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Abstract

Since at least the early 1990s, disability rights advocates have argued for the prohibition of sterilisation of women and girls with disability without their consent ('non-consensual sterilisation') except in that small proportion of instances where there is a serious threat to life. In part, this argument has been framed in terms of human rights: the act of non-consensual sterilisation (except where there is a serious threat to life) is fundamentally an act of discrimination and violence which violates multiple human rights including the rights to equality and non-discrimination, freedom from torture and personal integrity. In recent years these arguments have been increasingly supported by international human rights bodies which have framed non-consensual sterilisation of women and girls with disability as a violation of human rights and urged states parties, including Australia, to prohibit the practice.

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COURT AUTHORISED STERILISATION AND HUMAN RIGHTS: INEQUALITY, DISCRIMINATION AND VIOLENCE AGAINST WOMEN AND GIRLS WITH DISABILITY

LINDA STEELE*

I INTRODUCTION

Since at least the early 1990s, disability rights advocates have argued for the prohibition of sterilisation of women and girls with disability without their consent ('non-consensual sterilisation') except in that small proportion of instances where there is a serious threat to life.¹ In part, this argument has been framed in terms of human rights: the act of non-consensual sterilisation (except where there is a serious threat to life) is fundamentally an act of discrimination and violence which violates multiple human rights including the rights to equality and non-discrimination, freedom from torture and personal integrity. In recent years these arguments have been increasingly supported by international human rights bodies which have framed non-consensual sterilisation of women and girls with disability as a violation of human rights and urged states parties, including Australia, to prohibit the practice.²

* Lecturer, School of Law, University of Wollongong. Thank you to participants in 'Feminist Perspectives on Medical Bodies', University of Wollongong, 20 February 2015 for their feedback on an earlier version of this article. The author is grateful for feedback on drafts received from Fleur Beaupert, Felicity Bell and Trish Mundy, and anonymous referee comments on earlier versions.

1 See Carolyn Frohmader, Women with Disabilities Australia, Submission No 49 to Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, March 2013; Carolyn Frohmader, 'Submission to the United Nations Committee Against Torture' (Submission, Women with Disability Australia, 24 September 2014); Carolyn Frohmader, Leanne Dowse and Aminath Didi, 'Preventing Violence against Women and Girls with Disabilities: Integrating a Human Rights Perspective' (Think Piece, Women with Disability Australia, January 2015); Carolyn Frohmader and Stephanie Ortoleva, 'The Sexual and Reproductive Rights of Women and Girls with Disabilities' (Issues Paper presented at ICPD Beyond 2014 International Conference on Human Rights, The Hague, Netherlands, 7–10 July 2013); Carolyn Frohmader and Therese Sands, Australian Cross Disability Alliance (ACDA), Submission No 147 to the Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings, including the Gender and Age Related Dimensions, and the Particular Situation of Aboriginal and Torres Strait Islander People with Disability, and Culturally and Linguistically Diverse People with Disability*, August 2015.

2 See generally Juan E Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN GAOR, 22nd sess, Agenda Item 3, UN Doc A/HRC/22/53 (1 February 2013) [48]; Committee on the Rights of the Child, *General Comment No 13: The Right of the Child to Freedom from All Forms of Violence*, UN Doc CRC/C/GC/13 (18 April 2011) [16], [21]. In

Despite the persistent human rights arguments against sterilisation of women and girls with disability and a number of government reviews into sterilisation in Australia,³ non-consensual sterilisation of women and girls with disability is not prohibited. Instead, the practice is regulated. Where a woman or girl with disability is deemed to lack mental capacity to consent to medical procedures, non-consensual sterilisation can be lawful on two legal bases. One is that a third party (such as a parent or guardian) can provide their substituted consent to sterilisation of the woman or girl where this consent is authorised by a court or tribunal which determines that the procedure will be in the woman or girl's best interests ('court authorised sterilisation'). The second legal basis is that, pursuant to the defence of necessity, a medical practitioner can act without any consent (whether that of the individual herself or a third party) where there is an emergency situation which demands the sterilisation. Australia only criminalises (through general criminal laws of assault) sterilisation that is done without court authorised third party consent or that is not justified pursuant to the defence of necessity. Court authorised sterilisation is the focus of this article.

In 2008, the United Nations *Convention on the Rights of Persons with Disabilities* ('CRPD') came into force and has reinforced the status of sterilisation as a violation of human rights of women and girls with disability (regardless of whether it has been court authorised) and has provided increased momentum towards prohibition at a domestic level of all non-consensual sterilisation of women and girls with disability except where there is a serious threat to life.⁴ As will be discussed, the effect of the CRPD is that third party consent should not prevent sterilisation from being viewed as violence and hence falling within the scope of the criminal offence of assault because the denial of the individual's legal capacity and the reasons that courts authorise third party consent to sterilisation are grounded on discriminatory ideas about mental incapacity and disability more broadly. Court authorisation does not render sterilisation any less a violation and, in fact, court authorised sterilisation is *particularly egregious* because the judiciary's role in permitting this procedure renders this sterilisation a form of state-sanctioned violence. The United Nations Committee on the Rights of Persons with Disabilities ('UN Disability Committee'), the committee responsible for monitoring implementation of the CRPD, has urged states parties to 'abolish policies and legislative provisions that allow or perpetrate forced treatment' and has urged Australia to prohibit all non-

relation to Australia, see, eg, Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2–13 September 2013)*, UN Doc CRPD/C/AUS/CO/1 (21 October 2013) 5–6 [39]–[40] ('*Concluding Observations*'); Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Australia*, UN GAOR, 17th sess, Agenda Item 6, UN Doc A/HRC/17/10 (24 March 2011) 15 [86.39]; see also Frohmader and Sands, above n 1, 54–5 [206]–[210].

3 See government inquiries and reviews discussed in Malcolm Parker, "'Forced Sterilisation': Clarifying and Challenging Intuitions and Models' (2013) 20 *Journal of Law and Medicine* 512, 512–18; Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (2013) 2–3 [1.8]–[1.12].

4 Opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008).

consensual sterilisation.⁵ Thus, the *CRPD* provides a persuasive and powerful argument for viewing *all* non-consensual sterilisation of women and girls with disability including court authorised sterilisation (except where there is a serious threat to life) as an act of discrimination and violence and as a serious violation of the human rights of women and girls with disability.

Recently the Australian government, through the Senate Community Affairs Reference Committee ('Senate Committee'), considered the issue of sterilisation, including by reference to the *CRPD*. In its 2013 report, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*⁶ ('Senate Committee Report'), the Senate Committee made recommendations which would (in its view) locate sterilisation in a human rights framework. It recommended retaining the practice of court authorised sterilisation but reforming the legal test that governs court authorisation: substituting the current 'best interests' test with a 'best protection of rights' test.⁷ At face value the Senate Committee Report seems to be a significant step forward. Not only were human rights and the *CRPD* mentioned throughout the report, but the rights of women and girls with disability would now be 'protected' and specifically integrated into the legal framework of sterilisation. And yet, on closer consideration, the Senate Committee's 'human rights' approach runs counter to the *CRPD* approach to sterilisation, particularly by reason of two factors: sterilisation was not abolished but merely regulated pursuant to a different (albeit purportedly human rights) legal test and the human right of equality and non-discrimination was excluded from the rights which would be protected through the 'best protection of rights'. The fact that the Senate Committee's approach ultimately falls short of the *CRPD* is reflected in United Nations ('UN') human rights bodies' reports to Australia subsequent to the Senate Committee Report. For example, the UN Committee on the Rights of Persons with Disabilities stated it was 'deeply concerned that the Senate inquiry report ... puts forward recommendations that would allow this practice to continue'.⁸ It urged Australia to 'adopt uniform national legislation prohibiting the sterilization of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent'.⁹

In this article, I illuminate the troubling logic of the Senate Committee's approach to court authorised sterilisation and human rights. I do this by exploring how court authorised sterilisation can possibly be advanced as a means of protecting a woman or girl's human rights while simultaneously not respecting the human right of equality and non-discrimination. I explore court authorised sterilisation specifically in relation to the legal framework applicable to girls with disability. The article focuses on girls because the domestic judicial decisions

5 Committee on the Rights of Persons with Disabilities, *General Comment No 1: Article 12: Equal Recognition before the Law*, 11th sess, UN Doc CRPD/C/GC/1 (19 May 2014) 11 [42] ('*General Comment No 1*'); *Concluding Observations*, UN Doc CRPD/C/AUS/CO/1, 5–6 [39]–[40].

6 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3.

7 *Ibid* x.

8 *Concluding Observations*, UN Doc CRPD/C/AUS/CO/1, 5 [39].

9 *Ibid* 6 [40].

relating to human rights and sterilisation which were central to the Senate Committee's recommendations relate to girls, as opposed to women, and, secondly, the human rights issues are most apparent in relation to this group by reason of the young age of these girls and the unlikelihood that sterilisation would *ever* be contemplated let alone judicially sought for non-disabled females of the same age. Moreover, the article focuses specifically on court authorised sterilisation rather than also considering sterilisation justified pursuant to the defence of necessity, because the latter was not considered by the Senate Committee. However, sterilisation and the defence of necessity is an important site of analysis and some preliminary points of inquiry are noted below at Part III(B)(5).

I analyse the Senate Committee Report by reference to critical disability studies scholarship. Critical disability studies scholars draw upon a range of disciplines and theoretical standpoints to analyse the social, political and cultural dimensions of disability as a form of difference. Critical disability studies scholars critique medical approaches to disability which are focused on disability as an individual, biomedical deficit.¹⁰ Instead they analyse disability as a socially produced abnormality which is in a mutually constitutive relationship to 'normality'.¹¹ Importantly, the norms against which disability is constructed are not only norms of ability but social norms that sit at the intersection of multiple dimensions of difference including (relevantly for present purposes) ability, sexuality and gender.¹² Critical disability studies scholars focus on illuminating and contesting the material, cultural and institutional ways through which disability as abnormality is produced, and the material, cultural and institutional effects of abnormality, including the greater legal permissibility of violence against people with disability.

I argue that the Senate Committee's approach to sterilisation and human rights, notably the retention of court authorised sterilisation and the 'best protection of rights' test, constructs girls with disability as abnormal and hence subject to a different and lower human rights threshold than girls without disability. In particular, their abnormality means their inequality is to be expected and they are incapable of being subjected to the process of comparison in order to determine whether or not they have been discriminated against. Court authorised sterilisation becomes '*a-discriminatory*' – as incapable of ever possibly being contemplated as an act of discrimination. Moreover, court authorised sterilisation is a way to realise (other) human rights of girls with disability. Through my

10 Note, however, the argument by Helen Meekosha and Karen Soldatic about the possibility of the selective and strategic deployment of medicalised impairment in contesting oppression (although I argue that sterilisation is not such a means for the strategic deployment of medicalised impairment): Helen Meekosha and Karen Soldatic, 'Human Rights and the Global South: The Case of Disability' (2011) 32 *Third World Quarterly* 1383.

11 See, eg, Tanya Titchkosky and Rod Michalko, 'Introduction' in Tanya Titchkosky and Rod Michalko (eds), *Rethinking Normalcy: A Reader* (Canadian Scholars Press, 2009) 1.

12 See, eg, Kim Q Hall, 'Reimagining Disability and Gender through Feminist Disability Studies: An Introduction' in Kim Q Hall (ed), *Feminist Disability Studies* (Indiana University Press, 2011); Margrit Schildrick, *Dangerous Discourses of Disability, Subjectivity and Sexuality* (Palgrave Macmillan, 2009) 105.

analysis I argue that the Senate Committee cannot defend its recommendations on human rights grounds as they are not in conformity with the *CRPD* and the recommendations rely upon and themselves consolidate legal constructions of women and girls with disability that promote their discrimination and the enacting of lawful violence on their bodies. Ultimately I argue the Senate Committee's recommendations should be rejected and attention should focus squarely on prohibiting sterilisation, not least of all because it is a form of state-sanctioned and lawful discrimination and violence against women and girls with disability.

Two years on from the Senate Committee Report, the Australian government is yet to act on the Report's recommendations. Yet, it is timely to pause and give careful consideration to the Senate Committee's approach to court authorised sterilisation and human rights for at least three reasons. One reason is that a recent report by the Senate Committee into violence, abuse and neglect of people with disability in institutional and residential settings has taken an approach to medical treatment of people with disability pursuant to substituted consent or 'disability specific interventions' (of which court authorised sterilisation is one example) which is more in conformity with the *CRPD*.¹³ Disappointingly, the Senate Committee did not single out sterilisation for discussion: it is vital to ensure that court authorised sterilisation is explicitly included in all discussions about violence against people with disability (and is not forgotten in a focus on more gender-neutral medical interventions which might not require confronting society's deeply-held prejudices about disabled women's bodies and sexuality). The second reason is that in recent years, international pressure on the Australian government to prohibit court authorised sterilisation has intensified. Most recently, in November 2015 the United Nations Human Rights Committee 'raised concerns Australia is breaching the human rights of women with disabilities by allowing their forced sterilisation'.¹⁴ The third reason is that violence against people with disability is currently being considered in a variety of other contexts including the Royal Commission into Institutional Responses to Child Sexual Abuse¹⁵ and the safeguarding provisions of the National Disability Insurance Scheme.¹⁶

I begin in Part II with an introduction to the Australian legal framework of court authorised sterilisation. In Part III, I identify two competing international human rights approaches to court authorised sterilisation, and discuss why one of

13 Senate Community Affairs References Committee, Parliament of Australia, *Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings, including the Gender and Age Related Dimensions, and the Particular Situation of Aboriginal and Torres Strait Islander People with Disability, and Culturally and Linguistically Diverse People with Disability* (2015) ch 4. There are only three mentions of sterilisation in the entire 343 page report, and these are only passing references.

14 Bridie Jabour, 'UN Examines Australia's Forced Sterilisation of Women with Disabilities', *The Guardian* (online), 10 November 2015 <<http://www.theguardian.com/australia-news/2015/nov/10/un-examines-australias-forced-sterilisation-of-women-with-disabilities>>.

15 Commonwealth, Royal Commission into Institutional Responses to Child Sexual Abuse, *Redress and Civil Litigation Report* (2015).

16 National Disability Insurance Scheme, 'Proposal for a National Disability Insurance Scheme Quality and Safeguarding Framework' (Consultation Paper, February 2015).

these (that articulated by reference to the *CRPD*) is the legally and politically preferred approach. I then turn in Part IV(A) to introduce the Senate Committee Report. In Part IV(B) I analyse the Senate Committee's approach to human rights in relation to the retention of court authorised sterilisation and then in Part IV(C) I analyse its approach to the legal test for court authorisation. I conclude with some broader discussion of the implications of my analysis for thinking about the relationship between disability, violence and human rights more broadly.

II COURT AUTHORISED STERILISATION

In the seminal High Court decision of *Secretary, Department of Health and Community Services v JWB ('Marion's Case')*,¹⁷ the majority held that parental or guardian consent to sterilisation of a girl with disability who herself does not have the legal capacity to consent is sufficient to render the physical contact to the girl's body lawful.¹⁸ The majority articulated a bifurcated system depending on whether the sterilisation is for 'therapeutic' or 'non-therapeutic' purposes.¹⁹ When the sterilisation of a girl with disability without her consent is necessary to save the girl's life or to prevent serious damage to her health ('therapeutic sterilisation'), this sterilisation is lawful pursuant to the combined effect of the tort and criminal law defences of consent and substituted decision-making laws which recognise the legality of third party consent in these circumstances.²⁰ No court authorisation is required. An example of therapeutic sterilisation is to address a life threatening cancer, which could not be mitigated by less invasive means. While there are certainly issues related to how 'therapeutic' is defined,²¹ particularly in a broader context of the significance of the medicalisation of disability generally to the expansive rationalisation of non-consensual medical interventions on the basis of therapeutic benefit,²² these issues are not the focus of this article (although they are taken up briefly in a discussion of the doctrine of necessity below). However, it is important to note here that the focus in this article on 'non-therapeutic' sterilisation is because the article is about court authorised sterilisation and this legal mode of sterilisation applies only to 'non-therapeutic' sterilisation. Yet, as is clear throughout the article, and notably in

17 (1992) 175 CLR 218.

18 Ibid 235 (Mason CJ, Dawson, Toohey and Gaudron JJ).

19 Ibid 250 (Mason CJ, Dawson, Toohey and Gaudron JJ).

20 For a general discussion, see Linda Steele, 'Disability, Abnormality and Criminal Law: Sterilisation as Lawful and Good Violence' (2014) 23 *Griffith Law Review* 467.

21 On 'therapeutic' sterilisation, see, eg, Lesley Naik, 'When is the Sterilisation of an Intellectually Disabled Child "Therapeutic"? A Practical Analysis of the Legal Requirement to Seek Court Authorisation' (2012) 20 *Journal of Law and Medicine* 453; Joshua Shaw, 'De-Recognition of Disability: Canadian Parents Patriae Jurisdiction and Sterilization' (2015) 36 *Windsor Review of Legal and Social Issues* 147; Linda Steele, 'Making Sense of the Family Court's Decisions on the Non-Therapeutic Sterilisation of Girls with Intellectual Disability' (2008) 22 *Australian Journal of Family Law* 1.

22 Linda Steele and Leanne Dowse, 'Gender, Disability Rights and Violence against Medical Bodies' (2016) (forthcoming) *Australian Feminist Studies*.

Part III(B)(5), the author is critical of the division itself and the expansive notion of ‘therapeutic’ as it applies to people with disability.

Where the sterilisation of a girl with disability is for ‘non-therapeutic’ purposes parental consent must be additionally authorised by the Family Court pursuant to its welfare jurisdiction (now in section 67ZC of the *Family Law Act 1975* (Cth)), because parental consent to sterilisation in these circumstances falls outside of the scope of parental authority.²³ The Family Court can only authorise parental consent to sterilisation where there are no less invasive alternatives and it is in the best interests of the child.²⁴ Through the ‘best interests’ test the Court asks: is the sterilisation in the best interests of the individual who is to be sterilised (as against the best interests of a third party or society at large)? As the majority in *Marion’s Case* state: ‘if authorization is given, it will not be on account of the convenience of sterilization as a contraceptive measure, but because it is necessary to enable her to lead a life in keeping with her needs and capacities’.²⁵ Importantly, sterilisation which is authorised under the Family Court’s welfare jurisdiction relates to sterilisation which is by very definition *not* ‘therapeutic’, that is, is not necessary to save the girl’s life or to prevent serious damage to her health, but is nevertheless required for some other reason still considered to be in the girl’s ‘best interests’. As I have discussed at length elsewhere, court authorised sterilisation fits within a division of legal subjects in terms of mental capacity and incapacity which results in different thresholds of unlawful and lawful violence for people with and without mental capacity and hence differences in what constitutes the criminal offence of assault.²⁶ Pursuant to this division, women and girls with disability are subject to a lower threshold of unlawful violence meaning that court authorised sterilisation is permissible and, indeed, necessary and is thus a lawful or ‘good’ form of violence. At the heart of the legal status of court authorised sterilisation as ‘lawful violence’ is the idea of women and girls with disability as ‘abnormal’ which thus renders their differential treatment irrelevant. In this article I build on these arguments by exploring court authorised sterilisation at the nexus of domestic law reform and international human rights law.

When the current legal framework for sterilisation was articulated in the early 1990s in *Marion’s Case*, the majority was of the view that the human rights of girls with intellectual disability would be protected through judicial oversight of court authorisation and the ‘best interests’ test moderating such authorisation. This was on the basis that girls with mental incapacity could not consent and so their right to bodily integrity could only be realised through others giving substituted consent on their behalf, with judicial oversight protecting the individual against abuse of third party consent. Here the underlying assumption was that the human rights issue in court authorised sterilisation was the procedural question of consent. The subject matter of the decision whether or not to consent – the act of sterilisation itself – was not itself a violation of human

23 *Marion’s Case* (1992) 175 CLR 218, 249 (Mason CJ, Dawson, Toohey and Gaudron JJ).

24 *Ibid* 259–60 (Mason CJ, Dawson, Toohey and Gaudron JJ).

25 *Ibid* 260 (Mason CJ, Dawson, Toohey and Gaudron JJ).

26 Steele, ‘Disability, Abnormality and Criminal Law’, above n 20. See also Steele and Dowse, above n 22.

rights. This approach accepted the division of individuals in law on the basis of mental capacity, and did not see anything wrong with this division itself or the subsequent inequality between these groups – a point I will explain in greater detail in Part III below.

In the subsequent 1995 decision of *P v P*,²⁷ the Full Family Court considered in greater detail the legal test for court authorisation. The Court considered whether the best interests test should include reference to non-discrimination in the form of a ‘but for’ question (‘but for the disability, would this girl be sterilised?’). It is necessary here to provide some background to this decision, as this decision was central to the Senate Committee Report and I revisit it in some detail in Part IV(C). *P v P* was an appeal decision of the Full Court of the Family Court decided in 1995. The initial decision which was the subject of the appeal in *P v P* concerned an application made by the mother of ‘Lessli’ to the Family Court for authorisation of her consent to Lessli’s hysterectomy. At the time of the initial application for court authorisation Lessli was aged 16 years. Lessli was described as having temporal lobe epilepsy and low-moderate range intellectual disability and, additionally, as having obsessive behaviours, wandering habits, underdeveloped basic living skills, and poor social skills. Lessli lived in residential accommodation during the school week and spent the weekends with her mother (her parents were divorced). She was due to complete her schooling the following year, at which point she would return to living with her mother who would leave her employment to become her full-time carer.²⁸ Lessli’s mother sought Family Court authorisation for her consent to sterilisation on two key grounds. One ground was to prevent menstruation. Lessli became aggressive and upset when menstruating. She had frequent (twice per month) and heavy menstruation and had problems with hygiene related to her menstruation (she did not always wear pads and required prompting to change pads). Her mother argued Lessli had to be reminded to change her pad and would show people the pad.²⁹ The other ground was to prevent pregnancy. Lessli had little concept of personal safety and social boundaries, she was incapable of consenting to sexual intercourse such that any sex with her would constitute sexual assault and she had previously been sexually assaulted while living in the group home. There was a risk of seizures and general confusion in pregnancy, as well as concern that Lessli would be unable to care for a child. Also, there was apparently a risk of any baby being born to Lessli being born with ‘incapacities’, although this was not elaborated on.³⁰

The application for authorisation of sterilisation of Lessli was dismissed at first instance.³¹ Justice Moore applied the discrimination ‘but for’ test that is

27 (1995) 126 FLR 245.

28 Ibid 249–53 (The Court).

29 Ibid 252–4 (The Court). It should be noted that while the application for consent was brought by Lessli’s mother, generally the school (which also provided to the Court observations of her capabilities) gave a more supportive and positive account of Lessli’s skills and her ability to cope with menstruation: at 250–1 (The Court).

30 Ibid 254–5 (The Court).

31 Ibid 245 (The Court).

‘sterilisation should not be approved if it would not be contemplated in the case of an intellectually normal girl with similar epilepsy’.³² So, at first instance, the question of discrimination *was* central to the decision not to authorise Lessli’s mother’s consent to the sterilisation. Lessli’s mother then appealed this decision to the Full Family Court. Ultimately, the appeal was allowed and the mother’s consent to sterilisation was authorised by the Court. The Full Family Court was of the view that Moore J was wrong in applying a ‘but for’ test. Rather, the judge should have applied the ‘best interests’ test as set out in *Marion’s Case*. The Court dismissed the argument that discrimination is relevant to court authorisation, stating that the application of a ‘but for’ test might be ‘superficially attractive’ because it ‘is non-discriminatory and equates the intellectually handicapped person with the non-intellectually handicapped’, but ultimately the test has the opposite effect and is ‘conceptually incorrect’.³³ So, while the paramount consideration as per *Marion’s Case* is always the best interests of the child, following *P v P* in determining what is in a particular girl’s best interests consideration *cannot* extend to the question of discrimination.

I will return to *P v P* in Part IV(C) below. For present purposes, two points are relevant which I will develop in the rest of the article. One is that the effect of the exclusion of the ‘but for’ question from the legal test for court authorisation was to deem the right to equality and non-discrimination irrelevant to the individual judicial determination of court authorisation. The other is that, building on the division between mental capacity and incapacity in *Marion’s Case*, the court decided that the ‘but for’ test was not relevant because these girls were so different as to be unequal and incomparable to girls without intellectual disability.

III DISABILITY AND HUMAN RIGHTS

It may be apparent from my introductory discussion of the *CRPD* approach to sterilisation and the Australian judicial approach to court authorised sterilisation that there are two seemingly competing human rights approaches to court authorised sterilisation and specifically to the idea of equality. I now explore these two approaches, beginning with the earlier ‘mental incapacity human rights approach’ (reflected in the Australian judicial approach to sterilisation, and more recently in the Senate Report) and followed by the current *CRPD* ‘legal capacity human rights approach’ (reflected in the disability rights opposition to court authorised sterilisation). I will focus on showing how these two approaches diverge in relation to their vantage point for considering human rights. The legal capacity human rights approach views the *substance* of court authorised sterilisation as a violation of human rights, whereas the (earlier) mental incapacity human rights approach views the failure to follow *procedure* for consenting to court authorised sterilisation as a violation of human rights. These

32 Ibid 266 (The Court).

33 Ibid 266–8 (The Court).

two approaches have a fundamental difference in relation to disability and equality. The mental incapacity approach sees people with disability as inherently different to people without disability such that inequality between these groups is assumed and they are subject to a different set of human rights. The legal capacity approach sees people with disability as equal to others and demands equality between people with disability and those without, in turn demanding the same human rights should be enjoyed by all. In the parts that follow, I argue that it is the tension between these approaches, and the Senate Committee's preference for the *earlier* mental incapacity human rights approach (confusingly presented as a *CRPD* approach), which is at the heart of the Senate Committee's deliberations on sterilisation and human rights. This renders its recommendations particularly concerning.

A Mental Incapacity and the Historical Ambivalence of International Human Rights Law towards Court Authorised Sterilisation

The human rights arguments against court authorised sterilisation were always defensible by drawing on mainstream international human rights instruments. However, prior to the introduction of the *CRPD* the arguments against court authorised sterilisation were arguably obfuscated by prevailing approaches to human rights of people with disability which positioned them as legitimately 'unequal' to people with disability by reason of mental incapacity. These prevailing approaches are reflected in what I refer to as the 'mental incapacity human rights approach' to sterilisation.

Historically, people with disability have been subject to lower human rights thresholds by reason of their marginalisation in mainstream international human rights instruments and the existence of disability-specific international human rights instruments. As Frédéric Mégret states:

For a long time, some persons with disabilities were hardly considered human and were, as a result, denied basic rights ... Persons with disabilities have been victims of genocide, eugenism, and have suffered from massive discrimination resulting from a denial of their basic rights.³⁴

Mainstream human rights instruments such as the *International Covenant on Civil and Political Rights*³⁵ enshrine the right to equality and non-discrimination and hence in theory provide that *all* individuals should enjoy *all* human rights regardless of disability. Yet scholars have argued that 'their marginalised and disempowered social and political status' meant that people with disability historically did not 'enjoy the benefits of their human rights' under mainstream human rights instruments.³⁶ Adam McBeth, Justine Nolan and Simon Rice note 'a pattern of omissions' of disability in (mainstream) human rights instruments

34 Frédéric Mégret, 'The Disabilities Convention: Human Rights of Persons with Disabilities or Disability Rights?' (2008) 30 *Human Rights Quarterly* 494, 500 (citations omitted). See also Rosemary Kayess and Phillip French, 'Out of Darkness into Light? Introducing the *Convention on the Rights of Persons with Disabilities*' (2008) 8 *Human Rights Law Review* 1, 12–17.

35 Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) ('*ICCPR*').

36 Adam McBeth, Justine Nolan and Simon Rice, *The International Law of Human Rights* (Oxford University Press, 2011) 480.

prior to the *CRPD*.³⁷ The marginal status of people with disability is evident in the texts of general human rights instruments which do not explicitly identify disability as a basis for discrimination: ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status’.³⁸ While disability has been interpreted as falling under ‘other status’,³⁹ the absence of an explicit mention in the treaties themselves is notable.⁴⁰ Division of human rights subjects on the basis of mental capacity and incapacity was routine and differential treatment through the denial of legal capacity on the basis of mental incapacity and regimes for substituted decision-making were considered permissible under general international human rights instruments. For individuals with mental incapacity the focus was on ensuring procedural safeguards through which denial of legal capacity and substituted decision-making occurred. At this time, human rights had less (or nothing) to say about the *substance* of what could be done pursuant to substituted decision-making.

The marginal status of people with disability in international human rights law was compounded by specialist disability human rights instruments⁴¹ which were based on problematic assumptions about people with disability. These instruments focused on a medical approach to disability and provided for a lower threshold of human rights. For example, the *Declaration on the Rights of Mentally Retarded Persons* provided that: ‘[t]he mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings’.⁴² These instruments took a paternalistic approach to rights which legitimised differential treatment (particularly on the basis of mental incapacity) including segregation, restraint, institutionalisation and non-consensual medical treatment.⁴³ Like the approach to people with disability in mainstream international human rights instruments, these disability-specific instruments explicitly provided for substituted decision-making and focused on ‘procedural safeguards’.⁴⁴

37 Ibid. See also Piers Gooding, ‘Change and Continuity in Mental Health Law: The Long Road to the United Nations *Convention on the Rights of Persons with Disabilities* and Its Implications for Mental Health and the Law Today’ (2014) 20(3) *Web European Journal of Current Legal Issues* <<http://webjcli.org/article/view/367/470>>.

38 See, eg, *ICCPR* art 2(1).

39 McBeth, Nolan and Rice, above n 36, 479, quoting Committee on Economic, Social and Cultural Rights, *General Comment No 5: Persons with Disabilities*, UN ESCOR, 11th sess, 38th mtg, Supp No 3, UN Doc E/1995/22 (25 November 1994) [5].

40 Mégret, ‘The Disabilities Convention’, above n 34, 502.

41 See, eg, *Declaration on the Rights of Mentally Retarded Persons*, GA Res 2856 (XXVI), UN GAOR, 26th sess, 2027th plen mtg, Agenda Item 12, UN Doc A/RES/26/2856 (20 December 1971) (‘*Declaration on the Rights of Mentally Retarded Persons*’); *Declaration on the Rights of Disabled Persons*, GA Res 3447 (XXX), UN GAOR, 13th sess, 2433rd plen mtg, UN Doc A/RES/30/3447 (9 December 1975); *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, GA Res 46/119, UN GAOR, 46th sess, 75th plen mtg, UN Doc A/RES/46/119 (17 December 1991).

42 *Declaration on the Rights of Mentally Retarded Persons*, UN Doc A/RES/26/2856, art 1 (emphasis added).

43 See, eg, Gooding, above n 37; McBeth, Nolan and Rice, above n 36, 477–9.

44 For example, art 7 of the *Declaration on the Rights of Mentally Retarded Persons*, UN Doc A/RES/26/2856 provided that:

It is well-established in the scholarship that the earlier human rights approach reflects a medical model of disability that denied people with disabilities full access to human rights (indeed, this is routinely recognised as one of the core reasons for the *CRPD*, which I will discuss shortly).⁴⁵ This medical approach to disability saw individuals as naturally (in the double sense of biomedically and self-evidently) different and subject to lower human rights thresholds which rendered this violence permissible, a point I will return to below. The mental incapacity human rights approach organised the subjects of human rights by reference to mental capacity and incapacity, and attributed differential human rights thresholds on this basis. Similar to the role of criminal law and tort law (in the domestic context), human rights (in the international context) set differential thresholds for unlawful violence by reference to mental capacity. Notably, this approach did not see as violence medical interventions such as sterilisation, restrictive practices and forced psychiatric treatment. The implicit status of violence in the mental incapacity approach to human rights reflects the cultural role of human rights law in defining what it means to be ‘human’.⁴⁶ In organising individuals within and outside of full humanness, human rights have significant impacts on the material violence individuals can be lawfully subjected to.⁴⁷ The cultural role of human rights might be an example of Judith Butler’s notion of ‘derealization’. ‘Derealization’ is a process whereby certain lives are discursively denied the status of a life worth grieving in their subjection to physical violence or even death because they do not fit within the ‘dominant frame for the human’.⁴⁸ ‘Derealization’ results in their dehumanisation which ‘then gives rise to a physical violence that in some sense delivers the message of dehumanization that is already at work in the culture’.⁴⁹

By reason of their positioning outside the full, capable ‘human’ of human rights, people with disability are outside of the community of humans (‘common humanity’) of human rights law and in turn beyond comparison to these ‘equal’, mentally capable humans for the purpose of determining discrimination and realising equality. This exclusion from common humanity is important because discrimination is premised on the fundamental equality of all humans, as

Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.

45 See, eg, McBeth, Nolan and Rice, above n 36, 480.

46 See, eg, in the context of disability: Frédéric Mégret, ‘The Disabilities Convention: Towards a Holistic Concept of Rights’ (2008) 12 *The International Journal of Human Rights* 261, 262. See generally Anna Gear, ‘“Framing the Project” of International Human Rights Law: Reflections on the Dysfunctional “Family” of the Universal Declaration’ in Conor Gearty and Costas Douzinas (eds), *The Cambridge Companion to Human Rights Law* (Cambridge University Press, 2012) 17.

47 For an exploration of human rights and torture against people with disability see, eg, in the context of torture: Dinesh Wadiwel, ‘Black Sites: Disability and Torture’ (2017) (forthcoming) *Continuum: Journal of Media and Cultural Studies*.

48 Judith Butler, *Precarious Life: The Powers of Mourning and Violence* (Verso, 2004) 34.

49 *Ibid.*

members of a shared community. It is this fundamental sameness of members of a shared community that then enables comparison *between* groups of humans within this community despite differential characteristics between groups because these differential characteristics are viewed as superficial to the equal cores of all humans *across* these groups. Historically, non-discrimination and inequality vis-à-vis people without disability were not relevant to the rights threshold for people with disability because people with disability were seen as unequal by reason of their disability and rather than being viewed as a superficial characteristic their disability was a ‘synecdoche’⁵⁰ for the individual and ‘embedded in the very fabric of their physical and moral [or, in this case, legal] personhood’.⁵¹ As such, they were fundamentally unequal and thus outside of the community of humans and beyond comparison to people without disability for the purposes of discrimination.

Thus, through the division of human rights subjects on the basis of mental capacity and incapacity, human rights *accommodated* and, in fact, were *premised upon* the differential and discriminatory treatment of people with mental incapacity. At the same time, *inequality* and *discrimination* against people with disability *through* the historical ordering of international human rights law on the basis of mental capacity was not evident because the biomedical, internal, scientific psychological characteristic of disability made the mental capacity division seem like a self-evident (rather than political) contouring of human rights law.

Ultimately, the medical approach to disability resulted in an ambivalence in the interpretation and application of international human rights instruments towards acts done pursuant to substituted decision-making, with the focus being on procedural safeguards in the court authorisation rather than a focus on the actual substance of the court authorisation itself. This approach could not conceive of sterilisation as an act of violence – instead it was necessary medical treatment.

This ‘mental incapacity human rights approach’ is evident in the legal framework for sterilisation as per *Marion’s Case*. In reaching its decision, the majority in *Marion’s Case* considered the human rights arguments against court authorised sterilisation. The majority’s discussion of human rights focused on the right to personal inviolability.⁵² While the right to personal inviolability would typically be realised by ensuring individual autonomy over physical interventions to one’s body, in relation to girls with mental incapacity the right was upheld by withdrawing the ability to consent and *substituting* this consent with that of a third party who would act in their ‘best interests’. Judicial oversight of this substituted decision-making was considered sufficient to protect the *specific*

50 Catherine Mills, *Futures of Reproduction: Bioethics and Biopolitics* (Springer, 2011) 71 n 48.

51 David T Mitchell and Sharon L Snyder, ‘Introduction: Disability Studies and the Double Bind of Representation’ in David T Mitchell and Sharon L Snyder (eds), *The Body and Physical Difference: Discourses of Disability* (University of Michigan Press, 1997) 1, 3, citing Robert Murphy, ‘Encounters: The Body Silent in America’ in Benedicte Ingstad and Susan Reynolds Whyte (eds), *Disability and Culture* (University of California Press, 1995) 140–58.

52 *Marion’s Case* (1992) 175 CLR 218, 253–4 (Mason CJ, Dawson, Toohey and Gaudron JJ).

human right of personal inviolability of girls with disability.⁵³ So, while non-consensual sterilisation of an individual *with* mental capacity would be a violation of human rights, *mental incapacity* resulted in a lower human rights threshold which itself *permitted* non-consensual sterilisation (via substituted decision-making) as the very means for *realising* an individual's human rights. In comparison to this approach, Brennan J, in the minority, was of the view that non-therapeutic sterilisation would be a violation of a child's human right to bodily inviolability.⁵⁴ While Justice Brennan's view was in the minority, his view highlights that, even in the judicial decision establishing the legal framework for court authorised sterilisation of girls with intellectual disability, there were conflicting ideas of the relationship between sterilisation and human rights.

B Legal Capacity and the Contemporary Human Rights Approach to Sterilisation as Discriminatory Violence

The marginal status of people with disability in international human rights law and, in turn, the ambivalent status of court authorised sterilisation as a human rights violation, has been challenged through the coming into force in 2008 of the *CRPD*.⁵⁵ The *CRPD* is premised on a 'concern' that 'despite [mainstream international human rights instruments] persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world'.⁵⁶ The *CRPD* does not introduce any new human rights for persons with disabilities but instead aims to enhance recognition of existing human rights in relation to persons with disability. For present purposes, the *CRPD* achieves this in at least four ways.

1 Alternative Conceptualisation of Disability

A fundamental shift brought about by the *CRPD* is the redefinition of disability as a fluid, socially contingent concept thus challenging the pervasive medical approach to disability in the earlier mental incapacity human rights approach.⁵⁷ This shift demonstrates that disability is not an objective and fixed concept in international human rights law but can be framed in different ways. The *CRPD* provides a space in international human rights law to question how disability has historically been understood in international human rights law (and

53 Ibid 259–60 (Mason CJ, Dawson, Toohey and Gaudron JJ).

54 Ibid 265–9 (Brennan J).

55 For a history of the development of the *CRPD*, see, eg, Kayess and French, above n 34; Anna Lawson, 'The United Nations and the Convention on the Rights of Persons with Disabilities: New Era or False Dawn?' (2007) 34 *Syracuse Journal of International Law and Commerce* 563; McBeth, Nolan and Rice, above n 36; Michael Ashley Stein and Janet E Lord, 'Monitoring the Convention on the Rights of Persons with Disabilities: Innovations, Lost Opportunities, and Future Potential' (2010) 32 *Human Rights Quarterly* 689. For a detailed discussion of the development of art 12, see Amita Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?' (2007) 34 *Syracuse Journal of International Law and Commerce* 429, 438–56.

56 *CRPD* Preamble para k.

57 See, eg, Maya Sabatello and Marianne Schulze, 'A Short History of the International Disability Rights Movement' in Maya Sabatello and Marianne Schulze (eds), *Human Rights and Disability Advocacy* (University of Pennsylvania Press, 2014) 1, 15–20.

in domestic legal systems and society more broadly), and to identify this as itself central to the ultimate realisation of *all* human rights of people with disability. What this shift demonstrates is that there is not one constant, a priori disabled subject of human rights which persists across time and across the introduction of the *CRPD*. The cultural paradigm shift affected by the *CRPD* results in a *different* conceptualisation of the disabled subject of human rights (and in turn, arguably, the ‘human’ of human rights⁵⁸) which is fundamentally irreconcilable with the earlier mental incapacity approach to the disabled human rights subject, and it is from this core conception of the disabled subject that different interpretations of human rights and sterilisation flow.

The *CRPD* – *beyond* (and inextricably related to) what it says about substantive human rights – affects a cultural shift which provides new possibilities for domestic law makers and society more broadly to see disability in different ways. Moreover, as will become apparent below, in seeing *disability* differently, it is possible to see *new forms* of violence against people with disability (previously taken for granted as necessary and benevolent medical treatment) by reason of the critique of the medicalisation of disability.⁵⁹ This cultural shift then underpins the approach to substantive rights in the Convention and the status of court authorised sterilisation as a violation of human rights.

2 *Centrality of Equality and Non-discrimination*

The *CRPD* emphasises non-discrimination and equality, both as a right in itself⁶⁰ and a general principle governing its operation as a whole.⁶¹ Article 2 of the *CRPD* defines ‘discrimination’ as ‘any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms’.⁶² The *CRPD* demands that individuals with disability be compared to individuals without disability and in turn that individuals with disability have the same rights thresholds as other individuals. The interdependency and interconnectedness of all rights in the *CRPD*, coupled with the permeation of equality throughout the Convention,⁶³ means that states parties cannot pick and choose human rights if this will result in discrimination

58 Gerard Quinn and Anna Arstein-Kerslake, ‘Restoring the “Human” in “Human Rights”’: Personhood and Doctrinal Innovation in the UN Disability Convention’ in Conor Gearty and Costas Douzinas (eds), *The Cambridge Companion to Human Rights Law* (Cambridge University Press, 2012) 36.

59 While beyond the scope of this article, the shift affected by the *CRPD* suggests the co-construction of disability, human and violence under human rights law. On the co-constitution of the human and disability (but not also violence), see *ibid*; Tanya Titchkosky, ‘Monitoring Disability: The Question of the “Human” in Human Rights Projects’ in Michael Gill and Cathy J Schlund-Vials (eds), *Disability, Human Rights and the Limits of Humanitarianism* (Ashgate, 2014) 119. See also Judith Butler’s discussion of the co-construction of the human and violence (albeit with the notable omission of discussion of disability): Butler, above n 48, ch 2.

60 *CRPD* art 5.

61 *CRPD* Preamble, art 3(b).

62 *CRPD* art 2.

63 Mégret, ‘The Disabilities Convention’, above n 34, 501.

and inequality. This is particularly true for the right to legal capacity, as I discuss in the following section.

The centrality of the right to equality and non-discrimination in the *CRPD* is supported by the approach to these same rights in international human rights law more broadly.⁶⁴ Equality and non-discrimination is enshrined as a guarantee in the realisation of other human rights.⁶⁵ This latter aspect is particularly important if an individual belongs to a group which is typically marginalised.⁶⁶ McBeth, Nolan and Rice suggest that ‘[t]he principle of non-discrimination reflects the very essence of human rights, in that every person holds the same rights by virtue of being born human and not by virtue of some particular characteristic or membership of some particular social group’.⁶⁷ Therefore, while there might not be a formal legal hierarchy of human rights that places non-discrimination at its peak and privileges its recognition over other rights, international human rights law makes clear that in practice for other rights to be recognised in a meaningful way and with the same outcomes as per their application to people without a disability, these rights must be applied in conjunction with the right to equality and non-discrimination. Therefore, different human rights thresholds of people with disability, even on the basis of ‘protection’, can no longer be sustained: non-discrimination and equality are central to *all* human rights and cannot be ignored by prioritising other rights. This is a point I will further develop when discussing the Senate Report. This is a striking difference to the pre-*CRPD* mental incapacity approach to human rights where human rights were premised on an assumption of absolute difference and on the legitimacy of inequality.

3 *Right to Legal Capacity for All*

The *CRPD* also challenges the way in which perceived mental incapacity results in denial of legal capacity.⁶⁸ Article 12 of the *CRPD* provides ‘the right to recognition everywhere as persons before the law’ and that ‘persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’.⁶⁹ The UN Disability Committee in its General Comment dealing with article 12 released on 11 April 2014 emphasises that legal capacity is distinct from mental capacity.⁷⁰ The UN Disability Committee notes that in most countries law conflates the two concepts, so that a person is denied legal capacity where they

64 *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) arts 1, 2(1), 7; *ICCPR* arts 2, 3, 26; *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) arts 2(2), 3.

65 For example, art 3 of the *ICCPR* states: ‘The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.’

66 Daniel Moeckli, ‘Equality and Non-Discrimination’ in Daniel Moeckli, Sangeeta Shah and Sandesh Sivakumaran (eds), *International Human Rights Law* (Oxford University Press, 2nd ed, 2014) 157, 160.

67 McBeth, Nolan and Rice, above n 36, 111.

68 ‘Legal capacity’ is the basis for recognising an individual as a person before the law and specifically consists of ‘the ability to hold rights and duties (legal standing) and to exercise those rights and duties (legal agency)’: *General Comment No 1*, UN Doc CRPD/C/GC/1, 3 [13].

69 *CRPD* arts 12(1)–(2).

70 *General Comment No 1*, UN Doc CRPD/C/GC/1.

are considered to have impaired decision-making skills. In drawing on the right to equality and non-discrimination, the UN Disability Committee urges states parties to abolish substitute decision-making regimes in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.⁷¹ Significantly (on a conceptual level), the *CRPD* collapses the division of legal subjects on the basis of capacity and incapacity, grouping people with disability in the group of ‘common humanity’ and thus makes discrimination against people with disability conceivable.

4 Legal Capacity and Violence

Article 16 of the *CRPD* provides the right to freedom from exploitation, violence and abuse. Following the *CRPD*, the continuation of practices that deny legal capacity, including substituted decision-making, are discriminatory, and physical interventions (including medical procedures) done pursuant to substituted decision-making are discriminatory acts of violence. Furthermore, by reason of the discriminatory nature of the denial of legal capacity (and the discriminatory reasons for some medical treatment exclusively or primarily done to people with disability) this violence can also amount to torture.⁷² Judicial oversight in court authorisation in such circumstances is not protective – it is part of what renders such acts discriminatory, and in turn even torture, because the role of the judiciary renders this state-sanctioned violence.⁷³

The Disability Committee has explicitly labelled as *discrimination and violence* medical procedures (including sterilisation) done without the consent of individuals with disability, thus challenging the assumption that physical acts done to disabled bodies for medical purposes are inherently benevolent and the antithesis of violence.⁷⁴ The Committee has stated that ‘States parties must abolish policies and legislative provisions that allow or perpetrate forced

71 Ibid 6–7 [24]–[29]. The issue of whether art 12 requires the replacement of all substituted decision-making with supported decision-making regimes is highly contentious. For an overview of some of the issues, see Peter Bartlett, ‘The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law’ (2012) 75 *Modern Law Review* 752; Dhanda, above n 55; Piers Gooding, ‘Supported Decision-Making: A Rights-Based Disability Concept and Its Implications for Mental Health Law’ (2013) 20 *Psychiatry, Psychology and Law* 431; Tina Minkowitz, ‘The *United Nations Convention on the Rights of Persons with Disabilities* and the Right to be Free from Nonconsensual Psychiatric Interventions’ (2007) 34 *Syracuse Journal of International Law and Commerce* 405.

72 See, eg, in the context of torture: Wadiwel, above n 47.

73 For a discussion of violence and medical treatment, see Bernadette McSherry and Piers Gooding, ‘Torture and Ill-Treatment in Health Care Settings: Lessons from the United Nations’ (2013) 20 *Journal of Law and Medicine* 712; Minkowitz, ‘Nonconsensual Psychiatric Interventions’, above n 71; Tina Minkowitz, ‘Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities’ in Bernadette McSherry and Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing, 2010) 151.

74 The UN Disability Committee has explicitly stated that:

forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). This practice denies the legal capacity of a person to choose medical treatment and is therefore a violation of article 12 of the Convention

General Comment No 1, UN Doc CRPD/C/GC/1 [42].

treatment’ and recommends ‘that States parties ensure that decisions relating to a person’s physical or mental integrity can only be taken with the free and informed consent of the person concerned’.⁷⁵

5 Court Authorised Sterilisation as Discriminatory Violence

The implications of the Disability Convention for court authorised sterilisation are a shift from concern about the *procedure* (ie, judicial oversight) of sterilisation to a fundamental concern with the *act* of sterilisation itself which in turn renders *all* court authorised sterilisation a human rights violation and *any* judicial oversight of sterilisation additionally problematic rather than protective. It is the legal capacity human rights approach which is the basis for disability rights advocates arguing for the prohibition of all forms of sterilisation against women and girls with disability, except where there is serious threat to life.

It might be argued that denying access to sterilisation for people with disability is discriminatory because this could then put women and girls with disability at disadvantage in relation to their lifestyle or their health.⁷⁶ This argument is problematic for a number of reasons. First, in relation to ‘lifestyle’ sterilisation, while women without disability might seek sterilisation for matters related to life plan, lifestyle and family planning, these are *not* the reasons described in the cases relating to *others* deciding to the sterilisation of women and girls with disability.⁷⁷ As discussed below in Part IV(C)(2), sterilisation of women and girls with disability further limits their ability to experience the ‘lifestyles’ and life courses of women without disability. Secondly, caution must be exercised in supporting a space for ‘therapeutic’ sterilisation in health emergencies ‘equal’ to women without disability. This is because notions of emergency are interpreted differently in light of disability. In the leading necessity decision of *Re F*⁷⁸ (which concerned whether the defence of necessity could justify the sterilisation of an adult woman with mental illness) Lord Goff provided two contrasting examples of the application of the defence of necessity: an unconscious and injured (but otherwise usually mentally capable) passenger who is treated by doctors after a train accident and a mentally disordered person who is disabled from giving consent. Lord Goff characterises the former as ‘an emergency’ and the latter as ‘a permanent or semi-permanent state of affairs’. His Lordship explained that:

the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury. When the state of affairs is permanent, or semi-permanent, action properly taken to preserve the life, health or well-being of the assisted person may well transcend such measures as surgical operation or substantial medical treatment and may extend to include such

75 Ibid.

76 See, eg, Catherine Carroll and Gemma McGrath, ‘Intellectual Disability and the Right to Family Life: Equality Under the Law’ [2014] (122) *Precedent* 10, 12–13.

77 For example, one can compare the factual circumstances surrounding the consensual sterilisations of abled women giving rise to wrongful birth litigation in tort law with the factual circumstances of the cases discussed in this article concerning non-consensual sterilisation of women with disability: see, eg, *Cattanach v Melchior* (2003) 215 CLR 1.

78 [1990] 2 AC 1.

humdrum matters as routine medical or dental treatment, even simple care such as dressing and undressing and putting to bed.⁷⁹

Lord Goff's division of legal subjects of necessity indicates different *thresholds* of permissible violence by reason of the relationship between emergency and dis/ability. This manifests in terms of the kinds of procedures (the temporarily incapable – only what is immediately necessary; the permanently incapable – anything from the extreme to the mundane); different *localities* of emergency (the temporarily incapable – in the surrounding environmental circumstances, such as a car accident, or bodily circumstances, such as a transient health problem; in the permanently incapable – in their very disabled existence and disabled self) and different temporalities (the temporarily incapable – only what is immediately required; the permanently incapable – ongoing interventions). Thus, arguing for 'equal' access for women with disability to sterilisation in relation to emergency medical situations needs to be carefully considered because currently, the law views that a woman with disability's life is at serious threat by the very reason of her disability.

6 Can We Choose? The Priority of the Legal Capacity Human Rights Approach

I have outlined above two alternative human rights approaches to sterilisation: one that supports legal regulation of sterilisation where a particular procedure of court authorisation is met (mental incapacity human rights approach) and the other that supports the prohibition of sterilisation *even if* (and additionally because) it is court authorised (legal capacity human rights approach). The two are not of equal legal relevance: the latter approach reflects the current human rights approach to sterilisation and should be the approach that informs domestic legal frameworks. Importantly, the 'but for' approach which was flagged in *P v P* aligns with the approach to equality contained in the *CRPD*. The persistence by some states parties and scholars to adhere to the mental incapacity human rights approach to sterilisation might in part be due to a failure to appreciate both the centrality of *how disability is viewed* to how human rights are interpreted and applied and the now explicit redundancy of the medical approach to disability under the *CRPD*.

In thinking about how the *CRPD* applies in Australia, it is recognised that Australia has an interpretative declaration to the *CRPD* which includes its understanding that the *CRPD* 'allows for fully supported or substituted decision-making arrangements ... only where such arrangements are necessary, as a last resort and subject to safeguards' and 'that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards'.⁸⁰ Arguably, this might limit Australia's strict *legal* obligations. Yet, beyond this, the *CRPD* offers a new approach for how law can conceptualise

⁷⁹ Ibid 76–7.

⁸⁰ *Convention on the Rights of Persons with Disabilities*, ratification by Australia, 13 August 1980, 2515 UNTS 3 (with effect 16 August 2008); *Convention on the Rights of Persons with Disabilities Declaration 2009* (Cth).

disability and the disabled human rights subject, and in turn the relationship between disability and violence. This invites new ethical and cultural approaches to disability which have fundamental implications for how law is reformed beyond a fixation on the decision-making process, towards the *substance* of decisions being made about interventions in (and violence against) women and girls' bodies. This opens deeper philosophical, political and ethical questions about whether certain kinds of conduct should *ever* be permitted against people with disability *because* they should not be viewed as fundamentally different or exceptional to other humans.⁸¹

Therefore, the 'best interests' test for court authorised sterilisation and the associated rejection of the 'but for' test under *P v P* reflects an outdated human rights approach based on the absolute difference of people with disability and their legitimate inequality to people without disability. The *CRPD*'s legal capacity approach to human rights unsettles the domestic law framework of court authorised sterilisation and brings into question the very existence of court authorised sterilisation itself by foregrounding the equality between people with and without disability and demanding the same standard of human rights for them. Australian domestic law reform is currently grappling with this human rights shift, yet largely unsuccessfully as I now turn to discuss.

IV SENATE COMMITTEE INQUIRY

On 20 September 2012, the Senate Community Affairs Legislative Committee was tasked with inquiring into and reporting on the involuntary or coerced sterilisation of people with disability in Australia⁸² (which was later extended to intersexed children).⁸³ The terms of reference included 'the different legal, regulatory and policy frameworks and practices across the Commonwealth, states and territories, and action to date on the harmonisation of regimes' and 'Australia's compliance with its international obligations as they apply to sterilisation of people with disabilities'.⁸⁴ Interestingly, the Senate Committee did not consider sterilisation pursuant to the defence of necessity.

In its report, the Senate Committee received a number of submissions on sterilisation and human rights. The Committee began the discussion of its views by noting the division in submissions on the human rights status of sterilisation.⁸⁵ The submissions fell into one of the two human rights approaches discussed in Part III above. Leading disability advocacy organisations as well as some scholars whose submissions were premised on the contestation of medical

81 See generally Wadiwel, above n 47.

82 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 1 [1.1].

83 *Ibid* 1 [1.2]. On the Senate Committee's approach to intersex variations and sterilisation, see Aileen Kennedy, 'Fixed at Birth: Medical and Legal Erasures of Intersex Variations' (2016) 39 *University of New South Wales Law Journal* 813.

84 Commonwealth, *Parliamentary Debates*, Senate, 20 September 2012, 7474 (Rachel Siewert).

85 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 94 [4.35].

approaches to disability and the legal capacity human rights approach to sterilisation urged prohibition of court authorised sterilisation.⁸⁶ On the other hand, submissions by some other scholars (who did not explicitly challenge the medical model of disability or engage with the cultural shift affected by the *CRPD*) and government bodies and medical practitioners (which work within the medical approach to disability and/or within the very legal frameworks of substituted decision-making whose legitimacy has been challenged by the *CRPD*) made very different human rights arguments by reference to the mental incapacity human rights approach *in support of the continuation* of sterilisation.⁸⁷ Submissions in this latter group argued that sterilisation could realise human rights such as rights to health and to live and participate in the community and that court authorisation was sufficient protection against any rights abuses. This latter group of submissions argued that reference to the human right of equality and non-discrimination would deny other human rights and hence should be irrelevant to the inquiry – a point I explore below.

The Senate Committee's consideration was focused on making sense of which of these two approaches to human rights should inform its consideration of whether sterilisation should be banned and, if not, whether the 'best interests' test should be changed (including to a 'but for' test of the nature rejected in *P v P*). In the remainder of this Part, and the following two Parts, I will make sense of the Senate Committee's ultimate recommendations to retain court authorised sterilisation and to reform the legal test from 'best interests' to 'best protection of rights'. I do so in order to understand how the Senate Committee defended these recommendations on international human rights grounds and by specific reference to the *CRPD* but in a manner not reflecting this Convention's own legal capacity human rights approach to sterilisation and in a manner that perversely resulted in the very opposite result than that anticipated by the *CRPD* – the continuation of court authorised sterilisation.

A Persistence of Medical Approach to Disability

Recalling that the fundamental aspect of the Disability Convention is a shift in the conceptualisation of disability and the disabled human rights subject, the foundational problem with the Senate Committee's approach is that it viewed disability as an objective, fixed concept rather than contingent to social norms and subject to construction by law itself. Consequently, the Senate Committee

86 See, eg, Carolyn Frohmader, Women With Disabilities Australia, above n 1; People with Disability Australia, Submission No 50 to Senate Community Affairs Reference Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, March 2013; Linda Steele, Submission No 44 to Senate Community Affairs Reference Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, 24 February 2013.

87 See, eg, Wendy Bonython, Submission No 22 to Senate Community Affairs Reference Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, 14 February 2013; Diana Bryant, Submission No 36 to Senate Affairs References Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*, 22 February 2013; Adult Guardian of Queensland and the Public Advocate of Queensland, Submission No 19 to Senate Community Affairs Reference Committee, *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia*.

did not acknowledge and reject the medical approach to disability in the existing legal framework for court authorised sterilisation. The Senate Committee spent all but five paragraphs discussing how to approach disability⁸⁸ and simply cited the World Health Organisation definition of disability as:

an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a *problem in body function or structure*; an activity limitation is a difficulty *encountered by an individual* in executing a task or action; while a participation restriction is a *problem experienced by an individual* in involvement in life situations. Disability is thus *not just a health problem*. It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives.⁸⁹

This definition focuses on disability as an individual medical deficit, because even though it recognises the impact of 'features of the society', it ultimately still defines impairment itself as a 'problem in body function or structure' and hence disability is at its core an inherent and embodied individual trait. While the Senate Committee did go on in subsequent pages to discuss various 'stereotypes' encountered by people with disability in relation to sexuality, parenting and menstruation,⁹⁰ there was no attempt to relate these stereotypes to the conceptualisation of disability and hence to challenge at a fundamental level the definition of disability that governs the legal framework for sterilisation. As will become apparent below, the Senate Committee's medical approach to disability was fatal to its failure to disrupt the legal division of subjects on the basis of mental capacity and the ultimate retention of court authorised sterilisation *as a realisation of human rights*.⁹¹

B Retention of Court Authorised Sterilisation

The Senate Committee decided that the system of court authorised sterilisation should be retained. In doing so, the Senate Committee preferred a human rights approach focused on procedural protection (reflecting the mental incapacity human rights approach) and thus overlooked the *end result* of this legal process – the discrimination and violence embedded in the *act* of sterilisation itself.

Following from the retention of the medical approach to disability, the Senate Committee did not disrupt the division on the basis of mental capacity which is at the core of the majority's reasoning in *Marion's Case*. The Senate Committee accepted as self-evident that people with disability with mental incapacity should be subject to different legal thresholds in relation to consent (ie, substituted decision-making) and instead focused on making sure that people with disability who had mental capacity were not wrongly attributed mental incapacity. The Senate Committee was of the view that court authorised sterilisation is contrary to human rights *only* if the individual has mental capacity (again overlooking the

88 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 4–5 [1.16]–[1.20].

89 *Ibid* 4 [1.16] (emphasis added).

90 *Ibid* 15–48 [2.1]–[2.114].

91 See Parker who foreshadowed the need for the Senate Committee to engage with conceptual issues: Parker, above n 3, 527.

fact that in light of the *CRPD* it is *denial* of legal capacity itself that is a core human rights issue):

Failure to determine capacity strips persons with disabilities of their equality before the law. It perpetuates myths and stereotypes. ... There is *no place for substituted decision-making* in Australia without *first* determining that the person is *without the capacity* to decide for themselves. ...

In those cases where there is not capacity for consent, and no reasonable prospect that it may develop, laws and procedures may permit the sterilisation of persons with disabilities, but the circumstances in which this may occur must be narrowly circumscribed, and based on the protection and advancement of the rights of the person. ... In undertaking is [sic] review, the committee has as its objective the defence of the rights of persons with disabilities.⁹²

This illustrates that the Senate Committee works *within* rather than disrupts the division of legal subjects by reference to mental capacity as was set out in *Marion's Case*. This division is central to the Senate Committee's subsequent consideration of the significance to sterilisation of equality and non-discrimination.

In considering the issue of regulation and prohibition, the Senate Committee recognised competing approaches to human rights (along the lines discussed in Part III above).⁹³ Ultimately, the Senate Committee was particularly persuaded by the arguments reflecting the mental incapacity human rights approach.⁹⁴ In support of this approach, the Senate Committee quoted a submission by Dr Wendy Bonython which identified the right to dignity and quality of life.⁹⁵ The submissions reflecting the mental incapacity human rights approach clearly overlook the centrality of non-discrimination and equality which is at the core of the Disability Convention's approach to sterilisation, as discussed earlier in Part III(B)(2). As discussed above, while no one human right should be privileged, the interconnectedness of human rights and the importance of equality to the realisation of all human rights were overlooked.

The Senate Committee also considered the discrimination arguments about sterilisation, noting the polarisation of opinions on this point.⁹⁶ The Senate Committee quoted the Adult Guardian of Queensland and the Public Advocate of Queensland who argued that it would be discriminatory to *deny* the option of sterilisation to women and girls with disability where it is available to women and girls without disability.⁹⁷

92 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 95 [4.39], 96 [4.45] (emphasis added).

93 *Ibid* 83 [4.1].

94 *Ibid* 94–5 [4.36]–[4.39], 96 [4.43]–[4.44].

95 *Ibid* 90 [4.22].

96 *Ibid* 92–3 [4.31].

97 *Ibid* 93 [4.32].

Preventing discrimination is as much about allowing people with disabilities the right to decide between the same range of options that are available to people who do not have a disability as it is about ensuring that people with disability are not forced to undergo procedures that would not be applied to a person without disability where all other circumstances are equal. ... In accordance with this approach, if society and the law allow a Queensland adult without disability to undergo a medical sterilisation procedure by a medical practitioner, then adults with disability, including those with impaired decision-making capacity, should be afforded the same entitlement.

Unfortunately this approach held sway with the Senate Committee which concluded that it would be discriminatory to prohibit non-therapeutic sterilisation. Ultimately for a number of reasons this approach is problematic in arguing that women and girls with disability *need* sterilisation in order to be equal to women and girls without disability. First, it is important to pause here to note the vacuity of referring to the act of sterilisation as a ‘medical procedure’ – there is no recognition of the differential purpose or end to which sterilisation might be put vis-à-vis women and girls with and without disability, nor of the historical use of medical treatment as violence against people with disability (and, indeed, other marginalised groups such as women of racial and ethnic minorities, Indigenous women and poor women). Moreover, the reasons and timing of sterilisation of women and girls with disability (ie, prior to having any children or reaching a childbearing age, plus to address menstruation⁹⁸) means that it is not the *same* as for women without disability (eg, as a contraceptive following sufficient children or as following a life decision not to have any children) and never considered for girls without disability (and this is confirmed by the Senate Committee’s earlier discussion of stereotypes about disability, gender and sexuality/parenting). Further, court authorised sterilisation is non-therapeutic so not concerned with denying life-saving medical treatment to women or girls with disability, thus rendering the pervasive medical equality rationale problematic and obfuscating. The second respect is that court authorised sterilisation is *never* equal because there is a *different* person consenting – it is fundamentally unequal because for women and girls with disability they are not themselves given the opportunity of consenting. Following the *CRPD* this differentiation in consent simply cannot be sustained because it rests on a divide on the basis of mental capacity which itself is a source of inequality, an inequality which is then further compounded by the decisions that are enabled by virtue of this division. The *CRPD* makes *absolutely clear* that legal capacity is for all and denial of legal capacity on the basis of disability or mental incapacity is discrimination.⁹⁹

The Senate Committee stated:

The views of United Nations committees and officials, as conveyed by submitters to the inquiry, clearly articulate the need to eliminate discrimination. Some members of the international community indicated that there is no place for sterilisation to occur without the consent of persons concerned. However, as many submitters to this inquiry recognised, direction from the international community about how best to support persons without capacity to consent is not clear. ... supported decision-making is not only appropriate but is necessary to support the dignity and rights of persons with disabilities. The committee expects that, with appropriate supported decision-making, there will be very few Australians who altogether lack decision-making capacity. However, the rights of persons without

98 On the issue of temporality see generally Alison Kafer, *Feminist, Queer, Crip* (Indiana University Press, 2013) 48–9, 53–7.

99 Arguably (and to be facetious) to make it ‘equal’ on the basis argued by the Adult Guardian of Queensland and the Public Advocate of Queensland, above n 87, perhaps third party consent to sterilisation should be available *for all* regardless of disability whenever a third party can successfully argue it would be in the individual’s best interests.

decision-making capacity are no less valuable and no less valid. The rights of this minority require support and defence.¹⁰⁰

So, the Senate Committee was of the view that court authorised sterilisation and the denial of legal capacity brings about 'equality'. Moreover, they suggested that equality (in the sense understood in international human rights law discussed in Part III(B)(2)) is not very relevant because this would homogenise people with disability and in turn remove their dignity:

An outright ban of non-therapeutic sterilisation procedures without consent potentially denies the rights of persons with disabilities to access all available medical support on an equal basis with persons without a disability. It is a 'one size fits all' solution to a complex problem. An outright ban removes the focus from the needs and interests of the individual, placing it instead on generic notions of what is best for persons with disabilities as an homogenous group. On balance, the committee does not agree that Australia's laws, including relevant court and tribunal procedures, should be unable to consider the circumstances of individuals. Flexibility in strictly limited circumstances may help to ensure that all appropriate support is provided to people with a disability.¹⁰¹

This resort to anti-homogeneity as a human rights issue for people with disability is peculiar. This conveys the idea of people with disability as abnormal and outside full humanness. All people without a disability are perfectly capable of being 'homogenised' in a category in order to be viewed as equals for the purposes of comparison in the context of discrimination law. In contrast, rather than including people with disability as members of this common humanity (even in the face of their individual characteristics of human variation) the Senate Committee paints equality as negatively 'homogenising' in removing their differences (even though these very differences are the basis for their discrimination and sterilisation). As I will discuss further below, this approach constructs people with disability as incapable of comparison for discrimination purposes.

In understanding the 'logic' of the Senate Committee retaining court authorised sterilisation specifically for women and girls with disability on the basis of a mental capacity/incapacity divide by reference to the *CRPD* but clearly reflecting the earlier mental incapacity human rights approach, it is important to contextualise the Committee's recommendations in its broader approach to the *CRPD*. The Senate Committee was at pains to consider each mention of sterilisation in international human rights law and in light of Australia's international law obligations. Yet, this approach is narrowly concerned with obligations (particularly in light of Australia's interpretive declaration), rather than the cultural prism that the Convention provided (as was discussed in Part II above). As such the Senate Committee failed to consider how the cultural shift in approach to disability in the Convention provides a (realisable) ethical and legal ideal for the treatment of people with disability instead of being restricted to law's current proscription in relation to disability. This resulted in a rather self-referential approach to law reform which viewed current laws (in the sense of

100 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 94 [4.36].

101 *Ibid* 94 [4.37].

domestic capacity-based legal contouring and ordering, and international legal obligations) as setting the limits to the reformed possibilities, rather than thinking *beyond* the laws, particularly where these current laws are oppressive.¹⁰² So, for example, the Committee could have decided that *even if* substituted decision-making were to remain, some decisions about people's bodies and lives – such as the decision to sterilise someone else – are *beyond* the reach of substituted decision-making. Moreover, the focus on article 12 and reduction of the issue to substituted versus supported decision-making did not sufficiently consider the relationship *between* article 12 and other articles of the *CRPD*. Considering legal capacity in relation to other articles would have shifted the focus away from the technical and institutional dimensions of legal capacity and towards the substance of decisions about legal capacity (eg, in this case the violence inherent in sterilisation). In focusing on the fairness of court authorisation procedure, the Senate Committee overlooked the issue that, regardless of whether substituted decision-making is contrary to human rights, there is a discriminatory outcome (and a violence in the outcome) of sterilising women and girls with disability.

C The Test for Court Authorised Sterilisation: From 'Best Interests' to 'Best Protection of Rights'

Having established that court authorised sterilisation should continue, the Senate Committee then considered whether the existing 'best interests' test for regulating court authorisation was sufficient. The Senate Committee accepted 'the evidence that was provided by many submitters showing that, as currently applied, "best interests" tests are currently at risk of "a slewed interpretation"'.¹⁰³ While this is positive because of the longstanding disability rights critique of the best interests test by reference to the discriminatory ideas it reflects, it elides the discrimination in the legal capacity divide *itself*, which creates the space for substituted decision-making of women and girls without mental capacity, within which the best interests test is located.

The Senate Committee recommended replacing the 'best interests' test with a 'best protection of rights' test.¹⁰⁴ The 'best protection of rights' test would focus on authorising sterilisation where this enables the '[p]rotection of their rights', '[m]aximising [of] future options and choices' and allows '[d]ecisions to be made on the basis of the best support services available'.¹⁰⁵ In recommending the 'best protection of rights' test, the Senate Committee rejected the relevance of

102 This might in part be due to the fact that one of the terms of reference was to ask whether existing laws meet current international obligations.

103 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 130 [5.119].

104 It is interesting to note that the proposed test overlaps with the Australian Law Reform Commission's ('ALRC') recommended proposed test for supported decision-making in its recent report on legal capacity. According to the ALRC, if an individual's will and preference cannot be determined, then protection of 'rights' should guide decision-making: Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 75–85 [3.50]–[3.91]. I thank Fleur Beaupert for pointing this out.

105 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 130 [5.121].

discrimination both in its own right as the ‘but for’ test or as a dimension of the proposed ‘best protection of rights’ test.¹⁰⁶ The Committee was particularly persuaded by the submission against the ‘but for’ test made by the Chief Justice of the Family Court, citing *P v P*.¹⁰⁷ The Committee stated:

*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.*¹⁰⁸

Thus, curiously, court authorised sterilisation is not removed (contra the current international human rights approach that all should be prohibited) *but* will be authorised *only* where it will protect human rights (but not in relation to the right to non-discrimination which is central to the realisation of *all* human rights of people with disability). The Senate Committee’s reasoning is derived from the judicial decision in *P v P* in which the court considered that children with disability cannot be compared to children without disability. Thus, in order to analyse the status of non-discrimination in the ‘best protection of rights’ it is necessary to briefly return to *P v P*.

1 P v P and the Incomprehensibility of Violence

To recap, *Marion’s Case* held that the paramount consideration is always the best interests of the child. *P v P* built on this legal framework in holding that in determining what constitutes a girl’s best interests this *cannot* include consideration of non-discrimination. How was discrimination not relevant to the Family Court’s authorisation of parental consent? The Court’s logic involved it being impossible to remove from Lessli the characteristic of her intellectual disability in order to determine whether she would still be sterilised without her disability. The core and necessary question of any discrimination inquiry – would this sterilisation be conducted if this individual was not disabled – could not be answered here because there was no way to comprehend Lessli existing as ‘Lessli’ without the disability. Children with disability could not be compared to children without disability because the Court saw disability as not being an isolatable factor that could be removed from the girl for the purposes of determining discrimination. Rather, the disability was inherent to and synonymous with the individual. This reflects the individualised, medical model of disability introduced above when discussing the mental incapacity human rights approach, rather than viewing disability as a systemic, social or political problem. Rendering Lessli beyond comparison and sterilisation a-discriminatory involved two stages.

106 Ibid 130–1 [5.118]–[5.127].

107 Ibid 127 [5.106].

108 Ibid 131 [5.124] (emphasis added).

First, the Court referred to disability as an ‘immutable characteristic’ and explained that her intellectual disability could not be ‘isolated as a factor and then “subtracted” from the constellation of facts about her’.¹⁰⁹ All of the factors of Lessli – her intellectual disability, epilepsy, fertility and gender – were ‘interactive and cumulative and it is their combined presence in the child which has led to the application before the Court’.¹¹⁰ Through characterising Lessli’s disability (and its relationship to herself) in this way, the Court naturalises disability as an internal quality of Lessli (as opposed to a social or cultural phenomenon) – her disability is an individual, medical characteristic which is the responsibility of the individual and beyond human control and social challenge.¹¹¹ More than this, the Court constructed disability as inherent to and synonymous with the individual: a ‘synecdoche’ for the individual.¹¹² This conflation of the characteristic of disability with the very existence of the person is readily the case in relation to intellectual disability by reason of the pervasiveness in culture, and specifically in law, of the Cartesian split of mind and body – where the mind and the brain are core to what defines humans as a thinking and feeling (and legally responsible) species.¹¹³ The production of disability as an immutable feature of the individual also negates the role of law (and specifically the Family Court’s welfare jurisdiction) in constituting the abnormal legal subject,¹¹⁴ a point returned to below. Moreover, any discriminatory treatment of the individual is not a systemic social or political problem – instead it ‘just is’ by reason of the individual’s natural makeup.

The second stage of the reasoning in *P v P* is to identify intellectually disabled girls as not merely unequal but fundamentally *different* from other girls. Viewing girls with and without intellectual disability as the converse of each other is at odds with the very notion of discrimination which is premised on the fundamental equality of all humans – here there is no common ground to enable discrimination comparison. Girls without intellectual disability are referred to in the judgement as ‘intellectually *normal*’¹¹⁵ girls and Lessli is juxtaposed to this category. This location of Lessli as outside the category of ‘normal’ girls can be understood as constructing her as ‘abnormal’ in the meaning of critical disability studies. There is little discussion of Lessli’s intellectual or cognitive incapacities in a narrow sense, but rather the discussion focuses on the broader, applied contexts of her ability to meet gender and sexual norms of mothering, marriage,

109 *P v P* (1995) 126 FLR 245, 266 (The Court).

110 *Ibid.*

111 Dean Spade, *Normal Life: Administrative Violence, Critical Trans Politics, and the Limits of Law* (South End Press, 2011) 58.

112 Mills, above n 50, n 48.

113 Ngaire Naffine, *Law’s Meaning of Life: Philosophy, Religion, Darwin and the Legal Person* (Hart Publishing, 2009) 81–98. For a similar point in the context of human rights, see Quinn and Arstein-Kerslake, above n 58, 41.

114 See a similar point made by O’Connell in the context of stigmatisation: Karen O’Connell, ‘The Clean and Proper Body: Genetics, Stigma and Disability Discrimination Laws’ (2009) 14 *Australian Journal of Human Rights* 139, 145.

115 *P v P* (1995) 126 FLR 245, 260, 264–6 (The Court) (emphasis added).

having children in marriage and self-managing her fertility, menstruation and sexuality.¹¹⁶ The Court states:

The responsibility to assess the child's best interests is not furthered by compartmentalising one or more of her attributes and measuring the appropriateness of the proposed treatment *against a hypothetical child*. ...

If applied literally the test would mean that sterilisation could never be authorised other than for therapeutic medical reasons, because one would never contemplate the sterilisation of an *intellectually normal* 17-year-old other than for such reasons.

This is readily explicable upon the basis that an *intellectually normal* 17-year-old female, albeit suffering from epilepsy, can reasonably contemplate the likelihood that she may wish to engage in sexual intercourse for the purpose of having a child or children at any time during the next 35 years of her life, more commonly than not in the context of a marriage or like relationship and to raise and nurture such child or children. Further, she can consider and on advice decide upon the best method of contraception for her and to take or not to take contraceptives as she sees fit and to decide whether or not to have sexual intercourse as she sees fit. Finally, she can decide upon her own sterilisation, if not at the age of 17, at a time when she either decides as a mature adult that she does not wish to have a child or at a time when she does not wish to have further children.

None of these considerations apply to a child like Lessli.¹¹⁷

Central to the production of girls with intellectual disability as abnormal is the language which is used to describe their abnormality and the visceral aesthetics (in a broad sensorial meaning) of abnormality. The particular norms of ability, sexuality and gender that Lessli deviates from are centred on management of bodily boundaries, notably control of the visibility of menstrual blood because, for example, Lessli fails to wear or change pads to absorb the blood and has blood evident on her clothing.¹¹⁸ The descriptions of Lessli's menstruation are not balanced by descriptions of ideal menstrual management, hygiene and emotional response. In the context of anti-discrimination law, Karen O'Connell states that anti-discrimination legislation concerns 'questions of embodiment and materiality in often intimate detail'¹¹⁹ yet this intimate detail is restricted to the bodies of the abnormal whereas the normal female remains completely abstract and objective and devoid of any material content or identity.¹²⁰ One implication of this is that 'focusing on the body can limit the capacity to see the social and political construction of disability by returning to an idea of fixed and immutable impairment residing in the individual'.¹²¹ Moreover, the cultural representation of disability as abnormal, defective, useless and wasteful (here done by the visceral

116 Steele, 'Disability, Abnormality and Criminal Law', above n 20.

117 *P v P* (1995) 126 FLR 245, 266–7 (The Court) (emphasis added).

118 Steele, 'Disability, Abnormality and Criminal Law', above n 20, 478–81.

119 O'Connell, 'The Clean and Proper Body', above n 114, 143.

120 *Ibid* 144. See also Karen O'Connell, 'From Black Box to "Open" Brain: Law, Neuroimaging and Disability Discrimination' (2011) 20 *Griffith Law Review* 883, 894.

121 Isabel Karpin and Karen O'Connell, 'Stigmatising the "Normal": The Legal Regulation of Behaviour as a Disability' (2015) 38 *University of New South Wales Law Journal* 1461, 1481.

depictions of gendered bodily fluid) creates an opening for the greater permissibility of violence against the disabled body.¹²²

Through locating Lessli outside the category of ‘normal’ girls, it follows that abnormal girls with intellectual disability are not different in *degree* but different in *kind* – the converse of each other. The legal construction of girls with intellectual disability as the abnormal, binary opposite of able, ‘normal’ girls (both through the earlier recognition of incapacity and court authorised sterilisation, and here through the test for court authorisation) means that there is no common self or common body to enable this comparison at the centre of any discrimination inquiry. The construction of Lessli as abnormal necessitates placing girls with intellectual disability outside of full humanness and hence in a different category of human rights and subject to a different rights threshold.

On the basis of her abnormality as a result of her inherent disability, Lessli, and all girls with intellectual disability who deviate from norms of ability, gender and sexuality, are beyond comparison to ‘normal’ girls and on this basis discrimination through their sterilisation is incomprehensible. Whereas it is comprehensible that sterilisation on the basis of race or religion is discriminatory, it is impossible for girls with disability to be discriminated against when they are sterilised, thus reflecting Nussbaum’s point of disability as one of the last bastions of legitimate discrimination.¹²³ It also reflects comments made in the context of Australian anti-discrimination law by Margaret Thornton about the hollowness of equality vis-à-vis intellectual disability.¹²⁴ Therefore, sterilisation in relation to this group of individuals is ‘a-discriminatory’ (that is, sterilisation exists outside of discrimination).

122 See, eg. Linda Steele, ‘Policing Normalcy: Sexual Violence against Women Offenders with Disability’ (2017) (forthcoming) *Continuum*. See also Chris Chapman, ‘Five Centuries’ Material Reforms and Ethical Reformulations of Social Elimination’ in Liat Ben-Moshe, Chris Chapman and Allison C Carey (eds), *Disability Incarcerated: Imprisonment and Disability in the United States and Canada* (Palgrave Macmillan, 2014) 25, 35–6, 39–40; Nirmala Erevelles, *Disability and Difference in Global Contexts: Enabling a Transformative Body Politic* (Palgrave Macmillan, 2011) 95–120; Rosemarie Garland-Thomson, ‘Integrating Disability, Transforming Feminist Theory’ in Kim Q Hall (ed), *Feminist Disability Studies* (Indiana University Press, 2011) 13, 21, 26; Tanya Titchkosky, *Reading and Writing Disability Differently: The Textured Life of Embodiment* (University of Toronto Press, 2007) 108, 123.

123 ‘No group in society has been so painfully stigmatized as people with physical and mental disabilities. Moreover, many people who would wholeheartedly oppose all stigmatization based on race or sex or sexual orientation feel that some sort of differential treatment is appropriate for those who are different “by nature”’: Martha C Nussbaum, *Hiding From Humanity: Disgust, Shame, and the Law* (Princeton University Press, 2004) 305.

124 Margaret Thornton, *The Liberal Promise: Anti-Discrimination Legislation in Australia* (Oxford University Press, 1990) 21–2:

While traits such as physical impairment must be measured against physical normalcy, the grounds of race and sex are expressed in neutral and undefined terms which require the construction of a benchmark from a particular fact situation. For example, a person belonging to a particular racial group can complain of less favourable treatment *vis-à-vis* any or all other racial groups. ... Perhaps, the ground of intellectual impairment illustrates even more graphically the hollowness of the equality prescript as realised in omnibus legislation for, apart from the vexatious definitional problem inherent in ‘intellectual impairment’, there is virtually no way that the intellectually impaired and the intellectually normal can ever be said to be similarly situated in respect of either employment or education, for example, particularly in view of the pre-eminence accorded merit. In this context, equality of opportunity is totally meaningless.

The construction of Lessli as abnormal in *P v P* not only has important relational effects in placing Lessli beyond comparison. The exclusion of Lessli from full humanness and a community of equal humans also has important legal spatial effects in separating Lessli from ‘normal’ girls, resulting in a legal boundary between abnormal and normal legal subjects and the carving out for girls with intellectual disability a separate legal space of legality and legitimacy (beyond the reach of discrimination law).¹²⁵ Thus in *P v P* the non-application of discrimination law carves out a separate legal space for women with disability and in turn a separate category of legal subjects in relation to whom there is a different legal standard of permissible violence – a standard which is related to their abnormality. The focus on management of abnormality in turn means that the different treatment by reason of the legal framework of court authorised sterilisation is not *detrimental*, it is beneficial. This is reflected in the Court’s rejection of the ‘but for’ test:

One of the significant limitations of a discrimination approach is that some form of comparison is necessarily implied between the individual complainant and other persons who are similarly situated save for the characteristic which, it is claimed, leads to discrimination. ...

The favoured legal model is founded on the strict formal equality approach which values *treating likes alike, and unlikes differently*. ...

However, even in this area it is important to note that to come to a conclusion that, but for a certain factor, an individual would or would not have been treated in a particular way, is not the same as a finding that the result is discriminatory. Not all distinctions give rise to detrimental treatment. ...

[W]e do not think that the ‘but for’ test commonly applied in discrimination cases can be readily transplanted into this Court’s welfare jurisdiction. In cases such as Lessli’s, it is precisely because a distinction is drawn between the child in question and others in the community by a party claiming that the proposed treatment is to the child’s benefit that the matter falls to be decided under the protective jurisdiction of the Court. ... *The key issue than becomes whether a proposed treatment is a benefit or a burden having regard to that individual child’s circumstances.*¹²⁶

The girl who is the subject of this test is an ‘abnormal’ disabled girl, such that the ‘best interests’ test more specifically is: what is in the best interests of an abnormal child who is outside of social norms of sexuality, reproduction and mothering. The identity of the ‘child’ to whom the best interests test applies is contoured by reason of the non-application of discrimination, rather than merely the application of the best interests test reflecting discriminatory ideas. Moreover,

125 O’Connell, ‘The Clean and Proper Body’, above n 114, 146. O’Connell suggests that the legal inscription of the absolute boundary between normal and abnormal is itself a violent act of exclusion: Karen O’Connell, ‘The Devouring: Genetics, Abjection, and the Limits of Law’ in Margrit Shildrick and Roxanne Mykitiuk (eds), *Ethics of the Body: Postconventional Challenges* (MIT Press, 2005) 217, 228. For slightly different takes on a similar spatial conceptualisation see Vera Chouinard, ‘Legal Peripheries: Struggles over DisAbled Canadians’ Places in Law, Society and Space’ (2001) 45 *Canadian Geographer* 187; Roxanne Mykitiuk and Ena Chadha, ‘Sites of Exclusion: Disabled Women’s Sexual, Reproductive and Parenting Rights’ in Marcia H Rioux, Lee Ann Bassar and Melinda Jones (eds), *Critical Perspectives on Human Rights and Disability Law* (Martinus Nijhoff Publishers, 2011) 157.

126 *P v P* (1995) 126 FLR 245, 267–8 (The Court) (emphasis added).

sterilisation becomes beneficial and protective, in a manner that is arguably ‘unintended discrimination’ as per the discussion in Part III(B)(2).

Thus, four points follow from *P v P*. The first is women and girls with disability are legally constructed as abnormal and beyond comparison with ‘normal’, able individuals through their preliminary division on the basis of capacity in the system of court authorised sterilisation per se, and then in the test for court authorisation. The second point is that comparison between abnormal/disabled subjects of court authorised sterilisation and normal/able females is therefore impossible. Third, discrimination (which necessarily requires comparison between groups to ascertain inequality of treatment) is *incomprehensible* in relation to abnormal/disabled girls. The fourth point is that discrimination has been *excluded* from the legal framework of sterilisation and in turn the disabled female legal subjects of court authorised sterilisation applications exist *outside* of discrimination and in a separate legal space subject to different standards concerning the legality and legitimacy of sterilisation.

While *P v P* excluded the right to non-discrimination in the context of the best interests test, the Senate Committee went one step further and excluded this right in the context of a test purportedly about protecting human rights: the ‘best protection of rights’ test.

2 *Senate Report: Human Rights Are Best Protected through Violence*

The Senate Committee adopted the submission of the Chief Justice of the Family Court of Australia in *following* rather than *critiquing* the reasoning in *P v P* concerning the relevance of non-discrimination to the test for court authorisation of sterilisation, and this rests on the core failure of the Senate Committee to critique a medical approach to disability and the related mental capacity/incapacity divide. The Committee focused on the idea of disability as inseparable from the self as the basis for the incomprehensibility of discrimination (as demonstrated in the reference to disability being incapable of being ‘treated as an isolated feature of a person, which may be conceptually separated from the rest of their being’¹²⁷). Curiously, the Committee argued that non-discrimination would result in disability being treated as abnormality and this was not the best way to protect equality (‘a “but for” test requires life without disability to be taken as the ‘norm’, and disability is then defined as deviance from that norm’¹²⁸) rather than appreciating that it is the inapplicability of discrimination that is caused by and itself produces abnormality:

the committee agreed with the Full Court of the Family Court, that a ‘but for’ test should not be adopted by courts and tribunals. ... 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

127 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 131 [5.124].

128 *Ibid.*

the committee believes that a best protection of rights test, underpinned by a strong understanding and protection of equal rights, is the better approach.¹²⁹

What sets the Committee's approach apart from *P v P* is the simultaneous adoption of a rights-based test and a rejection of the relevance of discrimination to this test. But how can a test protect human rights but not the right of equality and non-discrimination? On closer examination, the 'rights' which the 'best protection of rights' test embodies are the rights of girls with intellectual disability as an *abnormal* and *unequal* group of individuals – in the vein of the pre-CRPD mental incapacity human rights approach.¹³⁰ The focus in the 'best protection of rights' test is medical rights. This is reflected in the Committee's explanation of this test:

whether an action represents the best available protection and fulfilment of a person's rights ... 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.¹³¹

Essentially, the Senate Committee's approach is about rights to access medical treatment, rather than the broader and interdependent conception of rights in the CRPD. The Committee's emphasis on rights to access medical treatment constructs the rights of the girls as strictly medical beings (contrary to the meaning of disability promoted in the CRPD and reflecting the earlier mental incapacity human rights approach to human rights for people with disability). Further, the focus is on women and girls with disability as *abnormal* medical beings by suggesting that sterilisation is what protects quality of life rather than sterilisation being seen as a violent denigration of quality of life (if sterilisation is de-medicalised and framed as an act of violence, through the application of the 'best protection of rights' test girls with intellectual disability have the right to access violence¹³²). Moreover, the Senate Committee's approach overlooks that the physical and mental effects of sterilisation are themselves further disabling – thus creating greater inequality and further limitations to meeting social norms and realising the lifestyles and life courses of women without disability.¹³³

The rights implicated in the best protection of rights test are heavily gendered – the 'right' to be a 'functional' woman trumps core rights to equality and non-discrimination. Other rights implicit in the 'best protection of rights' test (in light of the discussions in the report as a whole) include those related to inclusion in

129 Ibid.

130 See also John Tobin and Elliot Luke, 'The Involuntary, Non-Therapeutic Sterilisation of Women and Girls with an Intellectual Disability – Can It Ever Be Justified?' (2013) 3 *Victoria University Law and Justice Journal* 27.

131 Senate Community Affairs References Committee, *Involuntary or Coerced Sterilisation*, above n 3, 130 [5.120] (emphasis added).

132 See generally Marcia H Rioux and Lora Patton, 'Beyond Legal Smoke Screens: Applying a Human Rights Analysis to Sterilization Jurisprudence' in Marcia H Rioux, Lee Ann Bassler and Melinda Jones (eds), *Critical Perspectives on Human Rights and Disability Law* (Martinus Nijhoff Publishers, 2011) 243, 243.

133 In a different context, see the idea of 'emergent disability': Beth Ribet, 'Naming Prison Rape as Disablement: A Critical Analysis of the *Prison Litigation Reform Act*, the *Americans with Disabilities Act*, and the Imperatives of Survivor-Oriented Advocacy' (2010) 17 *Virginia Journal of Social Policy and the Law* 281.

society (including participation in work and being cared for by family), avoiding institutionalisation, and general wellbeing in not being distressed by menstruation or vulnerable to pregnancy through sexual assault. Through the delineation of rights in the test, individuals not only become medicalised but become very *functional* beings whose quality of day-to-day life is seen as trumping the core right of non-discrimination and consequently any sense of political, legal and social equality is trivialised. What has no function goes and what is needed to function (in a very narrow sense) is changed. This is heavily gendered. Reproductive organs and processes are reduced to function – if they will not be used in a very narrow sense then they are not needed – and they have no role in the broader identity of females.¹³⁴ The ‘rights’ reflected are those which *suppress* the physical manifestations of abnormality but fall short of *transforming* the individual into a ‘normal’ individual – instead they mimic some aspects of ‘normal’ life but not core aspects of ‘normal’ female gender because through sterilisation girls with intellectual disability are prevented from menstruating and having children. The ‘best protection of rights’ test maintains the divide between normality and abnormality.¹³⁵

The concept of discrimination constructs individuals as fundamentally equal and hence as belonging to a shared community. It does not posit an outside, but rather assumes an all-encompassing inside: a common humanity. The difficulty then in placing women and girls with disability as beyond the realm of discrimination is that it is a way in which they are legally constructed not only as unequal but in turn as excluded from shared community. The material effects of this are evident in the implications that sterilisation has on exclusion from a number of life processes and experiences, but culturally it is also apparent through the legal discourse of saying they are unequal. Ultimately, the ‘best protection of rights’ test results in the perverse situation where sterilisation, which pursuant to the *CRPD* is an act of violence and discrimination, is the means by which the rights to a non-sexual and ‘functional’ ‘inclusion’ and ‘quality of life’ can be realised at the same time that the sterilised girls are denied the right to equality and non-discrimination.¹³⁶ On a broader level this approach reflects a disappointing regression from the *CRPD* to a separate system of human rights for people with disability reflective of the earlier mental incapacity human rights approach.

134 This is reminiscent of the comment in *P v P*:

We note the Family Law Council’s reference to a supposed inconsistency of approach to menstruation in comparison to other bodily functions such as urinary and faecal control ... We regard this as an invalid comparison since the latter are necessary to maintain life and it could not be seriously suggested that colostomies are an appropriate alternative. Menstruation on the other hand has particular relevance to reproductive functions, but not to the maintenance of life.

(1995) 126 FLR 245, 269 (The Court).

135 O’Connell, ‘The Clean and Proper Body’, above n 114, 146.

136 See, eg. Laura H Norton, ‘Neutering the Transgendered: Human Rights and Japan’s Law No 111’ (2006) VII *Georgetown Journal of Gender and the Law* 187. I thank Susan Stryker for alerting me to this point.

V CONCLUSION

In *Foucault and the Politics of Rights*, Ben Golder suggests that human rights can be used strategically, but there is always the risk that they can result in further discipline of (and violence on) human rights subjects.¹³⁷ This is evident in the context of this article's analysis of the Senate Committee's 'human rights' approach to sterilisation where, despite the cultural shifts of the *CRPD*, ultimately women and girls with disability by reason of their abnormality are not included in full humanness and full community, and hence are not subject to the same human rights thresholds as women and girls without disability in being exposed to state-sanctioned discrimination and violence in the form of court authorised sterilisation. Moreover, the insistence that sterilisation *can be* the means for the realisation of the human rights of disabled women and girls is a perspective based on a narrow conception of human rights for two reasons. First, this perspective already excludes equality and non-discrimination. Second, this perspective focuses on particular rights – the right to health, to be in the community – which implicitly assume a certain mode of human flourishing and being that retains and, indeed, exacerbates their difference, inequality and separateness and in turn further disables them via discrimination and violence.

The Senate Committee's recommendations mark a worrying consolidation of the lawful violence done to women and girls with disability through court authorised sterilisation because no longer is sterilisation merely necessary for the protection of the individual, but is now necessary for their protection as a rights-bearing citizen. This shift demonstrates the risk (typically discussed in the larger-scaled geopolitical contexts of international development and international humanitarian interventions) that rights discourse can be subsumed into a humanitarianism that mobilises violence against people with disability (or violence that disables) masked as benevolence.¹³⁸ As such, this article has not only shown the fundamental problems with the current human rights approach to sterilisation, it has also begun to map some of the complex cultural co-constructions in international human rights law of disability, humanity and violence and shown how these have legal impacts on domestic law reform and very material impacts on the bodies of women and girls with disability. Yet, my analysis suggests that it is not human rights per se which is problematic, but rather one's approach to human rights *and* to disability.¹³⁹ Mindful of Golder's suggestion that human rights *can* be of strategic value, my analysis suggests that engagement with human rights by disability rights advocates in the course of participating in domestic law reform might extend to engagement with the

137 Ben Golder, *Foucault and the Politics of Rights* (Stanford University Press, 2015) 89–147.

138 See, eg. Maria Berghs, 'The New Humanitarianism: Neoliberalism, Poverty and the Creation of Disability' in Michael Gill and Cathy J Schlund-Vials (eds), *Disability, Human Rights and the Limits of Humanitarianism* (Ashgate, 2014) 27; Eunjung Kim, 'The Specter of Vulnerability and Disabled Bodies in Protest' in Michael Gill and Cathy J Schlund-Vials (eds), *Disability, Human Rights and the Limits of Humanitarianism* (Ashgate, 2014) 137; Meekosha and Soldatic, above n 10.

139 See a similar observation by Rioux and Patton in their comparative analysis of legal approaches to human rights and sterilisation across three jurisdictions: Rioux and Patton, above n 132, 262.

intersection of the cultural and the material dimensions of law, disability and violence. My analysis has shown that this intersection is a vital site for the continued legality and legitimacy of violence against women and girls with disability.¹⁴⁰

In its recent report into disability violence, the Senate Community Affairs Reference Committee in a welcome and surprising turn has recognised disability-specific interventions as capable of being understood as violence against people with disability.¹⁴¹ Building on the momentum of this report (and mindful of its worrying failure to explicitly name sterilisation as violence), it is timely to demand that the Australian government recognise court authorised sterilisation against women and girls with disability as a human rights violation. This is becoming increasingly necessary by reason of the enhanced focus on violence against people with disability as a public policy issue, as seen in the questions around redress and reparations in the Royal Commission into Institutional Responses to Child Sexual Abuse¹⁴² and the discussion on safeguarding provisions of the National Disability Insurance Scheme, as well as the persistent invisibility of violence against women with disability (particularly lawful violence) in mainstream public discussion on violence against women generally.¹⁴³ Yet, discussion should not stop at prospective matters of prohibiting and making legally actionable future instances of sterilisation, but additionally extend to developing a system to recognise, remedy and remember past instances of sterilisation when they were still lawful.¹⁴⁴ This might involve thinking about how law (both international and domestic legal frameworks) has dealt with mass atrocities, historical injustices and state-sanctioned violence in relation to other marginalised groups (though surprisingly rarely specifically in relation to people with disability as a distinct marginalised group).¹⁴⁵ Whether at a domestic level these demands are met depends on the willingness of law reformers, law makers and the public at large to confront long-held conceptions of disability and to challenge what violence against women and girls with disability we are willing to accept and have the law authorise.

140 On this point, see Golder's earlier work on the significance of the 'discursive' to criminal law reform: Ben Golder, "'It Forced Me to Open More Than I Could Bear': HAD, Paedophilia, and the Discursive Limits of the Male Heterosexual Body' in Andrew T Kenyon and Peter D Rush (eds), *An Aesthetics of Law and Culture: Texts, Images, Screens* (Elsevier, 2004) 53, 68; Ben Golder, 'Rethinking the Subject of Postmodern Feminist Legal Theory: Towards a Feminist Foucaultian Jurisprudence' (2004) 8 *Southern Cross University Law Review* 73, 90–4.

141 Senate Community Affairs References Committee, *Violence, Abuse and Neglect*, above n 13.

142 Royal Commission into Institutional Responses to Child Sexual Abuse, above n 15.

143 See, eg, Steele and Dowse, above n 22.

144 See, eg, Hege Orefellen, 'Hege Orefellen on Reparations' on *Campaign to Support CRPD: Absolute Prohibition of Commitment and Forced Treatment* (6 February 2016) <<https://absoluteprohibition.wordpress.com/2016/02/06/hege-orefellen-on-reparations/>>.

145 See, eg, discussion of 'transitional justice' in Frohmader and Sands, above n 1, 33–4.