hide evidence of their periods. Women's negative experiences of menstruation may be influenced by these negative social attitudes and pressures, however, menstruation is a normal physiological function. Although the emotional and physical effects of the menstrual cycle can present difficulties to some women, few of them would choose hysterectomy as a solution, without trying all other options that they are aware of. There is an increasing amount of medical literature about lifestyle approaches to menstrual management. Like all women, some women who have an intellectual disability may experience menstrual difficulties such as irregular, prolonged or "heavy" bleeding. Where these are an ongoing concern, the same processes of diagnosis and treatment that would occur for women who do not have an intellectual disability should be available.

Wilson also counters a number of common misconceptions parents and carers have about women with intellectual disabilities on this issue by setting out a table of "myths" with answering "facts" as follows:[18]

> 1. MYTH: a woman with an intellectual disability will never understand or learn how to manage her own menstruation.
>
> FACT: the majority of women with intellectual disabilities — given education inputs at an appropriate level — can learn to manage their own menstruation with limited or no support.
>
> 2. MYTH: a woman's menses (particularly if she has an intellectual disability) are 'dirty' and different from other bodily functions.
>
> FACT: the menses of women with intellectual disabilities is no different from other women and it is a natural function of every woman's life.
>
> 3. MYTH: a woman with an intellectual disability is unable to participate in decision-making about her own menstruation.
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> FACT: given appropriate information most women with intellectual disabilities are able to understand issues and actively participate in decision-making.

The Law Reform Commission of Western Australia considered these issues in its Report on Consent to Sterilisation of Minors[19] and formed the opinion that

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17 Wilson J et al, *Menstrual Management and Fertility Management for Women who have an Intellectual Disability: An Analysis of Australian Policy.* A research project funded by the Commonwealth Department of Health, Housing and Community Services (Brisbane, 1992) p 28.

18 Ibid, Appendix 7.

19 WLRC Project No 77 Part II (WALRC, Perth, 1994) at 82-84.

"considerable caution should be exercised before accepting the problem of menstrual management as something which justifies the sterilisation of intellectually disabled girls".[20] The Commission went on to state that:[21]

> It recognises that normal healthy children are unlikely to be sterilised for menstrual management purposes, and that it is therefore undesirable to treat intellectually disabled girls any differently. Parents of intellectually disabled children are often not aware of the implications of sterilisation or of the range of alternatives, and that there is a great need for better education and training and increased support for parents dealing with this difficulty. The Commission recommended that sterilisation be allowed to stop or prevent menstruation only if a court or tribunal was satisfied that the procedure was necessary to avoid grave and unusual problems or suffering that could be involved in menstruation for that child.[22]

Training

In *P v P* the Full Court of the Family Court looked at the question of training for menstrual management and the question of not treating intellectually disabled girls differently from healthy girls without that disability.[23]
The Full Court conceded that in this particular case, if menstrual management was the only factor favouring menstruation, the case for sterilisation had not been made out.[24] The Court also noted that there had been considerable advances in training intellectually disabled women in menstrual management, but went on to state:[25]

> However, we also think that some sense of proportion must be maintained and we question whether menstrual management training should be regarded as an end in itself, as sometimes appears to be the case. If the reality is, as it is in this case, that the person concerned cannot reasonably be expected to proceed with a pregnancy to full term and pregnancy itself is detrimental to her welfare, then we can see little value in subjecting her to laborious and unnecessary training to enable her to manage menstruation, particularly when it is highly unlikely that this process will be effective.

This opinion fails to take account the principle of normalisation which is central to all the recently enacted legislation in relation to people with disabilities and the current societal thinking about the place of people with disabilities in Australian society. Menstrual management training can and does help women with intellectual disabilities manage an important manifestation of their womanhood and free them

20 Ibid at 83.
21 Ibid.
22 Ibid at 114.
23 *P v P* (1994) 19 Fam LR 1.
24 Ibid at 23.
25 Ibid at 23.

from the pressure to take menstrual controlling medications or to have menstruation preventing surgery in circumstances where women without intellectual disabilities would not have such treatment.

The Family Court and the "but for" test

The Court also expressed the view that it was inappropriate to ask the question, would the sterilising procedure be performed "but for" the intellectual disability of the young woman concerned. The Court saw this as imposing a formal equality on women with intellectual disabilities when treating them the same as others may, in fact, produce serious inequality.[26]

The Court did not appreciate the value of asking this question as a means of keeping decision-makers focused on the normalisation principle and the notions of least intervention and least differentiation from others of the person with the disability.

The question needs to be asked in a range of circumstances where medical treatment is under consideration. In order to focus attention on the rights of a person with an intellectual disability the question has to be asked would you give this treatment to a person who did not have an intellectual disability? If the answer is yes, then, unless there are medical reasons for doing so, what is the justification for denying that treatment to a person with an intellectual disability? Turning the question the other way and asking would this treatment be recommended for a girl or young woman, particularly one who had not yet menstruated, is a valid step to take as part of the process of determining whether sterilising treatment should be given to a particular person.

Many others including the Commonwealth Human Rights and Equal Opportunity Commission, some State Guardianship Boards with jurisdiction to authorise sterilising treatment on adults, the Western Australian Law Reform Commission and the Family Law Council consider this a relevant question. The Family Court's refusal to ask it shows the Court moving away from the High Court of Australia's position that the sterilisation of children with a disability is a matter of last resort, with those proposing the treatment having to show that it is needed now and that it is the last resort.

The High Court's "best interests of the child but treatment of last resort" test

The High Court was clear that whilst the common law test to be applied by courts not constrained by criteria set out in legislation, was that of the "best interests of the child" that test was not an unfettered discretion. The majority of the High Court said:[27]

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26 *P v P* (1994) 19 Fam LR 1 at 20-23.

27 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 259.

> The function of a court when asked to authorise sterilisation is to decide whether, in the circumstances of the case, that is in the best interests of the child. We have already said that it is not possible to formulate a rule which will identify cases where sterilisation is in his or her best interests. But it should be emphasised that the issue is not at large. Sterilisation is a step of last resort. And that, in itself, identifies the issue as one within narrow confines.

They went on to emphasise:[28]

> . . ., in the case of a young woman, regard will necessarily be had to the various measures now available for menstrual management and the prevention of pregnancy. And, if authorisation is given, it will not be on account of the convenience of sterilisation as a contraceptive measure, but because it is necessary to enable her to lead a life in keeping with her needs and capacities. It is reasonable to summarise the majority's view as a "best interests but treatment of last resort" test. The majority left it to the judges (of the Family Court), with the range of expertise available to them to develop guidelines to give further content to the test when responding to applications for approval of sterilising treatment.[29]

The majority of the High Court then went on to say:[30]

> In the circumstances with which we are concerned, the best interests of the child will ordinarily coincide with the wishes of the parents.

This statement cannot be taken on its face value. To do so would be inconsistent with the reasoning of the majority referred to earlier in this article explaining why the decision to sterilise should not be within the scope of parental power to consent to medical treatment. In particular, the majority noted:[31]

> The decision by a parent that an intellectually disabled child be sterilised may involve not only the interests of the child, but also the independent and possibly conflicting (though legitimate) interests of the parents and other family members. There is no doubt that caring for a seriously handicapped child adds a significant burden to the ordinarily demanding task of caring for children. Subject to the overriding criterion of the child's welfare, the interests of other family members, particularly primary care-givers, are relevant to a court's decision whether to authorise sterilisation. However, court involvement ensures, in the case of conflict, that the child's interests prevail.

In any event the majority went on to say, in the very next paragraph, that:[32]

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28 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 259-260.
29 Ibid at 259.
30 Ibid at 260.
31 Ibid at 251-252.
32 Ibid at 260.

> On occasion, the courts may refuse to authorise a sterilisation desired by the parents.

Underlying the majority's view is the requirement that the non-invasive, reversible alternatives that do not require major surgery be considered, including the various measures now available for menstrual management and the prevention of pregnancy and an appreciation that sterilisation is not to be used as a convenient contraceptive measure.

Fertility management

With training, advice and support which is available, many young women with an intellectual disability can deal appropriately with their sexuality. Many others whose disabilities prevent them understanding those issues, lead lives in which they have access to the community but run no greater risk of sexual abuse or exploitation than do women without an intellectual disability.

Wilson notes misconceptions about sexuality issues often held by parents and carers of young women with an intellectual disabilities follows:[33]

> 1. MYTH: a woman with an intellectual disability will become sexually active and promiscuous.
>
> FACT: a woman with an intellectual disability has the same physiological functions as every other woman and has the same feelings and desires.
>
> 2. MYTH: a woman with an intellectual disability will never "grow up:" — she will always be like a child in her sexuality.
>
> FACT: a woman who has an intellectual disability matures physiologically at the same rate as every woman.

Wilson analysed six reported cases of applications to the Family Court between 1988 and 1992 for authority to carry out a hysterectomy on a young woman with an intellectual disability. She raised and commented on the fertility management and sexual abuse issues raised in those cases as follows:[34]

> In all of the cases, fertility management has been discussed, in addition to menstrual management, as a reason for surgical intervention. Menstruation is a sign of fertility. Potential pregnancy and its possible effects on the young woman who has a disability, her unborn child, and her family, are often a source of concern to care providers. The actual chances of an individual woman who has an intellectual disability and high support needs becoming pregnant, are not easy to assess. Is it sufficient to assume that an attractive appearance and affectionate behaviour will lead to pregnancy? Have attempts to assist the young woman to learn appropriate methods and situations for affectionate behaviour

33 Wilson, op cit Appendix 7.
34 Ibid at 6-7.

occurred? Perhaps the chance of pregnancy is being overestimated. If a woman who has a disability is choosing to be sexually active, fertility management options are available, which are used by many women, and which do not involve menstrual suppression. The risk to sexual abuse has been mentioned in several of the Family Court of Australia cases. If the woman is perceived to be at risk of sexual abuse, the limited research available suggests that the abuser is likely to be a family or staff member; that is, someone who knows her. It follows, therefore, that the risk of abuse may be increased if the potential abuser knows that detection through pregnancy will not occur.

The trauma of pregnancy and of childbirth to the young women with an intellectual disability are commonly raised as issues together with the risk of sexual assault or other abuse in more recent cases before the Family Court and the State and Territory Guardianship Boards that deal with applications for consent to sterilisation. It is clear that the parents and carers are concerned that pregnancy may be the consequence of either consensual or non-consensual sexual activity involving a young woman with an intellectual disability.

As already noted, the Family Law Council in recommending criteria relevant in determining whether or not authority should be given by the Family Court to the carrying out of sterilising treatment on female children with intellectual disabilities stated that sterilisation should never be authorised for the sole purpose of preventing such a person becoming pregnant as a result of sexual abuse.

For reasons that are not altogether clear, the Full Court of the Family Court saw fit to attack the Family Law Council for that view.[35] The Full Court is apparently unaware that applicants, perhaps only to tribunals other than itself, regularly put the possibility of pregnancy from sexual abuse as a key element of their application. To allow sterilisation of women with an intellectual disability against this possibility without other considerations coming to bear would turn sterilisation into a first rather than a last resort in that, particularly with women with an intellectual disability getting the opportunity to lead more normal lives in the community, no guarantee can ever be given that sexual abuse will never occur.

That seems obvious enough; but other considerations which may be relevant may affect the decision eventually made. These could include evidence that the health of the woman in question would be at significant risk should she become pregnant either because of existing conditions she has or because of conditions there is an evidential basis for believing she could develop during a pregnancy.

Whilst the Family Court in *P v P* confined its comments to pregnancies arising from sexual abuse, from the tenor of its judgment it would appear to doubt another of the Family Law Council's recommendations namely that sterilisation never be authorised as a contraceptive. Again, the Family Law Council, apparently not expecting that it would be misunderstood, expressed the view that it was inappropriate to

35 *P v P* (1994) 19 Fam LR 1 at 16-17.

radically interfere with the bodily integrity of a woman less than 18 years of age on that ground alone.

Again, as identified by Wilson and apparent from the experience of the State and Territory guardianship tribunals, complete and permanent protection against pregnancy is often the primary reason behind applications for authority to carry out hysterectomies on young women with an intellectual disability even though tubal ligations would achieve the desired outcome. This is why the guidelines adopted by Nicholson CJ in *Re Jane*[36] and the Full Court in *P v P* require consideration of the feasibility and medical advisability of less drastic means of contraception both now and under foreseeable future circumstance.[37] Also clearly that is what the High Court had in mind when it considered the matter in *Marion's Case*.[38] Too often, the less radical contraceptive options have either not been tried or not given an appropriate trial. Of course, evidence as to why it is inappropriate to try particular forms of contraceptive medication is always relevant.

The Full Court did not comment on the Family Law Council's recommendation that sterilisation for engenic purposes never be permitted.

Decision-making criteria

There is a genuine interest among the Guardianship Boards and Tribunals of the various States and Territories to develop a set of criteria that the Family Court, the Boards and Tribunals can apply in dealing with applications for consent to sterilising treatment.

The criteria developed by the Family Law Council and set out early in this article are all relevant to that matter and consistent with the statutory criteria which the State and Territory tribunals have to apply.

Although it is acknowledged that the High Court has left it to the judges to develop guidelines to give further content to the common law "best interests of the child/treatment of last resort "test, there seems little justification for the view that the law in this area should be settled by the Family Court of Australia rather than other institutions.

Legislative criteria have been established in a number of the Australian jurisdictions. These criteria can be, and are, supported by guidelines showing applicants the issues they must address and the kinds of evidence they will need to adduce to support their applications. There is a case for the Commonwealth Parliament to legislate criteria which would need to be supplemented by the practical guidelines developed for example by the Victorian Guardianship and Administration Board.

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36 (1988) 12 Fam LR 662.

37 *P v P* (1994) 19 Fam LR 1 at 25-26.

38 *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 at 259.

Concluding comments

The Full Court of the Family Court in a judgment that ranged much further than it needed to go in order to resolve the appeal before it, sought to dismiss a number of recommendations made by the Family Law Council and in the process revealed its lack of appreciation of some of the fundamental issues raised by proposals to sterilise children with an intellectual disability. It also revealed that elements of its approach were inconsistent with both those of the tribunals dealing with this difficult issue or the other organisations called upon to report to government about it.

Other considerations also cast doubt on the appropriateness of the Family Court having the central role in this matter. Jurisdiction in relation to sterilising treatment is about people with disabilities rather than children of a marriage. Consequently it is peripheral to the major functions of the Family Court.

The Family Court has no jurisdiction after the child turns 18. As note above, sterilisation is not a matter to be rushed into.

Furthermore, there appears to be a growing gap between the stated criteria and the application of those criteria in the Family Court. In 12 out of 13 known cases, the Family Court has authorised a sterilising operation on a female child with an intellectual disability. In at least five of those cases, the child in question had not menstruated at the time of the decision.

The Guardianship Boards of the States, particularly of New South Wales and Victoria have considerable experience in this field. They are multi-member, multi-disciplinary tribunals which sit in panels. Among their members are people with considerable experience and expertise in relation to the issues raised in these cases and in determining applications for sterilising treatment. It is inappropriate to ignore the contribution of others to decision-making in this area and to hand it over solely to judges whose experience and expertise is unlikely to extend to these matters.

APPENDIX

FAMILY LAW COUNCIL REPORT ON STERILISATION AND OTHER MEDICAL PROCEDURES ON CHILDREN — RECOMMENDATIONS

Recommendation 1

Council recommends that:

(a) There should be a new division in the Family Law Act regulating sterilisation of young people.

(b) The legislation should provide that it is unlawful to sterilise a child under 18 years except in circumstances prescribed.

(c) Any sterilisation must be authorised under the legislation. The consent of the child and/or of her/his parent(s), is not sufficient.

(d) The legislation should provide penalties for the performance of unauthorised sterilisation procedures. The penalties should apply to those performing, or arranging the performance of, such procedures. Those penalties should be no less rigorous than those currently provided for under section 35 of the Guardianship Act 1987 (NSW).

(e) The legislation should also provide children taken outside Australia for the purpose of sterilisation with the same protection as they would have in Australia.

Recommendation 2

Medical procedures, other than sterilisation, should continue to be governed by the general provisions of the Family Law Act. No additional legislation is currently considered necessary in view of the Australian cases to date. Council recommends that this situation continue to be monitored.

Recommendation 3

(a) Council proposes a three stage decision-making process to govern consideration of applications for authorisation of sterilisation. First, the legislation would indicate four situations in which sterilisation could never be authorised. There are:

— sterilisation for eugenic reasons;

— sterilisation purely for contraceptive purposes;

— sterilisation as a means of masking or avoiding the consequences of sexual abuse; or

— sterilisations performed on young women prior to the onset of menstruation, based on predictions about future problems that might be encountered with menstruation.

(b) The legislation should provide that no person under the age of 18 shall be sterilised unless the procedure is necessary to save life or to prevent serious damage to the person's physical or psychological health.

(c) In deciding whether there is serious danger to a person's physical or psychological health and decision maker must have regard to:

A: Whether the feasibility of less permanent means of contraception has been explored, where relevant; and

B: an evaluation of the person's response to training in menstrual management. If, at this stage, a decision maker is inclined to approve the application, s/he must not do so unless performance would be in the child's best interests.

Recommendation 4

Jurisdiction

(a) The Family Court of Australia should be given power to hear applications under the proposed new provisions of the Family Law Act in all States and Territories in respect of all applications for sterilisation relating to children under 18 years of age.

(b) Only specially trained judges should hear sterilisation applications.

(c) It should be the policy that a court hearing of an application should occur only after all other options have failed to produce a satisfactory outcome for the parties.

Counselling and advice to applicants

(d) Specialist counselling and advisory services should be made available to applicants and children in relation to all medical treatments which may or will result in sterilisation, and in relation to the alternatives to such treatment. Wherever possible protocols should be drawn up which make full use of existing State or Territory facilities and personnel.

(e) Specially trained officers of the court should be available to advise and assist applicants and the court with the provision of information and the gathering of evidence. They should liaise with appropriate State and Territory services and personnel.

Guidelines

(f) Guidelines should be prepared and promulgated for the proper counselling of children and their parents/guardians concerning all of the implications of medical treatments which may, or will, result in sterilisation. The guidelines should set out requirements for the notification of such treatment to an "appropriate authority", such as a specially designated registrar.

(g) The "appropriate authority" should be a specially appointed officer of the Family Court who should be responsible for all administrative aspects of sterilisation applications (including record keeping) in relation to persons under 18 years of age throughout Australia.

(h) Any person under the age of 18 years who is the subject of an application for sterilisation must have independent legal representation in the event of a court hearing.

(i) The cost of legal representation for the child and a parent/guardian applicant and all other costs associated with the application should be met by the Commonwealth Government.