MONASH University
Castan Centre for Human Rights Law

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Submission to Government of Western Australia

Department of Health:

Safe access zones-

Proposal for reform in WA

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INTRODUCTION

Our submission is based on empirical research undertaken over the past two years into the impact of anti-abortion picketing and effectiveness of safe access zones. Our research addresses the nature of the problem considered in the Department of Health's discussion paper and the most effective means by which it may be addressed; considering the experience of anti-abortion picketing throughout Australia and the legislative measures introduced in response. We have examined how women's experiences of seeking health care in Western Australia differ from those of women in other states and territories.

The discussion paper concludes that there must be clear reasons justifying the introduction of safe access zone legislation in Western Australia. Our research has illuminated a number of clear and compelling reasons for such legislation which are outlined in this submission. Safe access zones accord with Australia's obligations under international law, both in human rights treaties and under customary international law. Any doubt about the constitutional validity of safe access zone legislation has been removed by the High Court's recent decision with respect to Victorian and Tasmanian law.[1] Our submission endorses the proposed introduction of safe access zone legislation set out in Option 2 of the discussion paper.

OUR RESEARCH INTO SAFE ACCESS ZONES

We have conducted semi-structured, in-depth interviews with twenty-six health and policy professionals throughout Australia.[2][3] Our interviewees were selected on the basis of their ability to comment on the impact of anti-abortion picketing on patients, staff and others and to comment on the effectiveness of the legal frameworks established to address the picketing. Interviewees were asked a series of questions concerning the nature, prevalence and impact of anti-abortion picketing and, where legislative reforms have been implemented, how the experience of accessing premises has changed since the reforms were instituted. The operation of safe access zone legislation has then been analysed with reference to Australia's human rights obligations and constitutional law.

Our research has underpinned written submissions accepted and cited by the High Court in the context of the constitutional challenge to part of Victoria's safe access zone legislation.[4] Our written submissions (supporting the submissions of Victoria's Attorney-General) elaborated on the extent of the threats, intimidation and harassment experienced by clinic staff and patients seeking access to clinical services prior to the introduction of safe access zones. They demonstrated that the objectives of the legislation were not merely theoretical; and that women's safety, privacy, health and wellbeing have been undermined by picketing activity.

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[1] *Kathleen Clubb v Alyce Edwards & Anor; John Graham Preston v Elizabeth Avery & Anor* [2019] HCA 11 (10 April 2019)

[2] Our research received prior approval by the Human Research Ethics Committee at Monash University on the basis that it meets the requirements of Australia's National Statement on Ethical Conduct in Human Research. See Australian Government, 'Updated Statement on Ethical Conduct in Human Research' (2007) <https://www.nhmrc.gov.au/guidelines-publications/e72>

[3] See Australian Government, 'Updated Statement on Ethical Conduct in Human Research' (2007) <https://www.nhmrc.gov.au/guidelines-publications/e72> accessed 28 July 2018.

[4] Section 185D of *Public Health and Wellbeing Act 2008* (Vic).

We were granted leave to appear as amicus curiae by the High Court in *Edwards v Clubb*[5] with respect to our written submissions, which were then quoted by Nettle J with reference to the forms of conduct that might constitute prohibited behaviour under Victoria's legislative framework.[6] Further work which draws on our empirical research has included journal articles published in the Monash University Law Review and the Cambridge International Law Journal, which are attached to this submission.

After considering the nature of anti-abortion picketing below, we will outline the impact of picketing activities and the options set out in the discussion paper.

Clinic picketing in Australia

By positioning themselves outside clinics, anti-abortionists have targeted a captive, vulnerable audience for their wide-ranging efforts to prevent women from obtaining abortions and staff from performing them. Their activities have included the following:

- approaching, following or walking alongside people approaching clinic premises;
- dispensing plastic foetal dolls or pamphlets containing medically inaccurate information about the consequences of abortion;
- displaying posters and sandwich boards with distressing words or images, such as photographs of dismembered foetuses;
- engaging in acts of 'disturbing theatre' such as pushing a blood-splattered doll in a pram or carrying pigs' organs in prams or around their necks;
- castigating patients and staff as murderers;
- chasing, heckling, threatening and verbally abusing patients and staff;
- photographing and making video-recordings of persons entering and leaving clinics which have sometimes been used in the public shaming of women who have had abortions online or in the local community;
- preventing patients from exiting their cars; and
- obstructing footpaths outside clinics and clinic entrances.

People of all ages have been involved in picketing but most were described to us as 'older' men. Many belong to transnational religious groups such as the US-founded Helpers of God's Precious Infants (HOGPI) and characterise their behaviour as 'sidewalk counselling.'[7] This characterisation differs markedly from the range of activities described to us, which are furthermore not encapsulated by the term 'protest.' We have therefore chosen to use the term 'picketing' wherever possible to describe these activities and the term 'anti-abortionists' to describe the individuals engaged these activities.

[5] Submissions of the Castan Centre for Human Rights Law, 25 May 2018, available at http://www.hcourt.gov.au/assets/cases/06-Melbourne/m46-2018/Clubb-Edwards_CastanCentre.pdf
[6] *Clubb v Edwards, Preston v Avery* [2019] HCA 11 (10 April 2019) [181] per Nettle J.
[7] See generally HOGPI, 'Our Mission' at http://www.helpersbrooklynny.org/OurMission

In Western Australia and South Australia, where safe access zones are not in place, picketing continues and intensifies in the lead-up to Easter and Christmas. We were told of two groups that picket the Marie Stopes clinic in Midland, the first of which 'comes in the morning are quite in your face, they wear yellow clothing and hand out goody bags to patients coming through' with the second group 'still a bit in your face' but less confronting than the first.[8] Their 'goody bags' contain a number of items, including body creams, pamphlets, rosary beads and, particularly in the lead-up to Easter, baby products such as booties and singlets. They also contain 'food and lollies and things that if they eat they can't go ahead with their termination because it's a surgical day.'[9] The practice of handing out bags including food items in an attempt to subvert planned medical procedures has not been raised in our interviews in other jurisdictions. This form of subterfuge has seen anti-abortionists frustrate women's efforts to obtain lawful medical services in the context of deeply personal and private decisions.

Significant harm has been caused by the tactics employed by anti-abortionists to dissuade, frighten, condemn and intimidate the individuals they target, and even to sabotage their scheduled procedures. The broad-ranging impact of this conduct on patients, staff and others is examined below.

IMPACT OF ANTI-ABORTION PICKETING

Anxiety, distress and stigmatisation

Anti-abortionists were observed to have a lack of insight into the distress they caused to women seeking abortions, staff and others and would not desist from their actions when it was made clear that they were unwelcome.[10] Their presence and activities created an undercurrent of fear and stress and we were told of 'days when everyone coming in was crying'.[11]

The picketers' activities were observed to be deeply stigmatising and conveyed a sense of moral condemnation. The preponderance of male protesters was seen to contribute to a perception among some patients that the whole of society is judging them.[12] Women with a history of sexual or physical violence are particularly vulnerable to shaming, humiliation and stigmatisation.[13]

Impact on health and wellbeing

This shaming, stigmatisation and distress has undermined the health and wellbeing of patients, staff and others. A clinical psychologist and social worker stressed the importance of a supportive environment on patient well-being and the deleterious impact of an unsupportive or discriminatory environment.[14]

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[8] Interview with Nurse Unit Manager, Marie Stopes Midland (26 September 2018).
[9] Interview with Nurse Unit Manager, Marie Stopes Midland (26 September 2018).
[10] Interview with clinic staff, Melbourne (12 April 2017); Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[11] Interview with clinic staff, Melbourne (12 April 2017); Interview with Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[12] Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).
[13] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).
[14] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with a social worker, Melbourne (20 March, 2017).

While some women were relatively unaffected by their interactions with anti-abortionists, others were extremely traumatised, and considered by health professionals to be at heightened risk of adverse medical outcomes and ongoing psychological problems.[15] High anxiety levels may increase the physical pain experienced by women during or following medical examination or surgery.[16]

Our interviewees observed that while the impact of an abortion should not be traumatic and long lasting, there are risk factors which contribute to negative consequences and these include stigma, misinformation, shame and guilt, all of which are associated with clinic picketing.[17] The stigmatisation of abortion has been associated with the suppression of thoughts associated with the experience of abortion and intrusive thoughts which increased psychological distress over time[18] and created an increased risk of numerous health problems.[19]

The well-being of staff was also undermined by the stress and fear of confrontation and violence associated with the presence of picketers, considered below.

Access to healthcare services

Clinic picketing has operated as a barrier to access to reproductive health services, experienced most acutely by vulnerable and disadvantaged women.[20] Some failed to carry through their reproductive choices[21] or attend follow-up appointments[22] in order to avoid contact with picketers. Some deferred treatment in circumstances where timeliness is critical and delay can change the treatment options available (and the legal requirements for obtaining an abortion) while increasing the risk of complications.

We were told of women in regional Victoria who were 'very traumatised by the prospect of having to negotiate their way through protesters … and more inclined to delay the initial contact with the service, knowing what they're going to be up against when they eventually get into the service which … [is] sometimes booked out two or three weeks in advance'.[23] In one regional town in which picketing activities took place whenever the abortion clinic was open, members of HOGPI were known to routinely book bogus appointments in order to fill operating lists.[24]

[15] Interview with a social worker, Melbourne (20 March 2017); Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).
[16] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[17] Interview with a social worker, Melbourne (20 March 2017).
[18] Brenda Major and Richard H Gramzow, 'Abortion as Stigma: Cognitive and Emotional Implications of Concealment' (1999) 77(4) *Journal of Personality and Social Psychology* 735. See also David A Grimes et al, 'Unsafe Abortion: The Preventable Pandemic' (2006) 368 *The Lancet* 1908, 1914 on the link between stigma related to abortion and negative health consequences.
[19] Brenda Major and Laurie T O'Brien, 'The Social Psychology of Stigma' (2005) 56 *Annual Review of Psychology* 393.
[20] Interview with a social worker, Melbourne (20 March, 2017).
[21] Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).
[22] Ibid; Interview with Medical Director of a health service in regional Victoria (1 May 2017).
[23] Interview with health coordinator, regional health service, Victoria (1 May 2017).
[24] Interview with health coordinator, regional health service, Victoria (1 May 2017).

Clinic picketing furthermore has operated as a barrier to access by deterring staff from working in reproductive health services, resulting in reductions in service availability and the suspension of regional services due to an inability to recruit staff.[25]

Privacy

The activities of anti-abortionists have interfered in women's private, medical decision-making in circumstances where some were already fearful and anxious. Women are placed in the invidious position of being unable to seek redress without further incursions into their privacy.[26] Because of the secrecy and stigma around abortion and the emotional intensity of patients' experiences, women seeking abortion were not in a position to issue legal proceedings or complain to regulatory bodies or the media, as explained by a social worker in the following terms:

> [Women seeking abortions] were least likely to go public or to do the media or to do anything because they are dealing with a crisis at that moment in their lives. It's a crisis; it doesn't mean it's a crisis forever but at that moment it is … People are usually happy to make complaints about health services … Our practice wisdom experience tells us that women would say 'I just can't deal with doing anything about that it was horrible, I am angry, I am affected by it but I just need to get an abortion and I need support and I need to get through this.' So it is the least likely health experience where people are feeling energised to complain … or go to the media.[27]

The medical director of a community health centre indicated that making a complaint was tantamount to 'advertis[ing] yourself as going in for an abortion' which is 'really hard.'[28] Where safe access zones are not in place, women's inability to seek redress without further incursions into their privacy enables picketing to continue with impunity.

Safety

Fears about personal safety have been a corollary of clinic picketing. Health professionals told us of pervasive concerns about unpredictable behaviour and a threat of confrontation. One interviewee told us that she perceived 'the physical threat' as 'imminent'[29] and another spoke of her efforts to 'just blend in' when approaching her workplace, to never speak to the picketers but rather pretend they were not there because 'you don't know who you're dealing with.'[30] Another expressed concern that about being hurt and told us that speaking to picketers may 'aggravate them more and … make them become more aggressive'.[31]

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[25] Bendigo Weekly, 'GPs Could Help Staff Abortion Clinic' (25 January 2013) <http://www.bendigoweekly.com.au/news/gps-could-help-staff-abortion-clinic> accessed 28 July 2018.
[26] Ronli Sifris and Tania Penovic, 'Anti-Abortion Protest and the Effectiveness of Victoria's Safe Access Zones: An Analysis' (2018) 44 Monash University Law Review 317.
[27] Interview with a social worker, Melbourne (20 March, 2017).
[28] Interview with medical director of a community health centre (15 May 2017).
[29] Interview with a nurse practitioner and midwife (27 March 2017).
[30] Interview with clinic staff (12 April 2017).
[31] Interview with clinic staff (12 April 2017); Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).

We were told about picketers who would target health professionals by exposing them as 'murderers' in their local community and throwing red paint or pigs' blood at their houses.[32] Fears arose about picketers purporting to be patients, as described here:

> My biggest fear was they were going to send up a plant, and the plant would come and see me … and something would happen, or they would expose me, or target where I live, or target the kids. Because they'd done that with other doctors … I just knew the previous history of potential threats, and threats to target, and … I thought you just don't know … [whether] there [will] be any physical harm out of this? Are they going to target my car when I come to work?[33]

The experience of East Melbourne's Fertility Control Clinic (FCC) in Victoria demonstrates the extent to which the presence of picketers has undermined public safety. We heard about picketers identifying staff members' cars[34] and staff apprehending that they were being followed while travelling home. Staff were particularly conscious of personal details being exposed and family members were briefed about dealing with anonymous phone calls.[35] Staff sought to avoid contact with the picketers through means such as arriving at work early, using rear entrances and taking detours home after work.[36] Dr Susie Allanson, who worked as the FCC's clinical psychologist for 26 years, described the picketers as 'very, very creepy … and the difficulty is if someone steps over a line, you're just not sure how far they're going to go.'[37] Picketers would often provoke a hostile response from patients or their companions and physical altercations would sometimes ensue.[38]

Due to the fear and distress created by the picketers' continued presence, security guards were employed to escort patients and staff into the FCC. Verbal abuse and threats, including death threats, were directed at guards by picketers,[39] who were sometimes joined by people with a serious criminal history who were under police surveillance.[40] On 16 July 2001, a man who had previously engaged in picketing entered the clinic with plans for a massacre and murdered security guard Steve Rogers because 'he got in the way'.[41]

We believe that the safety of patients, staff and others cannot be safeguarded while picketers maintain a presence outside clinics.

Violations of women's rights

The targeted harassment of women seeking abortions has undermined women's human rights, including the right to privacy,[42] the right to the highest attainable standard of health[43], the right

[32] Interview with a nurse practitioner and midwife (27 March 2017).
[33] Interview with a nurse practitioner and midwife (27 March 2017).
[34] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[35] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[36] Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) pp 110-111.
[37] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[38] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[39] Allanson, *Murder on His Mind* 11–12.
[40] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[41] *R v Knight* [2002] VSC 498 (19 November 2002) [16] (Teague J).
[42] Article 17 of the International Covenant on Civil and Political Rights.
[43] Article 12 of International Covenant on Economic, Social and Cultural Rights.

to security of person,[44] women's equal rights to decide freely and responsibly on the number and spacing of their children[45] and equality of access to health care services, including those related to family planning.[46] It may constitute cruel, inhuman or degrading treatment.[47] The United Nations Special Rapporteur on Torture has found that subjecting women and girls to such 'humiliating and judgmental attitudes' in the context of accessing abortion is a form of torture or cruel, inhuman or degrading treatment.[48]

Anti-abortion picketing is furthermore a form of targeted discrimination against women, violating women's right to equality and freedom from discrimination which is a fundamental principle of international human rights law.[49] Article 1 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defines discrimination against women as encompassing any distinction made on the basis of sex which has the effect or purpose of impairing or nullifying the enjoyment or exercise of human rights or fundamental freedoms on a basis of equality with men.

Clinic picketing was likened by our interviewees to another serious form of discrimination; racial vilification or hate speech.[50] The targeted harassment of women was described by one regional practitioner as 'the equivalent of someone targeting a Muslim person because they're anti-Muslim'[51] and the failure to address picketing activities (where safe access zones are not in place) described by another in the following terms:

> I think it's really saying that it's OK to look the other way when someone else's rights are being infringed … I see it as akin to looking away when a racial slur is occurring, or someone with a disability is being undermined. I think it's looking away when you can see that harm is being done to someone. ... it's really saying that the parliament and the law makers think it's acceptable for people to be berated for what is essentially a decision that they're making for the welfare of themselves and their families. I think it's really a big negative… for human rights.[52]

Anti-abortionists have marginalised women and undermined their autonomy, resulting in a 'silencing of women's voices, minimising of what's actually important to women.'[53] The failure to prevent such conduct through the introduction of safe access zones has been described by a health practitioner in the following terms:

[44] Article 9(1) of the International Covenant on Civil and Political Rights.
[45] Article 16(1)(e) of the Convention on the Elimination of all forms of Discrimination against Women.
[46] Art 12(1) of the Convention on the Elimination of all forms of Discrimination against Women.
[47] Article 7 ICCPR and article 16 of the Convention on the Elimination of Torture and other Cruel, Inhuman or Degrading Treatment of Punishment.
[48] Juan Mendez, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/HRC/31/57, 5 January 2016) para 44
[49] See for example article 3 of the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural Rights.
[50] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with staff specialist working in reproductive health (1 May 2017).
[51] Interview with a nurse practitioner and midwife (27 March 2017).
[52] Interview with general practitioner working in sexual health (2 May 2017).
[53] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).

> It's an acceptance that the rights are lesser and that the voice is lesser, and the equality is not there; it's an acceptance that there's this disparity in equality. That you can tolerate this. It is gender specific. It's targeted at gender but it's OK.[54]

Harassment and gender-based violence

Clinic picketing falls within the purview of a further form of gender-based discrimination that seriously inhibits women's enjoyment of rights and freedoms on a basis of equality with men; violence against women.[55] Gender-based violence against women encompasses acts and threats that inflict physical or psychological harm within the general community[56] which are directed at women or affect women disproportionately.[57] The United Nations Special Rapporteur on Violence against Women, its Causes and Consequences has furthermore called on states to eliminate such forms of coercion and violence which present a 'serious obstacle to safe abortions'.[58]

The mistreatment of women and girls seeking reproductive health information, goods and services has been recognised by the UN committee which oversees the implementation of CEDAW to constitute gender-based violence which may amount to cruel, inhuman or degrading treatment.[59] Clinic picketing in Northern Ireland which is substantially identical to what has occurred in Australia was found by the committee to breach the obligation to eliminate discrimination in the field of healthcare and family planning and form part of a pattern of grave and systematic violations of CEDAW. The committee found that although police were 'frequently alerted' to such conduct, they would 'rarely intervene' with the consequence that picketers were 'emboldened by' impunity for 'assaults perpetrated against women seeking abortion'.[60] The committee called for the protection of women from such harassment and assaults.[61]

The obligation to exercise due diligence to eliminate and end impunity for such acts of gender-based violence falls within states' obligations under CEDAW and is furthermore a principle of customary international law. In preventing the targeted harassment of women outside clinics, safe access zone legislation accords with Australia's international legal responsibility of due diligence with respect to acts of gender-based violence perpetrated by non-state actors.

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[54] Interview with a nurse practitioner and midwife (27 March 2017).
[55] CEDAW Committee, General Recommendation 19: Violence against Women, 11th Session 1992 [6]; see also Declaration on the Elimination of Violence against Women, General Assembly, A/RES/48/104, 20 December 1993, [1]
[56] CEDAW Committee, General Recommendation 19: Violence against Women, 11th Session 1992 at [6]; see also Declaration on the Elimination of Violence against Women, General Assembly, A/RES/48/104, 20 December 1993, articles 1 and 2.
[57] CEDAW Committee, General Recommendation 19: Violence against Women, 11th Session 1992 at [6]; see also Declaration on the Elimination of Violence against Women, General Assembly, A/RES/48/104, 20 December 1993, [6]
[58] Preliminary Report Submitted by the Special Rapporteur on Violence against Women, its Causes and Consequences, Ms. Radhika Coomaraswamy, in Accordance with Commission on Human Rights Resolution 1999/44, Addendum, Policies and Practices that Impact Women's Reproductive Rights and Contribute to, Cause or Constitute Violence Against Women (n 100) paras 66, 88.
[59] CEDAW Committee, General Recommendation 35 on Gender-Based Violence against Women, Updating General Recommendation No 19 (14 July 2017).
[60] CEDAW Committee, Report of the Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to the Convention on the Elimination of all forms of Discrimination against Women, CEDAW/C/OP.8/GBR/1 (23 February 2018) at paras 19, 20 and 70.
[61] Ibid, para 72(e).

OPTIONS SET OUT IN DISCUSSION PAPER

Option 1: Status Quo

Option 1 in the discussion paper entails maintaining the status quo. Under this proposal, 'instead of government intervention, protection of patients and staff will depend on clinics addressing the problem through their own means' and 'individuals adversely impacted …will have recourse through the courts.' Such an approach would fail to recognise that the protection of patients and staff is a human rights issue which requires government intervention.

It is the role of the state, not medical clinics, to ensure that human rights are protected and violations prevented and prosecuted. It is furthermore unjust and unrealistic to expect individuals whose rights have been violated by clinic picketers to seek recourse through the courts. Our concerns with maintaining the status quo are elaborated below.

'*clinics addressing the problem through their own means'*

Clinics in which abortions are provided are concerned with providing professional medical services. Requiring them to police unlawful conduct imposes an unreasonable burden on medical practices. It is the state's role to exercise due diligence to prevent and punish the breaches of human rights norms perpetrated by anti-abortionists. The fundamental rights of women and staff should not rest upon clinics having the human and fiscal resources to address the problem themselves.

Once again, the experience of Melbourne's FCC is instructive. Security guards employed to escort patents and staff into the clinic were subjected to abuse and threats.[62] A guard resigned after a protester made a face-to-face death threat to her and another staff member.[63] The guard who then assumed the role was murdered by a clinic picketer. In order to address the chronic disruption, abuse and interference of anti-abortionists outside the FCC, clinic staff were required to call police on a regular basis. When police arrived, picketers would often have disappeared or accused the individuals they targeted of assaulting them. Where picketers were prosecuted for their unlawful activity, clinic staff would be required to give evidence in court, creating staffing issues for the clinic and trauma for staff who would be required to revisit stressful events or view obscene images.[64] Dr Allanson observed that 'we're just working at a women's health clinic just trying to do a normal job' and that the picketing activity, which could at times be heard inside the clinic, made her feel 'so unprofessional' and unable to provide women with a safe space.[65]

FCC staff called on the Melbourne City Council to take action to address the conduct of the picketers and, following the council's failure to do so, instituted legal proceedings to obtain a remedy for conduct constituting "nuisance". The action failed as the court decided that the council had the power to decide not to act so as to bring an end to the picketing.[66] As a result,

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[62] Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) p 12

[63] Susie Allanson, *Murder on his mind: The untold story of Australia's abortion clinic murder* (Melbourne: Wilkinson Publishing, 2006) p 11.

[64] See for example *Michelle Fraser v County Court of Victoria and Ors* S CI 2016 00291 (Supreme Court of Victoria) 21 March 2017 per Emerton J

[65] Interview with Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).

[66] See *Fertility Control Clinic v Melbourne City Council* [2015] VSC 424.

the inadequacy of legal remedies meant that picketing continued to cause harm with impunity[67] which only ceased when safe access zones were instated.

The discussion paper indicates that surveillance footage may capture evidence of breaches. But requiring clinics to police picketing does not prevent picketing activities. It communicates a message that such conduct is not the responsibility of the state, with the consequence that the harassment, intimidation and abuse of women seeking healthcare can continue. Capturing evidence of such conduct is of little value when prosecution is unlikely, as discussed further below.

'individuals adversely impacted ….will have recourse through the courts'

We have been told by Dr Allanson that in the FCC's efforts to address the disruption caused by picketing, it was limited to mechanisms that did not further encroach upon patients' privacy because 'our responsibility to our patients doesn't stop at our doorstep' and 'we couldn't go ahead with any legal action that meant that patients had to stand up.'[68] As noted above, women are extremely unlikely to complain about experiences connected with obtaining an abortion. The problem of obtaining redress was recognised by Victoria's health minister in the context of safe access zones. The Minister observed that clinic picketing often extended to criminal conduct in circumstances in which patients are unwilling to expose themselves to the stress and publicity associated with criminal proceedings, with 'the intensely private nature of the decision' that the picketers seek to denounce, effectively operating to protect them from prosecution'.[69]

Safe access zone legislation prevents clinic picketing in the first place. It serves to protect the right of patients and staff to privacy, safety and wellbeing, to signify society's condemnation of gender-based harassment and end impunity for breaches.

OPTION 2: Introducing safe access zone legislation

The advantages of safe access zone legislation set out on page 10 of the discussion paper are supported by our research. We have found that where safe access zones are in place, anti-abortionists have continued to assemble and express their views outside the zones' parameters.[70] The expression of their views no longer involves the targeted harassment of individuals. Picketing activity has accordingly been de-individualised; sending 'a wonderful positive message … that society won't condone that sort of behaviour' targeted at women accessing health services.[71] Our interviewees took the view that safe access zones are operating to protect the right of patients and staff to privacy, to facilitate safe access to health services and deter discriminatory behaviour which left women 'feeling like they're not legitimate members of society with legitimate rights.'[72]

[67] Susie Allanson, 'Abortion access versus anti-choice nuisance: Supreme Court action update' (presentation at Second National Sexual & Reproductive Health Conference, Melbourne, November 18, 2014).
[68] Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[69] Victoria, *Parliamentary Debates*, Legislative Assembly, 22 October 2015, 3973 (Jill Hennessy).
[70] Interview with clinic staff, Melbourne (12 April 2017; Interview with Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017).
[71] Interview with a social worker, Melbourne (20 March 2017).
[72] Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).

The zones promote equality by acknowledging women's freedom over their reproductive health,[73] recognising them 'as human beings who can make their own decision' and respecting their decision-making capacity.[74] One interviewee described the zones as a statement 'that women are equal and entitled to reproductive health services without fear of judgment, vilification, non-acceptance and gender-based vilification' and entitled equality in decision-making.[75] The law was seen to give 'permission for women to make the decisions that need to be made', stop them from feeling marginalised and '[allow] them to feel strong and confident that they know the right thing for their body, for their life, for their family, for their children' and providing 'a sense of empowerment and control over their bodies.'[76]

Safe access zones have accordingly been operating to prevent harassment and abuse and empower women. Nevertheless, the discussion paper expresses some concern about its effect on freedom of speech. We will address this concern and then consider the arguments opposing the introduction of safe access zones.

Identified Disadvantages

The Discussion Paper identified a number of disadvantages associated with introducing safe access zones. We address these below

1. Picketers 'may feel that their freedom of speech is being stifled'

The argument that the status quo should be maintained in order to protect anti-abortionists' free speech does not bear scrutiny. With respect to the freedom of political communication implied in the Australian Constitution, the High Court has validated safe access zone legislation in Victoria and Tasmania. In the recent decision of *Clubb v Edwards; Preston v Avery*[77] the High Court unanimously affirmed that the laws are constitutionally valid and affirmed their importance, with Justice Nettle commenting that 'women seeking an abortion […] are entitled to do so safely, privately and with dignity, without haranguing or molestation.'[78] With respect to the picketers' right to freedom of expression enshrined in international human rights law, it should be noted that this right (as well as the rights to freedom of thought, conscience and religion and freedom of assembly)[79] is not absolute. These rights may be subject to limitations provided by law which are necessary for the protection of public order, morals or health or the rights and freedoms of others.

In light of the threats and disturbances that have been a corollary of clinic picketing, safe access zones protect the safety of persons requiring access to clinics and may be justified on public health grounds due to the deleterious effect of the protest on psychological wellbeing and access to health services. Furthermore, as detailed above, safe access zones protect the rights of others, including women seeking abortions and staff seeking to access their workplace.

[73] Interview with a social worker, Melbourne (20 March 2017).
[74] Interview with Medical Director of a health service in regional Victoria (15 May 2017); Interview with Dr Susie Allanson, clinical psychologist, Fertility Control Clinic (22 March 2017); Interview with a nurse practitioner and midwife (27 March 2017).
[75] Interview with a nurse practitioner and midwife (27 March 2017).
[76] Interview with general practitioner working in sexual health in regional Victoria (2 May 2017).
[77] [2019] HCA 11.
[78] *Clubb v Edwards; Preston v Avery* [2019] HCA 11 para 258.
[79] See articles 19, 18 and 21of the International Covenant on Civil and Political Rights.

These fundamental rights are detailed above and include the right to privacy[80] the right to the highest attainable standard of health[81], the right to security of person,[82] freedom from cruel, inhuman or degrading treatment,[83] the right to protection against gender-based violence, women's equal rights to decide freely and responsibly on the number and spacing of their children[84] and equality of access to health care services, including those related to family planning.[85]

To the extent that safe access zones limit picketers' rights, they comply with the principle of proportionality. The limitations imposed are not overbroad. The distancing of picketing activities from individuals requiring access to clinics has not impaired anti-abortionists' ability to assemble and express their views. The following observations epitomise the views of our interviewees with respect to the picketers' free speech:

> I defy them to show me any evidence whatsoever that their freedom of speech has been impacted. They can keep talking about their opposition to abortion everywhere, except for within 150 metres of [clinics]. They can have their websites. They can put ads in the paper. They can be in the news. They can protest, make public protests everywhere, except for that exclusion zone … . It goes to show that if they think that that's denying them their freedom of speech then their freedom of speech is about the freedom to harass people … to make them feel bad, to cause them anxiety [and] to cause them to feel frightened.[86]

Safe access zones have imposed limitations within a confined geographic space that is necessary to avoid the targeting of a captive audience of individuals requiring access to clinics and its corollary of harmful and confrontational expression that constitutes gender-based violence. The rights of patients, staff and others cannot be respected, protected or fulfilled when picketers remain free to target women with impunity. Safe access zones strike an appropriate balance between the picketers' rights to assemble and express their views while upholding the dignity, safety, wellbeing and human rights of patients, staff and others which have for too long been subordinated.

2. Other disadvantages

The discussion paper notes that a new legislative framework would take time to design and implement and that successful monitoring may pose a practical challenge. Any legislative change takes time to achieve, but this is not a reason to maintain a status quo which is resulting in the violation of women's fundamental human rights. Further, with safe access zones now operating in six Australian jurisdictions, there is a clear precedent for legislative design. So the drafting of safe access zone legislation should be relatively straightforward given that the nature and content of the law has already been the subject of extensive deliberation in other Australian jurisdictions. The Victorian law, for example, would provide

[80] Article 17 of the International Covenant on Civil and Political Rights.
[81] Article 12 of International Covenant on Economic, Social and Cultural Rights.
[82] Article 9(1) of the International Covenant on Civil and Political Rights.
[83] Article 7 ICCPR and article 16 of the Convention on the Elimination of Torture and other Cruel, Inhuman or Degrading Treatment of Punishment.
[84] Article 16(1)(e) of the Convention on the Elimination of all forms of Discrimination against Women.
[85] Art 12(1) of the Convention on the Elimination of all forms of Discrimination against Women.
[86] Interview with Tracy Wing, former sexual and reproductive health policy officer, Department of Health and Human Services, Tasmania (3 November 2017).

a good model for Western Australia to draw on. With respect to the concern that successful enforcement and monitoring may pose a practical challenge, it is unclear why monitoring the behaviour of picketers outside a health clinic poses any greater difficulty than monitoring any other unlawful behaviour, such as public indecency.

Further, the discussion paper expresses concern about the impact of safe access zones on neighbouring churches, businesses and residents. The experience of safe access zones in Australia reveals these concerns to be unfounded. Safe access zones have no impact on sermons delivered in Churches that cannot be heard outside the Church building.[87] They furthermore have no impact on communications within business premises and residences that cannot be heard outside. Safe access zones may prevent churches, businesses and residents from taking the unlikely action of displaying anti-abortion messages or images outside their premises. But insofar as safe access zones are likely to affect residences and business within the zone, we believe that they are likely to be welcomed for distancing clinic picketers and averting the disruption and anxiety that are a corollary of their presence. With respect to residences or business on the border of the exclusion zone, it is possible that picketers will bother them, in the same way as they previously bothered those inside the zone. It is to be hoped, however, that the removal of the ability to individually target patients and staff will lead to the picketers adopting a different mode for the expression of their views.

SAFE ACCESS TO OTHER HEALTH SERVICES

For many years, abortion was the only health care service that was the subject of overt and explicit public protest aimed at preventing individuals from obtaining care. More recently, reports have emerged of anti-euthanasia picketers accosting cancer patients as they enter Melbourne's Peter MacCallum Cancer Centre.[88] The threat of interference in needle and syringe programs in Western Australia is also noted in the discussion paper.

We consider that individuals seeking medical treatment should never be the subject of harassment and abuse. The right to religious freedom and freedom of expression are not a licence to breach the rights of others with impunity. Laws which distance picketers from the strangers they seek to either influence or condemn are consistent with human rights obligations undertaken by Australia and norms of customary international law.

CONCLUSION

On 23 July 2018, the United Nation's CEDAW Committee issued its concluding observations on Australia's eighth periodic report under the convention. The Committee recorded its concerns about the lack of harmonisation in state and territory legislation concerning abortion and the continued harassment and discrimination directed to women and girls seeking abortion services.[89] It called on Australia to provide a report by July 2020 addressing four priority areas,

[87] See for example Victoria, *Parliamentary Debates*, Legislative Assembly, 22 October 2015, 3975 (Jill Hennessy).
[88] Peter Willingham, 'Patients, staff accosted by pro-life campaigners outside Peter MacCallum Cancer Centre', *ABC News*, 10 April 2019 at https://www.abc.net.au/news/2019-04-10/anti-euthanasia-flyer-upsets-patient-staff-peter-macallum-cancer/10987560
[89] CEDAW Committee, Concluding observations on the eighth periodic report of Australia, UN Doc CEDAW/C/AUS/CO/8 (25 July 2018), para 49(a).

one of which was to review state and territory laws, policies and practices to guarantee access to prescribed abortion services.[90]

Legislative reform is needed to guarantee such access in Western Australia. Our recommendation is for legislative reforms which introduce safe access zones and further reforms which regulate abortion as a health issue, and remove it from the purview of the criminal law. With respect to safe access zones, our research illuminates a number of clear and compelling reasons for the adoption of the discussion paper's Option 2. Safe access zones play a crucial role in preventing the targeted intimidation and harassment of individuals outside clinics which has caused serious harm. It is not the role of medical clinics to police such conduct. The protection of patients and staff is a human rights issue which requires state intervention.

[90] CEDAW Committee, Concluding observations on the eighth periodic report of Australia, UN Doc CEDAW/C/AUS/CO/8 (25 July 2018); para 50(a); 63.