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11th March 2013

Ian Holland,

Secretary,

The Senate Standing Committee on Community Affairs

Reference Committee

Parliament House

Canberra. ACT 2600

Dear Mr Holland

I welcome the *Inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia.* Involuntary or coerced sterilisation is a serious breach of fundamental human rights including, but not limited to, the rights to dignity and autonomy, to reproductive freedom and the right to family life. I make this submission based on my professional experience as a legal academic with over 20 years researching, teaching and advocating in the field of human rights, disability and law and from my personal experience as the mother of a 31 year old woman with disabilities.

Summary of Submission

The UN *Convention on the Rights of Persons with Disabilities* [CRPD] obliges States Parties to recognise the multiple discrimination experienced by women and girls with disabilities and requires States to take the necessary measures to ensure that women and girls with disabilities are able to enjoy their human rights and fundamental freedoms (Article 6). The Convention protects the physical integrity of all people with disabilities (Article 17) and their rights to freedom from torture or cruel, inhuman or degrading treatment (Article 15) and freedom form exploitation, violence and abuse. Article 23 sets out the right of people with disabilities to respect for home and family. This includes a right to found a family and to decide on the spacing and number of children. Involuntary and coercive sterilisation of people with disabilities, be they adults or children, breach these fundamental rights.

It is my submission that there should be national legislation prohibiting the sterilisation of all children, whether or not they have a disability, except where there is a serious threat to the life or health of the person concerned. The legislation should also prohibit sterilisation of adults with a disability unless the adult concerned fully and freely consents to the procedure.

The right to equal recognition before the law embodied in Article 12 of the UN *Convention on the Rights of Persons with Disabilities* [CRPD] includes the recognition that people with disabilities enjoy legal capacity on an equal basis with others in all aspects of life and that States Parties have an obligation to provide people with disabilities with access to the support they may require to exercise that legal capacity.

The national legislation should include a provision that enables people with disabilities to access the support they need to exercise their legal capacity to consent to, or to refuse sterilisation procedures.

It is not sufficient, however to prohibit sterilisation, *national legislation should also make it a criminal offense to sterilise a child (whether or not the child has a disability) except where there is a serious threat to life or health or to sterilise an adult with disabilities in the absence of her or his full and free consent. The legislation should also criminalise the removal from Australia of a child (whether or not the child has a disability) or an adult with disabilities with the intention of having a prohibited sterilisation performed.*

Response to Terms of Reference

1. *Some Relevant Human Rights*

There are numerous international human rights instruments that are relevant to this inquiry.[1] These are referred to in the submission of the Australian Human Rights Commission. While these treaties are all important, this submission focuses on the rights set out in the UN *Convention on the Rights of Persons with Disabilities* [CRPD]. This inquiry engages a number of rights and principles in the Convention.[2] Of particular relevance to this submission are the:

- principle of respect for inherent dignity and individual autonomy and independence, including the freedom of the person to make her/his own choices (Article 4);
- right to equality and non-discrimination (Article 5, Article 12.1);
- special position of women (Article 6) and children (Article 7);
- recognition that people with disabilities enjoy legal capacity (Article 12.2) and that States have an obligation to provide access to the support necessary to exercise that legal capacity (Article 12.3)[3];
- right to reproductive freedom - to found a family and to determine the number and spacing of children (Article 23.1) and to retain one's fertility (Article 23.1.c); and
- right to freedom from violence and abuse (Article 16)
- the right to freedom from torture, cruel, inhuman and degrading treatment (Article 17) and

[1] Australia is a signatory to key international human rights treaties and instruments including the *Universal Declaration of Human Rights,* the *International Covenant on Civil and Political Rights*, the *International Covenant on Economic, Social and Cultural Rights*, the UN *Convention on the Elimination of Discrimination Against Women* , the UN *Convention on the Elimination of Racial Discrimination* the UN *Convention on the Rights of the Child* and the UN *Convention against Torture and other Cruel, Inhumane and Degrading Treatment or Punishment*.

[2] Article 1 Purpose; Article 3 General Principles; Article 4 General Obligations; Article 5 Equality and Non discrimination; Article 6 Women with Disabilities; Article 7 Children with Disabilities; Article 12 Equal Recognition before the Law; Article 14 Liberty and Security of Person; Article 15 Freedom from Torture or Cruel, Inhuman or Degrading Treatment; Article 16 Freedom from Exploitation, Violence and Abuse; Article 17 Protecting Integrity of the Person; Article 22 Respect for Privacy; Article 23 Respect for Home and Family; Article 25 Health.

[3] See also Article 13 which requires States to ensure equal access to justice, including through the provision of appropriate accommodations.

- the right to health (Article 25)

Given Australia's commitment to human rights and it's ratification of the CRPD, it is my submission that the Committee should adopt a human rights framework for this Inquiry.

2. *Involuntary or Coercive Sterilisation*

2.1 Who are we talking about?

Although the terms of this Inquiry refer to children with disabilities and to adults with disabilities, in the vast majority of cases it is girls and women with disabilities who are subjected to involuntary or coercive sterilisation. Further, despite the use of gender neutral language in state and territory legislation, an examination of that legislation discloses that the main focus of the legislation with respect to sterilisation relates to female sterilisation. As a consequence, the discussion below focuses on the sterilisation procedures affecting girls and women.[4] It is, however, my submission that **sterilisation of all children, (and not just children with disabilities), should be prohibited unless there is a serious threat to life or health. It is also my submission that, in the absence of consent of the person concerned, sterilisation of all adults with disabilities should be prohibited**,

2.2 What are we talking about? 'Involuntary' and 'coerced' sterilisation

Any medical treatment that is performed without consent of the person concerned, or without the person being aware that it is being performed, is involuntary.

In some situations a person with disabilities is coerced into 'consenting' to a sterilisation procedure or the use of long acting contraception. Coercion can take a number of forms – it may involve pressure from someone in a more powerful position such as a carer or family member, or it may involve trickery (as in the case of 'Bella' reported recently in Marie Claire magazine)[5]. Treatment is also coercive where the person with disabilities is offered inducements to 'consent' without being told the true nature and implications of the surgery or medication.

Involuntary and coercive sterilisation is in breach of Article 3 (a) of the CRPD: *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices and independence of the person*.

Involuntary or coercive sterilisation, however, in my submission does NOT include the situation where sterilisation is performed in an emergency situation where there is a serious threat to life or health.

2.3 What are we talking about? Sterilisation Procedures[6]

[4] Cases of application for authorisation of a vascectomy on boys or men with disabilities are extremely rare and authorisation of such procedures for sterilisation purposes is even rarer. See the English case: *Re A* [2000] 1FLR 549 (CA).

[5] S Osfield "Investigation: Forced Sterilisation" Marie Claire June 2012 http://au.lifestyle.yahoo.com/marie-claire/features/world/article/-/14181722/investigation-forced-sterilisation/

[6] The information below is taken from the web sites of the NHS in the UK, http://www.nhs.uk/conditions/Female-sterilisation/Pages/Introduction.aspx and the Better Health Channel http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Female_sterilisation The Better Health Channel is fully funded by the Victorian government and "provides health and medical information that is quality assured, reliable, up to date, easy to understand, regularly reviewed and locally relevant." I am not an expert on these procedures but I

Sterilisation procedures take a number of forms. They can be permanent and irreversible or they may be reversible. A web search reveals three broad types of sterilisation of girls and women that are relevant to the inquiry.[7] The first two types of sterilisation are generally irreversible and require what may be described as major surgical intervention. A third method - long acting reversible contraception [LARC], as the name suggests, is a contraceptive treatment that has the effect of sterilising the girl or woman for the duration of the treatment.

- *Hysterectomy* – this can take a number of forms:
    - Total hysterectomy – where the womb and the cervix are removed;
    - Sub-total hysterectomy where the main body of the womb is removed leaving the cervix;
    - Total hysterectomy with bilateral salpingo-oopheorectomy – where the womb, cervix, fallopian tubes and ovaries are removed;
    - Radical hysterectomy where the womb and surrounding tissue including fallopian tubes, part of the vagina, ovaries, lymph glands and fatty tissue are removed.

  Hysterectomy is a treatment of last resort – it is not a recommended form of sterilisation for the general population of women and is not recommended purely for contraceptive/sterilisation purposes. One of the reasons for this, apart from the fact that hysterectomy involves major surgery, is the fact that where a hysterectomy involves the removal of the ovaries, surgical menopause is triggered no matter what the age of the person on whom the procedure is performed and hormone replacement therapy (HRT) is required to counteract the effects of menopause[8].

  Despite this, in Australia, where girls and women with disabilities are concerned, this is the procedure that is usually sought when an application for sterilisation is brought before a court or tribunal.[9] This is discriminatory and a gross abuse of human rights. Beyond the impact on fundamental human rights such as the right to be free from violence, the right to bodily integrity and right to reproduce, these procedures have a number of are serious, negative effects including: premature menopause, increased susceptibility to osteoporosis as well as psychological damage with respect to the sexual/gender identity of the person concerned. A procedure, which, in the general population of women is regarded as a treatment of last resort, is the treatment sought for prepubescent girls and teenagers with disabilities as well as for adult women with disabilities for contraception and menstrual management. **Hysterectomy should never be performed on children in the absence of a serious threat to life or health and should not be performed on women with disabilities without their consent.**

- *Procedures affecting the fallopian tubes:* Sterilisation can be performed in a number of ways by surgical procedures such as tubal ligation (making small incisions in the fallopian tubes) or hysterscopic sterilisation (blocking the fallopian tubes). These procedures are very effective forms of contraception and do not interfere with the normal menstrual cycle. While there is some possibility of reversal of a

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believe it is important to consider the different forms of sterilisation procedures and their impact on the health and well being of the girls and women concerned.

[7] Vasectomy

[8] Given the need for HRT to protect the health of a person who has undergone a hysterectomy, it is somewhat ironic that side effects from the contraceptive pill are often cited in legal argument as a reason for performing hysterectomy.

[9] In contrast in the English cases that concerned the sterilisation of girls with intellectual disabilities and in the Canadian case of *Re Eve* -where the Canadian Supreme Court found that sterilisation could not be authorised unless the woman concerned gave her consent – the procedure involved was a tubal ligation.

tubal ligation, once blocked fallopian tubes cannot be unblocked and sterilisation is permanent. However, generally they are not recommended for women who have not had children.

While a less invasive form of medical intervention, involuntary or coerced sterilisation by tubal ligation, also constitutes a violation of the right to be free from violence, of the right to bodily integrity and of reproductive rights of the girl or woman. **Procedures affecting the fallopian tubes should never be performed on children in the absence of a serious threat to life or health and should not be performed on women with disabilities without their consent**.

- *Long Acting Reversible Contraception* [LARC]*:* Sterilisation can be achieved by the administration of long acting medication via implants, intrauterine devices/systems or injections. These operate to
    - Prevent the release of eggs from the ovaries
    - Thicken the mucus from the cervix making it harder for sperm to penetrate
    - Thin the lining of the uterus so that it is unable to fertilise an egg.

  While injections are effective for 8-12 weeks, implants last for about 3 years and can be removed at any time. It would appear that the contraceptive effect of these forms of treatment cease soon after the treatment is discontinued so that sterilisation is temporary.[10] Involuntary or coercive contraceptive treatment of this nature is also constitutes a breach of the right to be free from violence, to bodily integrity and to reproductive freedom. **Long acting reversible contraceptive treatment should only be administered with the full and free consent of the girl or woman concerned.**

3. Prevalence of Sterilisation Practices

There is a lack of available data on the prevalence of sterilisation practices carried out on people with disabilities. Even where general data on sterilisation procedures is available, it is not disaggregated to reflect the experience of people with disabilities. Research into the incidence and experience of sterilisation practices is needed together with the development of good datasets.

4. The Current Regulatory Regime

Both the Commonwealth and the States regulate the sterilisation of people with disabilities.

Family Court of Australia

At the Commonwealth level, the Family Court of Australia has jurisdiction to regulate sterilisation practices and other special medical procedures with respect to children under the welfare powers contained in section 67ZC of the *Family Law Act* 1975 (Cth) (FLA). The approach taken by the Court was first set out in the 1992 High Court decision in *Marion's case* briefly discussed below.[11]

[10] American College of Obstetricians and Gynecologies Committee Opinion "Adolescents and Long-Acting Reversible Contraception: Implants and Intrauterine Devices" No 539 October 2012 http://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Adolescent%20Health%20Care/Adolescents%20and%20Long-Acting%20Reversible%20Contraception.aspx See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists , College Statements on Contraception http://www.ranzcog.edu.au/component/docman/cat_view/656-college-statements/658-clinical-gynaecology/663-contraception.html?Itemid=341

[11] *Department of Health & Community Services v JWB & SMB* (1992) 175 CLR 218

There are, however, constitutional limits on the scope of this power.[12] The Family Court's jurisdiction in relation to children rests primarily on the 'marriage'[13] and 'divorce and matrimonial causes'[14] powers in the Australian Constitution together with the powers referred by the states[15]with respect to "guardianship, custody, access and maintenance of children".[16] Strictly speaking this limits the power of the Family Court to regulate sterilisation practices with respect to children of the marriage[17], although on occasion, the Family Court has exercised jurisdiction to authorise special medical procedures on children born outside marriage.[18]

In *Marion's Case,* the High Court of Australia considered the question of who can consent to the sterilisation of a child and held that the starting point was a consideration of the legal capacity of the child to consent to the treatment. In establishing the child's competence the Court held that:

> "A minor is capable of giving informed consent when he or she achieves sufficient understanding and intelligence to enable him or her to understand fully what is proposed"[19]

As Marion did not have capacity to consent the Court went on to consider the scope of parental responsibility, concluding that consenting to non-therapeutic, serious medical treatment is beyond the reach of parental responsibility[20] except "where sterilisation is an incidental result of surgery performed to cure a disease or correct some malfunction"[21]. Given the serious, irreversible nature of sterilisation, the High Court held that sterilisation is a 'treatment of last resort and that the power to authorise such treatment rested with the Family Court of Australia acting in the 'the best interests' of the child.

The criteria for determining best interests of the child are found in section 60CC FLA. These criteria, which include consideration of the 'views' of the child have been developed to deal with a full range of issues with regard to parenting orders as well as the welfare power. Some of these criteria, such as the relationship with parents and with other family members are, in my submission, inappropriate factors when considering a question which has such a serious impact on the human rights of the child concerned**. In my submission sterilisation of all children should be prohibited by legislation except where there is a serious risk to life or health.**

State and Territory Guardianship Legislation[22]

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[12] *Minister for Immigration and Multicultural and Indigenous Affairs v B* (2004) 219 CLR 365

[13] s 51(xxi)

[14] s 51(xxii)

[15] s 51 (xxxvii)

[16] *Commonwealth Powers (Family Law –Children) Act* 1986 (NSW); *Commonwealth Powers (Family Law –Children) Act* 1990 (QLD); *Commonwealth Powers (Family Law –Children) Act* 1986 (SA); *Commonwealth Powers (Family Law –Children) Act* 1987 (Tas); *Commonwealth Powers (Family Law –Children) Act* 1986 (Vic)

[17] The jurisdiction of the Family Court is limited to applications in relation to children under the age of 18 years. It is also limited to a 'child of the marriage' under the Constitution, *P v P* (1994) 181 CLR 583. While the Family Court is able to deal with most parenting issues with respect to children born outside marriage as States have referred powers in relation to 'guardianship, custody, access and maintenance' of children to the Commonwealth, welfare powers have not been referred

[18] see for example *Re Brodie* [2008} FamCA 334

[19] ibid 237-238 per Mason CJ, Dawson, Toohey & Gaudron JJ

[20]

[21] ibid 235 per Mason CJ, Dawson, Toohey & Gaudron JJ

[22] *Guardianship and Management of Property* Act 1991 (ACT)[GMPA]; *Guardianship Act* 1987 (NSW) [GA]; *Adult Guardianship Act* 2011 (NT) [AGA]; *Guardianship and Administration Act Guardianship* 2000 (Qld) [GAA];

Each State and Territory in Australia has its own legal/regulatory regime and policy framework for the regulation of sterilisation procedures and treatment. Technically, the State and Territory Supreme Courts retain an inherent *parens patriae* jurisdiction in relation to adults and at least to children born outside marriage. However, as all States and Territories have guardianship legislation, which makes provision for the authorisation of sterilisation procedures for adults with disabilities it is unlikely a Supreme Court would be willing to invoke the *parens patriae* power[23] Three states, Queensland[24], New South Wales[25], and South Australia[26] have legislation that confers jurisdiction on guardianship tribunals to hear applications for the sterilisation of children as well as adults.

The Australian Guardianship and Administration Council has developed a *Protocol for Special Medical Procedures* (Sterilisation) to promote consistency between states and territories.[27] The legislation in each State and Territory treats sterilisation treatment as a matter separate from other medical treatment requiring oversight and authorisation by a tribunal or court and outside the normal authority of a guardian or parent. However, there is a divergence in approach to what constitutes a sterilisation procedure and the circumstances in which sterilisation may be authorised. In New South Wales, Queensland, Tasmania and Victoria it is the sterilisation *effect* of the proposed treatment that brings it under the jurisdiction of these provisions. [28] In Western Australia, on the other hand the focus is on the *purpose* of the treatment.[29] As a result, a hysterectomy (or other treatment) is not a 'sterilisation procedure' if it is for the purpose of menstrual management and incidentally results in sterilisation and tribunal authorisation is not required. [30] In Queensland there is a requirement of 'medical necessity' before the treatment can be authorised.[31] However, under the legislation medical necessity encompasses the situation where the person concerned is sexually active and there is no other means of contraception that 'could reasonably be expected to be successfully applied' and also extends to menstrual management where the procedure is the only practicable way to overcome the problems with menstruation.

In all States and Territories, legislation requires that the person who is subject to an application for authorisation of a sterilisation treatment has a cognitive impairment and lacks the legal capacity to consent to treatment. The principle for determining whether or not the sterilisation should be carried out is, in most jurisdictions, the best interests of the person.[32] While the wording the statutes varies, this is generally supported by the principle that the treatment is a treatment of last resort and that it is the least restrictive of the persons liberty and freedom. There is also generally speaking a requirement to ascertain the wishes of the person but no requirement to act on those wishes.

A major problem with the current regime is the paternalist approach to sterilisation and the indeterminacy

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Guardianship and Administration Act 1993 (SA) [[GAA]; *Guardianship and Administration Act* 1995 (Tas) [GAA]; *Guardianship and Administration Act* 1986 (Vic) [GAA]; *Guardianship and Administration Act* 1990 (WA) [GAA]

[23] Section 3A of the WA Act preserves the *parens patriae jurisdiction* –legislation in other jurisdictions is silent on the matter. See also: *Gardner; Re BWV* (2003) 7 VR 487 discussing the inherent jurisdiction in the context of withdrawal of life-sustaining treatment and the *Medical Treatment Act* 1988 (Vic) [99] per Morris J

[24] Section 80C *Guardianship and Administration Act Guardianship* 2000 (Qld) – this power is limited to children with impairments which are defined as cognitive, intellectual, neurological or psychological impairments (s80A).

[25] *Children and Young Persons (Care and Protection) Act* 1998 (NSW)

[26] Section 60 *Guardianship and Administration Act* 1993 (SA)

[27] 2009 , http://www.agac.org.au/images/stories/agac_sterilisation_protocal_30_mar_09.pdf

[28] GA (NSW) section 33(1); GAA (Qld) Schedule 2, Articles 7(b) & 9 for adults, 80B for children; GAA (Tas) section 3; GAA (Vic) section 3.

[29] GAA (WA) section 56

[30] See for example *JS v CS* [2009] WASAT 90

[31] GAA (Qld) sections 70, 80C

[32] GMPS section 70; GAA (Tas) section 45(1); GAA Vic section 42E;

of the 'best interests' test for determining whether or not to authorise the procedure. A better approach would be to ban sterilisation procedures and treatment in the absence of the persons consent except where they are necessary to preserve life or health of the person. Unfortunately, the current legal and regulatory regime has failed to protect the human rights of girls and women with disabilities. Hysterectomy continues to be the primary sterilisation procedure for girls with disabilities in cases that come before the Family Court and it is only very rarely the case that a Court or Tribunal refuses to authorise a sterilisation procedure when a case comes before it. Further, the 'best interests' standard used by courts and tribunals in their deliberations has not proved to be a champion of the human rights of the person concerned, as the criteria for determining best interests are extended to take account of the impact on parents and carers.[33]

5. Incidence of and rationalisation for involuntary or coerced sterilisation

Unfortunately, data available on the incidence of involuntary or coerced sterilisations is limited. Anecdotal evidence in recent reports, however, indicates that the practice continues[34] and may be on the increase[35]. Further, an examination of the rationales for sterilisation found in the reported decisions of courts and tribunals and discussed in detail in the recent report by Women with Disabilities Australia: *Moving Forward, Gaining Ground* [36] is illuminating for what it says about the entrenched discriminatory attitudes to women and girls with disabilities that are reflected in the practice of involuntary and coerced sterilisation.[37] These rationales relate to:

- Menstrual management – both in relations to personal hygiene during menstruation and to dealing with the array of symptoms that accompany menstruation. The taboos that are still associated with menstrual blood give added potency to these arguments even where the person concerned is doubly incontinent and using pads.

- Protection from sexual abuse and pregnancy – this rationale is significantly flawed. It is hard to see how removing the risk of pregnancy will protect a person from sexual abuse especially where the person has communication disabilities or is not in a position to refuse sexual advances because of a relationship of dependency.

- The perceived inability of the girl or woman with disabilities to develop a healthy sexual relationship. Again this rationale reflects entrenched discriminatory attitudes to girls and women with disabilities viewing them on the one hand as asexual or on the other hand as promiscuous.

- Parenting ability – or more accurately inability. There are two spurious assumptions here. The first is that a person with a disability is unable to be a 'good enough' parent. The second assumption flows from the first – if a person cannot be a 'good enough' parent then it is in order to sterilise them.

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[33] The indeterminacy of the 'best interests' standard in Family Law and the tension between a welfare approach, exemplified by 'best interests' and a human rights approach has been the discussion of ongoing academic debate for more than 30 years. In the Victorian Law Reform Commission's recent report on *Guardianship*

[34] Women with Disabilities *Submission to the Australian Attorney General on the Sterilisation of Girls and Women with Disabilities* July 2012 http://www.wwda.org.au/WWDASubtoAGJuly2012.pdf;

[35] Australian Human Rights Commission *Australian Study Tour Report: Visit of the UN Special Rapporteur on Violence against Women* 10-20 April 2012 http://www.humanrights.gov.au/sex_discrimination/publication/UNSRVAW%20report%202012/index.html Chapter 7

[36] June 2012 http://www.wwda.org.au/Moving_Forward_Gaining_Ground.pdf

- Disability prevention – here the concern is that any children with girl or woman with disabilities may have will themselves be disabled.

Each of these rationales highlights the discriminatory attitudes towards girls and women with disabilities that persist in the Australian community. None of the rationales would be acceptable justifications for the involuntary or coerced sterilisation of girls and women without disabilities. Further, when one looks behind the rationales, it becomes apparent that what is really at issue is a lack of

- Adequate services to support people with a disability, their families and carers in many aspects of daily life;

- Services and programs to support the people with a disability in managing their reproductive and sexual health needs, including menstrual management;

- Knowledge about human rights on the part of all concerned – people with a disability, parents, guardians, carers, medical practitioners – and in particular on the rights of people with disabilities.[38]

Given the nature and consequences of permanent sterilisation procedures considered above and given the negative impact on the physical and psychological well being of the girl or woman with disabilities who is subjected to involuntary or forced sterilisation, the current regulatory regime must be seen to be failing those very people it seeks to protect.

6. The need to address discriminatory attitudes and promote human rights

.As a signatory to the CRPD Australia is under an obligation "to ensure and protect the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability " (Article 4). There are a number of steps that Australia can take to fulfil this obligation. These include:

- Enacting national legislation that prohibits involuntary or coerced sterilisation of all children and of adults with disabilities. (Article 4)

- Public awareness campaigns to nurture receptiveness to the rights of people with disabilities and to promote an attitude of respect for the rights and dignity of people with disabilities (Article 8)

- The development of a broad education and support framework for girls and women with disabilities, their families, carers and health service provides to ensure that girls and women with disabilities are able to enjoy their sexual and reproductive rights, to deal with issues such as menstrual management, contraception and fertility control as set out in paragraphs 40 – 43 of the Australian Human Rights Commission submission.

[38] The limited of knowledge of human rights amongst people with disabilities is one outcome of a research project *Counting the Impact of Rights on People with Disabilities* the author has recently undertaken with Associate Professor Paul Ramcharan (RMIT) and doctoral candidate Christina David (RMIT) as part of the ARC funded Linkages Project *Auditing the Victorian Charter*.

I would like to thank the Inquiry for the opportunity to make this submission. I am currently overseas and can be contacted via email should I be able to be of any further assistance to the Committee.

Yours sincerely,

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