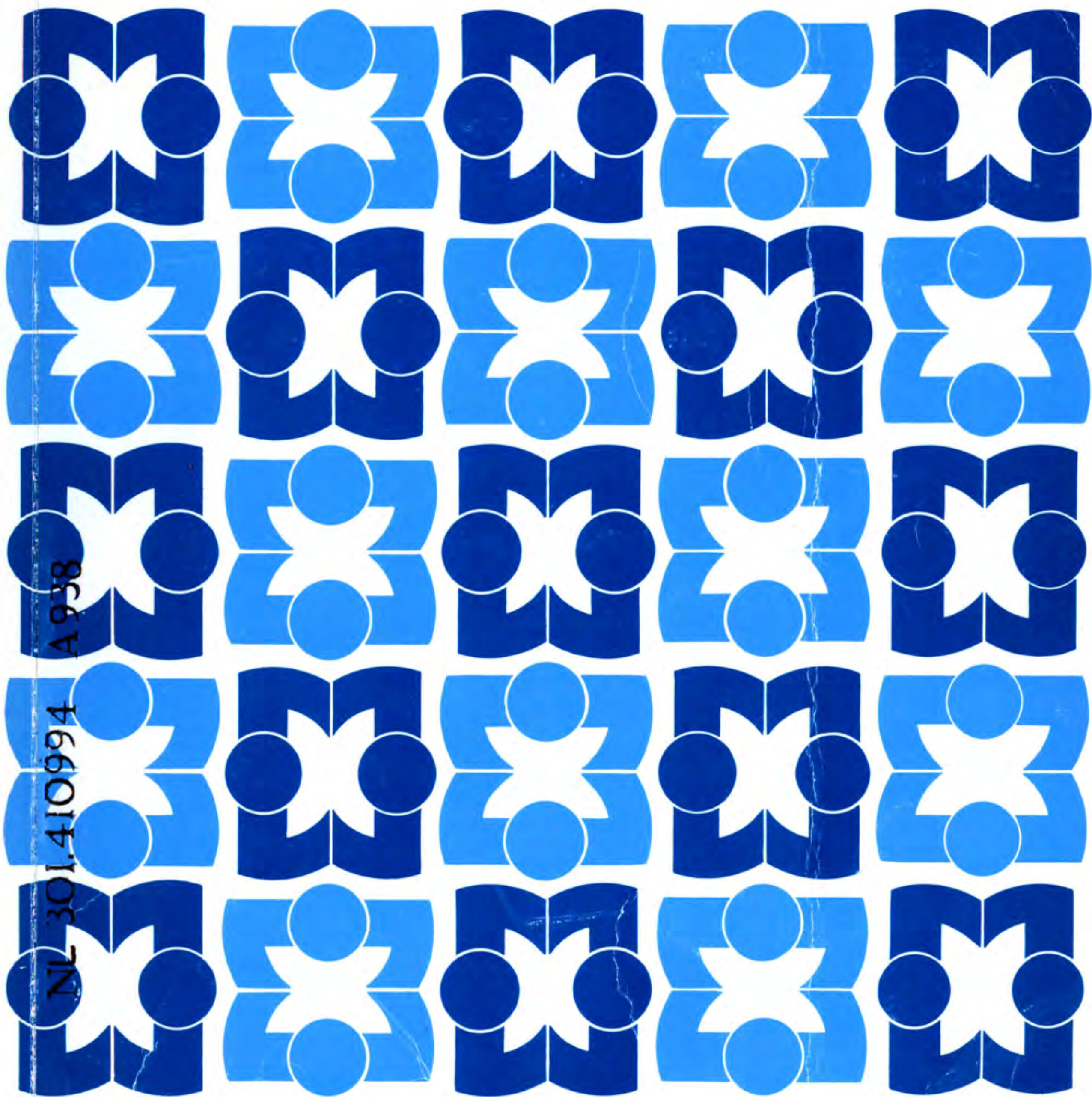
ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report
Volume 1



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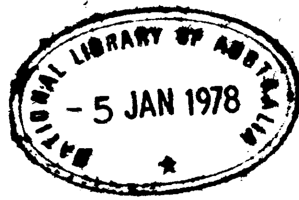
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ROYAL COMMISSION
ON HUMAN RELATIONSHIPS

Final Report

Volume 1

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Contents of the report

Introduction, summary and recommendations	Part I in Volume 1
Education for human relationships	Part II in Volume 2
Health and medical education	Part III in Volume 2
Sexuality and fertility	Part IV in Volume 3
The family	Part V in Volume 4
Equality and discrimination	Part VI in Volume 5
Rape and other sexual offences	Part VII in Volume 5

ROYAL COMMISSION ON HUMAN RELATIONSHIPS

Final Report
Volume 1

Part I
Introduction, summary and recommendations

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ROYAL COMMISSION
ON HUMAN RELATIONSHIPS

100 William Street
Sydney
21 November 1977

Your Excellency,

In accordance with Letters Patent, dated 21 August 1974, we have the honour to present to you the Final Report of the Royal Commission on Human Relationships, prepared as at April 1977.

Elizabeth Evatt
Felix Arnott
Anne Deveson

His Excellency
The Right Honourable Sir John Kerr
A.K., G.C.M.G., G.C.V.O., K.St.J., Q.C.
Governor-General of Australia
Government House
Yarralumla
Canberra, A.C.T. 2600

Commissioners

Justice Elizabeth Evatt (Chairman)
Dr Felix Arnott
Anne Deveson

Secretary

Robert Hyslop

Contents

Terms of reference
1. Contents of the report
2. The Commission and its task
3. Human relationships and social change
4. Summary of the report
5. Recommendations in the report
Annexes

Royal Commission on Human Relationships
Terms of Reference

To inquire into and report upon the family, social, educational, legal and sexual aspects of male and female relationships, so far as those matters are relevant to the powers and functions of the Australian Parliament and Government, including powers and functions in relation to the Territories:

To give particular emphasis to the concept of responsible parenthood, to have regard to experience in other countries and to include in your inquiry the following aspects of the said matters:

(a) the extent of relevant existing education programs, including sex education programs, and their effectiveness in promoting responsible sexual behaviour and providing a sound basis in the fundamentals of male and female relationships in the Australian social environment;

(b) the extent of relevant existing programs in medical schools and their adequacy to provide comprehensive medical training in contraceptive techniques, in the physical, psychological and sexual problems experienced by women in adapting to marriage and before, during and after menstruation and in matters relating to pregnancy, fertility control, spontaneous and induced abortions and childbirth and to encourage acceptance by the medical profession of its responsibilities in the field of contraceptive counselling;

(c) the provision, adequacy and effectiveness of existing family planning facilities, educational and activational information on family planning and methods of evaluation of all family planning techniques;

(d) the social, economic, psychological and medical pressures on women in determining whether to proceed with unplanned or unwanted pregnancies, having regard to:

  (i) the adequacy of housing, child-minding centres, pre-school centres, domestic assistance for families and working mothers, assistance to single parent families, other forms of assistance for mothers employed in industry, and adoption procedures;

  (ii) the disabilities of families with handicapped children; and

  (iii) the social status of women in the community; the social, psychological and medical results of termination of, or and failure to terminate such pregnancies;

(e) the adequacy and effectiveness of existing medico-legal determinations in relation to termination of pregnancy, the incidence of such terminations, the factors influencing their occurrence, the adequacy of medical training in an evaluation of methods of termination, consultative rights of the family or other persons concerned and the adequacy and effectiveness of pregnancy support services; and

(f) any other matters in relation to the family, social, educational, legal and sexual aspects of male and female relationships to which the attention of the Commission is directed by the Prime Minister in the course of the inquiry.

To make recommendations as to measures that are desirable with respect to the foregoing matters under existing or future laws of the Australian Parliament or of the Territories (including laws providing for grants to the States) and to indicate whether these measures should be implemented through existing bodies or through government instrumentalities to be created.

The Commission may present interim reports on any aspect of its terms of reference.

1. Contents of the report

Introduction

The report is in seven parts, printed in five volumes. Each part is divided into chapters; paragraphs are numbered within each chapter. Annexes are printed after the relevant part. Annexe I.F. lists the Commission research reports, which are being published in microfiche except where indicated in the Annexe.

List of topics in the report

The table of contents is printed in this part in comprehensive form for all parts of the report. As it is not practicable to prepare an index, we put here a list of important references to the topics shown, with the principal treatment printed in heavy type.

Topic	*Part*	*Chapter*
Aboriginals	III	3
	III	6
	IV	2
	V	3
	V	7
	V	10
	VI	**4**
	VI	Annexe VI.A
	VI	Annexe VI.B
Abortion	III	3
	IV	2
	IV	3
	IV	**4**
	IV	5
	IV	Annexe IV.K
	IV	Annexe IV.M
	IV	Annexe IV.N
	IV	Annexe IV.O
	IV	Annexe IV.P
	IV	Annexe IV.Q
	V	7
Adolescents *see* Youth		
Adoption	IV	3
	V	**7**
	V	Annexe V.C
	VI	6
Adult education *see* Education		
Aged	III	3
	IV	1
	V	**3**
Alcohol, other drugs	III	3
	V	9
	V	10
	V	**11**
	VI	4
Alternative life styles *see* De facto relationships, Homosexuals, Youth		
Birth control *see* Contraception		
Child abuse *see also* Violence	III	2
	III	3
	IV	3
	IV	4
	V	**10**
	V	Annexe V.D
	VII	14
	VII	15
	VII	17
	VII	18
Childbirth *see* Pregnancy		
Child care	III	2
	III	3
	IV	3
	IV	4
	IV	5
	IV	6
	V	**4**
	V	6
	VI	2
Children	I	3
	II	1
	II	7
	III	2
	III	3
	V	
	VI	5

Topic	Part	Chapter
Contraception, family planning	II	6
	III	3
	III	4
	IV	2
	IV	3
	IV	4
	IV	5
	IV	Annexe IV.D
	IV	Annexe IV.G
	VI	4
Corporal punishment	II	4
Counselling, social work *see also* Pregnancy counselling	II	8
	III	2
	III	3
	III	4
	III	6
	IV	1
	IV	2
	IV	3
	IV	4
	IV	5
	V	9
	VI	6
	VII	7
Country life *see* Isolation		
De facto relationships	IV	3
	V	5
	V	7
Discrimination	VI	
Divorce	V	2
	V	5
Domestic violence *see* Violence		
Education, adult education	II	
	III	3
	V	11
	VI	2
	VI	4
	VI	5
Employment, part-time employment	III	5
	IV	4
	V	6
	V	9
	V	11
	V	Annexe V.A
	VI	2
	VI	4
Family, families *see also* Lone parents	I	3
	II	1
	III	3
	IV	3
	IV	4
	IV	5
	V	
	VI	5
Family law, maintenance	V	5
	V	6
Family planning *see* Contraception		
Family violence *see* Violence		
Fathers, fatherhood *see* Parents		
Foetus	IV	2
	IV	4
	IV	6
	IV	Annexe IV.L
Fostering	V	8
Handicapped	III	3
	IV	1
	IV	2
	IV	4
	V	4
	VI	7
	VII	16
Health	II	2
	III	
	IV	1
	IV	2
	IV	3
	IV	4
	IV	5
	IV	6
	V	9
	V	11
	VI	4
Homosexuals, lesbians	III	3
	IV	1
	V	7
	VI	6
Housewives wage, mothers wage	VI	2

Topic	Part	Chapter
Housing *see also* Refuges	V	3
	V	6
	V	9
Human relationships education, sex education	II	
	IV	1
	IV	2
	IV	5
	IV	6
	VI	6
Illegitimacy	V	5
Incest *see* Sex crimes		
Institutions	III	3
Isolation, country life	IV	2
	IV	5
	V	3
Lesbians *see* Homosexuals		
Lone parents, single parents	IV	2
	IV	3
	IV	4
	IV	5
	V	4
	V	6
Maintenance *see* Family law		
Marriage	II	3
	II	8
	III	3
	IV	3
	IV	4
	V	2
	V	5
	VI	2
	VI	6
	VII	4
	VII	12
Media	II	3
	IV	1
	IV	2
	VII	9
Medical personnel, medical services, medical education	III	
	IV	2
	IV	4
	IV	6
	VII	6

Topic	Part	Chapter
Men *see* Women, men		
Menstruation	III	2
	III	3
	III	4
	IV	1
	IV	2
	IV	7
Mental health, mental illness	III	3
	IV	2
	V	7
	V	9
	VII	6
Mentally handicapped *see* Handicapped		
Migrants	II	8
	III	3
	IV	2
	IV	4
	IV	6
	IV	7
	V	2
	V	3
	V	4
	V	5
	V	Annexe V.B
	VI	2
	VI	5
	VI	Annexe VI.C
	VI	Annexe VI.D
	VII	4
Moral issues	I	3
	III	3
	IV	1
	IV	2
	IV	3
	IV	4
	IV	5
	IV	7
Mothers, motherhood *see* Parents		
Mothers wage *see* Housewives wage		
Parents, parenthood, fathers, fatherhood, mothers, motherhood	I	3
	II	1
	II	2
	II	6
	II	7
	IV	2
	IV	3
	IV	4

Topic	*Part*	*Chapter*
	IV	5
	IV	6
	IV	7
	V	
Part-time employment *see* Employment		
Planning, social planning	I	3
	V	3
Pornography	VII	2
Pregnancy, pregnancy support, pregnancy counselling, childbirth	II	4
	III	3
	III	4
	IV	2
	IV	3
	IV	5
	IV	6
	IV	Annexe IV.I
	V	2
	VII	6
Prisoners, prisoners' families, prisons	V	12
Prostitution	VI	3
Rape *see* Sex crimes		
Refuges	V	9
Sex crimes, rape, incest	IV	5
	VII	
Sex education *see* Education, Human relationships education		
Sex roles	II	6
	VII	2
Sexual behaviour	II	6
	III	3
	III	4
	IV	1
	IV	5
	IV	7
	V	12
	VII	2
	VII	9
	VII	14
	VII	15
	VII	16
	VII	17
Single parents *see* Lone parents		
Single people	IV	2

Topic	*Part*	*Chapter*
	IV	3
	V	3
	V	7
	VI	2
Social planning *see* Planning		
Social work *see* Counselling		
Unmarried mothers *see* Lone parents		
Unwanted pregnancy *see* Pregnancy, Abortion, Adoption		
Venereal disease	II	6
	IV	1
	IV	2
	IV	5
	IV	7
	IV	Annexe IV.A
	IV	Annexe IV.B
	VII	6
Violence, family violence *see also* Child abuse	II	3
	III	3
	V	9
	VII	
Women, men	I	3
	III	2
	III	3
	IV	1
	IV	2
	IV	3
	IV	4
	IV	7
	V	9
	V	11
	VI	2
	VI	5
	VII	2
Work *see* Employment		
Working mothers *see* Employment		
Youth	I	3
	II	6
	III	2
	III	3
	IV	2
	IV	5
	V	2
	V	11
	VII	2

Contents of each volume

I. Introduction, summary and recommendations

1. **Contents of the report**
   Introduction
   List of topics in the report
   Contents of each volume
2. **The Commission and its task**
   Submissions
   Evidence
   Consultations, conferences and overseas communication
   Other commissions and committees
   Research
   - Medical education survey
   - Abortion sequelae survey
   - Hospital admission procedures survey
   - A survey of the clients of Children by Choice, Brisbane, 1974–75
   - Unwanted pregnancies
   - The attitudes of young males to contraception
   - Attitudes to sexual issues
   - Attitudes to sexuality
   - Unreported rape
   - Families with an intellectually handicapped child
   - Domestic violence
   - The role and needs of non-working and working mothers
   - The basis of decisions about having children

   Organisation
   - Budget
   - Staff
   - Acknowledgments
3. **Human relationships and social change**
   Social change and the individual
   - Scope of the terms of reference

   Responsibility
   Law and morality
   The pace of social change
   Men and women
   Children and young people
   Planning and human relationships
4. **Summary of the report**
   Part II–Education for human relationships
   Part III–Health and medical education
   Part IV–Sexuality and fertility
   Part V–The family
   Part VI–Equality and discrimination
   Part VII–Rape and other sexual offences
5. **Recommendations in the report**
   Part II–Recommendations
   Part III–Recommendations
   Part IV–Recommendations
   Part V–Recommendations
   Part VI–Recommendations
   Part VII–Recommendations

Annexe I.A List of submissions

Annexe I.B List of witnesses

Annexe I.C Offices of Australian Archives where Commission public documents may be inspected

Annexe I.D Consultations, conferences and overseas communication

Annexe I.E Related Commissions and Committees

Annexe I.F Commission research reports

II. Education for human relationships

1. **Introduction**
   The learning process
   Early learning experiences
   Formal education
   The role of government
   The Commission's evidence
   Overseas experience
   The family as educator
2. **Programs for parents**
   Needed developments
   - Conclusions
3. **The role of the media**
4. **The role of the school**
   Criticisms of the school system
   - Discipline and punishment

   Rigidity or freedom
   - Conclusions

   The aim and scope of human relationships programs
   Controversial issues
   Selection and training of teachers
   - Conclusions

Communication within the teaching profession
Conclusions

5. **Present education programs**
The training of teachers presently employed
Teacher education preferences
Resources
Voluntary associations
Conclusions
The effectiveness of present education programs
Conclusions

6. **Social sexual behaviour: implications for education**
Sources of sexual knowledge
Conclusions
Early sexual activity and its risks
Scope and content of programs of education for human relationships
Sex roles
Social sexual relationships in adolescence
Communication skills
Parenthood
Conclusions
An open approach
What young people in schools say about the issues
Conclusions
Resources
Conclusions

7. **Implementation of programs at the various levels of education**
The young child: primary school
Parental involvement and the right to withdraw
Tertiary education and further training
Conclusions

8. **Learning beyond formal education**
Where does education end?
Education for living
Adult education
Conclusion
Preparation for marriage
The need
Who should provide education for marriage?
Who should attend?
Goals
Intercultural marriage
How should it be taught?
Professional training
Conclusions
Counselling
School counselling
Other counselling services

9. **General conclusions**

Recommendations

Annexe II.A Summary of proposed guidelines for sex education in the Swedish school system

Annexe II.B Statement on behalf of the 'School without walls', ACT

Annexe II.C Examples of resource material used in human relationships education

III. Health and medical education

1. **Introduction**

2. **Australian health, health services and personnel**
Introduction
Measures of health and resulting patterns
Conclusions
Approaches to health care
Research and information
Support services in community health
Health services for women, infants, schoolchildren
Health care personnel
Women in the health workforce

3. **Human relationships issues for medical practice**
Introduction
Problems in the doctor–patient relationship
Women
Cultural differences
Migrants
Aboriginals
The doctor's role in human relationships
Violence in relationships: the doctor's role
Sexuality and medical practice
Conclusion
Medical education and fertility control
Pregnancy and childbirth: medical attitudes
The doctor and sexual variations
Conclusion

Mental illness and community health
Conclusion
Medical practice and drug dependency
Conclusion
The health care of the handicapped
Conclusion
Children in hospital
Institutional care
Conclusion
The medical profession and death

4. Undergraduate medical education
Human sexuality
Fertility control
Community and social health
Conclusion

5. Post-graduate and continuing medical education
Introduction
Post-graduate medical education
The Colleges and post-graduate education
Interdisciplinary post-graduate education
Short courses in post-graduate education

6. Medical students
Characteristics of medical students: social background and some attitudes
Attitude changes during medical school
Conclusion

Recommendations

Annexe III.A Commission research report, no. 1, Medical education, survey questionnaire, 1976; ANU Survey Research Centre, technical report

Annexe III.B Summary of courses in sexuality in Australian medical schools

IV. Sexuality and fertility

1. Sexuality
Introduction
Sexuality and sexual problems
Conclusions
Sex and the handicapped
Rehabilitation and information
Removal of constraints
Education
Social activities
Conclusion
Sex and the ageing
Sexuality and life cycles
Menstruation
Menopause
Male and female cycles
Conclusion
Sexually transmitted diseases
Syphilis and gonorrhoea
Other sexually transmitted diseases
Programs to combat sexually transmitted disease
Treatment, notification and tracing contacts
Education

2. Fertility and fertility control
Introduction
Some important definitions
Fertility and fecundity
Fecundability
Fertility control
Contraception
Family planning
Abortion
Methods of contraception and their evaluation
Methods of contraception
Oral contraceptives
Intra-uterine devices
The diaphragm
Condoms
Withdrawal (coitus interruptus)
Spermicides
Periodic abstinence methods
Injectibles
The 'morning after' pill
Female sterilisation: tubal ligation
Male sterilisation: vasectomy
Future possibilities
Classification of methods
Mode of action
Time span of action
Source of method
Level of use of contraceptives
Evaluation of methods
Effectiveness
Naturalness
Safety
Mortality
Morbidity and side effects
Conclusions
Morbidity and other risks of pregnancy
Benefits from contraception

Contraceptive use
  Introduction
    Women at risk
  Knowledge and use of contraception
  Attitudes and other factors affecting contraceptive use
    Conclusion
  Attitudes towards contraceptive methods
  Problems in the use of contraceptives
    Inability to find a method to suit
    Difficulties in use and method failure
  Non-use of contraceptives
    Survey of reasons
      Young people
    Conclusion
  The male role in contraception
  External constraints
    Access to services
    Medical attitudes
    Other constraints
  Motivational factors
    The intra-psychic theories
    Role conflict
    Other factors affecting motivation
  Conclusions
Contraceptive services
  Introduction
  General practitioners and gynaecologists
  Family Planning Associations
    Nature and scope of services
    Distribution of services
    Need for expansion
    Funding
    Doctors and nurse practitioners
    Other problems
  Womens community health centres
  Community health centres
  Natural Family Planning centres
  Hospital services
    Outpatient clinics
    Maternity and abortion patients
  Contraceptive services run by State health departments
  Other sources of contraceptive services
    The pharmacist
    Community health nurses and community health workers
    Aboriginal health and medical services
    Remote areas and the Royal Flying Doctor Service
    Domiciliary workers and mobile clinics
    Student health services
    Occupational health services
    VD clinics and abortion clinics
  Policy goals for contraceptive services
  People with special needs
    The poor
    Migrants
    The handicapped
    Conclusion
  Cost of contraceptive services
  Cost of contraceptive supplies
  Planning for expansion
    General practitioners
    Clinic services
    Policies for expansion of services
Getting the message across
  Introduction
  Education and information
  Service provision
  Motivation
    Media
    Advertising campaigns by FPAs
      Victoria
      Australian Capital Territory
      Western Australia
      Other States
    Evaluation
    Overseas experience in advertising
    More effective campaigns?
    Views about advertising
  Conclusions
Contraception and the law
  Introduction
  Advertising of contraceptive supplies and services
Distribution, display and sale
  Prescription items
  Non-prescription items
Prescription requirements and paramedical personnel
  Oral contraceptives
  The intra-uterine device and diaphragm
Consumer protection
  Advertising claims
  Quality of products: standards
  Packaging and instructions

Pregnancy testing
Sterilisation—vasectomy and tubal ligation
Mentally handicapped and sterilisation
Infertility and artificial insemination

3. Unplanned and unwanted pregnancies
Introduction
Incidence and causes of unplanned pregnancies
Unwanted pregnancies
Incidence of unwanted pregnancies
Women at risk
Unwantedness—an unacknowledged problem
Reasons why pregnancies are unwanted
The reasons women give for their pregnancies being unwanted
Summary
Underlying reasons for unwanted pregnancies
Voluntary childlessness
The motherhood role
Pregnancies unwanted by the father
Costs and consequences of unwanted pregnancies
Consequences to the mother and her relationships
Consequences to the child and the family
Costs to the community
Unwanted pregnancies and the options
The options
Marriage
De facto relationships
Abortion
Adoption
Keeping the child
Pregnancy counselling and pregnancy support services

4. Abortion
Introduction
Legal and moral issues
The law and abortion
Abortion law in England
Abortion law in Australia
New South Wales
Victoria
Australian Capital Territory
Queensland
Western Australia
Tasmania
South Australia
Northern Territory
Summary
Other countries
Criticisms of the law
Policy of abortion law
Protection of the pregnant woman
Protection of the foetus
The foetus and human development
Definitions
Foetal development
Timetable
Summary
The right to be born
The moral issues
The role of the law
Abortion and contraception
Defining the circumstances: who decides?
Abortion on demand: the medical role
Counselling
Family consultation
Panels: assessors
Conclusions
Time limits on abortion: viability
The stages of pregnancy
Viability
Definition
England
United States
World Health Organisation
Sweden
Conclusion
Late abortion and infant preservation
Abnormalities
The mother's life or health
Infant preservation and child destruction
Australian Capital Territory
Abortion services
Introduction
Abuses in abortion practice
Unsafe procedures; lack of facilities and expertise
Delay
Overcharging
Lack of follow-up services
Disapproving attitudes and lack of counselling
Criteria for abortion services
Proper medical procedures, facilities and expertise
The avoidance of unreasonable delay which

may prejudice the safety of the abortion
Reasonable fees for the full range of services
Follow-up services
Proper counselling before and after; a friendly atmosphere is important
General comments
Abortion clinics
Range of services
Method
Fees
Staff
Counselling
Procedures, equipment and training
General comments
Private practitioners
Occasional abortions
Abortion specialists
Comments and conclusions
Public hospital services
The survey of admission procedures
Medical procedures
Morbidity rates
Medical experience
Intake procedures at public hospitals
Fees
Follow-up services
Referral
Hospital staff
Referral services
Methods of termination
Menstrual regulation
Expansion of services
Access to services
Regulation of private services
Incidence of abortion
World incidence of induced abortion
Incidence of abortion in Australia
Medibank services
Explanation of table IV. 34
Hospitals and clinics
Medical practitioners
Conclusion
Characteristics of women having abortions
Age
Marital status
Number of children—previous pregnancies
Country of birth
Religion
Employment
Northern Territory
Conclusions
Changing patterns of abortion
Consequences of abortion
Introduction
The consequences: definition
Mortality of abortion
Conclusions
Morbidity of induced abortion
Length of pregnancy
First trimester methods
Second trimester methods
Experience of operator
Sterilisation
Pre-existing medical conditions
Legality of abortion
Abortion facilities
Australian morbidity and the Commission survey
Long-term physical consequences of induced abortion
Conclusion
Psychological consequences of induced abortion
Conclusion
The psychological consequences of childbirth
The consequences of failure to terminate pregnancy
Effects of abortion on the family
Special risk groups
Conclusions
Attitudes to abortion
Australia
United States
United Kingdom
Conclusion

5. Young people and fertility control
Level of adolescent sexual activity and pregnancy
The risks of sexual activity
Pregnancy
Other risks
The need for action
Education, information and motivation
Services for young people
Contraception for young people
Age of consent
Consent by minors to contraception
Abortion
Consent to abortion

6. Childbirth
Changes during pregnancy

Pre-natal education
  Preparation for childbirth
Induction of labour
  The use of medication
  Hospital and medical procedures
  The father
  Breast-feeding
  Parent–child bonds
  Home births
  Post-natal care
    Post-partum depression
  Conclusions

7. **Research Institute for the study of human sexuality, reproduction and fertility control**

Recommendations

Annexe IV.A Extract from *Everything you've always wanted to know about VD* (Health Commission of NSW, 1974)

Annexe IV.B Extract from 'How Clanger Molloy caught the Clap and gave it to his girlfriend!' (WA Health Education Council)

Annexe IV.C Definitions of some terms used in Part IV

Annexe IV.D The ovulation method

Annexe IV.E Tables of mortality rates

Annexe IV.F
  Table IV.F.1 Services offered by FPAs
  Table IV.F.2 Statistics on visits to FPAs
  Table IV.F.3 Funding of FPAs
  Table IV.F.4 Cost of visits, FPAs

Annexe IV.G Extract from Remberg, Brice et al. showing some obstacles to effective contraception and media announcements to overcome them

Annexe IV.H Table of sterilisations performed in Australia

Annexe IV.I Pamphlet, 'Single, pregnant, what shall I do?', NSW Council of Social Service

Annexe IV.J
  Table IV.J.1 Services provided by Pregnancy Support Services
  Table IV.J.2 Telephone calls and visits to PSS
  Table IV.J.3 Personnel of PSS
  Table IV.J.4 Financial resources of PSS

Annexe IV.K Abortion laws in US and NZ

Annexe IV.L Description of foetal development

Annexe IV.M Methods of abortion

Annexe IV.N Table of patients known to have had abortion

Annexe IV.O Extract from 'Demographic aspects of abortion' written for the Commission by Dr L. T. Ruzicka (ANU, 1976)

Annexe IV.P The sequelae of abortion (Commission research report, no. 2)

Annexe IV.Q Report on hospital and clinic morbidity survey

V. The family

---

1. **Introduction**

2. **Changing patterns of family life**
  Marriage
    Age on marriage
    Intercultural marriage
    Views about marriage
  Family formation
    Pre-marital pregnancies and ex-nuptial births
    Family spacing
    Children leaving home
    Views of family formation
  Marital breakdown
    Divorce and children
    Views of divorce and marital breakdown
    Conclusions

3. **Family pressures and family policies**
  Introduction
  Commission evidence
    Poverty
    Housing
    The aged
    Single people
    Families living in remote and rural communities
  Family policies
    What kind of policy?
  Family services
    Prevention
    Community participation
    Homemaker services
  Use of services
    Conclusions

4. **Child care**
  Introduction
  Issues
  Present level of service

Child care services
Types of services
Day care centres
Family day care
Pre-school kindergartens
Play groups
Care outside school hours
Private minding
Work-based care
Shortfall
Lone parent families
Mothers at home
Migrant families
Handicapped children
Child care preferences
The role of government

5. Family law
Introduction
The Family Law Act
Federal and State powers
Matrimonial property
Present rules
Criticisms of present law
Unfairness of the law
Reform proposals
Sharing the matrimonial home
Equalisation of assets
Conclusion
Powers over property on breakdown
Succession
Probate and death duty
Family income and maintenance
Children
Jurisdiction
Custody and access
Enforcement of custody orders
Children born outside marriage
Legitimacy and legitimation
Status and disabilities
Establishing paternity
Fathers and their rights
Constitutional power and jurisdiction
Marriage
Relationships other than marriage
Migrants and family law

6. Lone parent families
Introduction
Isolation
Numbers of lone parent families
Poverty
Conclusions
Work
Lone mothers
Retraining
Part-time work
Conclusions
Social welfare
Numbers dependent on benefits
Anomalies in entitlement to benefits
Lone fathers
The cohabitation rule
Conclusions
Maintenance and social security
Housing
Short-term accommodation
Conclusion
Children
Effects on children
Social needs
Child care
Domiciliary help
Self-help groups

7. Adoption
Introduction
Adoption law
Statistics
The unmarried mother's decision
Dispensing with consent to adopt
Adoption and the natural mother
The mother's reaction to adoption
Adoption or abortion
Economic factors
Social factors
Psychological factors
Adoption and the child
Medical records
Access to records
The adoptive parents
Adoption and mental health; the need for parent screening
Parent preparation
Criteria for adoptive parents
Infertility and adoption
Eligibility to adopt
Single persons; de facto relationships
People without religious affiliation
Homosexuals
Conclusions
Aboriginal adoption
The placement of Aboriginal children
The recognition of Aboriginal tribal marriages
Administration of Aboriginal adoption
Conclusions
Future research

8. Fostering
Introduction
The reason for fostering
The problems of fostering
The economics of foster care
Conclusion

9. Family violence
Introduction
Incidence
The people involved
Nationality
Sex
Nature of the attack
Nature of the injuries
Nature of the problem
Family background
Alcohol
Unemployment
Mobility
Mental disturbance
Marriage expectations
Effects on women
Physical
Psychological
Effect on children
What can be done
Family crisis centres
Refuges
Housing
Health services
Employment
Services to men
Legal services
Injunctions
Knowledge of legal situation
Assault proceedings
Counselling
Conclusions

10. Child abuse
Introduction
Public abuse and family abuse
History and definition of child abuse
Conclusions
Dimensions of the problem
American statistics
Australian statistics
Conclusion
Understanding the problem
Environmental characteristics
Poverty
Alcohol
Roles and relationships
Attitudes to children
Conclusions
Precipitating factors
The families
The parents
The children
Unwanted children
The effects of maltreatment on children
Conclusions
What can be done
Community and professional education
Conclusions
Early identification and prediction
Conclusions
Legislation
Compulsory notification
The role of the police
Child abuse services
Self-help groups
Lay workers
Services to children
Conclusions

11. Alcohol and human relationships
Introduction
Alcohol in Australian society
Groups at risk
Men
Women
Young people
Aboriginals
Social effects of alcohol consumption
The community
Personal health
The family
Employment
Offences
What can be done; the problem and its solution
Education
Treatment
The role of government
Revenue and research
A national approach

12. Prisons and the family
Introduction
The problems of the prisoner
Marital status
Arrest
Remand
Financial problems
Family problems
Sexual problems
Rehabilitation
Deprivation of autonomy
Conclusion

Recommendations

Annexe V.A Extract from Harper and Worrell, Young mothers and the workforce, Commission research report, no. 12, 1976

Annexe V.B Extract from Cox and Martin, Stress amongst migrant women, Commission research report, no. 13, 1976

Annexe V.C Adoption case histories from 'Unwanted pregnancy phone-in'

Annexe V.D Poster—Parents' Help Centre, Perth

VI. Equality and discrimination

1. Introduction

2. Equality for women
- Introduction
- How discrimination works
- Education
  - How education discriminates against girls
  - What can be done?
  - Conclusions
- Employment
  - Forms of discrimination
    - Wage rates
    - Workforce structure
    - Job advertisements
    - Recruitment and dismissal
    - Vocational training
    - Superannuation
    - Other benefits
    - Workplace attitudes
    - Promotion opportunities
    - Lack of opportunities for employment
  - Causes of discrimination
    - Absenteeism and turnover
    - Conclusions
  - The public service
  - Women and trade unions
    - Participation by women
    - Attitudes neglectful of women's interests
    - Trade union support
    - Opposition to part-time work
    - Migrants
    - Action by and for women
    - Conclusions
  - Child care
- Credit, goods and services
- Discrimination in insurance
  - Sickness and accident
  - Life insurance
- Leisure and recreation facilities
  - Licensed premises
  - Clubs
- Women and the law
  - Legal documents
  - Discrimination in legislation
  - Women's access to the law
  - Probate and estate duty
  - Social security
    - Unemployment benefits
    - Sickness benefits
    - Age pension
  - Training programs
  - Marriage and economic dependence
  - Single women
    - Conclusions
  - Language
  - The media
  - Women in public life
    - Politics
    - Legal profession and judiciary
    - Trade unions
    - Statutory bodies
    - Voluntary organisations
  - The cost of discrimination against women
  - The persistence of discrimination
  - The movement for change
    - Sweden
    - The United States
    - International conventions
      - Maternity protection
      - Equal pay
      - Equality of opportunity
  - Legislation and discriminiation
    - State action
    - National action
  - Conclusion

3. Prostitution
- Introduction
- Issues
- The question of legalisation
  - In favour
  - In opposition
- The law
- Brothels
- Conclusion

4. Aboriginals
- Introduction
- Race relations—bridging the gulf
- Education
- Health
  - Alcohol
- Family planning and contraceptive services

Family and traditional life
Tribal marriage
Employment
Pacific Islanders
Welfare services
Self-determination
Conclusions

5. Migrants
Introduction
Communication
Migrant children and education
Learning English
Women and the family
Discrimination at work

6. Discrimination against homosexuals
Introduction
Definition of homosexuality
The medical definition
The legal definition
The causes of homosexuality
Medical opinions
The law and homosexuality
The Wolfenden report
The WA report on homosexuality
Recent reforms
Conclusion
Examples of discrimination
Education about homosexuality
Counselling services
Adoption and marriage
Research
Conclusions

7. Handicapped people
Introduction
Incidence
Families with handicapped children
Services
Diagnosis and counselling
Conclusions
Prevention
Education
Conclusions
Family services and residential care
Conclusions
Handicapped people and human relationships

Recommendations

Annexe VI. A List of recent Commissions and Inquiries which have reported on Aboriginal issues

Annexe VI.B Recognition of Aboriginal tribal marriages

Annexe VI.C Extract from Cox and Martin, Stress amongst migrant women, Commission research report, no. 13, 1976

Annexe VI.D Summary of evidence by Professor C. Price, ANU, Department of Demography

VII. Rape and other sexual offences

1. Introduction
Terminology
The victim
The offender

2. Rape and society
Contributory or causative factors
Changing social patterns and values
The emphasis on stereotyped sex roles
Pornography
Aggravating factors

3. Existing rape laws in Australia

4. Rape statistics
Reported rape
Australian statistics
New South Wales
General statistics
Conviction rate in rape
Age of offender
Age of the victim
Marital status of offender
Educational level of offenders
Country of origin of offenders
Multiple rape
Relationship between offender and victim
Level of violence
Distribution of rape
Victoria
South Australia
Queensland
Other States and Territories
Overseas statistics
Unreported rape

5. Police procedures in dealing with rape complaints

6. Medical procedures for dealing with rape victims
Mental health
Venereal disease
Pregnancy
Medico-legal aspects

7. Rape crisis centres

8. Committal proceedings

9. The procedure at rape trials
Legal representation for the victim?
Cross-examination of the victim on her prior sexual history
Cross-examination of the accused on his prior sexual history
Evidence of complaint by victim
Corroboration
Composition of court
Publicity

10. Sentencing in rape cases

11. Compensation to victims of rape and other sexual assaults

12. The need to redefine rape
The consent standard
The scope of the offence
Rape between spouses
Other forms of sexual abuse
The presumption relating to boys under 14

13. Attempted rape

14. Statutory rape and consent to sexual relations
Age of consent
Male and female offenders and victims
Reasonable belief in age
Proceedings
Indecent assault
Education and information

15. Sexual offences involving young children
Carnal knowledge of young children
Indecent assault
Summary trial
Protection of child victims
Child protection service
Child protection tribunal
Court procedures
Indictable offences
Summary offences

16. Sexual offences involving people with mental incapacity

17. Incest
Current law relating to incest
Social aspects of incest
Interests protected by incest law
Issues for consideration
Incestuous relationships between adults
Incestuous relationships with minors
Procedure in cases of incest

18. Restructuring laws relating to sexual offences
The grades of rape and other sexual offences
Point one
Point two
Point three
Point four
Point five
Point six
Point seven
Point eight
Consent
Miscellaneous provisions

Recommendations

Annexe VII.A Extracts of relevant portions of Crimes Act for each State and Territory

Annexe VII.B Discussion of *D.P.P.* v. *Morgan* and its possible effects in Australia

Annexe VII.C Extracts from Dr Paul Wilson, The other side of rape, Commission research report, no 9, 1977

Annexe VII.D Sydney Rape Crisis Centre statistics

Annexe VII.E Harbor General Hospital, message to house staff concerning rape

Annexe VII.F Information for rape victims

2. The Commission and its task

1. This is the final report of the Royal Commission on Human Relationships which was appointed, on 21 August 1974, to inquire into the family, social, educational, legal and sexual aspects of male and female relationships. Our conclusions and recommendations are based on information drawn from:

- written submissions from the Australian public and evidence heard at public hearings all over Australia;
- informal meetings and discussions;
- research done by and on behalf of the Commission; and
- literature and research material available in Australia and overseas.

2. To encourage public participation we introduced innovations in the running of the Royal Commission. The matters which we have investigated can affect the daily life of almost every Australian. We took steps to open channels of communication with all levels of the community. We sought to reach out to people who had views to express though not in organised groups and we made our inquiry as informal and flexible as possible. We invited people with an interest in our inquiries to put their point of view to us so that we might be better able to identify problems and make constructive suggestions for their resolution. We talked with many people of different ages, from the very old to the very young, with Aboriginals, migrant groups, people in cities and suburbs and with people in country towns and isolated places. Our invitation was open-ended and we had a very wide response.

3. An *Interim report*, dated 30 January 1976, was submitted in February 1976. That report dealt with the social background to the inquiry; its history and terms of reference; our approach to the task; the research program; and the organisation of the Commission. This final report brings up to date the information contained in the *Interim report*, which should be considered as an integral part of this report.

4. An addendum to the *Interim report* (dated 12 February 1976) stated that we had been asked by the government to complete our inquiry by the end of 1976. In order to try to meet the date asked for we had to abandon some projects and to compress our work in other areas. Due to lack of time we have been unable to complete a major review of submissions and material received in some areas.

Submissions

5. We received 1264 written submissions from individuals and organisations. People who responded were of various occupations and social circumstances; some wrote long and formal research documents. Many submissions were handwritten letters. We would like to record our appreciation to all these people. A list of submissions additional to those listed in the *Interim report* is at Annexe I.A.

Evidence

6. We heard oral evidence at public hearings and this was a major part of the Commission's work, giving a rich insight into contemporary life. Public hearings were held in Sydney (three times), Melbourne (twice), and in Brisbane, Canberra, Adelaide, Perth, Bunbury and Hobart. Members of the public attended all our hearings. A total of 374 people gave evidence. A list of witnesses additional to those listed in the *Interim report* is at Annexe I.B.

Consultations, conferences and overseas communication

7. In Annexe I.C we list our consultations, conferences and overseas communications additional to those mentioned in the *Interim report.*

Other commissions and committees

8. In Annexe I.D we listed the names of commissions and committees examining subjects within our terms of reference, additional to those listed in the *Interim report.*

Research

9. The basis of our research program is set out in the *Interim report.*.The addendum to that report points out that certain items could not be proceeded with due to the necessity to complete the inquiry earlier than had been intended. We had to abandon the publication of separate discussion and research papers; the work done towards these was used in the preparation of this report.

10. The research projects which were completed are as follows:

Medical education survey

11. This survey was to assess the extent to which medical students, and doctors at the post-graduate level, are taught about human relationships. We took a systematic national sample of general practitioners to ascertain their knowledge, attitudes and practice in the field of human relationships. Care was taken to ensure anonymity. The results of the survey are reflected in Part III of our report. Computer print-outs, a copy of the questionnaire and a technical report may be seen at Australian Archives, Sydney. A copy of the questionnaire and a technical report on the conduct of the survey is also on microfiche, number RCHR 1.

Abortion sequelae survey

12. This survey examined the social, psychological and medical consequences of the termination of pregnancy to make an objective evaluation of the information and opinions available to the Commission. The results of the survey are reflected in Part IV of our report. Computer print-outs and a copy of the questionnaire may be seen at Australian Archives, Sydney. A copy of the questionnaire is also on microfiche, number RCHR 2.

Hospital admission procedures survey

13. Information was gathered about the intake procedures of a sample of hospitals and private abortion clinics in regard to patients seeking termination of pregnancy. The results of the survey are reflected in Part IV of our report. Computer print-outs and a copy of the questionnaire may be seen at Australian Archives, Sydney. A copy of the questionnaire is also on microfiche, number RCHR 3.

A survey of the clients of Children by Choice, Brisbane, 1974–75

14. This survey reports on the characteristics of clients of the Children by Choice Agency in Brisbane, in the 2 years 1974–75. We considered the results of the survey when we were preparing Part IV of our report. A report of the survey, written by Mr Simon Rigg, is on microfiche, number RCHR 4.

Unwanted pregnancies

15. By means of media publicity in Sydney, we invited men and women to telephone and give confidential accounts of their personal experiences with unwanted pregnancies. The results are reflected in Part IV of our report. Computer print-outs and a copy of the pro forma on which we recorded calls may be seen at Australian Archives, Sydney.

The attitudes of young males to contraception

16. This research examined the attitudes of male students to the issues of contraception, the use of male methods, the use of female methods, responsibility for unwanted pregnancy and abortion. Data were collected at the Student Health Clinic of the University of Melbourne, using a sample of male patients. The research was carried out by Felicity Beighton and Dr J. B. Cole, both of the University of Melbourne. The results are reflected in Part IV of our report. The research report is on microfiche, number RCHR 5.

Attitudes to sexual issues

17. In order to provide more information about social attitudes to such issues as contraception, homosexuality, abortion, prostitution, sex education and divorce, Mr Simon Hasleton, a lecturer in psychology at the University of Sydney, was asked to do further work on data he had already gathered. The results are reflected in our report, particularly in Parts IV and VI. The research report is on microfiche, number RCHR 6.

Attitudes to sexuality

18. Two studies examined the educational and other origins of adult attitudes to sexuality. The results of the research are reflected in Parts IV and VI of our report. The report of the Melbourne study by Rev. A. J. Scott is on microfiche, number RCHR 7, and the Sydney study by S. Wills, E. Cox and G. Antolovich on microfiche, number RCHR 8.

Unreported rape

19. This project reports on cases of women who have experienced rape or attempted rape but have not reported to the police. The results are reflected in Part VII of our report. The research report by Dr Paul Wilson is on microfiche, number RCHR 9.

Families with an intellectually handicapped child

20. This project reports on the health and stress of adults in a family with retarded children at home, and assesses their difficulties and their need for community help. The findings were taken into account in the writing of Part VI of our report. The research report by Dr R. Barr and Dr Helen Molony is on microfiche, number RCHR 10.

Domestic violence

21. The causes and effects of domestic violence upon women and children were investigated in two projects–research at the Elsie Womens Refuge in Sydney and a 'phone-in' when people gave confidential accounts of their personal experiences with domestic violence. The results of these investigations were used in the preparation of Part V of our report. Computer print-outs and a copy of the pro formas used may be seen at Australian Archives, Sydney. The report of the Elsie Refuge research by Christina Gibbeson is on microfiche, number RCHR 11.

The role and needs of non-working and working mothers

22. Two studies examined the role and needs of women in relation to their family and whether or not they go out to work. The results of the studies are reflected in Parts V and VI of our report. The reports of the two studies are on microfiche–one by Jan Harper and Diane Worrell, Young mothers and the workforce, is on RCHR 12; the other by Eva Cox and Jeannie Martin, Stress amongst migrant women, is on RCHR 13.

The basis of decisions about having children

23. This research examined the factors affecting decisions about whether or not to have children. Its results were taken into account in the preparation of Parts IV and V of our report. The research report by Lyn Richards may be seen at Australian Archives, Sydney.

Organisation

24. An outline of our organisation is in the *Interim report,* chapter 5.

Budget

25. The cost of conducting the inquiry was in the order of $1 million, made up as follows:

	$ (rounded)
Office expenses (including advertising, printing, stationery, telephones, postage)	200 000
Contract research	80 000
Legal fees	80 000
Salaries, fares, allowances	640 000
	1 000 000

26. The difficulties encountered by the Commission in planning and budgeting are set out in paragraphs 507–518 of the *Interim report.*

Staff

27. The staff of the Commission were recruited from within the Australian Public Service and elsewhere. In general, staff were engaged for the duration of the Commission under terms and conditions of employment similar to those which apply to officers of the Australian Public Service. Some members of our staff were not with us for the whole period of the Commission; some staff positions were filled in turn by more than one person.

Secretary of the Commission
- Robert Hyslop

Secretariat
- Roberta Burke
- Mavis Cooney
- Diane Everingham
- Betty McGrath
- June Poole
- Lyne Quinn

Research
- Patrick Healey—director
- Joan Bielski
- Toni Church
- Yvonne Geikie
- Ian Manton
- Rosemary O'Grady
- Keith Windschuttle
- Alison Ziller

Community relations
- Robyn Lewis
- Stephanie Shwabsky

Library
- Bert Bier
- Beverley Lim
- Beverley Schurr
- Suzanne White

Documents
- Catherine McCosker
- Laurie Gray
- Faye Roberts

Administration
- Dennis Gilham—office manager
- Mathew Binge
- Kerry Latto
- Gabrielle Clifton-Smith
- Ray Pace
- Arthur Worthington

Legal
- Counsel assisting the Commission was Jane Mathews, instructed by Don Rugless, solicitor of the Crown Solicitors Office, Sydney.

Acknowledgments

28. Many people came forward in response to our invitation to make submissions. We were impressed by the common sense and wisdom that came through to us from individuals and from organisations. We thank them and the many people, expert in their fields, in academic institutions, welfare organisations, interest groups, the churches and government, who have helped us by giving us the benefit of their thoughts. We believe we have heard many differing views and have taken account of them in our report.

29. We thank the media for their sustained reporting of the inquiry; we thank the many experts we consulted; we thank the people in government organisations who have helped us, sometimes beyond the line of duty; and we thank our secretary and our staff for their assistance, their loyalty and their application to the task.

3. Human relationships and social change

Social change and the individual

1. The Royal Commission on Human Relationships is a product of profound personal and social changes in the area of male and female relationships. Our task has been to explore those changes and to make recommendations which will help our understanding and our institutions to reflect the reality of contemporary Australian society.

2. A comment on the lack of preparation of the individual to meet change was made by Dr James Ryan, Professor of Community Health, University of Queensland, at our public hearings in Brisbane:

> . . . instead of the impression we may have that we live in a sexually saturated and sophisticated society, having recently been in full-time general practice one is appalled at times at the level of ignorance and misconception in the community.[1]

It is important to take steps to overcome this ignorance if men and women are to grow in understanding of themselves and of our society and to assume responsibility for their own lives.

3. Throughout our inquiry we have been guided by a belief in the right and integrity of the individual to make free choices in the context of human relationships, and to have access to the knowledge and skills which give such a free choice meaning. We have been impressed by the thoughtfulness and concern of those who have helped us, whether by written submission, oral evidence or informal discussion.

Scope of the terms of reference

4. No inquiry can look at all social issues, yet our terms of reference are very broad. While this enabled us to avoid a narrow approach, it also created problems. The first was to define our limits; we were assisted in this by the many submissions we received, which helped us to focus on issues of immediate concern.

5. Another problem arose because many subjects of investigation overlapped the boundary between Federal and State legislative powers and functions. This overlap runs right through our terms of reference. It is clear, for example, that education is a direct State responsibility. We have taken the view that our terms called on us to take a broad national approach, though our recommendations are directed to the Commonwealth government.

6. A third problem was that, in the nature of things, our submissions and evidence tended to concentrate on the traumas of society rather than on its many positive virtues. Our concern for those in need should not obscure the fact that many Australians are contented and well adjusted, but this makes it the more important to eliminate inequalities and injustices which debar others from similar enjoyment.

7. A further problem involved the need to divide our subject matter into sections for convenience of treatment: to separate out issues under headings such as education, the family and fertility control. We regret having to do this, because subject division can too easily lead to placing of people into categories, each representing an identifiable problem, requiring identifiable services.

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1. Evidence, p. 1816, Prof. James Ryan.

8. We prefer the refreshing approach of the Volunteer Task Force in Perth:

> We have never kept statistics on exactly what type of people we work for and . . . I'm glad we haven't because it stops putting people in boxes.[2].

9. Although we had to divide our subject matter, we have endeavoured not to lose sight of the individual people we heard from: men, women and children. Whenever possible we have used their own words to describe their situation or to suggest a possible solution.

Responsibility

10. A number of submissions[3] raised the meaning of the word 'responsible' in our terms of reference, e.g. 'to give particular emphasis to the concept of responsible parenthood'; the effectiveness of existing education programs 'in promoting responsible sexual behaviour'; and 'to encourage acceptance by the medical profession of its responsibilities in the field of contraceptive counselling'.

11. The *Shorter Oxford Dictionary* includes among its definitions under 'responsible':

> . . . answerable, accountable; morally accountable for one's actions; capable of rational conduct; capable of fulfilling an obligation or trust; reliable; of good credit and repute.[4]

12. It would seem to us that accountability, a sense of obligation, an ability to think and act reasonably, are all essential in some degree for 'responsible parenthood' or 'responsible sexual behaviour'.

13. An act is not responsible unless the consequences of the action are taken fully into account. The consequences of the action should, as far as possible, promote the well-being of all affected by it. Responsibility implies the attempt to make the right choice between alternatives.

14. The subject was well raised in a submission by the Social Questions Committee of the Anglican Diocese of Melbourne:

> The language of the terms of reference, and the very existence of the Commission, presuppose that the government sees a need for members of the community, as individuals and in groups, to understand the consequences of their actions, and to want to make unselfish choices. They indicate, too, that the government believes that these needs are most likely to be fulfilled if the community is engaged in processes of a continuing educational kind . . .
>
> We believe . . . that, for behaviour of a responsible kind to be general in the community, it is *not* sufficient to spread knowledge of the facts. We believe that knowledge of the consequences of acts is essential to truly responsible behaviour . . .
>
> We invite the Commission, in considering the role and the effectiveness of the educational programs, facilities and measures to which most of the terms of reference relate, to take especial stock of the need for the imparting of knowledge to be accompanied by the imparting or strengthening of motivation to use that knowledge 'responsibly' for the well-being of others.[5]

Responsibility also rests with governments and communities to ensure the kind of environment in which people are able to live in love and security. Poverty, malnu-

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2. Evidence, p. 2139, Mr Greg McIntyre.
3. e.g. Submissions 146, Mothers and Babies Health Association of SA Inc; 216, Ms Valerie Yule; 611, Anglican Diocese of Sydney; 620, Future Lobby; 818, Anglican Diocese of Melbourne, Social Questions Committee; and many others.
4. *Shorter Oxford Dictionary* (two volumes, 3rd edn, 1974).
5. Submission 818, Anglican Diocese of Melbourne, Social Questions Committee.

trition, adverse discrimination, lack of family services and unemployment can stunt and sour human potential and make a mockery of the word 'responsible'.

15. Other writers appealed to the media to act responsibly 'in presenting material designed to strengthen the image of marriage and family life'[6], or called upon:

> . . . appropriate public authorities to protect the family from the present bombardment with advertisements for experience and possessions which are designed to create needs; for it is in pursuing the quest for gratification of artificially engendered needs that the individual comes under the pressures which are the cause of personal and relational breakdown.[7]

16. Young people today are vulnerable to the pressures of what is often regarded as a permissive society, and education and the creators of public taste and values need to make responsible use of their power. Thus the National Catholic Education Commission says:

> . . . if the responsible make no positive contribution to sex education, the irresponsible and the commercial exploiters will fill the vacuum so left.[8]

17. In regard to 'responsible parenthood', some saw it as meaning responsibility in regard to family planning and fertility control and sexual behaviour.[9] Others saw it as meaning the parents' responsibility towards the developing child. Thus Future Lobby wrote of:

> . . . a continuing commitment to provide for a child's optimal physical, emotional and cognitive development and socialisation appropriate to the environment in which he lives . . . programs should be very sensitive to community values and should not be planned at the top by professional persons or by pressure groups, and imposed on the rest of the community.[10]

18. The Royal Australian College of General Practitioners told us they preferred the term 'responsible adulthood and parenthood'.[11] So often marriage and family life are regarded solely in terms of sex, with the belief that sex education will resolve every problem. There needs to be greater recognition that parenthood involves responsibilities even more than rights.

19. Parenthood is not instinctive; parents have to learn the arts of care and nurture, particularly when the child is ill or handicapped in some way. Valerie Yule, a child psychologist in Melbourne, wrote:

> . . . responsible parenthood must involve some values such as patience, self-sacrifice, optimism, enjoyment of simple pleasures, loyalty and perseverance. Failure to consider what it must mean for a couple's previous freedom and intimacy [results in] intense feelings of suffering and martyrdom when they do realise this.[12]

20. The Mothers and Babies Health Association of South Australia spoke of parental responsibility as including the obligation to produce socially contributing young adults.[13]

21. Responsible parents will therefore welcome programs of human relationships education both for themselves and their children; equally they should recognise that

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6. Submission 610, Family Life Movement of Australia.
7. Submission 611, Anglican Diocese of Sydney.
8. Submission 816, National Catholic Education Commission.
9. e.g. Submissions 198, FPA, ACT; 207, Humanist Society of Victoria.
10. Submission 620, Future Lobby.
11. Submission 886, RACGP.
12. Submission 216, Ms Valerie Yule.
13. Submission 146, Mothers and Babies Health Assoc. of SA Inc.

the purpose of such education is not merely to give a knowledge of biology and sexual techniques, but to provide proper care for the development of children into responsible, stable and loving adults. This was well emphasised by Dr Clair Isbister:

> Parents and children require a family in which they live together, respecting each other's individuality, and can obtain those factors vital to human happiness in which the parents accept the responsibility and commitment necessary to rear children in a society that demands a long period of dependence—we must thus also consider the responsibilities of groups in the community and governments to create and preserve this kind of family.[14]

22. It has always been important to give young people a sense of moral values and this is still required, particularly as the young are exposed to an ever increasing range of experiences. New patterns of learning are necessary; there is a need to help all members of the family learn how to apply intelligence, initiative and common sense in meeting the changing demands of family life. To quote Valerie Yule again:

> . . . parents fail to realise that they have more intelligence and other resources than their little ones, and that they should use them in training, caring for and educating their children . . . parents' inability to enjoy simple pleasures also seems a factor in lack of a sense of humour and fun in child rearing.[15]

23. In our confused and complex society, responsible moral decisions have to be made about the sort of society we want and the values that are to be upheld. Advances in knowledge, human health and economic welfare are of little worth if achieved at the expense of human happiness and the lack of any sense of security for children.

Law and morality

24. Throughout our inquiry we encountered many areas of genuine moral conflict, areas where it could not truly be said that the law represents a general consensus of what acts should or should not be punished. In such cases it is our view that the law should not attempt to be the arbiter of moral values, but should take a neutral stand.

25. Increasingly morality has to become the preserve of the individual, making responsible choices in knowledge of the consequences of actions and regard for the well-being of those affected. This implies that human beings are able to act together on the basis of individual moral decisions united in a harmonious social whole. Such a view depends upon tolerance, rather than on dogma, and requires knowledge and understanding. Some continue to see social diversity as synonymous with moral decay and social collapse. A major irony of their fear of permissiveness is that it leads to a situation where knowledge itself is not permitted, but is suppressed in the interests of stability.

26. The diversification of society parallels the growth of participation by individuals in affairs that touch on them, and the extension of questioning into previously forbidden areas. Questioning implies two things: the right of the questioner to know the answers and the possibility of change if the answer is not adequate.

27. On the other hand, government cannot wipe its hands and leave all responsibility to the individual; help and care of various kinds still has to be given. As the submission on abortion by the Anglican diocese of Melbourne said in its conclusion:

> . . . the state has a continuing interest and responsibility for the consequences of the decision after it is made—whatever it may be—and it . . . should provide for all appropriate follow-up action in every case.[16]

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14. Exhibit 182.
15. Submission 216, Ms Valerie Yule.
16. Submission 818, Anglican Diocese of Melbourne, Social Questions Committee.

The pace of social change

28. While every generation seeks to reconstruct its society, change has become almost an obsession of the contemporary world. What is being experienced, however, is not necessarily the disintegration of all order but the transition from one form of order to another. This transition, whether described as progress or as decay, affects all the institutions through which society expresses itself, including the family.

29. The pace of social change has increased; but so has our capacity to cope with it. This is shown by the efforts which are made to study change and to direct it to make the world a better place rather than leaving it to chance. Technology is not an independent force outside our control; technology can be subordinated to values, and education can stimulate people to know their own minds and understand their values clearly enough to make effective choices.

30. Governments can intervene in social processes by means of investigations and policies. The point of intervention may occur where a personal problem becomes a social issue. For example, when one man is unemployed, that is a personal problem for him and his family. When 5 per cent of the workforce is unemployed, that is a social issue. A submission from the Australian Council of Social Service well illustrates this point:

> The absence of work, or employment in meaningless or demeaning work, is creating an increasingly intolerable situation. The human and community costs are manifested in workers' alienation, family instability, alcoholism, drug addiction and other symptoms of poor mental health. Likewise industry is paying through low worker productivity, sabotage, absenteeism and turnover.[17]

31. Similarly, when so many teenage girls become pregnant and have abortions, or when thousands of pre-school children are left without adequate care, these are social issues of magnitude as well as personal problems for those involved.

32. The defining characteristic of a social issue is that it involves institutions and resources that may be outside the control or even the understanding of the individual.

33. The changes with which our inquiry has been concerned are primarily those which affect the family, the roles and relationships of men and women and the development of children and young people. These have occurred in a context of wider political, economic and social changes.

Men and women

34. The roles and relationships of men and women have changed significantly in the 20th century. Most of the measurable changes affect women but also have important effects on men. As women become capable of economic independence, men's role as breadwinner for their families may seem less significant.

35. Some people question whether these changes are desirable or whether they are socially destructive. These doubts have been expressed by Margaret Mead as follows:

> How are men and women to think about their maleness and femaleness in this 20th century, in which so many of our old ideas must be made new? Have we overdomesticated men, denied their natural adventurousness, tied them down to machines that are after all only glorified spindles and looms, mortars and pestles and digging sticks, all of which were once women's work? Have we cut women off from their natural closeness to their children, taught them to look for a job instead of the touch of a child's hand, for status in a competitive world rather than a unique place by a glowing hearth? In educating women like men,

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17. Submission 591, ACOSS.

> have we done something disastrous to both men and women alike, or have we only taken one further step in the recurrent task of building more and better on our original human nature?[18]

These questions are valid and they need consideration. The fact remains that changes have been happening and continue to occur.

36. Perhaps the most important change is that most women in Australian society are able to control the number of their children. As a result of smaller families and longer lifespans, many are free of the responsibility for caring for young children for the greater part of their adult life. The desire of people to control their fertility is part of their assertion that they have the right to take personal reponsibility for important aspects of their lives, and this has also contributed to the changing role of women in society.

37. Another significant change is that of the workforce participation of women. Many more are now employed, including those who are married and have young children.

38. Many more men and women are married than in the 1940s or earlier. Most people are married most of the time and most marriages produce children. Despite this, the increased number of divorces and the factors affecting women's role in society lead some to the view that the family is under threat. The Catholic Womens League of NSW wrote to us:

> The family is the unit of the state—it follows that the state has a particular primary duty to protect the family . . . the efforts of the state must be directed to the security and happiness of the maximum proportion possible of ordinary families in their homes . . . Today we feel that the feminine role is denigrated, the stay-at-home wife and mother has the lowest status ever . . . We firmly believe that the traditional role of women, that of homemaker, giver of life, protector of the family, remains the *instinctive* role of a woman who chooses to marry . . . Upgrading of women cannot be achieved without defining sex roles in marriage, and cannot be achieved without recognising woman's *natural* role.[19]

39. In the report on *Population and Australia,* 1975, Borrie made the following comment:

> It is worth observing in conclusion that, whatever social factors may be facilitating marriage dissolution (e.g. divorce) or family breakdowns, the low levels of mortality now prevailing make—theoretically at least—for an extension of the years of complete family life. The joint lives of husbands and wives are longer than ever . . . childbirth has become safer than ever and very few children born fail to reach adult life within the family.[20]

Similarly, Alan Stoller, in his study of the Australian family, writes:

> . . . it may still be affirmed that the family in Australia, although subject to strains at the present time, remains the cornerstone of community stability and continues to exert a powerful influence in promoting the well-being of Australian society.[21]

Children and young people

40. The changing roles and relationships of men and women affect the socialisation of children, or the process by which they develop and learn to function within their

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18. Margaret Mead, *Male and female: a study of sexes in a changing world* (Penguin, Harmondsworth, 1974), p. 27.
19. Submission 586, Catholic Womens League of NSW.
20. *Population and Australia,* first report of the National Population Inquiry, vol. I (AGPS, Canberra, 1975).
21. Alan Stoller, 'Posing the problem', in J. Krupinski and A. Stoller (eds), *The family in Australia* (Pergamon Press, Sydney, 1974).

own culture. The human being is made, not born, and the family is part of the socialisation process.

41. The growing child does not, however, receive his values simply from the family or from a closeknit local community. The child's knowledge of the world extends, through education and social contact and by means of the media, to a great variety of life styles, attitudes and values. These are sometimes in apparent conflict with the values and attitudes of the immediate family, and may lead the child to question or reject the latter. Valerie Yule commented:

> Life becomes the mirror of art, and television predicts our future . . . Because horrid people are so interesting on television and 'good' people so dull, large sections of the population now fail to observe that horrid people are horrid in real life and 'good' people delightful, with serious consequences for their own self-ideals and choice of models.[22]

42. Unfortunately many of the values conveyed by the media are false values, based on the needs of the advertisers to boost consumption rather than on human values, and sometimes distorting those values to the ends of production and distribution. Children need secure values to withstand the impact of the media, especially that of television. They also need an understanding of the media so they can learn to be discriminating.

43. Consideration of these issues should not obscure the fact that the generation gap and the 'alienation of youth' are not necessarily the predominant pattern. Dr Jerzy Krupinski was of the opinion that:

> All the surveys mentioned reject the notion that Australian youth is becoming alienated from their parents; on the contrary, family ties seem to be strong and there are clear emotional bonds between children and their parents in the vast majority of cases.[23]

Planning and human relationships

44. Human relationships are in many respects personal and private and, to that extent, unaffected by planning and policies. But at certain points relationships are affected by social policies, whether in the fields of education, employment, transport, housing or health care. For, as the ACOSS submission reminded us:

> Health, housing, legal and other heavily bureaucratised systems can have a generally dehumanising influence on those who contact them, especially weaker groups.[24]

45. Policies are based on underlying assumptions about human behaviour, social roles and social institutions; they are determined within a set of values. Are our social policies well designed to serve human needs? Do they encourage and sustain individual growth and development? To achieve these purposes there needs to be open communication between policy makers, services and the people affected. This Commission has sought to act as a medium of communication between people and government.

46. Our overall impression is that present methods of assessing needs and of delivering services are inadequate. In particular, there needs to be a better flow of information.

47. Our evidence indicated that many people find it difficult to get help for social and personal problems, due to fragmentation and lack of co-ordination of government and non-government policies and to confusion in the administration and

22. Submission 216, Ms Valerie Yule.
23. Jerzy Krupinski, 'Family relationships in Australia', in Krupinski & Stoller, p. 35.
24. Submission 591, ACOSS.

funding of social programs.[25] An ACOSS statement criticised the complexity and conflict arising from the division of financial powers between the Commonwealth, States, local government and voluntary agencies which, it claimed, 'inhibited the provision of services at the expense of the needy and the deprived'.[26]

48. The Social Welfare Commission, from 1973 to 1976, played a role in co-ordinating policy and in bringing together the various departments and agencies involved in service delivery. The Australian Assistance Plan was established as a means of ensuring co-operation and co-ordination at local level, with the assistance and guidance of Regional Councils of Social Development. This program has fulfilled a valuable role in helping local community groups to identify local needs and to participate in decisions which enable those needs to be met effectively. The devolution of responsibility is a key factor in effective use of local resources; it can help to cut down on wasteful expenditure and duplication. For maximum efficiency, co-ordination of policy and implementation at local level is essential.

49. Social planning should be sensitive to social change—able to anticipate its direction without being too far in advance of current trends and attitudes. Failure to plan for changes in roles and relationships can lead to conflict and to hardship for those who are left to carry the burden of adjustment. These people are often the weakest and least advantaged.

50. When people are seen as resources, or as means to an economic end, the individual is diminished and his or her needs neglected. The Department for Community Welfare, WA, considered that in western culture there has developed an economic basis to human relationships. Worth equals wealth; the least productive are undervalued; and hard work is recognised only if it brings commensurate financial rewards. The poor have less value because of this, as do the old and helpless.[27]

51. In an expanding economy more resources will be available for welfare services.[28] In a contracting economy the reverse may apply while the need for services may in fact be greater. To an extent, expansion serves welfare needs; beyond a certain point, however, growth may be counter-productive and may set up stresses damaging to individuals and their relationships.[29] Here we have an inherent dilemma which can be resolved only by careful setting of goals and priorities which will maintain a proper balance. The economy should serve human needs and not the reverse.

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25. Social Welfare Commission, Submission to the Senate Committee on Constitutional Affairs, May 1975.
26. ACOSS, *The making of social policy* (Australian report, XVI International conference on social welfare, The Hague, 1972).
27. Submission 1056, Dept for Community Welfare, WA.
28. P. H. Partridge, *Consent and consensus* (Macmillan, London, 1971), p. 126.
29. Evidence, pp. 2453-60, Garry Egger.

4. Summary of the report

The detailed report of our inquiry spans five volumes; we here give a brief summary of what is contained in those volumes.

Part II Education for human relationships

1. Technological and social changes are a feature of modern western society. There is a 'knowledge explosion' and each generation is learning about areas unknown to parents and grandparents. In Australia we have seen a marked increase of women in the workforce. Our immigration policy means that, today, one in four Australians was born of non-Australian parents. Educational programs must be appropriate to the contemporary situation.

2. Our primary task has been to evaluate sex education as part of human relationships programs, and the effectiveness of these in the general context of education. Our evidence generally expressed concern that young people were being inadequately prepared for the challenges of modern life, and that they need help to appreciate the attitudes and values, religious, moral and social, which affect behaviour.

The learning process, early learning experiences and formal education

3. Learning is a lifelong and complex process; family, school, work, government, church, media and social life all offer learning experiences. The family establishes models of behaviour and values; unhappy childhood experience may lead to later dysfunctional behaviour. Formal educational institutions transmit group culture and develop competence through teaching various skills.

Role of government

4. Governments today are seen as planners, developers of guidelines, sponsors of research and providers of funds. Both Commonwealth and State governments are involved in these tasks and have encouraged various commissions and inquiries to evaluate their policies; they favour less rather than more centralised control over schools and encourage diversity. The Karmel report of the Australian Schools Commission (1973) is of particular importance in its discussion of autonomy. Teachers are taking greater responsibility for what is taught in classrooms.

5. The government acts as a clearing house for information, encourages and funds research and assists in the development of curricula and resource material.

The Commission's evidence

6. The belief that young people should be given education in human relationships was widely supported. Views differed about the best approach. Many favoured sex education in schools; others saw it as the sole prerogative of parents or thought that parents should be involved. Some emphasised the number of parents unwilling or unable to instruct in this field; they need education themselves. The doctor and the voluntary association also have their place.

The family as educator

7. Some of our witnesses were emphatic that parents should be the sole educators in family roles and sexuality, but it was agreed that parents needed to learn parental skills and to understand child development if they were to fulfil their task.

8. The Commission found that for many couples the advent of the first child was a frightening experience, because they were totally unprepared for parenthood. Help is needed for parents to improve their own relationships and to understand how their children learn about sex and sex roles. At present the absence of readily available resource material makes the parental task difficult. Parent education is a first priority.

Programs for parents

9. Work in this field is already being done to some extent by State health departments, voluntary organisations, the Family Life Movement, Mental Health Associations, Marriage Guidance Councils, by some adult education organisations and by church education departments. But programs are uncoordinated, fragmented, and tend to be concentrated in major cities. Financial resources are inadequate for extension of their work.

Needed developments

10. The Commission does not favour compulsion in parent education but sees the need to develop strategies which will reach parents where they are, and use established social networks.

11. Some aspects of child rearing have become a branch of preventive medicine. The behavioural sciences have useful insights into child care and parent–child relationships. The one community resource common to both parents and children and existing in every community is the local primary school; here parent education can best be introduced, but at present it is not part of the school's function nor do schools have the trained personnel available. Since the teaching profession is not oriented to problems or illnesses and its members are familiar with a whole range of normal behaviour, it would be an ideal group to provide this education if properly trained.

12. The competence and self-confidence of parents would increase if voluntary agencies, government agencies and professional bodies co-ordinated their activities to provide courses available to fathers as well as mothers, at suitable times and with child care provided. Parents need to be treated as partners. The programs should take place early in each school year, and should be adapted and repeated as children move to higher levels of education. The government should consider funding, in whole or in part, community education.

The role of the media

13. The media are also a powerful influence on young children, especially television, which can convey community attitudes and values in many overt and hidden ways. Both parents and children need to learn about the media and how to cope with the messages delivered by them.

The role of the school

14. Education authorities need to develop human relationships programs which will enable young people by the time they leave school to have acquired the knowledge and skills necessary to live socially and economically at a reasonable level. Views differ as to content of courses, e.g. whether topics such as contraception, VD and abortion should be included. There is a need to develop the whole personality and to help young people acquire a sense of responsibility for their actions. Joy needs to be a component of modern family life.

15. Education should produce an acceptance of sexuality, and individuals who know and accept themselves and are tolerant of the differences which exist in others.

16. There is concern that children are fed misinformation about sex and human relationships, with the media over-emphasising violent, deviant and sensational aspects. The schools do not appear to have provided children with information basic to survival.

17. Many witnesses viewed the school as lacking parental involvement, isolated from the community, often bureaucratic and authoritarian and failing to develop morally responsible adults. Schools are often too large for any real kind of personal relationship between children and teacher. They reinforce traditional roles, with father figures as principals and female teachers in supporting roles; boys are encouraged to be aggressive, whilst passive behaviour is demanded of girls. This stereotyping applies to many text books and to course content.

Discipline and punishment

18. The issue of physical punishment in schools was raised in many submissions; some wanted it abolished, others wished to see it retained. The Commission is concerned about the possible relationship between physical punishment and child abuse. It is our belief that this kind of punishment is not the best way of changing anti-social behaviour, and we hope that schools and child care agencies will come to abandon its use. Meanwhile research is desirable into more positive ways of handling the disruptive child.

19. We believe that human relationships courses which aim at developing self-motivated and socially responsible adults can only partially succeed as long as they are conducted in schools with an authoritarian structure and isolated from life outside.

Controversial issues

20. Many submissions asked for greater emphasis on moral values in the school; some demanded Christian morality. Many spoke of the resultant confusion about values and behaviour. The competence of teachers was questioned.

21. To meet such demands the NSW Education Department in 1973–74 set up an inquiry concerning the need for sex education and the form it should take. The report, often called the Barker report, has been generally approved by schools, parents and churches and the Commission recommends careful study of the document, believing it is along constructive lines. South Australia has also produced valuable reports on health education in schools. Values and standards must be based on the individual's understanding of his responsibilities in interpersonal relationships, in respect of his own worth and dignity and that of others. Parents should accept responsibility for providing their children with values on which they can base a satisfying life. The role of the school is complementary, to provide supportive service in fields of scientific knowledge, social education and health education; schools can also provide opportunities for the development of values because of the dynamic peer group interaction which the home cannot provide. Teachers should be able to discuss different points of view in a manner which will not inevitably lead to the rejection of any particular view.

Selection and training of teachers

22. Often a good teacher can make up for a bad home environment. Therefore adequate training of teachers is of high importance. Those States that are promoting human relationships programs in schools are trying to make sure that experienced and interested teachers are selected and given specific training. Dr Delys Sargeant is doing particularly valuable work through her courses in the Social Biology Resources Centre in Melbourne, and we consider they are a good model for what should happen

elsewhere. The NSW Education Department emphasised the problems faced by a teacher when dealing with values, and the need for teachers in this field to be mature, well-balanced persons.

23. Some colleges of advanced education are now instituting courses in human relationships.

24. The Commission sees the need for teacher education courses to study man in his full social and physical environment and to take account of the human life cycle and sexuality. Ethics should be a prerequisite field of study and teachers chosen for human relationships courses should have the same quality of experience and specific training as guidance counsellors.

Communication within the teaching profession

25. Teachers are often acutely aware of the isolation of their occupation, and look for aid from the behavioural sciences. It has been suggested it would be good for some of them to work for a while in other occupations and thus broaden their experience of life. Teachers need a national professional journal like those of other professions.

Present education programs

26. All States, except Queensland, have some sort of programs on human relationships in schools; in Queensland voluntary organisations are encouraged to hold classes out of school hours. In all States parents may withdraw children if they wish. In some States classes are mixed, in others separate. Sex education seems mainly to be taught in isolation from a personal development program, or linked to the science-biology strand. In NSW programs are aimed mainly at pupils in the secondary school; in Tasmania at 15-year-olds, though the more controversial subjects are left until the last year of high school.

Training of teachers at present employed

27. No education department in Australia, we were told, requires teachers to complete a course which includes human sexuality before they are registered for teaching. The authorities differed in ways of selecting teachers for human relationships courses; some looked to the social sciences, others to health educators, home economics or biology teachers, still others to physical education.

Resources

28. Most States with centrally co-ordinated programs in human relationships used the task force approach for their development; staff were drawn from experienced teachers whose tasks were to prepare printed and audio-visual materials for use in the school, develop guidelines, review books, films etc., and generally promote courses in discussion with other teachers and parents. Materials are made available to independent and Catholic schools on request.

Voluntary associations

29. Voluntary organisations have presented courses by invitation. They play an important, if diminishing, part. One of the oldest and most active is the Family Life Movement; its short programs and its involvement of parents are a model for similar organisations. The work of voluntary organisations is hampered by lack of money; further aid should be made available.

Effectiveness of present education programs

30. While there is now more discussion of sexual matters, young people are not necessarily better informed; in some ways they are more insecure. Parents, especially

in migrant homes, are often reluctant or unable to educate their children on these subjects and find communication with them difficult. Religious beliefs, once an important ally of the school, are now less valued and the sophisticated approach of the media exercises much greater appeal.

31. There are still shortcomings and mistakes in human relationships programs but better understanding of roles and relationships and more responsibility is attainable and is being encouraged.

Social sexual behaviour: implications for education

32. There is widespread ignorance of sexual matters that points to the need for comprehensive education.

33. Surveys in Australia and overseas on the sources of sexual knowledge show the influence of peers and their role in perpetuating misinformation, due mainly to lack of any other reliable source. There is a need for early and continuous sex education and for an educational program which will help young people to be responsible to themselves and to each other and to decide and act with knowledge, not in fear or ignorance.

Scope and content of human relationships education programs

34. Human relationships education has several aims: preventive; remedial; developing the whole personality; developing personal and economic skills for autonomy and survival. Sex education should be comprehensive, factual, frank and non-judgmental.

35. Some submissions stressed that education should take positive steps to break down sex role differentiation which is seen to restrict boys and girls from reaching their full potential. In our view programs should emphasise the common humanity of males and females and develop the ability of men and women to co-operate and to share each others' roles and responsibilities in the family and in society without losing individual identity or the ability to develop the special potential of either sex.

Social sexual relationships in adolescence

36. We have looked into the pressures on girls and boys to engage in sexual relationships. Moral and religious beliefs may help in withstanding these pressures. Girls need help in understanding their needs and their rights to assert their own wishes; they also need to know the risks of early intercourse and their responsibilities in such matters as rape and carnal knowledge.

37. Poor communication is often a factor in the failure of relationships between men and women. The communication barrier might be less formidable if programs were developed to help boys and girls to understand personality development, to communicate and to discuss questions of roles and relationships and to learn about peer pressure.

An open approach

38. Some submissions stressed the importance of dealing frankly in sex education with issues such as contraception, VD, abortion, masturbation, pre-marital sex, the law, homosexuality and sex roles.

39. Young people show that, when properly taught, they are able to consider difficult moral issues and make rational decisions about them and that they desire frank and broadly based programs. We agree that programs should adopt this approach, that they should be appropriate to age, tolerant of differences and begin in

primary school. The learning situation should be non-coercive and personal, and research should be carried out to determine the most effective types of programs.

Resources

40. We recognise the need for suitable educational materials of high quality. The Curriculum Development Centre in consultation with the States should continue to develop and expand curricula and teaching aids to facilitate competition with mass media.

Part III Health and medical education

1. 'Australians can no longer take their health for granted' says Professor Basil Hetzel of Victoria. By paying our taxes we are not absolved from our responsibilities as citizens to demand a high quality of community life and health. Our terms of reference ask us to look at existing courses in medical schools and how far medical training and practice can meet the many needs, especially of women, in our society.

2. We have examined courses on sexuality at the undergraduate and post-graduate level; the selection of students and their 'socialisation' into the profession and community. We conducted a survey of general practitioners and a review of medical schools, and we present a picture of Australian health, health services and personnel and, in particular, the human relationships issues which are of importance in medical practice.

3. The Commission recognises the part played by paramedical and allied health services. We require today a more broadly based health care service than that offered by the medical practitioner alone. The doctor needs to 'refer' to such services as well as to specialists more than he has done in the past.

4. We live in an age of increasing complexity and hurry, with consequent increase in stress; there are special at-risk groups, and here counselling services are necessary as well as a sensitive approach from those offering services, e.g. to migrants, Aboriginals, the poor and the handicapped.

5. Sexuality and the doctor–patient relationship is our main theme. We have especially noted human sexuality; fertility control; pregnancy and childbirth; preventive medicine; and community health programs.

6. Attitudes to health, its care and services are undergoing remarkable changes: our medical schools should produce not only a skilled professional doctor, but a broadly educated person who becomes such a professional through further training. Our courses, therefore, need to be adapted to social changes and revised priorities.

7. Hitherto health services have been medically oriented, preoccupied with dysfunction and disease. The profession now needs a wider perspective that embraces the family and the community. Hence the value of interdisciplinary courses involving sociologists and psychologists.

8. Our discussion on Australian health is concerned with deficiencies we have perceived of knowledge and practice; we have noted the tendency for health care to become more a matter of institutions, needing increasing manpower and finance. No issue, however, is as important as that which tries to place the welfare of the human person first.

Australian health, health services and personnel

9. We need in Australia, especially in the sprawl of our cities, a variety of health services. The work of the great hospitals and of the general practitioner needs to be supplemented by clinics and health centres in the local community, where patients feel more readily at home and where pressures of time are less acute.

10. The third report of the Commission of Inquiry into Poverty similarly emphasises the right of the individual to total health care, the need to prevent illness and promote health and the importance of community services.

Measures of health and resulting patterns

11. Dramatic changes have occurred during this century in the nature and treatment of disease. Deaths from infectious diseases have given way to the so-called diseases of civilisation. Alternative sources of health care are now needed to complement existing medical care. Education of the community is needed, and also research into health care, health services and the effects of government policies upon health. A balance is needed between curing and caring.

12. Life expectancy at birth has increased by some 20 years since the 1880s. Men still die earlier than women. Hospital admissions (excluding confinements) are commoner for women than men. The growing number of patients in mental hospitals highlights the load placed on the health care system by psychological dysfunction. More attention needs to be paid to the health of Australian women and to the services they require.

13. There has been a dramatic increase in the number of patients attending GPs for mental disorders. Our society seems to have medicalised its emotional disorders, with an increased prescription of drugs but little change in counselling.

14. Medical education needs to include training in counselling. Social pressures should be recognised alongside the psychological. Health is not restricted to a medical concept. For example, it is estimated that five people in every 100, outside institutions, are substantially handicapped in their social and recreational activities. Health care has to be concerned with both conditions that prevent full functioning of the patient as well as those dangerous to life.

Approaches to health care

15. The object of a health program should be to restore the sick and disabled to function again in the community as soon as possible. We note that a higher level of education correlates with increasing use of health services.

16. There are some achievements in the field of community health, with the establishment of 'service models'. Further study is needed.

Research and information

17. Better statistics are needed for the formulation of health policy. The poorer people, Aboriginals, migrants and those living in remote rural areas experience special difficulties in using provided services, and statistics at present often ignore this issue.

Support services in community health

18. In programs of community health the attitude of the personnel involved is vital. We welcome the government aid now being given for the prevention and early treatment of illness, and the rehabilitation of patients. Integrated primary care team work, involving medical practitioners and nursing, social and other related health and welfare personnel, is a development which should be extended. It minimises the present fragmentation of services.

19. Undergraduates who are gaining experience in the field as apprentices to professional workers have more flexible attitudes towards health care.

20. Pending the integration of community health services with other health services, certain at-risk groups need short-term special programs, including pre-school children and women. The Commission welcomes the establishment of the early childhood development complexes in Victoria, providing an integrated service for parents

and children from the beginning of pregnancy until the child is 6 years. The work of family planning clinics and womens health centres illustrate a response to specific needs.

21. There is an increasing proportion of women in the medical workforce. Changes are needed in the relationship between the male-dominated medical profession and the female-dominated paramedical professions.

22. The development of the Family Medicine Program is a welcome move in the medical curriculum. The number of workers in health occupations has been growing at a rapid rate, but there is still a shortage of clinical psychologists. Most university medical departments are becoming increasingly concerned with sexuality and human relationships. Similarly behavioural science is beginning to be introduced to students early in their courses, so that they quickly have direct contact with people.

Women in the health workforce

23. There has been a considerable increase in the proportion of female to male medical undergraduates, and there is better acceptance of women in the profession. Recent studies have disproved the view that women tend to drop out of the profession permanently; it is true that fewer of them reach specialist status, if they are also rearing a family, but determined efforts are being made in several States to retrain women doctors. Part-time registrarships and other shared appointments would make this process more effective.

Human relationships issues for medical practice

24. Here we look at medical practice in relation to sexuality, menstruation, menopause, fertility control, pregnancy and childbirth.

Problems in the doctor–patient relationship

25. Human communication needs more attention in medical courses. Better interview techniques and more effective communication with patients is essential. Clear, unemotional explanations and a sense of assurance are necessary parts of successful communication.

26. Patients need to be more involved in decisions. We favour diagnostic centres in each major city to collect data, carry out research, prevent abuse in drug prescriptions and encourage closer co-operation between the practitioner and other health personnel.

Women

27. It has been suggested that medical textbooks, especially in obstetrics and gynaecology, tend to preserve stereotyped sex roles, and that a biased attitude learnt here influences the doctor in his approach to women patients. Sometimes complaints may be typical not so much of male and female bias as of the tensions common between doctor and patient whatever their sex. Medical education must enhance understanding of the problems of female patients, e.g. menstruation, nausea in pregnancy or depression at the menopause. Teaching should combat biased attitudes to sex roles.

28. The Family Medicine Program, womens health centres and community medicine programs have flourished because the GP often seems unaware of women's needs. The GP is commonly regarded as the primary source of health care, and his training leaves much to be desired in terms of ability to communicate with patients.

Cultural differences

29. We are convinced of the reality of a conflict of cultures within Australia. We find ourselves in consonance with chapters 9 and 10 of the third main report of the Poverty Commission regarding migrants and Aboriginals. There is an urgent need for interpreter services in hospitals. The GP needs special qualities of sympathy when working with Aboriginals. There is much to be said for the development of a primary health care team, with a field nurse and nursing aides; the support of the tribal elders is essential for successful decision making.

The doctor's role in human relationships

30. GPs believe that counselling parents and children is their responsibility, but we were told that doctors are often unable to help with the day-to-day problems of the family. Better instruction is needed in child development.

31. Effective liaison is necessary between the GP and marriage guidance and family planning counsellors. The GPs need to support the role of the family yet also respect alternate life styles.

Violence in relationships: the doctor's role

32. Physical and emotional damage comes under various guises to the professional who accepts responsibility for maintaining family care. A sympathetic doctor will know that stress in relationships can easily lead to violence, and should be ready to open the way for free discussion. Doctors should be educated to recognise cases of child abuse and should take an active role in planning for new ways of handling this problem.

Sexuality and medical practice

33. While the GP, obstetrician, gynaecologist and psychiatrist are significant sources of sexual information, their lack of adequate knowledge in this field and their problem-oriented approach often mean they are unable to assume sole responsibility in this task. Until educational institutions improve their general knowledge of sexuality, problems concerned with sexuality will reach the medical practitioner first. Doctors' personal attitudes to sexuality need to be free of inhibitions and reactions likely to thwart the provision of good advice and care.

34. While some may doubt whether the doctor should be the provider of sexual counselling, he remains the obvious point of reference and he will prove a source of help if he exhibits a sympathetic approach and possesses a good working knowledge of the range of alternative sources of education and counselling.

35. Most medical practitioners who undertook a medical undergraduate course before 1974 would have received an inadequate training in sexuality. As a result medical practitioners often do not recognise the tentative efforts of a patient to initiate discussion on a sexual matter; some practitioners actively avoid it.

36. The capacity of many academics to teach sexuality is questioned, and the place of the subject as a part of human relationships generally is discussed. Courses on sexuality can be successfully integrated into the work of several different departments.

37. Education in sexuality is spreading beyond the undergraduate schools to post-graduate and continuing courses. The need for peer review and continuing education is exemplified by the fact that a high proportion of GPs have not undertaken any further education since their graduation.

Medical education and fertility control

38. While the medical profession appears to accept as a principle that it is responsible for ensuring that every member of the community receives adequate advice in family planning, individual practitioners are reportedly not providing adequate advice. Opportunities are missed and moral perspectives colour the kind of advice given.

39. When the practitioner refuses a patient adequate advice the rights and welfare of the woman concerned are at stake.

40. Family Planning Association clinics provide alternative sources of help in this field. The basic issue is whether the establishment of FPA clinics should be seen as an alternative to the medical practitioner. Nurses and other community-based workers should be given more responsibility.

41. While the medical profession submitted that there is widespread reluctance to perform pregnancy terminations, our survey of GPs indicated that many of them were prepared to recommend it. The stigma attached to the procedure would change if the legal restraints were modified.

Pregnancy and childbirth: medical attitudes

42. We received calls for more medical education in the psychological and social aspects of normal pregnancy and childbirth, and the delegation of more obstetric tasks to nurses. The father and family need to be more involved.

43. Hospital activities should be made more flexible to permit family involvement. Induction of births merely for the convenience of the doctor should be questioned. Women patients should be offered more choice in medical procedures.

The doctor and sexual variations

44. Medical education should stimulate discussion on the issues related to homosexuality; for example, whether it should be regarded as an acceptable life style or as a personality disorder. We press that discrimination against homosexuals by the health professions should cease. Education courses should reflect a view of homosexuality as a variation of sexuality rather than as a treatable disorder. GPs in particular should be encouraged to treat homosexuals for illnesses and not for their homosexuality.

Mental illness and community health

45. The efforts of the Community Health Program to reduce institutionalisation and increase community responsibility for the mentally ill should be encouraged. There is a need for 'non-attached community-based workers' who will more likely hold the values and goals of the people they serve.

46. Much needs to be done about mental illness: removal of the stigma; better community support; fairer social security and health insurance benefits; training in human relationships for those in touch with patients. Treatment and help within the community rather than institutionalisation should be a major aim of policy.

Medical practice and drug dependency

47. The GP is in a valuable position to recognise early signs of alcohol dependence, a subject to which attention needs to be given in medical education, along with alternative forms of health care.

48. It was recommended that greater control should be exercised in the prescribing, advertising and distribution of drugs and that drug dependency diagnosis and advisory centres should be established.

Institutional care

49. Students in medical school should be made aware of the debilitating effects of institutionalisation, especially for young children. More consultative services are needed.

50. Patients' rights are a special problem in mental institutions. Institutionalisation should be on the grounds of observable illness; the social context needs to be assessed before certification. Legal counselling should be considered.

The medical profession and death

51. The care and treatment of the dying patient needs to be given greater attention in medical schools and in discussions amongst doctors. Consultation with nurses, social workers and clergy could provide an enrichment of knowledge. The issues involved in euthanasia and in the administration of life-prolonging treatment should be of vital concern to the medical profession; education should prepare the doctor to face the decisions which he will have to make in practice.

Undergraduate medical education

52. It was suggested to us that medical students often graduate knowing less about sex than the average man and woman. Any course on human sexuality—our main interest here—must aim to modify attitudes of hostility and develop sensitivity to others. The attitudes of the teachers themselves are important; they must have adequate knowledge of the methodology of education and also inspire confidence in the student.

53. Evidence suggests that the students should first be concerned with the understanding and development of their own sexuality, and then move on to the more controversial topics; discussion in small groups and the use of audio-visual aids, preferably of local origin, are essential.

54. Questions raised were whether the course should consist primarily of lectures or group discussions and whether it should be offered as one 'block' or spread over the whole course. It is obvious that a suitable co-ordinator is needed if the work of the various departments is to be integrated. The student body must be involved as initiator as well as participator. In some cases the subject is examined and the students given credit for this achievement; in others it is regarded as an extra.

55. Students felt inadequate treatment is given to human sexual behaviour. They seemed to prefer a specific course in sexuality, in an extended rather than 'block' program.

56. Crowding on more topics and the use of traditional teaching methods are regarded as unsatisfactory. Student representatives pressed the need for the introduction of communication techniques, self-awareness, sensitivity training and counselling, with the use of drama, role playing and group dynamics.

57. A review was made of the courses offered at medical schools on human sexuality, the time spent and their effectiveness. Our evaluation of the courses at the Universities of Sydney, NSW, Melbourne, Monash, Queensland, Adelaide, Flinders, Western Australia and Tasmania showed the need for high level co-ordination if courses in human sexuality are to be well managed and integrated into other courses.

58. The new departments of community medicine offer the best prospect of teaching the subject and co-ordinating it with other departments. The teaching needs to view the whole person and not merely symptoms of sickness; it needs social perspectives of human problems and conditions; and it should offer training in interviewing and counselling.

59. We examined the teaching given in medical schools on family planning, fertility control and the termination of pregnancy. These topics are now generally recognised as being within the orbit of the medical school, though the human relationship aspect is frequently neglected. Many schools make use of Family Planning Association counsellors and other staff in organising their courses. We note that the government is interested in developing and expanding training programs for medical personnel at both the post-graduate and undergraduate levels.

60. Community medicine is the study of the health and sickness of populations, rather than the episodic illness of individuals. Quality of care requires not only high academic standards and technical skills, but also humanity and compassion. We look at the development of community health services, and their impact on womens health, preventive medicine, patterns of illness, social factors in health and disease, and the needs of special groups of people.

61. We considered the programs of community medicine at several universities; we were particularly impressed with the University of NSW, which provides lectures from representative people and exposes the students to aspects of medicine through work with GPs.

62. Such experiments make for better relations between the medical profession and the community and we support them. By bringing students and GPs closer together, there are distinct gains for both. Unfortunately the very different approaches being taken by some schools of community medicine are not everywhere understood or accepted by the more traditional schools which often exercise greater power in university and college politics.

63. We appreciate that the written accounts of courses and course plans do not always reflect accurately either the strength or weakness of teaching attempts. Nevertheless we note with pleasure the evidence of striking changes that are beginning to take place in some medical schools, and the growing awareness of the medical profession that it is concerned with people, whether as individuals or members of community groups. We are particularly gratified to see the wisdom with which newer departments relate students to practice and issues beyond narrow academic pursuits. This interchange of experience between academic training and the work of the doctor and other health team members in the field is to be commended. We are interested in the suggestion that medical students might do a 'year of apprenticeship' in the field before embarking on their final year; they would gain in knowledge of people as people.

64. If modifications are being made to particular courses, for instance in sexuality, we would expect that they should not be affected adversely by teaching methods and subject matter in the bulk of the medical course. We are concerned, however, that the traditional, didactic and essentially technical nature of much of the medical course would negate the benefits obtained in emphasising relationship factors in other parts of the course.

65. We recognise the importance of examinations in reinforcing the attitudes obtained in such vital areas as sexuality and other human relationships subjects. We are sceptical of the long-term benefits of course changes whose initiators have not

been at pains to ensure the retention of sensitive, responsive and humane attitudes towards those whose problems require supportive care rather than technical aid. In fact, if such essential attitudes and practices cannot be assured at the completion of a full course, we wonder whether other personnel should be made primarily responsible for relationships counselling. We suspect that a proportion of doctors will achieve the necessary attitudes, skills and knowledge required of sexual counsellors, and others will not. There will be a continuing need to encourage the provision of paramedical and allied health care personnel to complement medical deficiencies in this field.

Post-graduate and continuing medical education

66. The medical profession itself must ensure that post-graduate training is maintained and supported. But governments are also involved in an educational and financial commitment extending beyond the undergraduate years. The doctor's education is never finished until the day of his retirement; various forms of further medical education must be assured.

67. Post-graduate and continuing courses are conducted in three ways: those provided by the Royal Colleges; certain interdisciplinary experiments; and short courses, encouraged by the Royal Australian Colleges.

68. Continuing education needs to be initiated on a national scale. One problem is to motivate many medical practitioners to undertake courses; programs should not need to be forced upon professionals. The Colleges are beginning to be interested in sexuality and human relationships and the Royal Australian College of Physicians, with a grant from the Kellogg Foundation, is setting up centres of continuing education to make effective the slogan that 'good health is a prerequisite to human well-being'.

69. Post-graduate education has largely been the responsibility of the various Colleges, and the post-graduate committees of the medical schools, leading to a diploma, membership or fellowship of a College.

70. The Royal Australian College of General Practitioners, with funding from the Community Health Program, has established the Family Medicine Program, which enables trainees eventually to sit for the examinations for a fellowship and view practice against a real background of the social and psychological problems of life. The focus is upon the new and recent graduate and as far as possible conducted in local areas, each of which has its special co-ordinator for the program.

71. Co-operation with paramedical, professional and allied fields of studies is as important in post-graduate as in undergraduate education, and there has recently been a new emphasis placed on the value of interdisciplinary studies. We noted some good work being done by Mrs Delys Sargeant of the Social Biology Resources Centre in Melbourne, in conducting seminars on human sexuality for medical practitioners, teachers, social workers, legal officers, nurses and police.

72. The third field of post-graduate medical education is through short courses, mostly in local areas. Motivation for GPs to attend is often weak, and we welcome the new course proposed under the Family Medicine Program, which provides payment to compensate the practitioner's absence from his consulting room.

73. We value the suggestions from Queensland for established or retired practitioners to visit outback areas to enable GPs there to attend courses, and also the scheme for retraining graduates, mainly women, to come back into active practice.

Medical students

74. The present admission system favours the student who is good at finding answers, but not necessarily at asking questions; it probably excludes some potentially creative thinkers. Selection methods imply that the role of the medical practitioners should remain one of providing technical expertise.

75. It seems that more attention should be paid to motivation and capacities for self-learning and abilities to handle the wide range of functions encountered in practice in the community. There is need for more flexibility in structure, more liaison with the behavioural sciences and for developing skills in interviewing, counselling and communication generally.

76. At the moment there is a dearth of more mature students entering medical school, and students tend to be drawn from the higher social and economic groups in the community, from the private and independent schools, and from the families of those who are doctors themselves. Those from country or poorer area schools seem to be at a disadvantage in gaining admission, but there is no policy, as is sometimes supposed, against accepting women students.

77. Some medical schools use a 'random' selection for the final 10 per cent of their quota; others interview students, but cost and distance make interviews difficult in Australia and there may be no guarantee that such selections lack inequity and bias. Probably a combination of intellectual proficiency and proofs of emotional maturity and sensitivity to people would be the best method, these proofs being afforded by interviews or through appropriate referees.

78. A survey of medical students carried out in Sydney in 1969–71 showed that there was a preponderance of sons and daughters of professional or high executive fathers; nearly half came from private schools; the majority preferred to train for specialist or hospital appointments; if for general practice, they preferred a group practice. The values inculcated in the medical schools are not always cognisant of these trends; an Adelaide study showed that idealism decreased significantly when students reached the clinical years of their course, a time when their ability to help people was beginning to be developed.

79. Changes of attitude during the student's stay in medical school were considered; positive orientation towards treating patients with social and emotional problems was short lived when students returned to regular medical school environment. The newer programs of family and community medicine may fail if the context into which they are introduced remains basically unchanged.

80. The teaching of sexuality has caused a mild revolution but, in the traditional medical school, gaps between departments are wide, and students rebel against the fragmentary manner in which topics such as these are treated. They would like to see such courses more student centred, with opportunities for more role playing and discussion at depth. There is still obvious need to educate the educator. When lack of teacher training is linked with inhibitions that make teachers unhappy in talking about sex and its problems with young people, the resulting instruction can have a worse effect than no instruction at all.

81. If the medical practitioner of the future is to develop happy working relationships with those of a different philosophical approach to health care, he should learn them early, within his undergraduate course. It has been said by Professor Hetzel that modern urban man lives between past and present, uncertain of his future.

In this situation the support of friends, family, religion and occupation is still as important as it always has been, but support is more difficult both to give and accept. The medical practitioner, especially the family GP, has an invaluable role in providing such support.

Part IV Sexuality and fertility

Sexuality

1. The relaxation of earlier more rigid codes of behaviour has not yet been replaced by new standards of responsible sexual behaviour. Effective contraception has had an important effect on sexual behaviour.

Sexuality and sexual problems

2. While most people agree on the importance of enjoying sexual expression, ignorance, misinformation and false expectations lead to sexual difficulties and to marital disharmony and personal unhappiness. Restrictive attitudes emphasise the negative aspects of sex rather than the positive.

3. Many problems can be overcome; some people however are unable to identify their difficulties, or deny them, and are reluctant to seek help. Doctors are sometimes unable to cope with problems and there are insufficient clinic facilities. There is a need for public sex education and for the provision of adequate services to deal with sexual health as an aspect of general health and well-being.

4. Further provision is needed for professional education on a multidisciplinary basis and the incorporation of psychosexual counselling units as part of general services offering fertility control and other related services.

Sexuality and life cycles

5. There is widespread ignorance about the physical, psychological and social effects on women of menstruation, the menstrual cycle and menopause. Information on these matters should be included in sex education programs; further research is needed.

Sexually transmitted diseases

6. There has been an increase in venereal disease and other sexually transmitted diseases. Ignorance is a contributory factor. Further facilities for treatment and counselling are needed. There should also be a range of contraceptive and sexual counselling services. The importance of notifying contacts is stressed. Sex education and health education programs should cover the causes, symptoms and treatment of all sexually transmitted diseases. The use of condoms as a preventive measure should be encouraged.

Fertility and fertility control

Methods of contraception and their evaluation

7. The main methods of contraception in current use in Australia are described and classified. Figures from 1971 show that the pill is the most commonly used contraceptive in Australia. The methods are considered from the point of view of their effectiveness in preventing pregnancy, their naturalness and their safety.

8. The effectiveness of a method of contraception depends on a number of factors including motivation, ease of access and ease of use. Theoretical effectiveness is estimated on the basis of what can be achieved by well-motivated people. On this basis, in addition to sterilisation, the pill, the IUD, condoms and diaphragms are effective to prevent pregnancy. Spermicides used alone and withdrawal are less reliable.

9. There is some dispute about the effectiveness of the ovulation method of contraception. A recent study suggests that some women are unable to identify and interpret

the physiological phenomena adequately. While the method may be preferred by some, and may for religious reasons be the only acceptable method to many, its effectiveness is open to doubt.

10. We do not consider that any method of contraception can truly be called natural.

11. The safety of a method of contraception is measured by its rate of morbidity (illness and disease) and mortality. Where contraceptive failure results in pregnancy, the mortality rate associated with pregnancy and childbirth or with abortion needs to be taken into account. Theoretical model studies show that the risk of death associated with the use of the IUD or pill is lower than the risk of death from uncontrolled fertility (except in the case of women over 40 taking the pill, when it is higher). Uncontrolled fertility involves a greater risk of mortality from pregnancy and childbirth than the use of any efficient method of contraception, except in the case of women over 40 taking the pill.

12. The morbidity or side effects of contraception are considered. In regard to the pill, while side effects are observed, the risk of serious complications appears small, and has not been conclusively established. Certain high risk categories may need special advice and in some cases substitution of another method may be required. Serious side effects of the IUD have not been fully established. The prescribing routine for the pill and the IUD should include information about side effects.

13. Contraceptive methods can bring benefits to their users, both in relieving physical disorders and in releasing women from the fear of pregnancy.

Contraceptive use

14. What can be done to ensure more effective contraception by people who do not want to become pregnant? The women at special risk are identified as the young and single, and married women with large families, particularly those belonging to poor families and migrant families. Ineffective contraception arises from many social and personal factors.

Knowledge and use of contraception

15. Knowledge of the various methods of contraception in Australia is fairly high and tends to increase with the level of education. The young appear to have inadequate knowledge. The level of contraceptive use and the method used are affected by several variables. Among married women the less well educated, migrants and Catholic women appear to use less effective methods. Women with more children are more likely to be using less effective methods.

Contraceptive methods: attitudes and problems

16. Some people find contraception or particular methods of contraception unacceptable, unsatisfactory or even frightening. Some are unable to find a method that suits them. Others are unable to use a method effectively. All these factors need to be taken into consideration in providing services.

17. Method failures account for some unwanted pregnancies. In some cases women have become pregnant after being advised to discontinue oral contraception without being given an alternative.

Non-use of contraceptives

18. Most unwanted pregnancies occur as a result of failure to use any method of contraception. The reasons for this failure include ignorance or misinformation; lack of access to services or supplies; religious objections; fear of or refusal by the doctor;

unpreparedness; failure of the partner to take precautions; fatalism or risk taking; inertia; dislike of interfering with sex. These factors affect all groups in different ways and need to be considered carefully in planning services.

The male role in contraception

19. Methods such as the condom, withdrawal and periodic abstinence depend on the male attitude and willingness to co-operate. Male methods and male dominance in fertility are still common among southern European immigrants.

20. Husbands can obstruct contraception—in some cases to affirm their virility.

21. The use of the condom by young males is worth promoting as a contraceptive means in intermittent relationships, particularly as it can reduce the risk of venereal disease.

External constraints

22. Many people have difficulties in obtaining advice or supplies because of the absence of facilities, their hours of work or the cost of supplies. Better distribution of services and supplies is needed.

23. The attitudes of doctors, pharmacists, parents and others may inhibit access to services or effective contraception.

Motivational factors

24. Women are sometimes said to be ambivalent about pregnancy and therefore erratic in their use of contraception. Some women experience conflict over contraception because of assumptions about their role, e.g. that 'nice girls don't expect sexual relationships and don't prepare for them'. We consider that these are not the main factors inhibiting contraception though they are relevant to some.

25. We note that women who have had abortions show improved contraceptive practice; all women having abortions should have contraceptive counselling and services should be readily available.

Conclusions

26. Contraceptive programs and services should make a special effort to cater for the needs of the young and single; the less well educated; migrant groups; the poor with large families; and those whose cultural backgrounds and language make access to services difficult. Programs should take into account the reasons for non-use or ineffective contraceptive use and should have educational and motivational content as well as extending access to services.

Contraceptive services

27. Most contraceptive services are provided by medical practitioners and voluntary agencies. Governments have become aware of the need to improve and extend services. Comprehensive government policies should ensure equal access by all to effective contraceptive services.

General practitioners and gynaecologists

28. GPs and gynaecologists provide contraceptive services for the majority of users. The advantages of this kind of service are that GPs are located throughout the community and are generally easily accessible. They also sometimes have knowledge of a patient's medical history. Disadvantages are that until recently undergraduate training in this area has been inadequate, even for gynaecologists. Some doctors have negative attitudes towards patients requesting contraceptive services, particularly

young single women. Opportunities to raise the subject of family planning are sometimes missed.

29. The GP is usually not able to provide the range of services offered by FPA and other clinics, e.g. pathology tests and counselling. Although only a minority of methods involve strictly medical considerations, it is suggested that some GPs tend to make the decision about method rather than leaving it to the patient to decide. These criticisms do not apply to all GPs. There is a continuing role for the GP in this area; changes in medical education may lead to improvements in the service.

Family Planning Associations

30. The next major source of services are the Family Planning Associations. Advantages of the clinic service include anonymity, specialisation, training, multiple services at one location, counselling and referral services. One disadvantage is that there are few clinics in country areas. Centralisation of services may involve patients in travel.

31. The funding arrangements for FPAs are very complex. No additional funds have been made available to meet increased costs, especially those arising from the changes in Medibank.

32. It is difficult to recruit enough doctors to provide clinic services, particularly in country areas. Nurse practitioners could be trained to provide many contraceptive services.

Womens community health centres

33. Six womens community health centres in Australia provide contraceptive services. Their funding should be continued subject to the establishment of medical advisory boards to review procedures.

Community health centres

34. Ninety-seven community health centres in Australia offer primary medical services, including contraception and, in some cases, counselling. They could potentially provide the basis for a network of contraceptive services throughout the community.

Natural Family Planning centres

35. Natural Family Planning centres provide information and instruction in periodic abstinence methods, including the ovulation and other sympto-thermal methods. In our view information about these methods should be more widely available. Though they are less effective they meet the needs of some people. FPA services should include instruction in these methods as a first step towards integration of services.

Hospital services

36. Only a few hospitals operate family planning clinics approved for RCOG training purposes, and most of these are in large urban areas. These should be developed as effective teaching units providing a full range of contraceptive services to hospital patients and the local community. Hospital policies should ensure that contraceptive advice is given to all abortion and maternity patients.

Services run by State health departments

37. Victoria is the only State which provides contraceptive services through its own family planning clinics. Their clinics attract proportionately fewer clients than the FPA clinics in that State. Steps could be taken to improve attendance and reduce overhead costs.

Other sources

38. Pharmacists supply all contraceptive products and are well placed to provide advice, services and referrals. Education in contraception should be included in training programs for pharmacists.

39. Community health nurses and community health workers should be trained in contraception and should be employed in community health schemes including services planned for Aboriginal communities. Each Aboriginal community should be helped to develop and run their own contraceptive services using indigenous health workers and nurses.

40. The health needs of country women should be met by providing contraceptive services through community health nurses and educators, the Royal Flying Doctor Service and the community health program.

41. Each FPA should be funded to employ a domiciliary worker to meet the needs of clients who are unable to visit clinics, but who are in need of services. A pilot project should also be undertaken to develop the use of mobile clinics, especially in remote areas.

42. Student health services, occupational health services, VD and abortion clinics are briefly reviewed.

Policy goals

43. An effective and comprehensive government policy on contraceptive services is needed for the health and welfare of individuals and families, to save costs in other areas of government expenditure, and to ensure equal access by all people. The Commonwealth government should adopt a policy that all persons should have ready access to information and advice about conception, contraception and contraceptive services.

People with special needs

44. The groups most in need of an expansion of services are the poor, the young, ethnic minorities and Aboriginals. It is important to develop specialised services with a wide range of choices, such as clinics, mobile clinics, domiciliary workers, Aboriginal and migrant health workers and family planning educators. Services should be aware of age, class, ethnic origin and marital status as factors affecting access to and attitudes to services. The handicapped also need specially planned services.

45. Community leaders and members of special groups should be directly involved in planning services.

Cost of contraception

46. The goal should be a free service; funding policies should ensure that fees are waived for those who cannot pay. The government should seek ways to reduce the cost and promote the more effective distribution of all contraceptive products.

Planning for expansion

47. In our view there should be a choice of GP or clinic services, and all services should aim at the same standard. Medical training in contraception is needed. Clinic services should be maintained at a high quality, available to everyone, and should be expanded to meet special needs.

48. The government should recognise that contraceptive services are an important part of preventive health programs and should ensure the extension of services by

State or voluntary agencies. The goal should be to establish a national network of contraceptive clinics in community health centres run by State health departments.

49. Funding for the extension of services, for co-ordination of services and for training, education and advertising should be provided.

Getting the message across

50. Many people are ignorant of sexuality, conception and contraception. They may also be unaware of available services which could help them. Sex education programs given in a personal development context should include information about contraception and about relevant community services such as family planning and VD clinics.

51. Contraceptive services should be responsive to people's different needs and different cultural values. People with special needs should be involved in planning services, and services should reach out to the community to learn about those special needs and how to provide for them. Outreach programs should include education, information and motivation. Services should be readily accessible and visible. Doctors and pharmacists should be involved in disseminating information about contraceptive services. The government should ensure that information is widely distributed.

52. The media have a potential role in informing people about services and in motivating them to use services. Advertising campaigns run by FPAs have led to an increased demand for services in the short term, but it is uncertain whether they have had any longer term effect on awareness or motivation. Overseas experience suggests that careful planning and evaluation is needed to bring about significant changes in behaviour.

53. Some oppose the advertising of contraception in the media on the ground that it might encourage promiscuity among young people. Others believe that everyone is entitled to information and services and that advertising helps to make them freely available. We do not consider that advertising of contraceptive services or supplies should be restricted; absence of advertising may have a negative impact.

54. A comprehensive contraceptive service should include advertising. The government should initiate and support nation-wide and local campaigns to encourage the use of contraceptive services. These should be seen as part of an overall program to develop in people the capacity to take responsible decisions about their sexuality. The overall program should include:

- education and information for people of all ages
- ready access by all people to services and supplies suitable to their needs
- motivational programs to develop responsible sexual behaviour

Contraception and the law

55. Legal restrictions in some cases restrict access to contraceptive services and goods.

Advertising of supplies and services

56. The present legal situation is confused and confusing. In some places there are no restrictions; in others advertising is precluded; in yet others approval to advertise is required. Media policy and the lack of money can also be a barrier to advertising. We consider that people are entitled to be informed of services which are important to their health and welfare, and that there should be no special restrictions on the advertising of contraceptives or contraceptive services. The media should adopt a more positive position.

Distribution, display and sale

57. Oral contraceptives are available only on prescription. Some pharmacists do not stock contraceptives. The law about vending machines varies from State to State. In our view the condom should be widely available at all retail outlets and it should be available via vending machines.

Prescriptions and paramedicals

58. Specially trained nurse practitioners now perform many contraceptive services in relation to oral contraceptives, IUDs and diaphragms under the supervision of a doctor. Paradoxically doctors may prescribe all these items without having any specific training. This limitation inhibits the expansion of services and innovation in family planning services. We consider that specifically trained nurses and other personnel should be able to fit IUDs and diaphragms and prescribe oral contraceptives.

Consumer protection

59. Legislation is needed to protect people against misleading claims in respect of contraceptives. There is inadequate provision for setting and monitoring the standard of contraceptives, especially non-prescription items such as condoms. We consider that a committee should be appointed by Federal and State governments to set and enforce standards. These should include adequate packaging and instructions in several languages.

Pregnancy testing

60. An efficient and speedy pregnancy testing service is needed, especially for those without access to doctors or clinics. A reliable kit needs to be developed and approved for distribution without prescription.

Sterilisation—vasectomy and tubal ligation

61. The present uncertain legal situation may inhibit some doctors from proceeding, even with the consent of both spouses. Increasing numbers of male and female sterilisations are being performed and it is important to remove any doubts. In our view a doctor who acts on request with due care should be protected from legal liability if the person requesting the operation is over 25. In the case of persons over 21, a 6-month 'cooling off' period should be imposed. The problem of sterilising the mentally handicapped needs further consideration.

Artificial insemination

62. Although as many as 50–75 AID procedures are performed each week in Australia, the legal status of the child remains uncertain. The doctor acting with due care with the consent of the parties should be free of liability and the child should be treated as the child of the parties for all purposes.

Unplanned and unwanted pregnancies

63. Unplanned pregnancies are those not consciously planned. Many unplanned pregnancies occur because people do not necessarily consider pregnancies to be a matter for planning, because of risk taking and because of ambivalence about pregnancy. Many of these pregnancies are wanted and are accepted willingly. Others are not.

64. Unwanted pregnancies, i.e. those rejected after they occur, are a more serious phenomenon. They may lead to abortion or to the birth of an unwanted child; it is estimated that about 100 000 pregnancies each year are unwanted. About 60 000 of these unwanted pregnancies are terminated. In some cases adoption is arranged; in others there is a marriage of the parents. Where an unwanted pregnancy results in the birth of an unwanted child, serious social problems may arise.

65. The main reasons given for not wanting a pregnancy are the inability to cope with the child because of the absence of supportive relationships, financial problems, anticipated social pressures and stigmas, lack of accommodation or too many children. The expectation of emotional disturbance was also mentioned.

66. There are sometimes underlying reasons why women do not want pregnancies. These include the wish to remain childless; the desire to avoid the traditional motherhood role; and difficult family or social circumstances.

67. There is some evidence about negative reactions by fathers to pregnancies; sometimes they do not want pregnancies wanted by the mother (and vice versa). They may wish to remain childless or to avoid the stresses of being a father.

68. We consider the costs and consequences of unwanted pregnancies. An unwanted motherhood role can lead to disturbance and depression. The mother's physical and mental health may suffer, with consequences for her marital relationship.

69. The consequences to children born of an unwanted pregnancy who remain unwanted are potentially serious. Their development shows disadvantages compared with wanted children; they run the hazard of abandonment or abuse.

70. There are also costs borne by the community. The unwanted child and his family may place a greater than average burden on welfare resources. If the unwanted child grows up maladjusted, he may continue to impose costs on the community.

71. Among the alternative courses of action which may be contemplated by a woman with an unwanted pregnancy are marriage, abortion, adoption and keeping the child. Each of these solutions has its benefits and disadvantages. Because of the many pressures on the woman it is important that she have access to impartial counselling.

72. The woman with an unwanted pregnancy needs a range of services to help and advise her. There are agencies which offer support and counselling. The Pregnancy Support Services have worked to help women in difficulty with their pregnancy, but they do not consider abortion as a solution. Abortion clinics and referral agencies also offer counselling.

73. In principle it would be preferable to provide and support a separate pregnancy support and counselling service to advise women on all the options, to help them make decisions and to provide referral and ancillary services. The unwanted pregnancy is a sufficiently serious problem to require this kind of support.

Abortion

Legal and moral issues

The law and abortion

74. Abortion law reform has been a major topic of public interest in recent years. In the UK the Act of 1861 made unlawful abortion a felony. A 1938 decision determined that an abortion was not unlawful if done in good faith to preserve the life of the woman. The Abortion Act 1967 authorised abortion by a doctor if two doctors consider that the risks to the life or physical or mental health of the woman if the pregnancy continues would be greater than if it were terminated, or where there is a substantial risk that the child may be seriously handicapped. The report of the Lane Committee on the working of the Act (1974) and of the Parliamentary Committee on Abortion (1976) are considered.

75. In Australia abortion laws fall into three categories: in NSW, Victoria and the ACT the law is based on the UK Act of 1861. It has been determined judicially in NSW and Victoria that an abortion is not unlawful if the doctor honestly believes it is necessary to preserve the life or the physical or mental health of the woman; in NSW the effects of social and economic stress may be considered. In Queensland, Western Australia and Tasmania there is a statutory exemption from the basic provision of the 1861 Act where an operation is performed on an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. In these States there has been no judicial interpretation similar to those in Victoria and NSW. In South Australia and in the Northern Territory provisions similar to the UK Act of 1967 apply.

Criticisms of the law

76. The main criticisms of the present law in Australia from those seeking liberalisation of the law are: that the law causes more harm than it prevents by driving abortion underground, leading to malpractice and danger to health; that the law is ineffective to prevent abortion; that the law operates to deny abortion to many who need it and that it applies unequally; that the law is uncertain and lacks uniformity. Opponents of abortion law reform argue for the sanctity of human life from the moment of conception and consider that abortion cannot be justified except to save the mother's life.

Policy of abortion law

77. Current abortion laws have no clear policy as between protection of the pregnant woman's health and safety and protection of the life of the unborn child. We do not consider that criminal sanctions are necessary to protect the mother's health provided that abortions are carried out openly by medical practitioners in appropriate conditions.

The foetus and human development

78. The development of the foetus from conception to delivery is traced in a timetable and it is concluded that life is continuous from conception to birth and throughout life. The destruction of the foetus destroys life and raises issues of serious concern.

The right to be born

79. We do not consider that the abortion issue can be determined by reference to a category of legal rights such as the right to be born; moral and social values also have to be assessed.

The moral issues

80. The views of Christian religions are divided on the abortion issue. The Roman Catholic Church condemns all abortion. Other churches do not necessarily have a definitive view; within those churches there are differing views about the moral issues and also about the extent to which the law should prohibit abortion; some oppose abortion; some would accept abortion in limited circumstances; others favour the removal of legal sanctions.

81. Social attitudes are also divided. There is no clear majority favouring prohibition of abortion. We consider that the life of the foetus is different in quality from the life of a human being after birth, and that it is valid to take into account the social circumstances of the mother in deciding whether abortion is justified.

82. Although abortion is not seen as desirable, its consequences must be weighed in the balance against the consequences of proceeding with the pregnancy.

The role of the law

83. We do not consider that easier access to abortion should be seen as a substitute for effective contraception or that it would have this result. Improvements in contraceptive services are needed, although they would not necessarily eliminate the need for abortion.

84. In our view the persons best placed to assess the need for abortion are the woman herself and her doctor. The doctor's role is to weigh up the circumstances, to advise of the risks and to ensure proper medical practice. The woman should have counselling to enable her to consider the options free of pressure. A doctor performing an abortion at the request of the woman concerned within the time limits we propose should not be subject to criminal sanctions.

85. Neither a doctor nor a nurse nor any other person should be obliged or required to take part in an abortion if unwilling to do so.

86. Although we think it desirable for a woman to discuss her problem with other members of the family, we can see no justification for imposing a legal condition requiring the consent of any member of the family of an adult woman to an abortion. Nor do we think that decisions about abortions should be referred to a panel or referee.

87. As a first step towards the amendment of the law, governments should state their intention not to initiate criminal proceedings against a medical practitioner who performs an abortion provided that it is performed in appropriate conditions within the time limits we propose.

Time limits on abortion

88. If abortion is to occur it should be done as early as possible. Relaxation of the law should help ensure this. In some cases, however, the question of late abortion will arise. We consider the evidence related to viability and current developments abroad. The viability of a particular foetus cannot be determined in advance. In fixing time limits for abortion there should be a bias in favour of the life of the foetus. We propose an upper limit of 22 weeks pregnancy (taken from the commencement of the last menstrual period).

89. Where a serious mental or physical abnormality of the foetus is diagnosed as likely to lead to serious handicap we consider that abortion should be authorised beyond that time.

90. Termination of pregnancy should also be authorised after these limits where it is necessary to preserve the life or health of the mother or to avoid grave risk to her health. In these cases efforts should be made to preserve the life of the child.

91. Apart from acts done in performance of an authorised abortion, it should be an offence to destroy the life of a child capable of being born alive unless the act is done in good faith to preserve the life of the mother.

Abortion services

92. In this section we consider existing abortion services and make recommendations to improve those services. We draw upon some of the results of our survey of hospitals and clinics (which has not been written up fully).

93. There have been significant changes in the provision of abortion services since 1969, due to changes in the law and in the interpretation of the law especially in New South Wales, Victoria and South Australia. The pattern of services in each State and Territory is noted and the main methods of abortion are set out at Annexe IV.M.

Abuses in abortion practice

94. More liberal abortion laws can help to overcome some of the worst abuses which occur under restrictive laws, such as poor service, overcharging and hostile attitudes. While the picture has changed, abuses have occurred in the past, and still can occur. These abuses include unsafe procedures; lack of facilities; lack of expertise; delay; overcharging; lack of follow-up procedures; and lack of counselling. Some instances of abuse are recorded.

Criteria for abortion services

95. The criteria which we think should apply to abortion services are as follows:

(a) Proper medical procedures; trained medical and paramedical staff; aseptic conditions and appropriate equipment.

(b) The avoidance of unreasonable delay.

(c) Reasonable fees for the full range of services offered.

(d) Follow-up services, including contraceptive information and advice and 24-hour emergency telephone service.

(e) Proper counselling before and after the procedure to ensure a choice of options, free of pressure.

We consider how well existing services measure up to these criteria.

Abortion clinics

96. The services offered by Preterm and Population Services International in Sydney and by the Fertility Control Clinic in Melbourne are considered. In general they provide a full range of services including pregnancy testing and counselling. All use the vacuum aspiration method for early terminations. The fees range from $96 to $150, depending on the type of anaesthetic and the extent to which pathology tests are given.

97. We consider that counselling is an essential part of an abortion service: to advise clients of all the options open to them; to ensure that they are not being coerced into an abortion; to help them before, during and after the operation; and to offer contraceptive services. The government should support counselling services. We consider that women should have a free choice between general and local anaesthetic, that they should be informed of the alternatives and referred elsewhere if necessary.

98. The advantages of free-standing clinics lie in the attitude and expertise of their staff and in the counselling services they offer.

Private practitioners

99. The services offered by private practitioners are briefly considered; little information is available about their operations. Some practitioners are experienced and skilled. Few employ counsellors. Abuses can still occur, especially in States where the law is restrictive.

Public hospital services

100. Our research project surveying hospital and clinic admission procedures provides the basis for an analysis of public hospital services. The general picture is that some hospitals, especially country hospitals, continue to use the older and less safe methods of termination, especially in the second trimester, and some lack experienced practitioners and counsellors; other disadvantages are the uncertainty of medical attitudes, delays and the requirement for inpatient procedures.

101. We stress the need for all abortion patients to be given contraceptive advice at the time of termination in the clinic or hospital.

102. Some hospitals have set up special clinics to deal with abortion referrals. These appear to have some advantage for patients and staff provided that counselling and contraceptive services are provided as in the case of free-standing clinics.

Referral services

103. In all States and Territories voluntary agencies such as family planning clinics arrange for pregnancy testing and in some cases provide counselling and refer women to private practitioners, hospitals and clinics offering abortion services in their own or in another State. Their activities are briefly considered.

Expansion of services

104. The disadvantages of hospital services are alleviated by the range of facilities and equipment they can provide and their geographical distribution. Changes in the law have imposed a workload on hospitals which for the most part had to be met without expansion of services. The abortion clinics were set up partly to fill the need which hospital services could not meet.

105. Abortion services should be considered as a general health service and as part of a range of fertility control services to which every woman should have access. These services can be provided by hospitals, by specialist clinics or as part of community health programs.

106. Hospitals should arrange for the selection and training of staff, the provision of day patient facilities, counselling and contraceptive services as part of their gynaecological services. Some degree of specialisation should be possible in larger O & G hospitals, which should also provide undergraduate and post-graduate training in abortion techniques.

107. The attitudes of staff in clinics offering abortion should be considered and no one should be required to take part in an abortion procedure against his or her will.

Regulation of private services

108. The imposition of legal regulations on the operations of private abortion clinics might, in our view, unduly restrict access to those services without necessarily improving their standard. The appropriate course to take is to ensure the provision of an adequate number of facilities of a good standard. This could be facilitated by establishing operating standards for public and private clinics and encouraging their acceptance on a voluntary basis.

Access to services

109. The provision of abortion services is divided between public and private facilities which are unevenly distributed. We consider that health and medical authorities have a responsibility to ensure that adequate services are available to women in all areas. This can be achieved by developing hospital services, clinic services and community health services.

Incidence of abortion

World incidence of abortion

110. Statistics are quoted showing the abortion rate in a number of countries. These range from 70 per 1000 women aged 15–44 in Cuba to 12 per 1000 in Tunisia.

Incidence of abortion in Australia

111. Estimates of the number of abortions in Australia are hard to make as only South Australia keeps full official statistics. On the basis of figures from the Department of Health, from a survey of doctors, and from information supplied by doctors and others we estimate that a minimum of 60 000 abortions are performed each year in Australia.

112. This figure would give a ratio of one abortion to every 3.9 live births and an annual rate of 21.7 abortions per 1000 women between the ages of 15 and 44.

Characteristics of women having abortions

113. Data from surveys of abortion patients are used to compile a picture of women having abortions.

114. About one-third of all abortions occur to women under 20, and up to 40 per cent of pregnancies occurring in this age group end in abortion. For women over 20 the likelihood of a pregnancy being terminated increases with age, especially after 35.

115. About half of all abortions occur to women who are single. Approximately half of all the pregnancies of single women end in abortion.

116. The majority of single women having abortions have no children whereas nearly all the married women securing abortions have one or more children. Women with no children or with more than two children are more likely to have a pregnancy terminated than women with one child.

117. The percentage of women having abortions who are Catholics is similar to the percentage of Catholics in the population as a whole.

118. The two dominant groups of women having abortions appear to be:

- young single women aged 15–24 with no children
- married women with two or more children

The effect of a change of law on the incidence of abortion

119. In South Australia as in England and Wales the initial increase in the number of legal abortions occurring after the law was changed has levelled off. The last 2 years have shown a decline in abortions for women resident in England.

120. It cannot be determined how many illegal abortions are now performed or have been performed in the past. It is difficult therefore to show conclusively that liberalising the law has led to a substantial increase in the total number of abortions. It is probable that there has been some increase in the number of abortions performed each year in Australia since 1969. At the same time there has been a reduction in mortality associated with abortion and the morbidity rate in those States where substantial numbers of abortions are performed openly is low.

121. We do not consider that changing the abortion law leads to the abandonment of contraception. The level of contraceptive use among married people is high; many young single people, however, are not using effective contraception. Other special groups are also at risk. To achieve a reduction in the number of abortions it is necessary to expand contraceptive services and to provide effective education and motivation, particularly to meet the needs of young people and others who have special needs.

Consequences of abortion

122. We received many conflicting views about the complications and long-term effects of induced abortion. We established a committee to examine published research reports and other material, and we undertook a survey of hospitals and clinics to establish their complication rates. The research report and the results of the survey are at Annexes IV.P and IV.Q.

123. Since 1973 there has been one death in Australia arising from legal abortion; this was attributable to the administration of anaesthetic. Overseas experience has been that liberalisation of abortion leads to a significant reduction in the rate of abortion-related deaths, especially in early abortion. Late abortion and the use of abdominal methods increases the risk. The death rate of abortion is well below the death rate from pregnancy and childbirth.

124. Many variables make it difficult to assess accurately the rate of complications for abortion. Factors which tend to minimise the risks appear to be: early termination; use of the vacuum aspiration method; experience and skill of the operator; specialised facilities. Those which increase the risks are: late termination; abdominal methods, such as hysterotomy; performing sterilisation in conjunction with abortion; pre-existing medical conditions.

125. The morbidity rate of legal abortion is considered to be lower than that of illegal abortion. Australian morbidity rates from legal abortion have shown improvements in the 1970s with a reduction in the percentage of hysterotomies, improved skill and experience, and the use of the vacuum aspiration method. Our own survey of abortion morbidity showed a high rate of use of vacuum aspiration and very few hysterotomies and sterilisation procedures. The complication rate was low.

126. Information about the long-term effects of abortion is inadequate and hard to compare. It does not support any definite conclusion and points to the need for further studies. Some trends can be identified. The effect of abortion on later fertility and pregnancy may be reduced by skilful operation early in pregnancy; it may be increased by the extreme youth or age of the woman and by the use of abdominal methods.

127. There is no firm evidence to suggest serious long-term psychological effects from abortion. Factors which may reduce the risks of emotional disturbance are the ability to make a free choice without pressure and the support of family, counsellors and medical practitioners. Adverse factors include late termination, especially where foetal abnormality is suspected. The vital importance of counselling before and after abortion is stressed. The short-term and long-term depressive effects of childbirth, especially in the case of an unwanted pregnancy, need to be considered.

128. Many women refused legal abortion find other ways of obtaining a termination of pregnancy. Where the child is born there may be harmful effects for both mother and child, whether the child is kept or given for adoption.

129. Abortion may have an effect on the marriage or relationship of the woman and her partner if they are in disagreement about it. Abortion may itself be a result of marital tension. Counselling and support of the husband or partner is desirable in some cases.

130. Girls under 16, older women, women who have had many children and women who seek successive abortions are identified as groups who may have an above average complication rate or risk of further unwanted pregnancies. The need for special attention to counselling these women and advising on contraception and (if appropriate) sterilisation may arise.

131. There is no case for imposing legal restrictions on abortion because of the morbidity and other risks. The adoption of the best procedures, the development of the necessary skills and the provision of appropriate facilities are necessary to bring the complication rate as low as possible. All women contemplating abortion and their medical advisers should be aware of the risks and of how they may be minimised. Information about facilities should be readily available and counselling services provided.

132. Sterilisation should not be routinely performed in association with abortion and abdominal methods should be avoided unless there are special indications.

133. A standard format should be adopted for recording information about the complications of abortion. There is no need to provide for compulsory notification.

Attitudes to abortion

134. Evidence shows that public opinion in Australia is increasingly in favour of liberalisation of abortion laws. While the interpretation of opinion polls must be approached with caution, there seems to be a general willingness to accept the need for abortion on specific social or psychological grounds. In all the Australian surveys referred to, more people favoured liberalised abortion laws than were opposed to abortion. Education, socio-economic status, religion and birthplace are all significant factors affecting attitudes.

135. It is concluded that the majority of people of all groups—even many Catholics—approve of the further legalisation of abortion. Only a minority oppose abortion under all circumstances. Most are prepared to take into consideration the physical, emotional and social circumstances of the woman concerned. Extreme expressions of opinion and publicity campaigns on each side of the issue do not seem to have had a marked effect on opinion.

136. Analyses of surveys from the United States and the United Kingdom also show an increase in support for liberal abortion.

Young people and fertility control

137. There is some evidence that increasing numbers of adolescents are sexually experienced. The adolescent generally has a low level of effective contraceptive use, and the incidence of pregnancies, ex-nuptial births and abortions among the under 20s is very high.

138. The main risk of sexual activity among young people is pregnancy. This can be a traumatic experience for the boy and the girl. It can interrupt a girl's education and career prospects. An ex-nuptial child may also affect her future and that of the child. The experience of pregnancy and childbirth followed by the surrender of the child for adoption may cause adverse reactions. Forced marriages among the young have a high failure rate. Abortion may have risks for the very young, especially if they delay getting advice until the pregnancy is well advanced.

139. The facts of teenage sexuality cannot be ignored. They call for a positive response in the form of special services for young people. Ignorance is not a protection for the young, but an extra risk.

140. Educational material for young people should adopt a style and format which they can readily understand and which will capture their interest (e.g. comics, slides, short films).

141. General practitioners sometimes refuse contraceptive advice to minors. Adolescents may be reluctant to approach doctors or FPA clinics, though most FPAs run special clinics for young people. An Action Centre has been established in Melbourne to give advice to young people on a wide range of sexual, contraceptive and relationship matters. These new ideas are welcomed as a way of reaching adolescents. Other schemes which could be studied and adapted include the Grapevine project which trains young counsellors who then make contact with young people in their own environment.

142. Contraceptive methods advised for adolescents should have regard to cost and availability and to the casual, intermittent nature of some youthful relationships. The use of the condom should be promoted and the advantages of withdrawal should not be overlooked when no other method is available.

143. Legal uncertainties about the provision of contraceptives to minors should be removed. Doctors prescribing or supplying contraceptives in good faith should not incur civil or criminal liability because of the absence of parental consent provided that the patient is over 14. Where the patient is under that age and the parents' consent could not be obtained, the doctor would have to determine what was best in the patient's interests and his view of the possible risks of failing to act.

144. It is desirable that efforts be made to involve the parents in any decisions regarding abortion of a minor under 16 and that the young person receive adequate counselling. A doctor performing an abortion in good faith on a girl over 14 should not incur civil or criminal liability because of the absence of parental consent. Where the girl is under 14 and it is not practicable to obtain parental consent, the doctor should be protected if the operation is considered necessary to protect the interests of the girl.

Childbirth

145. Pregnancy and childbirth are crisis periods in human relationships, when new family relationships are formed and existing relationships are changed.

146. If a woman has a poor experience of childbirth it can affect her relationship with the newborn child.

147. A woman experiences immense changes during pregnancy, physically, socially and emotionally. Sex education programs should discuss these changes, and men as well as women need to understand them.

148. Doctors, nurses and educators in pre-natal classes need to learn a better understanding of the emotional changes that occur during pregnancy. Migrant women particularly suffer from a lack of emotional support and even basic information. Translations of material on pregnancy and childbirth are urgently needed.

149. The education of doctors and nurses in the field of obstetric care should have regard to the social and emotional needs of the mother and child during pregnancy and childbirth, as well as being concerned with medical needs.

150. Women who exhibit a high level of anxiety during pregnancy are more likely to have complicated deliveries. These problems should be detected in the pre-natal period. At present doctors are too busy, pre-natal hospital clinics lack social workers, and lack of privacy due to poor hospital design inhibits discussion.

151. Pre-natal classes should be more widely available, and should give more attention to psychological aspects, and to subjects such as contraception, sexuality, child rearing and marital relationships.

152. Good pre-natal education and training may reduce the amount of medication or anaesthesia needed during childbirth, shorten labour, produce a more relaxed childbirth and reduce the need for forceps and episiotomies.

153. Many expressed concern about the increasing trend towards induction of labour for the sake of professional rather than parental convenience. A woman should not be persuaded to have an induction unless it is medically necessary. Women should also be given the choice regarding medication during labour, having first been advised of its effects.

154. Professor Carl Wood, Professor of Obstetrics and Gynaecology at Monash University, criticised a failure to collaborate between childbirth educators, physiotherapists, medical and nursing staff: this results in lack of continuity between what the woman is taught in pre-natal classes and what happens in hospitals. There are often discrepancies between what the patient expects and what actually occurs.

155. Childbirth organisations and individuals claimed that hospital routine often takes precedence over patient needs. It was felt that doctors and nurses do not pay enough attention to the feelings of the mother and the father during childbirth.

156. The role of the father during childbirth is important. Some hospitals encourage fathers to attend; others make it difficult. Some will not allow the baby's biological father to attend, or relatives and friends in place of the father. We consider that these rules should be changed.

157. Australia was said to be the only country in the world where there is an increase in the breast-feeding of babies. Criticisms were made of hospital procedures which delay the time of the first breast-feed, and restrict contact between mothers and babies to routine feed times. We consider that mothers should be allowed to breast-feed on demand, and at night if they wish.

158. Maximum contact should be encouraged between mother and child in the early days by providing for rooming-in facilities or unlimited access by mothers to their babies. Fathers should be encouraged to make as much contact as possible. Mothers should be trained to help care for premature babies to ensure early contact. Maternity care should be family centred, and other children should be allowed to visit their mother and new baby in hospital.

159. Some women elect to have their babies at home. This is difficult, as there are few trained midwives; the medical profession does not favour the idea. Home deliveries should always be supported by back-up services such as ambulance and blood transfusion. Because complications can occur during childbirth, it would be better to make hospitals more homely than to switch all deliveries to the home.

160. Mothers continue to need support after the birth of their child. Hospitals should offer post-natal programs on parenthood and infant care. Post-partum depression, particularly in its mild form, is a common occurrence following childbirth, but is insufficiently acknowledged and understood. Research is required.

Institute for research into human sexuality, reproduction and fertility control

161. Research into human sexuality, reproduction and fertility control should be given a high priority in research because so many Australians are directly affected by these matters. We believe that an independently funded Research Institute should be established to promote, co-ordinate and carry out direct research and to inform the professions and the public about research developments in Australia and overseas. Current research in these areas should continue to receive support and funding should be expanded.

Part V The family

1. Of all our institutions, the family is the most influential. Though it has had and will have many different forms, it is unlikely that it will ever disappear.

2. Within the family a child learns about himself and the world outside. He learns what it means to be a boy or girl, what it is to love and be loved, what it is to feel anger, what it is to be a part of mankind. Yet paradoxically, the family, which can give a child so much, can also bring it harm. Within family life can lie ignorance, neglect, violence and despair. And just as the child is vulnerable to the family, so are families vulnerable to the society of which they are a part. Malnutrition, poor housing, unemployment, discrimination are only a few of the pressures which can affect family life and well-being. Therefore society carries a responsibility to see that families can function effectively, particularly where the care of children is concerned.

3. Family relationships are central to our terms of reference. Our evidence shows that in Australia today the family is the focus of much public debate. Some staunchly defend it as the cornerstone of society and see its existence threatened. Others call for its abolition because they feel in its present form it destroys the individuals within. Anxieties have arisen because the family is in the process of change.

4. Both defenders and critics of family life identify certain truths about family relationships. The family has many virtues but at present is afflicted by many weaknesses.

5. Part of the reason for controversy about family life lies in the fact that people define the family differently. We have chosen to use the term very broadly to cover a varying range of people living together in relationships of commitment. Our view is that we need to accommodate many different life styles and to learn from these experiences rather than to reject them. Although people may appear to live very differently, they share many common desires.

6. The fundamental question we must ask ourselves is whether the family in Australia today is receiving the support it needs to fulfil its primary role, that of caring for and nurturing its young. Have our family programs and policies kept pace with social change and, if not, what more needs to be done?

Changing patterns of family life

7. More Australians are marrying now than ever before. Fifty years ago, only half the population over 15 were married; today the proportion is two-thirds. More than nine out of ten Australians will marry at least once in their lifetime. Australians are marrying younger. From 1939 to 1973, the proportion of minors (under 21) in the total number of married persons increased from just over 4 per cent to 16 per cent for males, and from 20 per cent to over 43 per cent for females. The trend towards early marriage seems to have stabilised with a swing in attitudes against early marriage.

8. There are many marriages between the Australian born and migrants from western Europe. Only about one-third of eastern Europeans, however, marry Australians. Many couples prior to marriage do not appreciate the effect a different national or cultural background may have on marriage.

9. Social pressures probably influence many people to marry. Early physical maturation contributes to earlier marriage.

10. The pattern of childbearing in Australia has changed. The birth rate was high in the late 1940s and 1950s but since 1961 has steadily declined, and in 1975 reached its lowest rate since 1938.

11. Completed family size has declined. Families with two or three children have become the most common—half the size of families before the 1914–18 war.

12. The number of adults who become parents has increased. Less than one-tenth of women now bear no children compared with one-fifth in the 1930s. More children are being born to younger mothers.

13. About two out of three brides marrying at ages below 17 are pregnant at the time of marriage, the proportion declining markedly with increasing age. The incidence of pre-marital pregnancies among teenage brides was higher during the 1920s and 1930s.

14. Ex-nuptial births account for about 10 per cent of live births. About 40 per cent of first births are either conceived or born out of wedlock. Of total births, however, some five-sixths are both conceived and born in wedlock. This pattern is common to other countries with similar backgrounds.

15. The period of married life devoted to childbearing is shorter, and children are born closer together. Children tend to leave home earlier and they leave for higher education or work rather than for marriage.

16. The rate of divorce is increasing, but changes in the divorce laws do not necessarily lead to an increase in marital breakdown. As the divorce rate has risen, the separation rate, in comparison, has declined. In fact, an increasing divorce rate has to be considered in conjunction with the increasing popularity of marriage in the post-war world. About 75 per cent of divorcees remarry.

Family pressures and family policies

17. Many people who gave evidence to us were concerned with pressures which affect family life. Some saw these arising out of underlying social values, such as concern with materialism and a desire to achieve economic growth at the expense of human growth. Others spoke about social changes which create stress, for example changes in the roles and relationships of men and women, greater family mobility, more married women entering the workforce and isolation of families from their traditional supports.

18. Poverty was seen as damaging to human relationships and family life. People on low incomes often live in Housing Commission estates devoid of community facilities and distant from work. They are vulnerable to breakdown and need better family services.

19. Old people are increasingly segregated from the rest of the community. Everyone suffers from this segregation. There is a pressing need for low rental accommodation for old people, as well as services to enable them to remain in their own homes. The status of domiciliary service needs to be upgraded. Few people plan wisely or early enough for retirement, and trade unions should play a greater part in retirement programs. The aged suffer from being stereotyped. They should be recognised for their individual characteristics. Being no longer economically productive, they are seen by some as having inferior status.

20. Single people are affected by living in a society where marriage and family life is the norm. They are often regarded as 'failures'. Human relationships programs in schools should encourage discussion about the single state so that young people are able to contemplate it and to avoid choosing marriage because of social pressures.

21. Families living in remote and rural communities suffer many pressures because of their geographic isolation. Women in mining communities have a higher incidence of mental illness than men. Many of these communities are almost all male and there are few old people; this imbalance limits the scope and distorts the nature of human relationships. Families in remote areas have little access to family services. Mobile teams should visit country areas, and local people should be trained in counselling and other forms of community work.

22. Australia has never had a unified family policy and, as a result, services tend to be fragmented, overlapping and inconsistent. Families are frequently confused by this partitioning of responsibility, and do not know the range of available services nor how to apply for them.

23. The aim of a family policy should be an equitable distribution of services and resources to allow all families to achieve common social goals–adequate income, housing, education, health, recreation and legal protection.

24. One way of helping to ensure that family interests are not neglected, at the policy-making level, would be to introduce a family impact statement whenever new policies or programs are introduced which affect family life.

25. Australia suffers from a shortage of preventive services; effort is concentrated on family breakdown after it occurs, rather than trying to prevent it happening. We recognise the need for 24-hour crisis services, but would like to see these incorporated in family centres, widely available, well publicised and locally staffed. Such centres should provide information about family services and act as referral points. More homemaker services are required and should be available to any family in need. They should be based on social needs as well as health needs.

26. Voluntary organisations have a valuable role in assisting families. They are usually close to community needs and deal with emerging problems in advance of statutory bodies. They should receive government encouragement.

27. People are often unaware of help that is available; many services are inaccessible and are disproportionately located in middle class areas. Migrant and Aboriginal groups suffer because services are usually not sensitive to their cultural needs.

28. Information about services should be given in all the main ethnic languages. Government information and publicity should constantly acknowledge that family services are available to the community as a right; there should be no stigma attached to approaches for help.

Child care

29. Child care is often the subject of disagreement. Some believe that to separate the young child from its mother causes harm or maternal deprivation, and that to increase child care services would encourage more mothers to go to work. Others believe that caring for children should be a community concern, and that in present society it is asking too much of parents to expect them to carry this responsibility alone. Other arguments canvassed the benefits to children from having child care outside the home, the rights and needs of women to choose whether to work or not and the desirability of providing alternative environments to those in which many Australian children are raised.

30. In discussing child care it is essential to understand the social changes which have occurred in post-war years, altering both family life and its environment and in turn affecting child care needs. Urban development, increasing job mobility, social

isolation, changing family structures and the rapid increase of married women in the workforce all have obvious implications for child care needs. In our present society we believe it is essential that the community should share in the nurture of young children by offering a range of child care services, small in size and locally based.

31. Increases in government-subsidised child care services reflect a national child care policy which dates from the Child Care Act of 1972. Child care is provided in a number of ways: through Commonwealth government support and subsidy, through State governments, community groups, parent groups and through commercial enterprises. Services include long day care, sessional pre-schools, family day care, kindergartens, play groups, care outside school hours, private child minding and work-based care. Very few companies provide this last kind of care. Those that do would like to receive government funding but, even where their centres run at a financial loss, they feel that this is outweighed by staff satisfaction, increased productivity and less sick leave. The Womens Trade Union Commission aims to involve unions and industry in providing low cost, quality child care. They receive a government subsidy.

32. Our evidence and other research studies indicate that in Australia today there is a serious shortage of child care facilities of all kinds. Services have increased, but many children still have no access to child care. The majority of children of working parents are still privately minded. This is not always satisfactory. Distribution of services is uneven, favouring higher income districts. People living in rural areas often lack child care.

33. A Commission research study showed that few of the working mothers of pre-school children who were surveyed used formal child minding centres, mainly because they were unavailable or the mothers wished to avoid paying for child care.

34. There is a shortage of out-of-school care, as well as assistance for working parents when their child is sick. Many submissions made the point that occasional care was also needed for the mother who chooses to stay at home.

35. For migrants, the problem of child care is often one of crisis. Several studies have revealed pictures of migrant women deeply distressed at their child minding problems. Migrant access to registered child care is more limited than that of Australians, because as newcomers they do not know how to find places in short supply. Also they tend to live in poorer areas which have few family services. For example, in the Sydney metropolitan area, the ratio of children to long day care centres (suitable for working parents) is one centre for over 2000 children. A Commission research study of some 1000 women living in an inner city area of Sydney found that only one in eight of the children whose mothers worked was in any type of registered centre. Eighty-five per cent of those migrant women with pre-school children saw the care of their children as a problem.

36. The government's involvement with child care is reflected through the Office of Child Care which was established in June 1976. The Office provides policy advice to the government and administers the child care program including the allocation of funds to State governments and community groups. Priority is given to children with particular needs.

37. Our view is that child care policy should be based on the fundamental right of every child and parent to have access to child care services of a type best suited to their individual needs. Not to provide child care particularly penalises the poor, as commercially operated services are beyond the reach of lower income families. We therefore believe the government should continue to support a wide range of child care services and to ensure their equitable distribution. The government should assist

the establishment of work-based child care centres by way of direct grants and tax concessions. We would like to see the government set an example by establishing and evaluating work-based child care for its own employees.

Family law

38. Family law has been in a state of transition during the term of our inquiry with the implementation of the *Family Law Act* 1975 and the passage of the *Marriage Act* 1976. We have looked at certain aspects of family law, particularly those involving the exercise of Federal legislative power.

Federal and State powers

39. Legislative power in respect of family law is at present divided between the Commonwealth and the States. Federal legislative power is limited to marriage, divorce and matrimonial causes and related matters. The adoption of children and the status, custody and maintenance of children from outside marriage are governed by State law. This division of powers had led to anomalies, particularly since the establishment of the Family Court of Australia. In our view it is highly desirable to achieve a unified family law and family jurisdiction in Australia by extending Federal legislative power.

Matrimonial property

40. We consider in this section the laws governing the ownership of and interest in matrimonial property, and the powers of the Court to deal with such property during marriage and on or after divorce. Some consider that the present rules provide insufficient security and protection particularly to women, who are often dependent on the exercise of discretion by the Court to obtain an interest in the matrimonial home and other assets.

41. Proposals to reform matrimonial property law are considered. In principle these would be advantageous in providing for automatic joint ownership of the home. There are, however, constitutional obstacles to such proposals; they would involve changes in the property laws of all States and Territories to achieve uniformity.

42. Systems of equalisation of assets have been introduced in some countries and are under consideration in others. Under these systems the spouses share equally at the end of the marriage the net assets acquired by their efforts during marriage. We consider that such a system would have many advantages and that it would provide a measure of security for a dependent spouse. The Family Law Council and other law reform agencies should examine ways of introducing such a system.

43. At present the Family Court has no power to deal with interests in property or to order transfers or settlements of property until an application has been made to the Court for principal relief, such as divorce. In our view the Court's powers should be extended to enable it to deal with property matters at any time.

Succession

44. The succession rights of a surviving spouse are at present determined by State laws relating to intestate succession and testators family maintenance. These laws differ from each other in a number of respects. We consider that ways should be examined of achieving unified or at least uniform laws of succession and inheritance rights throughout Australia.

Children

45. A decision of the High Court and consequent changes to the Family Law Act have led to the exclusion from that legislation of power to deal with the custody and maintenance of children, such as stepchildren and ex-nuptial children, who are not the children of both parties to the marriage. We consider that these powers should be restored. The Family Court should also have power to determine custody disputes between a parent and a third party, such as a grandparent.

46. Recent legislative reforms in some States have improved the status and rights of children born outside marriage. These reforms have not been uniform and in some cases do not go far enough. We consider that it should be possible for a blood test to be ordered in respect of a party or a child in any case where a Court has to determine paternity or maternity. Fathers whose paternity has been acknowledged or declared should be entitled to apply to the Court in respect of custody or access. Where the parents have been living together at the time of the birth it would be appropriate to regard them as joint custodians.

47. The present division between Federal and State legislative powers tends, in our view, to perpetuate the distinctions between children born to married parents and those whose parents are not married to each other. In our view it is desirable to achieve unified legislation and jurisdiction to deal with the custody, access and maintenance of all children and this should be achieved by extending Commonwealth legislative power.

Marriage

48. The present law provides for different marriageable ages for male and females. In our view the age of 14 is too young for girls to take on the responsibilities of marriage and parenthood. We consider that the minimum age for marriage for males and females should be 16 and that parental consent should be required up to the age of 18.

Relationships other than marriage

49. There is some evidence of greater acceptance of relationships which are not formalised by marriage. Questions are sometimes raised as to the respective rights and obligations of parties to stable de facto relationships. We consider that there is some scope for limited legal recognition of the obligations assumed by the parties to such a relationship. The rights and status of children should, in our view, be the same as those of children of a marriage.

Lone parent families

50. Ten per cent of all families with dependent children are lone parent families. Mothers and fathers who are required to perform the roles of parent, breadwinner and housekeeper are generally ill equipped to do so and receive little help.

51. Lone parents may be separated, widowed, divorced or unmarried. Altogether 160 000 lone parents, including 28 000 lone fathers, care for 285 000 children.

52. Half of the families headed by a lone mother are poor or rather poor, the second highest rate of poverty for any Australian group. The worst affected are separated women and divorced women. Those in poverty are the ones who are dependent on government benefits as their main source of income.

53. Most lone mothers who have jobs work in traditional female occupations. They suffer the general lower status, poor security and lower wages of all women workers. However, because they are breadwinners, their need for higher wages is greater than

that of the married woman who works to supplement a two-parent family income. The recent downturn in employment opportunities for women has not spared lone mothers. They need to become skilled workers to give them some bargaining ability in the workforce and to lessen their chances of unemployment. Current retraining schemes do not serve well the needs of lone mothers. Child care during working hours is also essential. There are insufficient opportunities for part-time work.

54. Two-thirds of lone mothers and a handful of lone fathers receive some form of government financial assistance. As with all pensions the benefits offered are below the prevailing level of wages. Most would be better off if they could enter employment. However, many lone parents cannot get jobs either because of the needs of their children or because of lack of job opportunities. Some lone fathers, particularly those with pre-school children or large families, cannot join the workforce and should be given government pensions. Not more than about one in ten of lone fathers would be expected to apply for such assistance, as most prefer to work.

55. The cohabitation rule, which precludes benefits being paid to a woman living with a man as his de facto wife, has many disadvantages. Inquiries necessary to enforce the rule are an intrusion into people's personal lives. However, all forms of regulation present their own complications and, on balance, we see no practicable alternative to the cohabitation rule provided officers exhibit a sensitive attitude to claimants and benefits are not withdrawn suddenly without adequate notice.

56. The present Social Security Act requires a lone mother to make reasonable attempts to obtain maintenance for herself and her children before being eligible for a pension. We believe, however, that the minimum social security benefit should depend upon the needs and means of the parent and not on the income level of the other parent. This does not preclude the lone parent from pursuing maintenance but does ensure immediate assistance.

57. About 40 per cent of lone parents have to move house soon after they reach that status. This usually provokes a housing crisis. The private housing market is too expensive for most lone parents but public housing has not taken their needs sufficiently into account. Lone parents favour housing that has the facilities they need—schools, child care, health centres, shopping and recreation—but they would prefer to be integrated into the community and not housed together. Short-term emergency accommodation is needed to prevent children being committed to institutions.

58. Research into the effects of lone families on children is uneven in quality and does not allow many conclusions to be drawn. The provision of child care for preschool children and of after-school and holiday care for schoolchildren are the most important reforms needed in this whole area. Domiciliary help should be made available to lone parents on a short-term emergency basis to reduce the number of children of lone parents in institutions.

59. Self-help groups for lone parents provide the best means of informing governments of changing needs of lone parents, interpreting official policies and programs to members and giving practical and emotional support. These groups should receive government assistance. Lone parent families cannot be turned into two-parent families, but much can be done to overcome their disadvantages.

Adoption

60. We consider certain aspects of adoption relevant to the terms of reference, in particular the effects of adoption on the mother, the child and the adoptive parents.

61. The underlying principle of adoption is that the welfare of the child is paramount and that the needs and rights of the natural and adoptive parents are secondary.

The unmarried mother's decision

62. It is generally considered that more young single mothers are keeping their children rather than surrendering them for adoption. Some are able to cope well. Others, particularly teenagers, find it difficult to cope with the demands of parenthood; some children may become at risk because of this. There is a need for community support and advice for young unmarried mothers to help them to provide adequate care for their children.

63. While there is evidence to suggest that adopted children fare better than children brought up by single mothers, we do not consider that this factor or the youth of the mother should alone be a ground for removing a child from its parent or for dispensing with consent to adoption. Where an application is made to dispense with consent, the mother should be entitled to legal aid and advice.

Adoption and the natural mother

64. We sought information about the experiences of women who had surrendered children for adoption following upon an unwanted pregnancy. Some of the case histories are set out at Annexe V.C. They show a range of reactions and outcomes. Some experienced regret over the decision and wished to know about the child. Others accepted that adoption gave both the child and the mother a better chance in life.

65. There is a need for counselling services for women with unwanted pregnancies to help them to reach their decision and to provide support. Where counselling and support is available, before and after adoption, the mother may be less likely to suffer distress.

66. Unsupported mothers should receive sufficient financial assistance to maintain reasonable health and comfort prior to and after the birth of the child. In view of the shortage of babies now available for adoption, and in view of the inability of some parents, married and single, to provide adequate care for their children, it is suggested by some that there is a need to encourage greater public approval for the adoption of children.

67. A review of the sealed record system which precludes the mother from obtaining information about the child may lead to more children being available. There should be a possibility for the mother to obtain social information of a non-identifying kind about the child.

Adoption and the child

68. Some adopted children find they are in difficulties because they have no access to their own medical history or to that of their parents. We consider that the social and medical history of the child and its natural parents should be recorded, where possible, and made available to the adoptive parents.

69. Some adopted children experience a strong wish to find out about their natural parents. Adoptive parents regard this with mixed reactions; some are prepared to accept it, while others feel they are entitled to privacy and would not welcome the intrusion. We consider that an adopted child should be able to obtain social, non-identifying information about its parents on reaching 18. Agencies should assist adopted children and parents who seek to make contact with each other, but should

not disclose identities unless both agree. A court order for the disclosure of records should only be made in exceptional circumstances, taking into account the interests and privacy of the natural and adoptive parents and the child.

70. The adopted child is to some extent vulnerable, particularly where he or she experiences uncertainty and anxiety about his or her identity. Adoption agencies and departments should assist adoptive parents and ensure that they are able to inform and help children to understand their origins.

The adoptive parents

71. Evidence suggests that adopted children are over-represented in groups of children requiring psychiatric treatment. This emphasises the need to apply appropriate criteria to the selection of adoptive parents. These should be based on the environment which can be offered and on the ability to contribute to the welfare of the child. It is important to ensure that adoptive parents are physically and emotionally able to take on the parenting role and that they have a basic understanding of child development. Agencies and departments could establish learning programs for adoptive parents as well as pre-and post-adoption counselling.

Infertility and adoption

72. It is important that infertile couples should accept and adjust to their situation before considering adoption. If they are unable to adopt because, for example, no babies are available, a further period of adjustment may be needed. Adoption agencies should take on, as part of their responsibility, the counselling of infertile couples before adoption and in cases of failure to adopt.

Eligibility to adopt

73. The child's welfare is paramount; as a consequence it is inappropriate to refer to a right to adopt. The main criterion for eligibility should be the ability to contribute to the welfare of the child. It does not follow from the adoption of such a criterion that any particular group should be automatically excluded from consideration, even though in individual cases they may not qualify.

74. We do not consider that single people should be excluded from consideration, particularly in cases where there is already a relationship with the child. While it could be a disadvantage for a child to be brought up by partners to a stable de facto relationship, the possible benefits to a particular child may outweigh these disadvantages; we do not consider that couples who have a relationship of 3 years standing should be automatically excluded from consideration. Persons who have no religious affiliation should not be excluded from consideration as adoptive parents, if otherwise they would qualify.

75. While there is no evidence that homosexuals or bisexuals are ineffective parents, we do not support the proposal that homosexual couples, male or female, should be entitled to adopt. To do so would be to risk imposing an additional source of stress on a child who may already be vulnerable because of the adoption.

Aboriginal adoption

76. Some issues related to Aboriginal adoption were raised in evidence and other material. There is a strong feeling among many Aboriginals that children of part-Aboriginal blood should be placed with Aboriginal rather than white families. This is considered necessary to help the young person to establish his or her identity.

77. The failure to recognise Aboriginal tribal marriages has been an obstacle to adoption by the couples concerned. We consider that there may be cases where the

welfare of the child would be best served by such an adoption and that parties to a tribal marriage should be regarded as eligible to adopt if otherwise suitable.

78. We consider that Aboriginal communities should be assisted to set up adoption agencies and that, so far as possible, Aboriginals should be involved in arranging adoptions of Aboriginal children. The family customs of Aboriginal people should be understood and respected.

Fostering

79. Fostering is a form of temporary substitute family care though it can sometimes endure for a long time. Its special nature as non-permanent care can be a cause of stress.

80. The need for foster care arises when parents are unable or unwilling or have been found unfit to care for their children. The ideal is to provide temporary care while the family recovers and to involve the natural parents.

81. Where fostering becomes long term, the desire of the foster parents to adopt may bring them into conflict with the natural parents. The interests of a child in long-term foster care may be best served by adoption, especially where there has been no contact with the parents. Such cases should be reviewed regularly. On the other hand, it is important that policies have as their aim the maintenance or restoration of the family unit where that will advance the welfare of the child.

82. Welfare policies now favour the cottage home for foster children rather than institutional care, where family care is not available or is inappropriate. Handicapped children are sometimes placed in cottage homes. There are reports of local opposition to the setting up of cottage homes. To overcome this, local involvement in planning and public education may be needed. All children, and especially those who are disadvantaged, need a home and family life as nearly normal as the community can provide. Community acceptance and goodwill are part of this.

83. Current allowances paid to foster parents are considered by many to be inadequate, having regard to the importance of fostering and to the pressures, financial and emotional, on foster parents. We consider that foster parents should be relieved of financial stress.

84. Recent schemes for 'family' fostering and parent aides to help families in crisis are discussed. These schemes can be used to help in cases of child abuse. To ensure greater participation of women in these schemes, payment of out-of-pocket expenses should be provided.

Family violence

85. Family violence is an issue of major social concern, calling for short-term and long-term action on the part of government and the community. Family violence is widespread right across Australian society. The damage done to women and children is often severe, and the capacity for violent behaviour can be passed from one generation to the next.

86. Family violence is defined as acts of violence by one spouse against the other spouse, including a de facto spouse, or against the children.

87. The size of the problem is indeterminate. From March 1974 to June 1976, a total of some twenty-five refuges have offered shelter to over 5000 women and nearly 7000 children. In addition many women and children were sheltered at church and welfare homes.

88. There is no single cause of domestic violence nor is it easy to distinguish cause from effect. Some people are more predisposed to violent behaviour than others. Family background is an important factor. Children who are raised in violence are more likely to be violent in adult life. Socialisation which encourages men to be aggressive and to treat wives as possessions provides a climate for domestic violence. Unemployment, poverty, inadequate housing, excessive drinking and job demands are all factors which can lead to conflict.

89. Many men and women who are involved in domestic violence present bleak pictures of violent childhood. Excessive drinking is a frequent factor. Seventy per cent of the women in a Commission study of 111 women at Elsie Womens Refuge, Sydney, said the man with whom they had been living drank too much or was an alcoholic. Nearly half of the husbands in the Elsie study had no regular work. A high level of unemployment also featured in another Commission study on domestic violence. Many of the families in both studies seemed to spend their time on the move. Nearly half of the men in the Elsie study had received psychiatric treatment. Most of the women had entered marriage with little understanding of its realities.

90. Nearly 40 per cent of the Elsie women were permanently injured or scarred as a result of the attacks. Their general level of health was poor. Attacks also affected their confidence and self-esteem. Many of the women felt society disapproved of them.

91. Their children suffered from poor health. Over one-fifth of the children in the Elsie study had been subjected to constant attack. One-third of the children had tried to intervene in their parents' disputes. All the children were at risk of being violent themselves in adult life.

92. Problems facing women in situations of domestic violence are serious. They have accommodation difficulties, financial problems, worries about bringing up their children single handed and they have to contend with a social climate which is often unsympathetic. Many stay in situations of danger and conflict because they can see no other alternative.

93. We believe that these women need immediate physical protection; a place of refuge and later more permanent accommodation; counselling; legal and social advice; medical treatment both for themselves and their children; access to agencies and help in dealing with them. Well-publicised, well-distributed family crisis centres are needed.

94. More refuges are required. Most are full and many women and children are being turned away. Some refuges have had to close for lack of money. Funding of refuges should be a Federal responsibility by way of direct grants. The level of funding should be flexible and should cover all costs, including salaries.

95. Housing regulations should be waived to allow women to set up co-operative households. Housing authorities and banks should be funded to provide access to special low-deposit, low-interest housing loans.

96. Health service workers, particularly doctors, need to have a better understanding of the dynamics of marital conflict. They should be able to refer women to appropriate community agencies.

97. Husbands involved need help; without it they are likely to repeat the violence if their wives return, or to carry it into new relationships. Emergency mental health teams should be considered as an alternative to police intervention. Police and lawyers should be educated to refer men charged with domestic assault for counselling or treatment.

98. Many victims of marital violence are ignorant of their legal rights. Education programs are needed to inform women of their legal position and of available community resources. Courses should be organised at times and places convenient to women.

99. Women appear reluctant to call the police, stating that police do not take action unless serious injuries are inflicted. The reluctance of women to press charges, the number of cases withdrawn and the difficulties of interviewing in a domestic situation may affect the attitude of the police. Ordinary training does not equip police to deal with domestic violence. Special training is needed.

100. Proceedings for assault appear to be a relatively ineffective remedy, given the objective of protecting the woman rather than punishing the man. Many cases are not pressed. If the husband is fined or bound over, he may still commit further acts of violence. In more serious cases the husband may be imprisoned, but this is no solution. There is often pressure from the man for the woman complainant not to proceed.

101. The experience of women in courts where they have gone to charge partners with assault has been less than satisfactory. Injunctions and orders are legal remedies not psychological ones and criminal courts are not the most appropriate places for dealing with such cases.

102. A woman in a situation of violence affecting her marital relationship may call upon the counselling services of the Family Court. The success of counselling would depend on how receptive the husband was to the proposal; it is not compulsory for any person to attend for counselling.

Community education and information

103. Community education is essential to ensure that marital violence is frankly discussed and that women are encouraged to seek help.

104. There needs to be good knowledge in the community of the location of womens refuges and of the social services available; information booklets should be prepared and distributed.

105. More attention should be paid within schools to the problems of family violence. Children need to grow up with an understanding of the nature of conflict and of the roles and relationships of men and women; they should have information about community resources, basic family law and social services. Girls should understand the consequences of dependency and their need for job skills. Education about alcohol is essential. Tertiary and adult education programs for those likely to come into contact with cases of domestic violence should include information about family conflict and how to deal with it.

106. It may not be possible to eliminate family violence, but as a society we must examine our attitudes to violence. We must question our views of family roles and family relationships, for these may contain the seeds of conflict. We must look at our values and customs. If we neglect the needs of violent families, violence is likely to persist from one generation to the next.

Child abuse

107. Our investigations into child abuse coincided with growing public concern about the problem. All State governments introduced new child abuse laws or programs of management during the period of our inquiry.

108. Cases where children are harmed by members of their family attract most attention. Child abuse also occurs at the public level and manifests itself in statistics on infant hunger and malnutrition, mortality, poverty, inadequate medical care, poor education, racial discrimination. Public abuse can be found within our institutions such as schools, courts and hospitals. These issues are important because they may contain the genesis of child abuse within the family.

109. Definitions have broadened since the term 'battered child' was first used in 1962 by eminent American paediatrician, Dr Henry Kempe; it originally meant young children who had suffered serious physical injury. Today's definitions of child abuse usually take in a broad range of maltreatment including sexual abuse, physical or emotional injury or neglect.

110. State governments and research workers have used many different definitions in Australia. This makes it difficult to compare research studies and statistics, thus limiting our knowledge. The government should convene discussions between Federal and State Attorneys-General and other appropriate child protection agencies in an attempt to frame common definitions of child abuse, for both legal and research purposes.

111. The true incidence of child abuse in Australia is unknown. The vast majority of cases are unreported. One American estimate is one case reported to every 100 unreported. Australian estimates are usually based on American data and have previously ranged from between 1500 to 4000 cases a year. A South Australian study, however, indicates that the incidence of non-accidental physical injury to children under 15 in Australia could well be as high as 13 500 cases a year or thirty-seven children injured every day.

112. People who abuse their children may be male or female and from many different races, nationalities, social, economic and educational backgrounds. Only about 10 per cent of people who abuse their children are mentally ill. The remainder are neither insane nor criminal. Some have poor impulse control, some have missed out on their own parenting, some have rigid obsessional personalities and punish to excess. There appears to be a relationship between young parents and child abuse, but any parent, given the circumstances, could abuse their child.

113. Young children are more vulnerable to child abuse than older children but research shows more older children are maltreated than was previously recognised. Further research is needed into the abuse of adolescents and a national seminar should be convened. Many abused children have special characteristics which appear to make them 'different'; for example, they may be premature, adopted, mentally or physically handicapped. Often one particular child in a family is singled out for abuse. There is no means of knowing whether child abuse is increasing. Lack of knowledge makes it difficult to plan effective services. Nation-wide studies should be initiated to provide realistic information.

114. It is a mistake to treat all cases of child abuse as belonging to a single group or having a common cause. Many social and cultural factors are related such as poverty, unemployment, isolation, lack of family services, unwanted pregnancy, poor health, alcohol abuse, attitudes to parenthood and to family roles and relationships.

115. Many people rush into parenthood with little understanding of its responsibilities, and with widespread ignorance of childhood development. As parents they have unreal expectations of their children and get angry when these are not met. The dividing line between physical punishment and child abuse is sometimes narrow. Parent education programs are required, both in schools and in the community. These should include discussion on discipline.

116. The abused child may become the abusing parent. It is important to do more for abused children than just treat their physical injuries. They need long-term emotional, social and educational support.

117. If early warning signals are ignored, results may be tragic. Studies have shown nearly 50 per cent of battered children have serious injuries. Ten per cent may die. One-third may have neurological damage. Many children receive hospital treatment, only to return home to receive further injuries.

118. The law should not be punitive but should aim to protect the child at risk and help the family. Criminal sanctions are a poor way of preventing child abuse. Legislation should provide the framework for special child protection services in each State and Territory. Reporting laws by themselves do not resolve the problem of child abuse; without effective back-up services they will achieve nothing. Agencies need to be established with non-punitive powers to investigate and place children under protection pending investigation. The government should establish a national centre for child protection.

119. Child abuse services in Australia are often fragmented, overlapping and unco-ordinated. One designated statutory authority in each State and Territory should have prime responsibility for co-ordination and integration. Voluntary services should be part of a total community plan. Many tragedies have occurred because information has not been shared. Services need to be regionalised, adequately funded and staffed and well known. A system is needed whereby any person at any time knows where to ask for help, either for themselves or for a child.

120. Services should include child protection units at major hospitals; 24-hour crisis telephone services; counselling services; child care services (day and residential); family therapy programs, including long-term programs for abused children; family support services and financial assistance for families in need; lay therapists; self-help groups; and family counselling centres not only for families in crisis but for families before they reach the point of crisis.

121. A national health visitor scheme should be established with right of entry; this would assist in identifying children at risk. Parent aides could be specially trained lay people.

122. Maternity hospitals should do more to identify parents who are having difficulties relating to their child. American studies (in Denver, Colorado) have shown it is possible to identify vulnerable families, in the pre-natal period and at the time of birth. This work should not label people as 'potential baby bashers' but, rather, identify families in need of help.

123. Research shows there may well be a link between child abuse and the mother's childbirth experience. Premature babies are significantly at risk. Maternity hospitals should try to foster parent-child bonding.

124. A national conference should be convened to discuss ways of implementing the above suggestions. The NHMRC should allocate funding for research into the relationship between parent-child bonding and child abuse.

125. There is widespread reluctance to accept the fact of child abuse. Community and professional education programs are required, and protection services should be widely advertised.

126. Prevention of child abuse should be our ultimate goal, even if an idealistic one. Prevention requires a better understanding of the causes of child abuse and an approach that is supportive, not punitive, so that parents seek help early. It requires better education in parenthood and family life, more sensitive pre-natal and childbirth services, better and more widely distributed family services and the realisation that environmental stresses, such as poverty or inadequate housing, are significant factors. Prevention also requires a critical assessment of the value accorded children in our society, and of attitudes to violence, discipline and children's rights.

Alcohol and human relationships

127. Alcohol is a common element in situations where human relationships are broken or damaged; it causes distress for the people immediately concerned and suffering for a wider circle.

128. There are two opposing views about the problem aspects of alcohol abuse: one defines it as a disease; sufferers from it are sick and require medical treatment. This view is endorsed by many doctors and mental health professionals, as well as by Alcoholics Anonymous. But the clinical symptoms of heavy drinking can be treated, with competence and skill, and yet leave the underlying problems which produced the symptoms untouched. The second view, therefore, sees the problems of alcohol abuse in a social context, with counselling and rehabilitation as the key needs. The disease label may relieve the patient of responsibility; the social approach involves the family as well as the patient.

129. Alcohol in our society is one of a range of psychotropic drugs with a potential for abuse. Similar drugs are nicotine, analgesics, sedatives and tranquillisers. Alcohol may be the most dangerous addictive substance known to mankind; the effect may be pleasant or beneficial in some people, but harmful in others.

130. Moderate use of alcohol may have some social benefits, but abuse is costly in personal, community and social terms. Alcohol impairs judgment, slows reactions and creates a sense of dependency; in excess it can be toxic. The per capita consumption of alcohol in Australia more than doubled between 1938 and 1970.

131. One in twenty-five of Australia's workforce has a drinking problem, at a cost of possibly 1 500 000 man days and $1000 million a year. Many trade unions and government departments have shown little concern for those with alcohol problems, although there is some progress.

132. Many crimes are significantly affected by alcohol—drunken driving, rape and assaults.

133. The drinking of alcohol is expected social behaviour in Australia, although the addicted individual is rejected by society. Young people drink in imitation of their parents. The pressure of advertising is of particular significance where young people are concerned.

134. Advertisements, especially on television, give a misleading picture and encourage the young to drink to be socially successful. Greater responsibility should be exercised by the media, especially in programs or publications aimed at young people.

135. Treatment programs need to be based on an awareness of environmental factors which reinforce and reward excessive drinking.

136. Doctors and other health professionals should be educated to understand and deal with alcohol-related health problems, and to have a knowledge of the support services available.

137. Country areas need advisers to provide back-up assistance for health personnel and to initiate volunteer training programs in the community.

138. Self-help and community organisations should receive government encouragement and support. A national policy on alcohol should be developed by the co-operation of Federal and State governments.

Prisons and the family

139. We look at the tensions in human relationships that arise out of imprisonment and affect both the prisoner and his family.

140. Of the 9000 prisoners in Australia, most are young men (less than 3 per cent are women) and about one in ten have been neither convicted nor sentenced. About a quarter of male prisoners and rather more females are married.

141. Most of our submissions on prisons deal with the separation of women and children from partners and fathers in prison. Many families carry severe burdens which arise as a result of imprisonment.

142. A major difficulty is the feeling of helplessness arising from separation. The prisoner needs to feel that someone outside the prison is waiting and caring for him. Family ties are specially important. Better arrangements for visits are seen as important.

143. Imprisonment raises a problem of the denial of heterosexual relationships and the connected problem of homosexual harassment. There were calls for conjugal visits. Another suggestion was that prisons be staffed by persons of both sexes. Some pressed the need to find alternatives to prison for offences of a sexual nature. Research is needed here.

144. Submissions sought relaxation of rules on mail for prisoners, and referred to the dehumanising aspects of prison such as prison uniforms, forfeiture of possessions, use of numbers, restricted visiting and lack of meaningful work.

145. Problems in the care of the children of women prisoners were raised, and also the desirability of special release of prisoners in the case of serious illness in the family. The custodial right of women prisoners to their children should not be disturbed unless special circumstances demand it.

146. We conclude that even a short term of imprisonment can have serious effects on the prisoner and upon his or her family. Those involved in sentencing policy should be aware of the repercussions for the family and should develop alternatives to imprisonment where possible. Conditions in prison should be substantially improved to allow for more family contact.

Part VI Equality and discrimination

Equality for women

1. It is claimed that women in Australian society do not share equally with men in status, power, privilege or responsibility and that they suffer discrimination and injustice. We consider that in many respects this claim is justified and that measures should be taken to rectify this situation. A number of areas are considered in which discrimination and injustices are said to occur.

Education

2. Education is one of the principal factors which determines the status of women in our society. The education system could play an important role in fostering women's abilities. Until recently, however, it has largely failed to build up the confidence of women to undertake wider roles in society. This is evidenced by the earlier age at which women abandon education and their concentration in female-dominated occupations.

3. Evidence has shown that our schools emphasise sexism, in so far as it is suggested that girls and boys are expected to behave differently and have different futures. This is done through the school organisation, and through curricula content and vocational guidance. The education system fails to encourage girls to achieve; it restricts their options.

4. Programs to end discrimination in schools will succeed only if student teachers are made fully aware of all the issues in their training and retraining programs. A visible commitment by government, by allocation of resources, is also essential.

Employment

5. Evidence received by us included many complaints about discrimination in employment. In the area of wage rates, despite equal pay provisions, women's incomes are generally lower than those of men. The discrepancy is caused, in part, by less access to overtime, fewer fringe benefits, such as over-award payments, and longer and more frequent periods of unemployment. The channelling of many women into lower paid positions also affects their wage levels. Even in the professions women usually represent the low-paid base of the professional hierarchies.

6. In looking for a job women run up against the initial problem of discrimination in job advertising. In some States legislation precludes discrimination; in others, however, advertisements still contain sex specifications for jobs which are often irrelevant and unnecessary. At interviews women are often asked personal questions about plans to marry or to have children, which are not asked of men. A woman's job security may be disturbed by events such as her marriage or decision to have a child.

7. The issue of entitlement to superannuation or discrimination in superannuation schemes was raised by several submissions. Other fringe benefits, such as family travelling allowances and bank loans to employees, may also be denied or be different where the employee is a woman.

8. Submissions suggested that male workers are often guilty of keeping women in low-paid, low-status jobs. Many beliefs about women workers are based on traditional attitudes rather than fact, yet they continue to limit the scope of women to engage in employment.

9. Such factors as the denial to women of opportunities to participate in training were given as reasons for their inability to reach senior positions. Myths about women's capabilities may be used to prevent them from reaching supervisory positions in commerce and industry.

10. Higher turnover rates and absenteeism were cited as justifications for discriminating against women in employment. The comparisons are not, however, correlated to the status of the job. They take no account of the large numbers of women in low skill jobs, nor of women's dual role as both workers and housekeepers. Greater opportunities for job satisfaction and an alleviation of some of the burdens of housework could make a significant difference.

11. To change these matters there needs to be public education and public commitment by government, unions and employers.

12. The public service offers a good example of the present situation in womens employment; most women are clustered at the lower levels of the hierarchy. The Royal Commission on Australian Government Administration made some useful recommendations in this area, including anti-discrimination legislation and policies aimed at increasing opportunities for participation in policy making. Women seeking re-entry into the service should be given credit for skills acquired in the family, home management and voluntary work; current selection procedures disadvantage women who are forced to leave the workforce due to home commitments.

Women and trade unions

13. The failure of unions to respond to the needs of women members was raised in submissions. Distinction in awards between the employment of men and women, with regard to pay, conditions, hours, overtime and part-time work were outlined. Some unions have responded to women's needs and actively taken up campaigns for such improvements as child care. Some have complained that women take too little interest in union activities, but, at the same time, lack of concern by the union in the problems and the burdens of two jobs, at home and at work, prevents many women from actively participating in union affairs. The issue of part-time work is one area where the interests of the union and of women workers have conflicted. Migrant women suffer particular disadvantages both as workers and in trade union representation.

14. Such bodies as the Melbourne Working Womens Centre and the Sydney Womens Trade Union Commission are playing an important role in acting on behalf of all women, to develop positive attitudes and action by trade unions.

15. The recently established Trade Union Training Centres could provide the mechanisms to develop women as trade union leaders and to establish more positive attitudes within the trade unions to women.

Child care

16. A major factor in establishing equal employment opportunities for women is the provision of adequate child care facilities. At present child care options are few and often expensive and unsatisfactory. This in turn reduces employment prospects. We consider that government, employers and trade unions should take part in planning the extension and improvement of child care facilities.

Provision of credit, goods and services

17. Discrimination in credit and finance were documented in our evidence. Women's relatively poor income prospects, due to a lack of marketable skills, their vulnerability to unemployment and assumptions about their dependent position affect their ability to obtain credit and loans.

18. Discrimination was seen to exist in such areas as insurance against loss of income due to accident or sickness, and disability policies to cover the cost of employing home help. Women's supposed greater susceptibility to illness due to their reproductive functions was given as the reason for this type of discrimination. As housewives are not 'income earners' in the technical sense, insurance against disability is not generally available, despite the heavy cost of a housekeeper.

19. The kind of discrimination which prevents women from becoming full members of recreational clubs was also alluded to in submissions. In country areas particularly, these clubs provide the major source of sport, recreation and entertainment; to exclude women from full use of their facilities is to prevent them from fully participating in the social life of the community.

Women and the law

20. We were not so much concerned about discriminatory legislation as such, but rather that there seemed to exist cases where the law was not impartially applied, and where women lacked access to legal remedies.

21. It was suggested to us that women need a special legal assistance service because of the difficulties, both financial and otherwise, in dealing with the legal system and the legal profession.

22. Probate and estate duty often discriminate against women because they are more likely to be financially dependent and more likely to outlive their husbands. Since the family assets are so often vested in the husband, the burden of duty falls on widows in most cases. Some States have abolished duty on estates passing to spouses, but these reforms are not universal and do not apply to Federal probate duty.

Social security

23. Discrimination in social security benefits was also suggested in submissions. Because women are treated as dependants their needs are subsumed under 'family' in social security policy. In particular, a married woman who loses her job is not entitled to unemployment benefits if her husband is working. A married woman is able to receive sickness benefits only if her husband is unable to support her.

Marriage and economic dependence

24. The financial dependence of married women was seen by some as a great disadvantage; suggestions for a wage for housewives were made. Women sometimes have little choice other than to remain in a dependent situation because of their lack of education, training and employment prospects. Women in crisis need housing resources in addition to training and employment opportunities to enable them to develop independence.

Single women

25. Some single women consider that they are disadvantaged by the emphasis of social planning on the family. Discrimination against single people, particularly those who support dependants, is institutionalised in taxation, superannuation, finance and housing. The plight of single elderly women who are often forced to exist without aid on extremely low incomes was pointed out.

The media

26. The portrayal of women by the media is seen by some to distort their role and to be unrealistic in many ways. The powers of the media should be used positively and responsibly, not destructively as is often the case. This can be done by improving the balance of sexes working in the media, especially at policy-making level. Guidelines for non-sexist journalism should be developed and adopted.

Women in public life

27. We noted the lack of women in high-ranking political positions and especially in government. This can probably be traced to two factors: discrimination within the political parties and a lack of women in the type of positions from which political candidates are chosen, such as the legal profession, trade union officials and high-ranking business executives. The political parties should encourage women members to advance within the party structure and initiate more equality in selection of candidates for elections.

28. Positive action should also be taken to appoint women to the upper echelons of the legal profession, in particular to the bench, and to integrate them into all levels of trade union activity so that they have the opportunity to be elected to higher positions. Another area of power and influence is statutory bodies—positive action should be taken to increase the number of women on such bodies. All voluntary associations should also seek to involve women in the active policy-making bodies.

Move towards equality

29. Discrimination against women persists because it is built into the customs, practices and institutions of Australian society.

30. The movement to promote female equality has a long history. Efforts to promote equality have centred around workforce problems. This emphasis now appears to be changing towards efforts to overcome unequal education and training.

31. Programs in both Sweden and America show how such bodies as departments of labour can initiate and develop programs to promote equality in employment.

32. Ratification of international conventions is another way in which the Australian government could actively encourage equality amongst men and women. In particular, ILO Convention no. 103 on Maternity Protection (1952) should be a high priority for government ratification. Australian government employees already have the benefits of paid maternity leave and most State government employees also have some provisions, although, generally speaking, they are not up to the standard of the Convention. In private employment there is a need to incorporate provisions for maternity and paternity leave into employment, either by way of awards or by some system of social security benefits.

33. The ILO Convention on Equal Pay, passed in 1951, was not ratified by Australia until 1974. Despite the closing gap between male and female average wages, there are still factors such as overtime and over-award payments which favour male workers.

34. National and State Committees on discrimination in employment have been established to promote equality of opportunity and treatment in employment. The function of the the Committees is to investigate and resolve complaints of discrimination and to initiate education programs. The operations of the Committees are limited, however, by several factors: their ability to investigate only individual complaints and

not systematic discrimination against groups of people; their confinement to methods of persuasion and conciliation with no recourse to penal sanctions; and their policy of not publishing details of any cases investigated.

35. We support the suggestion that anti-discrimination legislation should be passed to express society's disapproval of anti-social behaviour and to allow for stronger sanctions, if they are necessary. We note that already South Australia and New South Wales have passed legislation to make discrimination unlawful. Victoria is formulating and debating such legislation. There is a need for nation-wide legislation against discrimination on the grounds of sex or marital status, in employment and other areas. This should be combined with a program for public education.

36. The inequalities suffered by women in this society require the intervention of government by legislation, education and other programs to raise the status of women in Australian society to one of full equality with men.

Prostitution

37. This chapter deals almost exclusively with the female prostitute as we received little evidence on the practice of males soliciting.

38. Evidence of recent history points to a new move by prostitutes to organise themselves to agitate for their rights. This seems to have been influenced by two factors, the impact of the womens movement and indication that fewer prostitutes are under the influence of pimps or protectors of one sort or another. A survey conducted for the Commission seems also to indicate a changed attitude amongst the general public to prostitutes and greater acceptance of their existence and their right to be free of legal harassment.

39. Arguments for and against the legalisation of prostitution centred around the issues of public health; the connection with organised crime; the influence on other sex crimes; and the impact on society's morals. Allusion was also made to the connection between prostitution and police corruption. It was suggested that the current practice of fining prostitutes was rather more a method of collecting revenue than a serious attempt to stamp out the existence of prostitution.

40. The law does not penalise prostitution in itself but rather offences such as soliciting, being on premises used for prostitution and living off earnings from prostitution.

41. It has been suggested, with regard to soliciting, that there is no need to have such an offence and that crimes such as causing a public nuisance would be sufficient to supply a remedy for those who found the actions of prostitutes offensive. The offence of soliciting is the most commonly used law against prostitutes and the conviction rate is over 90 per cent. It has been recognised, however, that laws against soliciting do not stop prostitution and that where soliciting laws are tightened there is resort to other methods.

42. The offence of being on premises used as a brothel, which is less common, discriminates against prostitutes, as clients are not liable for prosecution.

43. Several submissions called for the legalisation of brothels and some even suggested that they be run by governments. There was also considerable opposition to government control of brothels, some people seeing this step as only another way of inviting official corruption and possibly intimidation of prostitutes.

44. Some suggested that legalisation of prostitution represented a threat to family life and morality. On the other hand, it was contended that the existence of an increasing amount of pre- and extra-marital promiscuity was probably a greater threat than prostitution, which historically has existed side by side with marriage for centuries.

45. We consider that the prohibition and punishment of prostitution as such is not justified except to the extent necessary to protect the immature, to prevent violence and coercion and to prevent public nuisance.

Aboriginals

46. We sought to make contact with members of Aboriginal communities to gain an understanding of how the human relationships issues raised in our inquiry affected those communities. Our efforts were not entirely successful; there appeared to be several barriers impeding effective communication between an inquiry such as ours and Aboriginal people.

47. Since white settlement of Australia, the Aboriginal people have found it difficult to preserve their culture and to adapt to white culture. There has been much misunderstanding of and prejudice towards Aboriginals. To overcome this it is important to educate and inform white people about Aboriginal culture, to foster relationships between Aboriginal and white Australians and to improve the social and economic position of Aboriginals. Special assistance programs for Aboriginals are needed to achieve equal opportunity.

48. Education for Aboriginal children should aim to build a bridge between the culture and values of Aboriginal communities and those of white communities. Teachers need to learn about Aboriginal customs; Aboriginals should be involved in planning education programs. Adult education is needed for both urban and tribal Aboriginals.

49. The Aboriginal community has many health problems. There is a need to develop the Aboriginal Medical Service and to involve Aboriginal nurses and health workers in the delivery of health services to Aboriginals. Involvement of the local community in planning services is very important.

50. A serious effect of white settlement has been the breakdown of traditional patterns of tribal and family life and the breaking of links with the cultural heritage of many Aboriginals.

51. There is a need for effective contraceptive services for all Aboriginals. There has been some suspicion of such services in the past. It is important that the services involve the Aboriginal community and use Aboriginal nurses and health workers wherever possible. The Aboriginal Medical Service should also be involved in the planning and delivery of contraceptive services.

52. Special training and employment opportunities are key factors in improving the social and economic conditions of Aboriginals.

53. Descendants of South Sea Islanders brought to Australia last century are not eligible for benefits available to Aboriginals though they share many of the same disadvantages. We consider that eligibility for benefits should be extended to these people.

54. Aboriginals are not always able to make effective use of existing health, education and welfare services because of cultural and other barriers. We consider that, wherever possible, services providing for the needs of Aboriginal people should employ Aboriginal liaison officers to help Aboriginals to use the service and to provide a link with the Aboriginal community.

55. There is a continuing obligation on the Australian community to assist Aboriginals to find a place in Australian society, and to choose freely whether to preserve their own culture and adapt it to meet modern pressures or to seek equality of opportunity in a white society. Support should be given to self-help programs aimed at building confidence and independence among Aboriginal people.

Migrants

56. Twenty per cent of Australia's population were born outside Australia. Although Australia has derived benefits from the migrant program, migrants suffer many disadvantages in Australian society. These have been well documented in numerous official and unofficial reports.

Communication

57. A central problem is that of communication. This is more than a problem of language; it extends to the culture, attitudes and social mores of migrants and Australians. One in every seven children comes from a home where English is not the first language. Many of the parents come from peasant backgrounds and are unskilled or even illiterate in their own language.

58. Our evidence showed that there appears to be hostility towards migrants joining their own ethnic groups and an assumption that they should adopt and understand Australian customs and practices.

59. A pressing need for bilingual professional services exists and for professional interpreters in all areas where migrants encounter authority or require services. Information about services and such things as industrial safety should be available to migrants in their own language. Ethnic radio and TV programs could be used to overcome the problems of those who are illiterate even in their own language.

Children and education

60. Problems of migrant children include the conflict between an often strict home and the more relaxed Australian school system. Children are under peer pressure which conflicts with family environment. Parent–child relationships may be upset because children have to act as interpreters for non-English-speaking parents. Ethnic liaison officers are needed in schools. The result of lack of assistance for migrants at school is that, generally speaking, migrant children are poor achievers. This means migrant communities are unable to produce bilingual professionals to service their needs.

61. Programs on ethnic culture should be part of the general teaching programs of all schools to promote understanding between migrant and other children, and to preserve migrant children's rights to their own culture.

Learning English

62. The large number of migrants who still cannot speak English is attributable to lack of encouragement, the unsuitability of the hours of classes and the fact that the classes are not geared to the range of literacy and ability which may exist in any one group of non-English-speakers. Often migrant men refuse to allow their wives to attend classes because it means their going out at night and leaving the children. The home tutor scheme could be particularly valuable to these women.

Women and the family

63. Migrant women are probably the most disadvantaged group among migrants, particularly as many of them come directly from backward rural life and are immediately exposed to a new industrialised, urban society in Australia. For many the experience is one of total isolation, cut off from the rest of the community by language and by the attitudes of some husbands who consider it proper to keep them confined to the home.

64. The lack of access to family planning facilities and the different cultural attitudes to contraception and abortion present other difficulties for migrant women.

65. The fact that, by contrast to their place of origin, the majority of migrant women in Australia work in industrial employment could be seen as a method of exposing them to new ideas and freeing them from isolation. For most migrant women, however, the jobs they can obtain are in the worst paid and most unskilled areas of employment which are physically tiring and leave little time for communication with other workers. Coupled with this, the full responsibilty for home and family is still carried by the women. Child care services are either non-existent or do not cater for the language and cultural needs of migrants.

Discrimination at work

66. For migrant men as well as women there is little chance to break out of the low-paid unskilled job cycle. Almost no training courses are available. Migrants are prone to industrial accidents as little literature or even danger signs are translated into non-English languages. Little emphasis is placed on the rehabilitation of injured workers. There is a need to investigate workforce discrimination on a case-by-case basis, and to eliminate systematic discrimination.

67. Nothing in this chapter is really new. Most observations about the discrimination and problems migrants face have been made before. We join with others in calling for positive remedial action to overcome the existing problems and to promote migrant welfare.

68. Some of the problems which arise between migrant parents and children brought up in Australia, and when migrants marry established Australians, are discussed in Annexe VI.D which highlights some of the demographic characteristics of migration in Australia.

Discrimination against homosexuals

69. Homosexuality is an issue on which the community at large is divided in its attitude. Some believe that the government and the law have an obligation to restrict homosexual behaviour as something perverted. Others believe it is a matter of private behaviour, and no danger to public morals is involved. Some see homosexuality as an alternative life style and consider that the homosexual needs to feel welcomed and encouraged.

70. We interpreted our terms of reference to include all aspects of human relationships; we saw homosexuals not so much as a social problem, but rather as people against whom society seemed to discriminate. Objections were raised in Sydney to our hearing evidence on this question, and our decision is covered in our ***Interim report*** (page 44).

71. The definition of 'homosexual' comes from the Greek word 'homos', of the same kind. The term carries social and emotional implications and those labelled with it incur social disapproval which can amount to violence. The medical profession gives it no clinical connotation, and the law proscribes certain homosexual acts without giving any legal definition of the term.

72. A variety of reasons have been advanced as to why some people are homosexual—genetics, environment, family situation. Whatever may be the cause, it would seem that most homosexuals do not wish to be otherwise, and that those who seek a 'cure' are the dissatisfied and non-accepting.

73. The Wolfenden (UK) report was satisfied that homosexuality was not a disease, and most contemporary psychiatric opinion would agree. Most consider that it is as natural as heterosexuality and should be freely expressed. The Australian and New Zealand College of Psychiatrists believe that existing laws need reform when concerned with homosexual acts by consenting adults in private.

74. Laws concerning homosexual behaviour in Australia vary from State to State; South Australia and the ACT have exempted from criminal liability homosexual acts in private between consenting adults. Penalties vary widely and in some ways are savage. The Wolfenden report led to a more humane and tolerant approach, which affected public opinion. It elucidated many of the issues concerning homosexuality and the law, and made a clear distinction between homosexuality and homosexual offences.

75. We received evidence that the attitude of the churches is changing. Roman Catholic, Anglican and other churches have pleaded for just and fair treatment of homosexuals, although the Anglican Diocese of Sydney could not recognise homosexuality as an accepted form of sexual activity in society. Mental health authorities similarly have urged repeal of discriminatory legislation, as did a Royal Commission in Western Australia in 1974. This Commission found evidence of discrimination, physical violence and blackmail, as we have found, and emphasised the need for education on the subject.

76. There seems a willingness to accept homosexuals as persons with equal rights to love and fellowship. Statements by the Roman Catholic Commission for Justice and Peace and the Anglican Dioceses of Canberra and Goulburn and of Melbourne were significant indicators of a change of view.

77. Dr J. H. Court, a psychologist from Flinders University, pointed out that few people are completely either male or female, and sexual orientation is age related, sex related and culture related. The moral issues are quite distinct from the legal ones.

78. Whatever the various moral views that may be put forward, it seems unnecessary to include homosexuality under the criminal code.

79. It is the problem of discrimination in employment and society that is most resented by homosexuals. It was suggested to us that the major anti-homosexual employers in Australia appear to be the Commonwealth and State governments, whatever their political affiliations. The public service, education departments and, above all, the Defence Department seem determined to exclude homosexuals. It is our belief that they should certainly not be automatically excluded; their employment should be determined on the same criteria as heterosexuals. Often homosexuals accept poorly paid and low status jobs in order to avoid investigations into their personal history.

80. It is our conviction that education should be given to children in schools, to parents, teachers and medical students about homosexuality and that selected homosexuals should be involved in such programs. Such programs must be factual, balanced and non-judgmental. Better sex education programs will help to eliminate prejudice and discrimination.

81. It is important that well-informed and sympathetic counselling services should be available for homosexuals. Much of our evidence expressed strong opposition to aversion therapy, psychosurgery, and use of certain drugs to 'cure' homosexuals. On the other hand, Dr Court, whilst hesitating about the use of electric shock and certain drugs like apomorphine, yet believes it is now possible to refute categorically the view that the homosexual cannot be effectively treated. We do not, however, accept that homosexuals should seek or be seen as in need of such treatment.

82. We did not feel able to recommend amendment of the marriage law to recognise marriage of homosexuals or accept the proposal that homosexual couples should be entitled to adopt children except in cases of natural relationships. To do so in the present social climate and in the absence of long-term research would be to risk imposing an additional source of stress on a child who may already be vulnerable.

83. We were helped in our work by three research projects, with specialist consultants, in Sydney and Melbourne. It is clear that there are two levels of feeling. Most people wanted to see homosexuals with the same rights and responsibilities as heterosexuals, but to treat it as a valid alternative life style may still raise public anxiety.

84. We consider that encouragement should be given to a wider understanding and acceptance of the homosexual as a person entitled to equality of status and rights, whose private sexual behaviour is not a matter of public concern solely because it is homosexual behaviour.

Handicapped people

85. Throughout history society has treated handicapped people as outcasts or objects of pity. Attitudes are now changing but our evidence indicates that the treatment of handicapped people in Australia still leaves much to be desired.

86. The description 'handicapped' covers people with a mental and physical disability which limits their self-dependence, education or employment. We include this chapter under the heading 'Equality and discrimination' because handicapped people are taught to be different, even lesser human beings. Adverse discriminatory attitudes often, in themselves, impose additional handicaps or reinforce existing ones. Prejudice and ignorance limit potential.

87. The extent of physical and mental handicap in Australia is unknown. A follow-up survey to the 1976 census which would have given this and other more detailed information about the handicapped was cancelled for financial reasons. We believe lack of information must seriously limit the ability of governments to plan effective services.

88. A Commission research project to study the effect on families of having an intellectually handicapped child or young person living at home revealed that these families tended to have a lower income than the control group. This has implications for their financial well-being, particularly since the Poverty Commission revealed that having a handicapped member often imposes severe financial burdens.

89. Our evidence indicates that families of handicapped children are subject to severe strains which are aggravated by a lack of appropriate services. Services are provided by a wide range of public and private agencies that have varying policies and overlapping programs. There is need for long-term planning. There is also need for a body outside government to monitor services and to provide a focal point for leadership, research and information. We recommend the establishment of an Australian Institute on Mental Retardation.

90. More diagnostic centres are required on a regional basis and should be linked with treatment and training centres. Many doctors are unaware of the various services that are available or needed. Health professionals need to be better educated in this field. Public education programs could assist diagnosis and assessment.

91. Early detection of handicapping conditions is vital. The rights of a child to physical and mental well-being should be protected by screening at birth and then at yearly intervals until school age. Many parents complained about the failure of health professionals to give them adequate information and counselling. Whenever a child is diagnosed as handicapped, counselling should be given to the family, who should be put in touch with support services. Information booklets on support services are required and should also be available in the main migrant languages.

92. Governments can help people to avoid giving birth to children with a handicapping condition, for example by providing contraceptive facilities to women over the age of 35 (the most vulnerable group) and by adequate genetic counselling facilities. Clinics and school health services should encourage girls to be immunised against german measles.

93. Handicapped children, no less than other children, have a right to a free and appropriate education. Some handicapped children in Australia are still not getting education. Wherever possible, education programs for the handicapped should be integrated within normal education programs. More attention should be given to and resources made available for developing early intervention programs. Education should also extend into adult life. Social skills including education in human relationships and sexuality are important.

94. A shortage of support services for families of handicapped children sometimes results in these children being put into residential care when otherwise they could have stayed at home. This is unsatisfactory. More residential care is also urgently required. We were disturbed by accounts of the quality of care in some institutions. The situation needs to be investigated immediately and conditions substantially improved. Nationally recognised standards need to be developed and licensing should be tied to funding arrangements.

95. All the evidence we received shows that underlying the criticisms of services, the despair and frustration of parents and the stories of children denied their basic rights is an issue of human relationships. Handicapped people are not subhuman and do not want to be treated that way. They ask only for 'normal' social welfare systems to be modified to accommodate their needs; one of the main ways to achieve this is through integration into the mainstream of society. Their quest is to live lives as close to normal as possible. This can only be achieved by everyone in the community playing a part.

Part VII Rape and other sexual offences

1. In this part we consider forcible rape, incest, statutory rape and other sexual offences. There has been increasing interest in and concern about rape, due partly to womens groups who see women as victims not only of the crime but also of the legal procedures for dealing with rape. The theme we pursue is that greater emphasis should be placed on the violence and assault which often accompany rape and less on the sexual aspects of the crime.

Rape and society

2. Attitudes to rape can affect the rapist and the victim; they can affect the commission of the offence and can aggravate the distress of the victim. Rape is often seen as a crime arising from sexual impulses with insufficient attention given to its aggressive and violent nature. The causes of rape seem to lie in social factors rather than in psychological disturbances.

3. Factors which seem to contribute to the incidence of rape include the concentration in urban communities of groups of young single men with low levels of education and therefore frustration which finds its outlets in acts of physical violence. Another factor is the expectation that the male role is aggressive and the female role passive. Rape is often an act of aggression. There is a common view that women secretly want to be raped, and a lack of understanding about the realities of a rape attack. There is need for education to promote a better understanding by men and women of each other's role, and to improve communication. While resistance should be used with discretion, because of the danger of provoking more serious injury, women should at least learn some skills in this area.

4. We can find no clear evidence to establish a link between rape and the availability of pornography.

5. The attitude that a woman 'asked for it' is damaging to her own personality and ability to recover, despite the fact that there are few instances where the victim precipitates the rape. We consider that the law should give more emphasis to the violence involved in rape rather than to the act of intercourse.

Existing rape laws in Australia

6. In common law, rape means sexual intercourse with a woman other than one's wife, without her consent. Each State and Territory has its own legislation dealing with the offence and penalty. Rape can occur if consent is induced by force or by threats. Separate offences are created where consent is obtained by false pretences. The question of a mistaken belief by the accused that the victim was consenting is considered.

Rape statistics

7. Reported rape has a relatively low incidence compared with other serious crimes. The number and rate of reported cases have increased substantially particularly in the 1970s.

8. In New South Wales, despite an increase in the number of reported cases, the number of trials and convictions has remained fairly steady. About 80 per cent of persons convicted are under 25 and of these half are under 20. The greatest increase is among the young age groups. About 70 per cent are unmarried and 80 per cent have not attained school certificate. About 90 per cent are Australian. Multiple rape has occurred only in recent years and is an offence mainly committed by young persons.

Half the victims in the NSW rape convictions were under 21; 57 per cent did not know the offender, though some went voluntarily with him. Violence or threats of violence featured in about 45 per cent of cases in one study.

9. In other States a comparable pattern appears though there is less information.

10. Analyses of unreported rape cases show that they have a broadly similar pattern to reported cases. There appears to be a substantial number of such cases. In a research study conducted for the Commission the main reason for failure to report was the desire to forget the incident; fear of giving evidence was a less significant factor.

Police procedures in dealing with rape complaints

11. Complaints were made about the insensitivity and hostility of police to rape complainants in some cases. Though the problem is not universal it does appear that some police do not regard rape as serious unless there is physical injury and tend to doubt the genuineness of complaints. Special sexual offences squads should be set up with equal numbers of men and women and with women police officers of equal rank and experience to their male counterparts. Officers selected for these squads should have appropriate attitudes and should have some training in psychology and crisis intervention.

12. Initial police investigation should be kept to the minimum required for effective action and further investigation postponed until the woman has had any necessary medical examination or treatment. Police investigation should avoid 'cross-examination' on past sexual history.

13. Police should co-operate with rape crisis centres and inform victims of the services they are able to offer.

Medical procedures for dealing with rape victims

14. Medical services for dealing with rape victims are in some respects inadequate. Major hospitals should have panels of male and female doctors with adequate training and information to conduct examinations. Rape victims are sometimes reluctant to be examined by a male doctor.

15. The victim should be treated with sympathy to minimise emotional shock. She should be given advice on venereal disease and follow-up testing should be arranged. Pregnancy should be discussed and, where appropriate, treatment given or follow-up arranged.

16. Hospitals and doctors should have suitable printed information and checklists of services to be provided and examinations to be performed. The victim should also have written information about necessary medical tests and available services.

17. To avoid doctors spending time at court unnecessarily their evidence should be in written form unless either the Crown or the defence requests attendance.

Rape crisis centres

18. Rape crisis centres have been established by active womens groups concerned to help the victim. They are now in all capital cities and provide telephone and personal counselling. They could provide more effective help with some basic training in crisis counselling.

19. Better relationships should be established between the police, the medical profession and the centres, to ensure that all victims have the opportunity to receive immediate help. The centres need to be more broadly based to enable rapport with the police and doctors and to provide a more effective service for women of all ages who may need their help.

Committal proceedings

20. The rape victim usually has to give evidence at the committal proceedings and again at the trial. On each occasion she is liable to cross-examination. In our view, the effect of this ordeal should be dispensed with provided that the accused is not prejudiced. We propose that the right of cross-examination at committal proceedings be limited to special circumstances and that the victim's evidence be in the form of a written statement. All statements made by the victim should be supplied to the defence. If she has to give evidence at committal proceedings this should not be in open court.

The procedure at rape trials

21. The victim in a rape trial has to relive the experience which may be felt as humiliating and degrading. In some cases she is made to feel that she is on trial. She may have had no experience of court proceedings and may feel totally isolated from the Crown prosecutor who presents the case to the court. While we see no case for separate representation, we consider that the prosecution could relax the normal practice of not speaking to witnesses in order to inform the victim of the likely course of the proceedings and to reassure her that her interests are protected.

22. The cross-examination of a rape victim often extends to her past sexual behaviour. It has been accepted historically that this may be relevant to the issue of her credit as a witness. It may, however, create the impression that, if she has engaged in sexual experiences before, she may well have been a consenting party. No such cross-examination of the accused is permitted. We think that the present practice is unduly prejudicial to the victim and that the right of cross-examination should be limited to cases where we consider that consent should remain as a defence, e.g. cases where no violence or threats of violence are used by the accused. The matter should be left to the discretion of the judge exercisable only in defined circumstances: where the prior sexual acts are alleged to have taken place between the victim and the accused; where they were part of a pattern of behaviour similar to that at the time of the offence; or where evidence of a sexual act is relevant to explain the origin of semen, pregnancy or disease. The accused should have the right to call rebuttal evidence. Evidence of the victim's chastity or her moral character should not normally be admitted.

23. If the reforms relating to the victim's past behaviour are implemented we do not think any change is needed in the rule which normally precludes evidence or cross-examination about the convictions or antecedents of the accused. His right to make a statement from the dock should not be abrogated.

24. Complaints made by the victim within a short time of the offence have been admissible in evidence, but only on the issue of her credibility. We think this rule is confusing and unrealistic. There is no reason to conclude that an early complaint is more trustworthy than a later one. Evidence of a complaint should be admissible only in accordance with the general rules of evidence.

25. As a matter of practice the judge in a rape trial and in other sex offence trials warns the jury that it is dangerous to convict on the uncorroborated evidence of the victim and that they ought not to do so unless they are clearly convinced that the evidence is true. In our view this adds nothing to the duty which the jury already has and does not carry any real advantage for the accused. We think this distinction between sex offences and other crimes should be abandoned.

26. In most States juries in criminal trials consist almost exclusively of men. South Australia is a notable exception. We think it important to provide for a better balance of the sexes in all aspects of the legal process, not so much to change the outcome of the trial but to ensure a broad range of attitudes and the participation of women in legal proceedings. This is especially necessary in sexual offences and we think that special provision should be made for a minimum of four men and four women on juries in such cases.

27. In our view the publication of material which could identify the victim of a sexual offence should be prohibited and the court should have a discretion to prohibit publication of any part of the evidence in such cases.

Sentencing in rape cases

28. Sentences in rape cases are usually heavy, particularly where violence is involved or in multiple rape. In our view opportunity for rehabilitation and education should be taken to help the offender overcome any propensity to violence against women.

Compensation to victims of rape and other sexual assaults

29. Victims of crime may claim compensation for physical injury and in some cases for other loss under State legislation, but not in the ACT. There is an upper limit on the amount which can be recovered, varying between $2000 and $10 000. These amounts are below damages awarded in civil cases and in our view all are inadequate. We think that the limit should be raised to $20 000. Legislative provision should be made for compensation schemes in the ACT and Northern Territory, for victims of crime whether or not a conviction is recorded, to replace the present ex gratia payment system. Publicity should be given to the scheme.

The need to redefine rape

30. Absence of consent is an essential element in the crime of rape. We think that there is too much emphasis on the actions of the victim rather than on those of the accused. While violation of the person by non-consensual intercourse is a serious matter, violence and threats of violence, which frequently accompany rape, are more serious. These unlawful acts used to secure intercourse should be the main focus of the criminal law. Consent would remain relevant where there were no such unlawful acts.

31. In conformity with the above view we consider that rape offences should be graded according to the degree of violence or other unlawful acts which accompany it.

32. A man cannot now be convicted of raping his wife as she is presumed to consent to intercourse. This rule is condemned as unrealistic and has been displaced, in some countries, in cases where the spouses are separated. In South Australia a husband can be convicted of rape under a new law if the rape is accompanied by violence, gross indecency, serious humiliation or threats of any of these. We consider that when violence or threats occur husbands should not be immune from prosecution and, further, that it should be possible to charge a husband with rape when spouses are living apart even if there is no such threat or violence.

33. We consider that homosexual rape and other forms of sexual abuse should be punishable offences.

34. The presumption that a boy under 14 is incapable of having sexual intercourse and therefore of commiting rape should be abolished.

Attempted rape

35. In most States there is an offence of attempted rape. As with rape the emphasis is on the issue of consent and on whether penetration was achieved. We think the more important issues are the degree of violence or threats and the extent of injury, and that these are far more significant than penetration. We doubt the need for a separate offence of attempted rape.

Statutory rape and consent to sexual relations

36. The minimum age of consent to sexual relations varies from 16 to 18 in different States and Territories. The limits are arbitrary and some think them too high. They appear unrealistic in view of the actual pattern of sexual behaviour among young people. We think that a person of 15 is sufficiently able to make decisions about sexual relations without the other party incurring criminal liability, though we would extend protection up to 17 where the other party is in a position of authority, such as a teacher. Between the ages of 13 and 15 it is our view that, if the other party is within 5 years of the age of the consenting party, there should be no criminal liability for sexual relationships. Below 13 we make no specific proposal though we do not consider criminal action appropriate where the children are close in age and there is no coercion. Intercourse with a child under 10 should not be permissible in any circumstances.

37. We consider that the laws relating to sexual offences should apply whatever the sex of the offender or victim.

38. The defendant should be able to escape conviction if he can show that he reasonably believed the girl to be over the age of consent; the burden of disproving this should be with the Crown.

39. The matter should be tried summarily by a magistrate where the victim is aged 13 or over and the defendant is not a family member or school teacher. A 6-month limitation period should be imposed on the commencement of proceedings.

40. Where acts amounting to indecent assault are consented to there should be no criminal liability if both parties are 15 or over or one party is between 13 and 15 and the other is less than 8 years older.

41. Young people should be informed of their legal and moral responsibilities in sexual relationships.

Sexual offences involving young children

42. Intercourse by an adult with a young child can cause serious emotional and physical injury and is often procured by coercion or intimidation. We consider that all children under 10 should be protected by the existence of special offences equivalent to the most serious rape. Where sexual penetration is not effected and no violence or injury is involved, sexual assaults on young children should be treated as indecent assaults and should be triable summarily at the option of the defendant.

43. The young child who is the victim of a sexual attack may suffer more serious consequences from the proceedings and the necessity to give evidence than from the attack itself. Many families of such children are in need of social assistance and where this occurs the attacker is more likely to be related to the child. The public interest in prosecuting the offender needs to be set against the interests of the child. Existing legal machinery is inadequate for this purpose; there should be intervention by an appropriate social agency and a body should be established to assess the competing interests.

44. A child protection service should provide assistance to the child and its family and have power to request that no criminal action be taken. In cases where the police seek to proceed, the parent or a social worker should have the right to apply to an independent tribunal presided over by a judge. The tribunal should have access to written reports and submissions and should have power to recommend that the proceedings be discontinued.

45. When a case proceeds to trial the normal rule is that a child old enough to give evidence must attend to give evidence and to face cross-examination. In accordance with our earlier recommendations concerning rape, we consider that in committal proceedings the child's evidence should be given in the form of a written statement unless there are special circumstances. After committal there should be a pre-trial conference between the judge and parties' representatives to determine how to provide minimum participation by the child consistent with the rights of the defendant. Similar procedures should be adopted in relation to summary offences tried in the magistrates court.

Sexual offences involving people with mental incapacity

46. Laws which make it an offence to have carnal knowledge of a woman who is known to be an idiot or imbecile are unnecessarily restrictive of sexual freedom and should be replaced by the prohibition of intercourse with a person known to the offender to be unable to understand the nature and consequences of the act.

Incest

47. The law prohibits sexual relationships between persons within certain blood relationships, e.g. father and daughter. Most offences occur between father (or step-father) and daughters in their early teens. The family is often disturbed, with a high incidence of disruption. Genetic factors are no longer considered as a sufficient justification for incest laws. The main function of incest laws is to protect the young person from sexual advances within the family circle. It does not follow that criminal sanctions should apply to incestuous relationships between adults and we think these should no longer be liable to prosecution as a crime.

48. Cases of incest involving children are covered by other laws relating to sexual offences. Provided that the age of consent is raised to 17 in respect of intercourse with specified relations we consider that there is no need for special laws relating to incest.

49. When a sexual offence of an incestuous nature occurs, it is important to consider what action to take to prevent a recurrence after the criminal law has taken its course. The intervention of a child protection agency could be used to assess the situation and decide whether the child should be removed from the home. All the procedural measures aimed at the protection of children should be available.

Restructuring laws relating to sexual offences

50. We propose specific amendments to the sexual offences laws of the ACT to give effect to our recommendations about the restructuring of laws relating to sexual offences.

5. Recommendations in the report

Part II Education for human relationships

Recommendations

We recommend that:

1. The government should require the Department of Education to make a major effort to change the policies of all concerned with education so that these policies will be designed and directed to ensure the fullest possible development of the whole person, physically, emotionally, intellectually and socially. Within this fundamental policy, we make these further recommendations.

2. The Department of Education should initiate and carry through reforms to enable educational institutions to respond to the community's desires for better education for human relationships at all levels of the education system.

3. Education for human relationships should aim to be an integral part of education in all subjects at every stage and level.

4. Education in all fields and at all levels should provide opportunities for boys and girls to:

   (a) develop a knowledge and understanding of the functions of emotion, feeling and caring in relationships;
   (b) become aware of the varying attitudes to male and female roles in society and the ways in which these attitudes affect aspirations;
   (c) discuss situations in their own lives and in society in which boys and girls, men and women are treated differently and to examine the origins of these differences and the reasons for their continuation;
   (d) assess the effect of peer pressure;
   (e) learn to appreciate the power of social forces and institutions (including the media) to influence the development of individual personality and choice of life style;
   (f) develop skills in communication and interpersonal relationships, and for this purpose to
   (g) acquire a correct vocabulary of sexuality.

5. Education departments should develop comprehensive human relationships education programs that:

   (a) are appropriate to age and tolerant of differences in background and origins;
   (b) begin in the primary school and are completed by school leaving age;
   (c) are factual and frank;
   (d) are comprehensive in the range of subject matters;
   (e) are given by specially trained teachers in small groups of boys and girls;
   (f) are constantly researched and evaluated.

6. At primary school level and below, parents should be able to withdraw children from classes of human relationships education.

7. Teacher education courses should look at women and men in their social and physical environment, at the human life cycle and at human sexuality.

8. A course in human relationships education, including ethics, should be a prerequisite in undergraduate training of teachers.

9. Information should be available to teachers about local community resources able to deal with family relationship and human relationship problems in specific areas.

10. Experienced teachers who are to work as specialists in the human relationships field should be selected according to the same criteria as guidance counsellors, i.e. after some years in the classroom and after further specific training.

11. Established teachers should be given opportunities to undertake retraining in communication skills including new approaches to the process of learning.

12. Research should be directed to:

(a) the issues of teacher education in matters related to human relationships;

(b) the evaluation of human relationships education programs and methods of delivering them;

(c) the effects on individual development of the characteristics, organisation and staff of schools.

13. Tertiary education institutions should develop interdisciplinary courses in human sexuality and such courses should be a prerequisite for the professional recognition of teachers, and should also be recommended to social workers, welfare workers, nurses and health professionals.

14. The government, in collaboration with education and broadcasting authorities, should explore ways of developing programs to support and supplement school human relationships and personal development programs.

15. The government should contribute to a professional education magazine which should especially draw attention to education in human relationships, and bring this to the classroom teacher throughout the nation with news and information on resource material.

16. Parent education programs should begin early in each school year and both parents should be encouraged to attend when their child enters infants school or pre-school, again on entry to primary school, and again at the age of puberty.

17. Each school district or local government area should employ a community education officer to work with the P & C, the school, and the voluntary associations, to promote programs of parent education. The community education officer should be government funded.

18. The local primary school should be the focal point for involving parents in education for child rearing and indeed for other general community purposes.

19. Voluntary associations should be enlisted to evolve suitable programs of parent education, and some of these should be scheduled for Saturday afternoons, or times when child care facilities could be provided, and when both parents, and single parents who work, could attend.

20. Parent education programs should be funded in hospitals as part of pre- and post-natal classes and ways should be sought to increase parent education programs to people expecting the birth of a child.

21. Ways should be sought to enable secondary school students to have supervised experience of child rearing as part of their personal development course.

22. Educational aids, such as films, should be developed for use in state systems, and made available for the use of voluntary associations and the non-state systems.

23. The Departments of Education and Health should assist in funding the work of voluntary associations in education for human relationships, and schools should be funded to pay sessional fees for their services.

24. Voluntary associations should be assisted to develop as resource organisations for locally based programs of human relationships education for children involving both mothers and fathers and at times and circumstances which give most opportunity for both parents to attend.

25. The Schools Commission should seek educators and schools willing to undertake research on how to bring the school closer to the community.

26. Professionals who are involved in maternity hospitals and baby health clinics should direct the attention of parents to support services.

27. On preparation for marriage:

(a) the government should sponsor further research, including pilot programs, and evaluation of preparation for marriage courses;

(b) the government should extend its support of training programs and the preparation of resource material through additional funding;

(c) the government should publish and distribute pamphlets to marriage celebrants as a guide for those intending to marry; these should be in the main ethnic languages as well as in English;

(d) the government should extend financial support for the development of marriage education programs by approved voluntary agencies;

(e) ways should be sought of using all branches of the media as an effective part of marriage and parent education programs.

28. Schools and child care agencies should relinquish physical methods of punishment and, to assist this, educational authorities should research the best ways of handling the disruptive child, including the provision of alternative education.

29. Degree and diploma courses in community health with an interdisciplinary approach should be developed in tertiary educational institutions.

Part III Health and medical education

Recommendations

We recommend that:

1. Undergraduate medical education should give more attention to human relationships and their effects upon illness and health care.

2. Sexuality should be regarded as a proper subject for medical study; those selected to teach it should be properly trained, preferably with interdisciplinary experience.

3. Medical textbooks, especially in obstetrics and gynaecology, should be assessed to ensure that sexist attitudes are not perpetuated.

4. Family planning and fertility control measures, including conception, should be included in a human sexuality course in medical schools.

5. Universities and colleges of advanced education should co-ordinate courses for medical and paramedical students.

6. Courses should be designed to cover problems faced by Aboriginals and migrants of a lower socio-economic status.

7. In support of the recommendation of the Poverty Commission, places should be reserved in medical and paramedical quotas for qualified migrants and Aboriginals.

8. Child care and development should be a positive feature in undergraduate courses.

9. Medical education, both undergraduate and post-graduate, should ensure that adequate information is given on alternatives to drug prescription, in cases of emotional stress and neurosis, and that students receive instruction and experience in the resources available in the community, and counselling techniques.

10. The government should be more generous in the recognition of professional and technical qualifications of migrants.

11. The Royal College of Obstetricians and Gynaecologists should offer more courses for women for specialist or refresher training.

12. The Family Medicine Program of the RACGP should expand retraining programs for women, who have given up practice for a time.

13. Hospitals should institute part-time work and job sharing for women doctors, especially as registrars.

14. The government should encourage schemes to break down divisions between city and country and enable outback doctors to attend refresher courses.

15. Universities and government health authorities should undertake job analyses of tasks which can be done by paramedical and allied health workers.

16. The medical profession, as a result of such analyses, should delegate some of their tasks to obstetric nurses or qualified family planning nurses.

17. State and Commonwealth government authorities, especially those responsible for the community health program, should examine the training and use of health educators and health visitors:

(a) to establish liaison with education programs in schools;

(b) to meet the special health needs of Aboriginals, migrants and at-risk sections of all Australian communities.

18. A universal pre-school health scheme should be implemented by State health authorities to screen all pre-school children for physical, psychological and social dysfunctions or disorders, with the health visitor as the first and continuing contact person in such work; and such a scheme should work in close collaboration with broadly based community health and welfare services to ensure proper long-term care.

19. The health professions should develop a comprehensive and easily communicable health record system, where possible, between hospitals and community-based services and GPs.

20. Patients should be afforded sufficient information concerning their health problems, and the drugs prescribed with their side effects, to enable the patient to have some share in making decisions, and there should be no reflection on a doctor when asked to refer the patient.

21. Every patient, if it be her wish, should receive adequate advice on fertility control methods, including pregnancy termination, and if such procedures are unacceptable to the patient's own doctor, she should receive such advice by referral.

22. The patient's wishes should be respected, as far as is possible, in childbirth with regard to anaesthesia, induction and presence of husband.

23. Government health services should give full encouragement, through the community health program, to support of the handicapped and the mentally sick.

24. Mental Health Acts should be reviewed with a view to consulting a wider range of health personnel before certification of patients to institutions.

25. Research should be promoted to facilitate the maintenance and improvement of community health programs in both country and city areas.

26. Research should be funded to inquire into community perspectives of health, the socio-economic causes of stress and the range of services that need to be provided to relieve it.

27. An ombudsman should be part of the staff of every large hospital, especially mental institutions, to receive complaints of poor care or neglect from patients or their relatives and friends and to advise on services available.

28. Interpreters should be available in all large hospitals, especially in gynaecological or womens wards, to encourage understanding between migrants, doctors and nurses.

29. The Department of Health should analyse and evaluate the full results of our survey of GPs.

Part IV Sexuality and fertility

Recommendations

We recommend that:

1. Schools, colleges and tertiary institutions should provide education programs in human relationships including sex and reproduction, sexual expression, sexual behaviour and its consequences, and the causes, symptoms and treatment of sexually transmitted diseases.

2. Teachers and counsellors should be ready to encourage discussion of sexuality and related matters and to offer referral to other agencies when appropriate.

3. Adult education programs should help people to identify and seek help with sexual problems.

4. Education for the medical and other helping professions should include training in identification of sexual problems and in treating those problems or referring them to specialists; where possible this education should be provided on a multidisciplinary basis.

5. More professionals, including clinical psychologists, therapists and social workers should be trained, and sexual counselling units should be established in major centres as part of clinics or other facilities offering fertility control and related services (including family planning clinics, VD clinics and community health centres).

6. Consultation fees for these professional services should be refundable under Medibank and also covered by private health insurance.

7. The sexual needs of the handicapped and disabled people should be recognised and accepted in social planning and in the administration of institutions; isolation and segregation of the sexes should be avoided.

8. Training of medical, paramedical, educational and social work professionals should pay attention to the sexual needs and sexual options of handicapped and disabled people and to methods of help and counsel in these problems.

9. In-service training and information should be provided for medical and paramedical personnel involved in the care of the handicapped, disabled and aged, about their sexual needs.

10. Hospitals, institutions for the handicapped, FPAs and other educational institutions should provide information, education, rehabilitation and counselling services for the handicapped, disabled and aged in sexual matters.

11. Appropriate sex education should be provided for the disabled and handicapped of all ages by institutions responsible for their education and care.

12. Voluntary organisations, institutions and hospitals should be supported and encouraged to arrange social activities for the handicapped to meet and have opportunities for the development of personal relationships.

13. Professionals and institutions concerned with the care of the ageing should avoid isolation and segregation of the sexes.

14. Further research should be undertaken into puberty, menstruation and the menstrual cycle, the menopause and life cycles; information about these matters and the results of research should be incorporated into medical education and into public sex education programs.

15. Community health centres, family planning clinics and special clinics should be supported and equipped to deal with venereal disease and other sexually transmitted diseases; funding should be provided for counsellors to advise on the prevention of sexually transmitted diseases and on the importance of informing contacts and encouraging them to seek treatment.

16. Clinics treating sexually transmitted diseases should offer contraceptive advice and services and counselling on sexuality and sexual problems.

17. Sex education programs should include ethics and responsibility in human relationships and should stress the importance of advising partners of symptoms of sexually transmitted diseases and of encouraging them to seek treatment.

18. Public health education programs should be funded to provide information about all sexually transmitted diseases and about services for their treatment; special campaigns should be organised in high risk areas.

19. In prescribing the pill, doctors should advise on and be alert to complaints of side effects and disorders which may warrant discontinuance and use of another method.

20. All persons seeking advice on contraception should be given adequate information, counselling and advice on the choice of method, its proper use and effect and the possible side effects; the personal attitudes and beliefs of the person should be considered.

21. Information about a method of contraception, its use, effect and side effects should be included in every package of oral contraceptives, diaphragms and condoms and other contraceptive products; this information should be as full and as clear as possible and should also be in the main migrant languages.

22. Contraceptive services and the supply of contraceptive products should be more widely distributed geographically; opening hours should be more flexible and take account of working hours and shift work.

23. There should be more field workers in remote and rural areas with special training in related areas of gynaecology and sexuality.

24. Cultural factors should be given special attention in planning educational programs and in providing services.

25. The needs of young people should be given special attention in educational programs and services.

26. Educational and activational programs in contraceptive use should give special attention to the role of the male.

27. The use of the condom should be encouraged and restrictions on its distribution removed; education programs should emphasise its advantages of accessibility and its role in reducing the risks of VD.

28. Further surveys should be undertaken of the contraceptive practices of married couples, single women and men, and to bring up to date the information derived from the Australian Family Formation Project.

29. Further research should be undertaken into contraceptive technology and into the acceptability of the various methods of contraception.

30. The government should declare a basic policy that all persons should have easy access to information and advice about conception and contraception, and contraceptive services should be brought within the reach of all Australians.

31. A National Advisory Committee should be appointed to advise on policies for co-ordinating, integrating and expanding contraceptive services and on training programs for all professionals concerned in contraceptive services.

32. The government should ensure the extension of services by State or voluntary agencies, and should provide the funding and subsidies necessary to achieve this end.

33. The government should continue to fund womens community health centres as specialist centres providing primary medical care, counselling, education and undertaking research, subject to the requirement that each centre should establish a medical advisory board or similar body to advise on and review medical procedures.

34. Family Planning Associations should receive additional funding to establish instruction sessions in female cycles and the periodic abstinence methods.

35. Public hospitals should provide contraceptive advice, including information about services and supplies, instruction and counselling to post-partum and abortion patients.

36. Obstetric and gynaecology hospitals should include the full range of contraceptive services as part of their responsibility to their patients.

37. Training courses for pharmacists should cover contraception; special refresher courses on contraception should be organised for pharmacists. Pharmacists should be encouraged to display contraceptive items, or a sign indicating that these are available in the shop.

38. Funding should be made available for each State FPA to employ at least one domiciliary worker selected and trained for the position.

39. Resource centres and community information centres should carry information about contraceptive services; pilot programs should be established to test ways of using mobile clinics, especially in remote areas.

40. Occupational health workers should be trained to provide contraceptive information, advice and services at the workplace with special emphasis on the needs of migrant women. The training should cover aspects of sexuality and sexual problems.

41. Women having abortions should receive contraceptive counselling; services should be available. Abortion services should ensure that women having abortions are provided with information about contraception and encouraged to use some form of contraceptive protection.

42. The government should encourage and support the training and employment of family planning nurse practitioners.

43. Nurse practitioners should be employed by FPAs, by health departments in community health services, in hospital clinics and in VD clinics; nurse practitioners should be trained and authorised to undertake contraceptive procedures, including insertion of IUDs and prescribing oral contraceptives.

44. Nurse training courses should include programs on sexuality, contraception and human relationships; continuing education and refresher courses in these subjects should be provided for nurses.

45. The government should support by funding and otherwise the extension of the FPA training programs.

46. Adequate training in contraception should be required as a condition of funding for community health nurses and community health workers; they should provide contraceptive services especially where no other source is available.

47. Members of Aboriginal and migrant communities should be trained as community health nurses and community health workers and educators; training should cover all aspects of contraception.

48. Each Aboriginal community should be provided with trained community health nurses and allied workers.

49. The government should ensure that contraceptive services are provided in country areas through the community health program, community health educators, and the Royal Flying Doctor Service.

50. Information on contraception should be prepared in the major ethnic languages and should be available to migrant social workers, ethnic communities and migrant women; information should accord with the migrants' cultural background; family planning clinics should have the services of interpreters or ethnic staff and counsellors.

51. Migrant women should be trained as voluntary workers to give family planning information to other members of their communities; and members of ethnic communities should be involved in planning contraceptive services for migrants.

52. Members of groups with special contraceptive needs, such as people in remote areas, migrants, Aboriginals and people in poverty, should be involved in planning services to meet those needs.

53. The government should promote responsible sexual behaviour by initiating and supporting programs:

(a) to educate and inform people of all ages about sexuality, conception and contraception;

(b) to provide ready access by all people to contraceptive services and supplies suitable to their special needs;

(c) to motivate people to develop their ability to make responsible decisions.

54. The government should initiate and support nation-wide and local advertising campaigns to encourage the use of contraceptive services; it should also fund FPAs and other voluntary organisations to advertise their location and services.

55. The government, in co-operation with State governments, should ensure the wide dissemination of contraceptive educational literature and information about the location and nature of contraceptive services; the FPAs should be funded to produce this information, which should be in several languages. Translations should take account of cultural factors.

56. Booklets should be prepared for school leavers containing information about sexuality, conception, contraception, sexually transmitted diseases and about relevant community services.

57. Laws and regulations expressly restricting the advertising of contraceptives or fertility control services (including pregnancy testing) in the media should be repealed; it should be made clear that a reference to contraceptive services or products does not of itself breach any law about offensive publications.

58. The media should reconsider their policy in this area and the Department of Health should encourage them to accept advertisements relating to contraceptives and fertility control.

59. Family planning clinics and medical practitioners should be authorised to supply the contraceptives they prescribe.

60. Laws restricting the sale of non-prescription contraceptives such as condoms to a defined time or place should be repealed.

61. The government, in conjunction with State governments, should establish standards of training for nurses and other professionals in prescribing oral contraceptives and should give recognition to training programs; persons who have completed the appropriate training should be authorised to prescribe oral contraceptives and to fit IUDs and diaphragms.

62. The government should facilitate proper insurance provision to enable Family Planning Associations and similar services to employ trained personnel for the above purposes.

63. The government should investigate advertising in respect of contraceptive products and take steps to secure their withdrawal if it is unsubstantiated or inaccurate or misleading.

64. A joint Commonwealth-State committee should be established to set standards for contraceptive drugs and devices and to monitor those standards.

65. The government should take action to ensure that condoms on sale in Australia:

(a) comply with appropriate standards;
(b) are date stamped;
(c) are in packets containing information about storage and use;

and to ensure that all contraceptive products are distributed with appropriate instructions (in several languages) on use and effectiveness.

66. The Department of Health should encourage the development of a prompt and efficient pregnancy testing service by post or otherwise, and it should support the development and distribution of an effective and easy to use self-testing kit without the need of a prescription.

67. The law should be clarified to ensure that a medical practitioner acting with due care should not be criminally liable nor civilly liable in respect of a sterilisation operation provided that the patient has consented to the operation with knowledge of the consequences, is 25, or is over 21 and the operation is performed not earlier than 6 months from the date when the request was first made in writing.

68. Where both spouses consent to an AID procedure the doctor acting with due care should be free of criminal or civil liability and the child born as a result of the procedure should be regarded for all purposes as the natural child of the parties.

69. Every woman who has an unwanted pregnancy should have access to pregnancy support and counselling services to advise her on all the alternatives open to her and to help her decide what course to take; support should be given for the provision of such services.

70. Subject to what is said later about time limits, abortion should be free of legal regulation when performed by a registered medical practitioner at the request of the woman up to the end of the twenty-second week of pregnancy (measured from the commencement of the last menstrual period).

71. No doctor, nurse or other person should be required to take part in an abortion if he or she does not wish to do so.

72. Counselling services should be provided to every woman seeking abortion to ensure that she makes a free choice. These services should be supported by public funds.

73. The consent of a woman's husband or partner should not be required legally as a condition of an abortion.

74. It should be declared that no criminal proceedings will be taken against a registered medical practitioner who performs an abortion in appropriate conditions within the time limits specified.

75. Abortions should be authorised where mental or physical abnormality may result in serious handicap.

76. In all cases other than those mentioned in recommendations 70 and 75 abortions should be authorised only where it is necessary to preserve the life of the mother, or to avoid grave risk to her health; every effort should be made to preserve the life of any child born as a result of such termination.

77. Except in those circumstances where abortion is authorised, it should be an offence to destroy the life of a child capable of being born alive unless the act is done in good faith to preserve the life of the mother.

78. The government should ensure that women in all areas have access to adequate abortion services by encouraging and supporting the development of hospital services, clinic services and community health services.

79. Abortion services should be available as a general health service and as part of a range of fertility control services.

80. The Commonwealth and State governments should research and establish standards for the delivery of abortion services by hospitals and clinics. Guidelines should be established for the delivery of services in remote and rural areas. The need for interpreters and counsellors with language skills should be taken into account.

81. Obstetric and gynaecology public hospitals should set up as part of their services small abortion clinics, along the lines of the Preterm clinic in Sydney, performing abortions on an outpatient basis with full medical back-up facilities, counselling services and staff training facilities.

82. General hospitals, especially obstetric and gynaecology hospitals and those in country areas, should provide for abortion services to be delivered by staff selected and trained for that purpose, on a day patient basis, with counselling services.

83. Private abortion clinics should be encouraged to adopt voluntarily the standards of operation referred to above and funding provided for such services should be conditional upon compliance with these criteria.

84. In cases of early termination by vacuum aspiration where clinics do not provide general anaesthetic, women should be informed of this and referred elsewhere if they wish; women should have a choice of local or general anaesthetic.

85. Hospitals which are unable to offer amniotic replacement methods of abortion in the second trimester should refer patients to other hospitals or services able to offer this procedure; where possible hospital staff should receive training to enable the methods mentioned to be provided.

86. The government should ensure that information about the comparative safety of different methods of termination is widely distributed and should encourage hospitals to provide training and equipment to facilitate the use of the safest methods.

87. Abortion patients should be screened for blood type, venereal disease and cervical cancer.

88. Abortion patients should receive contraceptive advice at the time of termination; clinic and hospital policy should ensure that this is done by specially trained staff; contraception should be checked at a follow-up visit to either clinic, hospital or local doctor.

89. Counselling services should be available to every woman seeking termination of pregnancy; selected counsellors should receive specific training for the job and should be employed in every private and hospital clinic offering abortion services.

90. The government should encourage and support by subsidies or otherwise the cost of training and employing counsellors at clinic and hospital abortion services.

91. No person should be required to take part in an abortion procedure if this is contrary to his or her conscience.

92. In the selection and rostering of hospital staff for abortion services, the personal beliefs of those selected should receive due respect.

93. The data from our survey of intake procedures (Commission research report, no. 3) should be analysed and a report prepared.

94. When an abortion is considered necessary, it should take place as early in the pregnancy as possible, without administrative delays either in arranging consultation or performing the operation.

95. Steps should be taken to improve and expand the facilities for abortion and to ensure that information about these facilities is readily available to all women who seek abortion.

96. Abdominal methods of abortion should be avoided unless there are significant medical indications for such procedures.

97. Sterilisation should not be carried out in association with induced abortion unless there are strong medical, social or psychological indications for it. Most important, sterilisation should not be made a condition of obtaining an abortion.

98. Patients should be informed of the immediate and long-term risks attached to abortion and of any special risks which particularly apply to them; counselling should be available, and its importance stressed, to all women before and after abortion and to their husband or partner.

99. Women in special risk categories, such as women under 16, older women, women who have had many children, and women who seek successive abortions, should be given special attention in counselling and contraceptive advice.

100. A standard pattern should be adopted for the recording of complications related to abortion.

101. The data from our survey of the morbidity of abortions performed in hospitals and clinics (Commission research report, no. 2) should be fully analysed and the results published.

102. The WHO report on long-term consequences of abortion should be studied and further long-term studies of a similar kind should be undertaken in Australia.

103. Special services such as action centres should be provided to give information and advice to young people about sexuality, conception and contraception; 'outreach' programs should be introduced on an experimental basis with the aim of reaching young people in their local environment.

104. Young people should be actively involved in planning and organising such special services.

105. Education programs for young people should include information about sexuality, conception and contraception and about community services available to help young people in these matters.

106. Education and information material prepared for young people should adopt an easily understood and acceptable style and format.

107. Research should be undertaken in conjunction with services for young people, to monitor service provision and to determine the best ways of reaching young people most at risk.

108. The use of the condom by young people should be encouraged; young people should also receive instruction in the method of withdrawal.

109. (a) A medical practitioner prescribing or supplying contraceptives or performing an abortion on a person aged 14 with the consent of that person should not incur criminal or civil liability by virtue of the absence of parental consent.

(b) In the case of a person under 14 years the doctor should not incur liability if the patient is sufficiently mature to appreciate the matter and consents to the operation or treatment, provided that the practitioner considered that the interests of the patient required the treatment or operation and it was impracticable to obtain parental consent.

110. Counselling should be available for all young people seeking contraceptive advice or treatment; access to counselling is essential to all contemplating abortion; counselling should stress the importance of involving the parents of a girl under the age of 14 in the discussions.

111. The Department of Health should initiate seminars throughout Australia to discuss ways in which the emotional and social needs of the mother at the time of childbirth can be better respected and better met. Such seminars should involve hospital administrators, obstetric health care professionals, child-birth educators and representatives of concerned voluntary organisations.

112. More emphasis should be placed on the emotional aspects of pregnancy and labour in medical and nursing schools, both at the undergraduate and post-graduate level. Obstetric hospitals should have access to a psychosocial unit, involving psychiatrists, psychologists and social workers.

113. Human relationships education should include pregnancy and childbirth and should discuss the social, emotional and physiological changes they induce.

114. Literature on pregnancy, childbirth and infant care should be made available in the main migrant languages and, to overcome language difficulties, audio-visual material should be used in pre-natal classes wherever possible. Interpreters should be available in classes involving a large number of migrants.

115. Hospitals, pre-natal clinics and private doctors should ensure that pregnant women are given opportunity to discuss their social and emotional needs and should offer help when problems are identified.

116. Hospitals should provide privacy for obstetric patients to consult with doctors.

117. The government should fund pre-natal classes which prepare women and men for the emotional and social adjustments they will have to make, as well as for the physical changes that will occur. The classes should discuss contraception, parenthood and marriage relationships.

118. Pre-natal classes should be seen as an integral part of hospital and health services.

119. The induction of birth for convenience rather than for medical reasons should be discouraged; women should be given the choice on induction, except in cases of medical necessity.

120. The administration of analgesics and anaesthesia should be decided in consultation with the mother. She should be advised of the effects that obstetrical medication may have on herself and her baby.

121. Hospitals should encourage consultation between childbirth educators, physiotherapists and medical and nursing staff, so that a consistent approach is adopted to ensure that mothers presenting at hospital for the birth of a child are aware of the routine they can expect.

122. Fathers should be allowed to attend the birth of their babies, subject to the wish of the mother. In the absence of the father, mothers should be allowed to nominate someone else. Unmarried fathers should not be treated differently from legal fathers.

123. Hospitals should encourage breast-feeding and should allow women to breast-feed on demand or to night-feed should they desire.

124. Hospitals should encourage parent–child bonding, particularly in the early stages of infant life. In premature birth, or other cases requiring special care, the mother should be trained to assist in looking after her baby.

125. Rooming-in facilities should be offered wherever possible; otherwise mothers should be allowed ready access to their babies.

126. Hospitals should allow siblings to visit their mother in maternity hospitals and units.

127. Health care professionals who are in contact with women during the post-partum period should be sensitised to the need to recognise the early symptoms of emotional disturbance, particularly depression.

128. Maternity hospitals should provide programs on child rearing for parents in the period immediately following the birth of their child.

129. More research should be conducted into the effect of psychological and emotional factors on the course and outcome of pregnancy.

130. Further studies should be made into the effects upon the newborn of drugs dispensed to the nursing mother.

131. Health services should consider developing midwife services to allow child-birth at home, provided such services are backed by ambulance and transfusion services.

132. The government should establish an independently funded Research Institute for the study of human sexuality, reproduction and fertility control; a committee should be appointed to advise the government on the setting up of the Institute, with the functions of promoting, co-ordinating and carrying out direct research and of disseminating information to the professions and the public about research developments in Australia and overseas.

133. Current research projects in the fields of human sexuality, reproduction and fertility control should continue to receive funding and further funds should be made available for research in these areas.

Part V The family

Recommendations

We recommend that:

1. The government should initiate a national family policy.

2. The government should introduce the concept of a family impact statement in respect of changes proposed in policies, programs and capital works. Such a statement should be required both of governments and of the private sector.

3. Governments should co-operate to increase the provision and distribution of family support services, especially preventive services and programs including home help and homemaker services.

4. Family centres should be established and evaluated.

5. Specialised services for particular groups of people (e.g. the aged) should be integrated within normal family services.

6. In planning and providing family services, governments should encourage user participation.

7. Government departments responsible for family services should recruit more lay workers.

8. Government departments should ensure that social policies and family services are better known. Information brochures written in the main ethnic languages should be widely distributed.

9. Community centres should be established immediately people move into new housing estates.

10. Travel and accommodation subsidies should be available, on a means test basis, to families living in remote and rural areas to assist in such expenses as visits to health and welfare services in the cities.

11. The government should move to bring family support services to people living in country towns and remote areas.

12. Marriage and family counselling services should be funded to send counsellors to country areas and to train people living in country areas.

13. The policy of the government should be to ensure that all children throughout Australia have access to child care of a type best suited to their needs and the needs of their parents.

14. Child care should be subsidised to ensure rates that parents can afford.

15. A range of child care should be available to all families, including those where one parent chooses to stay at home, but with preference for children in greatest need such as children of lone working parents, Aboriginal and migrant children, handicapped children, children 'at risk' and children who are geographically isolated.

16. Industry and commerce, organisations and institutions should sponsor a proportion of child care places in community centres.

17. Employers should be encouraged to provide child care facilities in consultation with trade unions and government; in appropriate cases they should be eligible for subsidies.

18. Continued support should be given to the Womens Trade Union Commission and the Working Womens Centre to develop child care programs and to encourage union involvement.

19. Aboriginal and migrant people should be encouraged and assisted to train in child care work, and special short-term training programs should be devised for this purpose.

20. Child care services for handicapped children should be integrated with normal services wherever possible. Special assistance should be given to those pre-schools and child care services which include a high proportion of handicapped children.

21. Child care buildings should be so designed that they can accommodate handicapped children.

22. The government should establish and evaluate work-based child care centres for its own employees.

23. High rise residential buildings should provide child care and recreational facilities (indoor and outdoor) for children of all ages, with residents using the facilities paying a nominal fee.

24. The government should publish and distribute regional information booklets giving details of available child care.

25. The government should seek ways of achieving a unified family law as to both legislative powers and the exercise of jurisdiction throughout Australia.

26. The Family Law Council and law reform agencies throughout Australia should examine ways of unifying and harmonising family law throughout Australia.

27. The government should consider a Constitutional amendment or the States should consider surrendering to the Commonwealth their powers in relation to all ex-nuptial children so that they could be covered by appropriate Federal legislation.

28. The Family Law Council and Australian and State law reform agencies should consider the law relating to the ownership of matrimonial property and to the financial obligations between husband and wife. Special attention should be given to the means of introducing a system of equalisation of assets acquired by husband and wife during marriage, intestate succession and inheritance rights, and to achieving uniform law throughout Australia on these matters.

29. The Family Law Council should examine ways of extending the power of the Family Court to deal with declarations, transfers and settlements of property of spouses in cases where an application for dissolution has not been made.

30. The Family Court should be given power to deal with the custody and maintenance of stepchildren and ex-nuptial children of either party living as a member of the household of the married couple at the time of separation (who are not the children of both parties).

31. The Family Court should be given jurisdiction in disputes between a parent and a third party in respect of the custody or maintenance of a child of a marriage.

32. The Institute of Family Studies should investigate the long-term effects on children of marital breakdown and of custody and access orders.

33. The Family Law Council should give consideration to the enforcement of custody orders, particularly in respect of children who have disappeared; funds should

be made available to assist partners to enforce custody orders in respect of children who have been taken interstate or overseas; consideration should be given, inter alia, to allowing an application to be made to the Family Court for a recommendation that the Department of Social Security disclose the address of a child in respect of whom a custody order has been made; child search officers or enforcement officers should be appointed to assist in tracing children in respect of whom custody orders have been made.

34. In any civil proceedings in which paternity or maternity falls to be determined the Court should have power to order a blood test in respect of a party or the child and to draw inferences from the failure of a party to submit to a blood test.

35. All necessary steps should be taken to ensure equality of status and rights for all Australian children whatever the marital status of their parents and, in particular, all Federal, Territorial and State laws which distinguish between the legitimate and illegitimate child should be reviewed and reformed.

36. A child's relationship to his or her parent should not be defined by terms such as 'legitimate' or 'illegitimate' nor should the child's status be so defined.

37. Provision should be made for the unification of legislation and jurisdiction in regard to the custody and maintenance of all children, whether by a referral of power, amendment of the Constitution or otherwise.

38. Fathers who have acknowledged their paternity or whose paternity has been judicially determined should be entitled to apply to the Court in respect of custody and access.

39. A uniform marriageable age of 16 for males and females should be introduced.

40. Persons under the age of 18 should not be able to marry without parental consent or an order dispensing with or granting consent.

41. Persons below marriageable age should not be able to marry under any circumstances.

42. The government should introduce a supporting parents pension to be payable to any single parent, with the present 6 months qualifying period abolished.

43. Steps should be taken to make the NEAT system more appropriate to the needs of lone parents both for training and retraining to enter the workforce.

44. Retraining schemes should, where appropriate, give priority to lone parents.

45. Part-time work should be incorporated into the career structure of the Commonwealth public service.

46. The taking of maintenance action should not be a prerequisite for eligibility for a widows pension or a supporting parents pension.

47. Public housing schemes should pay greater attention to the needs and wishes of lone parents whose housing should be integrated with the rest of the community.

48. The government should assist in the provision of short-term accommodation for lone parents.

49. The government should make provision for housing subsidies to lone parents, both by way of low interest loans and repayable cash grants to meet housing deposits.

50. Child care services should give priority to lone parent families.

51. Where government-subsidised child care is not available to lone parents, subsidies should be paid to enable the children to attend private child care.

52. The government should subsidise domiciliary care, home help and homemaker services, with particular recognition for lone fathers.

53. Self-help organisations for lone parents should be encouraged and supported by the government, which should also distribute printed information about self-help groups.

54. The State and Territory child welfare and health authorities should maintain contact with very young mothers and provide support and advice for the mother in the interests of the child until the mother demonstrates ability to cope.

55. The natural parent should be entitled to legal aid for advice on her position before an order is made dispensing with consent to adoption.

56. Women who have unwanted pregnancies or who are contemplating adoption or abortion should have access to counselling services to help them to understand the options and consequences and to reach an independent decision.

57. The sealed record system should be reviewed to enable natural mothers to obtain, from the adoption agency or department, general social information about the child and its progress; adoption agencies should record such information to enable them to answer queries.

58. Identifying information about the natural parent or adopted child should not be disclosed to the other party (or to the adoptive parents) except by the direction of a Court in exceptional circumstances taking into account the interests and privacy of natural and adoptive parents and of the child. Applications to the Court should not be possible until the child has attained 18.

59. Adoption agencies should collaborate in an education program to develop community understanding and approval for mothers who relinquish children for adoption, and should accept as part of their responsibility the continuing counselling of the mother after she has released a child for adoption.

60. Babies and children being placed for adoption should be subject to detailed medical screening at birth; a social and medical history of the natural parents should be ascertained and recorded, so far as is practicable, and should be made available to the adoptive parents.

61. An adopted person on reaching 18 years of age should be permitted to apply to the department or agency in his State or Territory and should be entitled to obtain social information about his parents and their background from the relevant department or agency.

62. Upon the request of an adopted person aged 18 or over, or the natural parent of such a person, the department or the agency should endeavour to contact the other party and, if contact can be made, should inquire if that other party wishes to meet the requesting party; if so the agency should help to effect a meeting.

63. Adoption agencies, government and private, should contact adoptive parents from time to time to ensure that the adoptive parents inform and help children in their understanding of their origins; counselling services should be available to assist parents in this respect.

64. Adoptive parents should produce a certificate of physical and mental health including a certified medical history before they are admitted to the lists of prospective adopting parents.

65. Departments and adoption agencies should ensure that adoptive parents have a basic knowledge of child development patterns and that they receive adequate preparation for parenting; where necessary adoptive parents should be referred to a suitable agency for pre- and post-adoption education and counselling.

66. Government authorities and adoption agencies should collaborate in developing group learning programs and counselling programs for adopting parents.

67. Adoption agencies should accept as part of their responsibility the counselling of infertile couples who seek adoption, both pre-adoption or after failure to adopt; in appropriate cases infertile couples should be referred to other agencies for continuing counselling.

68. Health departments should alert health professionals to the need to develop a community acceptance of both infertility and childlessness.

69. The criteria for the selection of adoptive parents should be based on such factors as the ability to provide a suitable environment and to contribute to the welfare of the child. A person or couple should not be automatically excluded from consideration on the ground that the person or couple is or are unmarried or without religious affiliation.

70. Parties to an Aboriginal tribal marriage should be considered as persons eligible to adopt if they satisfy the general criteria.

71. Government authorities and adoption agencies should make every effort to employ Aboriginals to arrange adoptions of Aboriginal children, or develop special adoption agencies manned by Aboriginals for this purpose. Agency practice should recognise and respect the family customs of the Aboriginal people.

72. The Department of Aboriginal Affairs should make grants to Aboriginal welfare agencies to develop specialised adoption and fostering services.

73. Research should be undertaken into:

(a) infertility and its social effects;
(b) the psychological effects of adoption on the natural mother;
(c) the sealed record provision in relation to adolescent identity.

74. Regulating government agencies should subsidise fostering families to the extent of their costs, and include adequate recompense for the mother, or a subsidy for the voluntary organisations which provide cottage care.

75. Successful foster families should be encouraged to share their experience through foster parent self-help organisations, so that other families are encouraged to undertake this activity.

76. Where long-term fostering is considered appropriate because of the need to keep large families together, or because of the difficulties of placing atypical children, cottage homes should be encouraged with natural parents retaining access at all times. Community acceptance of such homes should be encouraged through local involvement and public education.

77. Members of Aboriginal communities should wherever possible be involved in the placement of Aboriginal children for fostering.

78. Training in childhood development should be available for foster parents and they should have constant access to professional counselling and support.

79. Family centres should be available throughout Australia, well publicised, widely distributed and open 24 hours a day.

80. The government should continue to fund womens refuges; the level of funding should be substantially increased until such time as there are sufficient refuges, appropriately distributed to answer community needs.

81. Funding for womens refuges should be flexible and should cover all costs, including salaries.

82. Housing authorities should provide half-way houses and flats, located near refuges, as a second stage in a woman's rehabilitation.

83. Housing authorities should waive regulations prohibiting women from setting up co-operative households.

84. The undergraduate and post-graduate education of health professionals and others likely to be involved should include information about marital conflict and how to deal with it.

85. People in health and other social services who encounter cases of family violence should be educated to deal with such cases and should have knowledge of local agencies able to assist.

86. Mental health emergency teams should be provided to attend serious cases of domestic violence as an alternative to police intervention.

87. Government child care services should specially provide for child care needs at womens refuges.

88. The needs of men in situations of domestic conflict should be researched and a pilot remedial program should be instituted and evaluated.

89. Public education programs about community resources, social services and legal remedies in cases of domestic violence should be organised at times and places convenient to women.

90. Information booklets should be written and distributed to women seeking help and should also be available in the main ethnic languages.

91. Police should have an understanding of domestic conflict and of how to deal with it.

92. Human relationships programs in schools should include discussion about conflict and violence, particularly in the family setting, and of the roles and relationships of men, women and children in family life. Programs should also provide information about community, social and legal services.

93. Parent education programs and school programs should help adults and young people learn constructive ways of dealing with anger and frustration rather than erupting into violence.

94. Parents and schools should help girls understand the possible consequences of dependency and their need for job skills.

95. The government should enact legislation to provide a national child protection centre within the Office of Child Care, which should receive adequate long-term funding to initiate programs for the management of child abuse, to conduct research, to convene national seminars, to act as a leader and co-ordinator in the field and to sponsor programs of community education.

96. National studies should be initiated concerning the extent and nature of child abuse in Australia.

97. Whenever a child has been diagnosed as abused, or is considered at risk of abuse, long-term follow-up procedures to safeguard the well-being of the child should always be implemented.

98. Abused children should receive long-term remedial programs especially designed for their individual needs.

99. Families of abused children should receive counselling, advice and long-term rehabilitative assistance.

100. Where there is a conflict between the needs of the child and the needs of the family, those of the child should come first.

101. Every effort should be made to initiate and support self-help groups thoughout Australia, by way of government subsidies, professional assistance, research and evaluation.

102. The government should encourage the use of lay workers in the field of child abuse by providing training programs and subsidies.

103. The government should support community-based services particularly voluntary ones. Long-term financial assistance is required and also research and evaluation.

104. The government should initiate and fund a conference, similar to the first national Australian conference on the battered child, to investigate the issue of the older abused child.

105. Child abuse services should be extended to cover the adolescent child.

106. Twenty-four hour family crisis services should be established, both for parents and for young people.

107. Agencies (government and voluntary) concerned with adoption or fostering should, without fail, tell adopting or fostering parents if children have had a history of abuse. Such parents should be given professional advice and support.

108. Maternity hospitals throughout Australia should exert their maximum effort to ensure that parent-child bonding is fostered within the hospital setting.

109. Hospitals should evolve programs to identify those parents likely to need extra support, and call on all possible appropriate agencies for help. Such programs should involve evaluation.

110. The Department of Health should convene a national conference to discuss ways of implementing recommendations nos. 108 and 109.

111. The National Health and Medical Research Council should allocate funding for research into the relationship between parent-child bonding experiences and child abuse.

112. Health visitor schemes should be piloted, evaluated and introduced if successful.

113. The government, through the Office of Child Care, should convene discussions between State and Commonwealth Attorneys-General and other appropriate child protection agencies (government and voluntary) in order to frame common definitions of child abuse, for both legal and research purposes.

114. The government should initiate and encourage parent education programs in a wide variety of settings including schools, local communities, the workplace, maternity hospitals, baby health clinics and via the media. Such programs should foster constructive non-violent ways of dealing with family conflict and discipline.

115. Schools and child care agencies should relinquish the use of physical methods of punishment; education of teachers and child care workers should teach constructive disciplinary techniques that are not based on physical punishment.

116. All professional and community workers likely to come into contact with child abuse (e.g. doctors, nurses, teachers, social workers) should be educated to understand the nature of the problem and how to help. Programs should be at both undergraduate and adult education level, as well as through special courses for people already in the field. Programs should include information about family support services.

117. Police officers and police trainees should receive education and skills to deal with cases of child abuse, and should be aware of all those community agencies likely to be of help.

118. The government should acknowledge the profound effect alcohol has on human relationships and should develop and announce a national policy on alcohol.

119. The government should sponsor a nation-wide education campaign on alcohol use and abuse, and develop suitable programs.

120. Education for health and welfare professionals should cover problems related to alcohol, with special attention to human relationships.

121. The government should consider means by which some of the revenue obtained from liquor could be diverted into education, prevention and treatment programs.

122. The government should encourage the development of programs in industry and commerce about alcohol and should show the way through programs in the public service.

123. The government should encourage and assist self-help and community groups which offer support to alcoholics and their families.

124. Alternatives to short terms of imprisonment should be further developed, including weekend work and community services.

125. Efforts should be made to reduce the period of remand before trial.

126. Provision should be made adjacent to a prison for spouse and family visits maintaining the privacy and dignity of the parties; where possible prisoners should be allowed weekend visits home.

127. Prisoners should have more liberal permission to write and receive letters and more liberal access to phone calls and newspapers.

128. Where a parent is in prison and children are in care of a department, provision should be made to ensure that contact is maintained with the children, e.g. by arranging for them to be brought on visits; custodial rights should not be disturbed unless necessary for the welfare of the child.

129. Special visiting leave should be granted in cases of serious family illness.

130. Provision should be made where appropriate for transfer of prisoners (including interstate transfers) or for fare subsidies (e.g. free rail passes) to ensure that a prisoner can maintain contact with the family.

131. Prison counsellors and interpreters should be concerned to assist in maintaining family ties and passing on family information to the prisoner.

Part VI Equality and discrimination

Recommendations

We recommend that:

1. The Commonwealth and State governments should adopt a joint and comprehensive policy against discrimination on the grounds of sex and marital status, and should set up national and State machinery to put the policy into effect.

2. The policy should apply to agencies of Commonwealth, State or local government, to industry and commerce, employers and unions, as well as to education authorities and to the supply of goods and services.

3. The policy should be implemented by way of legislation providing for conciliation, compulsory powers of investigation, enforcement through legal procedures and penalties and the award of damages.

4. Public education programs should be initiated on the nature and effects of discrimination, and positive action programs should be provided for and pursued.

5. Equal employment opportunity for males and females should be the required policy of government departments, Commonwealth corporations, agencies set up under Commonwealth law, agencies requiring government licensing, agencies which are publicly funded and organisations obtaining government contracts.

6. The government should allot funds annually to promote the education of girls and women.

7. An expert advisory committee on the education of girls and women should be set up to advise the Schools Commission and to promote curriculum research, vocational guidance for girls and women, and public awareness of their educational needs.

8. The Schools Commission should fund remedial programs in schools to develop equal educational opportunities for girls.

9. Research should be undertaken into the effects of sex role prejudice on teaching practices and on pupils, and the results of this research should be incorporated into teacher-training programs and disseminated among teachers.

10. Women should be given encouragement to advance to high level positions in schools, tertiary institutions and Departments of Education.

11. The organisation of schools should be examined with a view to removing unnecessary sex distinctions.

12. Boys and girls should have equal course options and should be encouraged to learn basic practical skills and to share sporting activities so far as possible.

13. School books should be revised to ensure that men and women are portrayed in a full range of working roles and domestic responsibilities.

14. Vocational guidance programs and literature should be reviewed to ensure that there are no sex-based restrictions.

15. Men and women should have equal opportunities to enter further education courses for apprenticeships, as well as colleges and universities.

16. Adult educational opportunities should be expanded for women whose access to education has been restricted, with training allowances in cases of need, specialised counselling and orientation courses.

17. A committee should be appointed to monitor government publications to ensure that they contain no unnecessary sex stereotyping in text or illustration.

18. The Department of Employment and Industrial Relations should collaborate with State departments, employers and trade unions to develop programs to remove the imbalance in the numbers of men and women in particular categories of employment.

19. Job advertisements excluding applicants of a particular sex without bona fide justification should be prohibited.

20. The Commonwealth Employment Service should establish units in major centres to advise women on employment and to foster new employment opportunities for women in commerce and industry.

21. Government programs related to employment and training should be open to all without discrimination on the grounds of sex or marital status.

22. Training allowances should be made available to dependent women, or women without training, and training programs should be planned to take account of the possible need for child care and flexible hours.

23. The Trade Union Training Authority should give instruction on the working problems of women, especially migrants, and it should encourage female participation in courses.

24. Trade unions should integrate women into all levels of trade union activity and should seek to ensure a better level of participation by women. They should actively seek out women to be trained for union office and should encourage women to stand for election.

25. The government should contribute financially to the Working Womens Centre Melbourne, the Womens Trade Union Commission Sydney, and other similar working womens centres; in particular these should be assisted in developing child care schemes.

26. The government should develop foreign-language illustrated information leaflets on employment, unions, industrial legislation and social services addressed to migrant women.

27. The government should set up an inquiry into the working conditions of migrant women, their health, their child care arrangements, language problems and need for education.

28. The government should investigate public and private superannuation schemes and move to ensure that men and women are given equal terms.

29. The government should enter into discussion with State governments, trade union and employer organisations on ways and means of ratifying and implementing ILO Convention No. 103, concerning Maternity Protection, to extend to all employed women the benefits now applied to women in the Commonwealth public service, and to give fathers parental leave.

30. The government should invite discussions with organisations of employers and employees to examine work patterns, flexible working hours and part-time work; part-time employment should be introduced as part of the public service career structure.

31. The government should move to set up multiple-shift child care centres, should provide subsidies for these services and should seek to involve trade unions and employers in planning and providing child care facilities.

32. The director of the office of equality in public service employment should publish accounts of activities and research.

33. Full-time child care facilities should be provided for public service employees.

34. Vocational guidance materials used by the government should be reviewed to ensure that they encourage both men and women to consider a wide range of occupations.

35. Public service recruiting policies should be reviewed to ensure that job advertisements and recruiting programs encourage women applicants from within and outside the public service, and that qualifications required for appointment to senior positions do not exclude suitable women applicants.

36. Special steps should be taken to ensure that women are available for training for senior positions in the public service.

37. Programs for retraining and re-entry into the public service should give credit for experience acquired in family and home management and in voluntary work.

38. Where a job classification within the public service is now dominated by persons of one sex, preference should be given to persons of the other sex.

39. There should be no discrimination between men and women in public service conditions of employment and in superannuation.

40. Legislation should prohibit discrimination between men and women in the terms upon which insurance is offered.

41. Clubs should re-examine their conditions of eligibility to remove unnecessary restriction or distinction between members on the grounds of sex or marital status.

42. Anti-discrimination legislation should prohibit the exclusion of males or females from membership of large business, sporting, social or professional clubs which provide major facilities for entertainment, recreation or refreshment, and which receive any public benefit such as tax remission or the favoured use of public property.

43. Girls and boys should have equal opportunities to participate in athletic and sports activities.

44. The government should examine and revise legislation to remove discrimination between males and females.

45. Womens legal advice and resources centres should be funded.

46. Juries should be composed of at least four persons of each sex.

47. Legislation and government forms and documents should be reviewed to ensure that women are not required to describe themselves by their marital status unless essential to the purpose of the form or document.

48. Federal estate duty on estates passing between spouses should be abolished.

49. Conditions for eligibility for unemployment, sickness and other benefits should be reviewed particularly with regard to the effect of dependency on entitlement to benefits.

50. Government financial and social policies should provide for the single person who is a breadwinner responsible for the support of dependent relatives.

51. Legislative drafting and official documents should substitute so far as possible the word 'person' for 'man' or 'woman', and the male and female personal pronouns with a new word such as 'id'.

52. As part of its policies on employment in its own offices, the media should encourage employment of women, adopt part-time work and flexible hours, and ensure a balance between the number of men and women.

53. The Australian Press Council, the Australian Broadcasting Tribunal, the Media Council of Australia, the Australian Journalists Association and the Advertising Standards Council should collaborate to publish and promote guidelines for the media on the treatment and portrayal of women.

54. The major political parties should involve women in party activities at all levels and include them as party delegates proportionately to their membership.

55. The political parties should ensure that women take part in preselection for Commonwealth, State and local government elections, and that women candidates are given a fair chance of selection.

56. The political parties should enter into an agreement to select a minimum percentage of women as their candidates for Commonwealth, State and local government elections; the percentage should be increased progressively.

57. Governments should appoint women to judicial office from the various branches of the legal profession.

58. Government appointments to statutory bodies and other agencies, councils, committees and commissions should include a substantially increased number of women; the goal should be equal representation.

59. Voluntary organisations and associations should involve women in policy making, encourage women to seek election to office, and make such changes as are necessary to enable women to participate fully.

60. It should be no longer regarded as a criminal activity to be a prostitute.

61. The activities of prostitutes should be regarded as offences only to the extent that they cause public nuisance or annoyance; soliciting should be no longer an offence as such.

62. It should be no longer an offence to be on premises used for the purposes of prostitution or to permit premises to be used as a brothel except to the extent necessary to protect minors or prevent a general nuisance.

63. Places used for prostitution or as brothels should be subject only to such restrictions as are required by planning laws relating to business premises or by-laws relating to public health and safety.

64. The offence of living off the earnings of prostitution should be related to some element of coercion or force.

65. Education authorities should encourage and provide courses in schools, tertiary institutions and through adult education to educate and inform white Australians about Aboriginal tribal life and customs, the impact of white settlement on Aboriginal culture and the process of adaptation to social change.

66. The education of Aboriginals should aim to reinforce their identification with the Aboriginal community while providing adequate opportunities for them to live and work among the white community should they choose to do so.

67. The government should subsidise and support adult education for Aboriginals to learn about urban life and tribal life and to learn language and literacy.

68. Aboriginal people should be involved in planning and presenting the education programs referred to above.

69. Health and medical workers involved with Aboriginals should have training in Aboriginal customs and, wherever possible, in Aboriginal languages.

70. Health education for Aboriginals should be developed and carried out by community health services using members of the Aboriginal community.

71. Health and medical services should employ Aboriginal health workers or liaison officers to help Aboriginal people to use and understand the services.

72. Contraceptive services should be widely available to Aboriginal people; where possible they should be provided by Aboriginal Medical Services.

73. Members of the Aboriginal community should be involved in planning contraceptive services for members of the community.

74. Contraceptive services for the Aboriginal people should use Aboriginal health workers and community workers, in addition to community health nurses.

75. Australian descendants of South Sea Islanders should be considered eligible for health, education and welfare benefits available to Australian Aboriginals and Torres Strait Islanders.

76. Government departments should assess whether their services meet the special needs of Aboriginals; members of Aboriginal communities should be consulted and involved in planning services to meet their needs.

77. Health, education and welfare services providing for the needs of Aboriginal people should employ Aboriginal liaison officers to help Aboriginals to use those services.

78. Special programs of assistance to Aboriginals should continue to be provided. Self-help programs aimed at developing independence and confidence among Aboriginal people should be supported and encouraged.

79. The government should support and encourage programs to educate and inform migrant people about Australian society and its cultural values, and to educate and inform Australians about ethnic groups and their culture.

80. Education authorities should encourage and provide courses in schools, tertiary institutions and through adult education to enable established Australians to learn the languages and culture of ethnic communities.

81. Members of ethnic communities should be involved in the planning of the education courses and programs mentioned above.

82. (a) The government should subsidise migrants who wish to attend full- or part-time courses to learn English, and should fund voluntary organisations to provide such courses.
(b) Special language programs should be developed by educational authorities and voluntary organisations and provided to unions and management; the workplace should be used for program delivery and for the distribution of information about community services.

83. The government should support the home tutor plan for teaching English to migrants, especially to women.

84. The government should actively promote the recognition of overseas professional and technical qualifications.

85. (a) Government departments should assess whether their services meet the special needs of ethnic communities.
(b) Members of ethnic communities should be consulted and involved in specifying their special needs and in planning services to meet them.

86. Family planning services should plan for the special needs of ethnic communities in consultation with members of those communities; they should employ migrants as counsellors and they should use interpreters.

87. (a) Government departments and agencies should ensure that information about their services is available in significant ethnic languages.
(b) A working party including ethnic representation should be established to ensure that this is done and to ensure that translations and information are adequate to inform and educate migrants about services.
(c) Information should be distributed widely in all areas of migrant concentration, including the workplace and clubs.

88. The government should encourage and support programs to train and employ social workers in ethnic voluntary organisations.

89. Migrant women should be employed as detached workers by authorities such as local councils, community health centres, government departments and ethnic groups, to disseminate information and assist in establishing community networks.

90. The government should support ethnic broadcasting, including radio and TV, which should be expanded to provide information services to migrants and to provide contact with women who are isolated in their homes.

91. The government should encourage and support, by funding or otherwise, programs by State or voluntary agencies to train and employ professional interpreters with special attention to health services and hospitals.

92. The government should support the telephone interpreter service and enable it to expand to country areas where there are significant numbers of migrants; information about the service should be distributed to professions and organisations likely to need it.

93. Sexual acts between persons of the same sex should be no longer classed as a criminal offence in circumstances where a sexual act between persons of different sexes would not constitute an offence.

94. Homosexual offences should be treated in the same manner as heterosexual offences so far as penalties, age of consent and questions of public decency are concerned, and, if possible, there should be uniformity of laws throughout Australia.

95. Every effort should be made to enable homosexuals to be accepted by society and violence and blackmail against them should be strongly suppressed.

96. The Public Service Board should set an example to employers generally in Australia by implementing a policy of non-discrimination against homosexuals and similar minority groups.

97. Committees on discrimination should include discrimination on the ground of homosexuality as part of their provision for discrimination on the ground of sex.

98. The Defence Department should remove automatic discrimination against homosexuals in the services and judge their qualifications on the same criteria as would be applied to heterosexuals.

99. Sex education authorities should include homosexuality as a component in programs of sex and human relationships education both in schools and for adults. Such programs should be factual and balanced not condemnatory or judgmental; selected homosexuals should be involved in these programs.

100. Adequate attention to the issue of homosexuality should be included in medical, paramedical and social welfare training courses.

101. Public health authorities should show due care for the health of homosexuals by reaching them in publicity campaigns against venereal disease.

102. Consideration should be given to allowing certain rights and benefits to partners of the same sex living together, e.g. in housing loans, inheritance, income tax, probate duty and next-of-kin rights.

103. At this stage, recognition should not be given to homosexual unions as legal marriages, or to allowing homosexual couples to adopt children except in cases of natural relationship.

104. The use of aversion therapy in the treatment of homosexuals should be investigated by the Department of Health.

105. Schools, churches and the media should join in a campaign to change public attitudes to homosexuals.

106. The government should determine and publish a policy for the development of services for handicapped people.

107. Services to the handicapped should be multidisciplinary and integrated within services for the general population.

108. The government should proceed with the follow-up survey of handicapped people based on the 1976 census.

109. The government should support the establishment of an Australian Institute on Mental Retardation similar to the Canadian Institute.

110. The government should encourage and support media and educational programs about the handicapped which show their potentials and abilities.

111. The Department of Health should investigate various methods of developmental screening; an intergovernmental committee should be established to report on the best means of ensuring that every child in Australia between the age of 0 and 5 is regularly screened.

112. Contraceptive programs should pay attention to the woman over 35; such women should be fully informed of their special risk of having a Down's Syndrome child.

113. Where such techniques are appropriate, amniocentesis and counselling should be available to all women who are considered to be at risk of bearing a handicapped child.

114. Genetic counselling should be discussed in school human relationships programs.

115. Genetic counselling facilities should be available throughout Australia.

116. Health authorities should ensure that girls are immunised against german measles.

117. The education of medical, nursing and other professionals likely to come into contact with handicapped people should include counselling techniques, an understanding of the needs of handicapped people and their families and a knowledge of support services available.

118. Maternity hospitals, diagnostic centres and doctors making diagnoses should assist families of handicapped children to receive counselling and support.

119. The Department of Health, in collaboration with the Department of Social Security and relevant State government and private bodies, should write and distribute information booklets on handicaps for professional workers and for families.

120. Ombudsmen should be appointed to all large hospitals to receive and investigate complaints; such ombudsmen should have a full understanding of the needs and problems of handicapped people and their families.

121. Handicapped people should be given an education to enable them to reach their full potential. This should begin in babyhood and extend into adult life.

122. Education Departments should assume responsibility for the education of handicapped children in institutions and hospitals.

123. Education Departments, in conjunction with Health and Social Welfare Departments, should develop early education programs—domiciliary, play group and pre-school—suited to local needs.

124. Ways should be investigated of fostering the integration of handicapped children into the normal school system.

125. Handicapped children should receive education in human relationships and sexuality, appropriate to their development.

126. Vocational training and job experience programs should be made available to handicapped adolescents.

127. More specialist teachers should be recruited, trained and used.

128. The government should make more funds available to State governments to enable them to develop support services for families with handicapped members. Such services should be locally available and integrated within the normal range of community services and should include residential accommodation.

129. Handicapped children and adults should be moved out of large institutions into smaller units, cottage homes or hostels.

130. Standards should be fixed and applied to institutions which accommodate handicapped children and adults.

131. Staff caring for handicapped people should be trained.

132. The government should investigate ways of developing, assisting and evaluating self-help movements (such as the Total Care Foundation).

Part VII Rape and other sexual offences

Recommendations

The following are our recommendations for this part. The detailed suggestions for substantive changes in the law which are made in chapter 18 of this part are intended to be suggestions rather than recommendations.

We recommend that:

1. Special police squads should be established consisting of equal numbers of men and women of each rank to deal with sexual offences, including rape, in the main population centres.

2. Police questioning of rape victims should be kept to a minimum until the victim has had such medical examination and treatment as is necessary, and should not be conducted in a hostile fashion.

3. Members of the squad should be given special training in psychology and crisis intervention.

4. All large public hospitals should have a panel of doctors, trained in the examination and treatment of rape victims, available to examine rape victims at any time.

5. Such panels should include a sufficient number of women to enable any victim to be examined by a woman doctor if she so requests.

6. Country doctors who might be involved in the examination of rape victims should be kept adequately informed of the procedures to be followed and the matters to be investigated.

7. A pamphlet containing guidelines for the medical treatment and management of rape victims should be prepared and made available to all hospitals and to all doctors who may be called on to deal with rape victims.

8. Appropriate steps should be taken to care for the rape victim's mental health, and also to deal with venereal disease or pregnancy resulting from rape.

9. A pamphlet containing information about medical treatment, counselling and legal services should be prepared and made available to rape victims.

10. Legislation should be passed providing that, in all cases where it is part of the Crown case to prove that sexual penetration was either effected or attempted, the evidence of any medical practitioner relating to medical matters may be given by the production of his or her report unless the Crown or the defence apply for the practitioner to attend and give evidence, in person.

11. Legislation should be passed providing that, at committal proceedings for any offence in which it is part of the Crown case to prove that sexual penetration was effected or attempted, the evidence of the victim should be given by the production of her appropriately verified statement.

12. The presiding magistrate may order, upon application by the prosecution or the defence, that the victim should attend and give oral evidence, but only if special circumstances are shown to justify the making of such an order.

13. Where the evidence of the victim is given by the production of her statement, the defence should be supplied with copies of all statements made by her to the police.

14. If the victim does attend and give oral evidence, only the parties and their representatives, essential court staff and police officers should remain in court during her evidence, except with the leave of the presiding magistrate on special circumstances being shown.

15. Legislation should be passed providing that the victim in a trial in which consent is in issue should be cross-examined relating to her prior sexual acts only on leave being granted by the trial judge.

16. Such leave should be granted only where the evidence sought to be introduced is so closely relevant to the issues before the court that it would be unfair to the accused to exclude it, and, in any case, only in the following situations:

(a) where the prior sexual acts are alleged to have taken place between the victim and the accused;
(b) where the prior sexual acts were part of a pattern of behaviour which was strikingly similar to her alleged behaviour at or about the time of the alleged offence; or
(c) where evidence of the prior sexual acts is relevant to explain the source or origin of semen, pregnancy or disease.

17. Any such application should be made in the absence of the jury.

18. In no circumstances should evidence be adduced as to the victim's sexual reputation or moral character, whether by way of cross-examination or otherwise.

19. No cross-examination as to the victim's prior sexual history should be allowed at committal proceedings.

20. If the Crown or the victim raises the issue of her own sexual experience, or lack of it, the accused should be entitled to refute such evidence by cross-examining her and/or by introducing evidence of specific acts of the victim.

21. Legislation should be passed providing that, unless a complaint in a sexual case is admissible under the general rules of evidence, evidence of such complaint should no longer be admissible.

22. The requirement that the trial judge give a corroboration warning in sexual cases should be abolished.

23. Legislation should be passed providing that all juries sitting on cases involving allegations that sexual penetration was either effected or attempted should consist of at least four men and four women.

24. The publication of any material which might identify the victim of sexual offences should be prohibited.

25. Judges and magistrates should have a discretion to order that any part of the evidence in trials or committal proceedings for sexual offences should not be published.

26. Provision should be made in the ACT and Northern Territory along the lines of the Victorian *Criminal Injuries Compensation Act* 1972 providing for a maximum amount of $20 000 to be payable to victims of crime whether or not a conviction is recorded.

27. The existing offence of rape should be abolished and should be replaced by a series of offences, along the lines suggested in chapter 18 of this part, and consent should be irrelevant in relation to offences involving the use of violence, threats, false pretences or drugs.

28. There should be no immunity between spouses in relation to offences involving the use of violence, threats, false pretences or drugs, and, in relation to offences to which consent is a defence, there should be no immunity between spouses who are living separately and apart.

29. Sexual penetration should be defined to include all forms of vaginal, anal and oral intercourse, including the insertion of foreign objects into the victim's anal or vaginal cavities.

30. The presumption that boys under the age of 14 are incapable of having sexual intercourse should be abolished.

31. In relation to the more serious sexual assaults, involving the use of violence, threats, false pretences or drugs, there should be no distinction in law between cases where sexual penetration was effected and those where it was attempted.

32. In relation to the less serious sexual assaults, where there is no allegation of violence, threats, false pretences or drugs, the offence of attempted rape should be abolished, and replaced with the summary offence of indecent assault.

33. Subject to special rules as to parents, guardians, teachers and others *in loco parentis,* the age of consent of both males and females to sexual intercourse should be 15.

34. No person should be convicted of statutory rape on a male or female aged between 13 and 15 years if that person is less than 5 years older than the said male or female.

35. All charges of statutory rape relating to sexual intercourse alleged to have taken place between the defendant and a person over the age of 13 should be tried summarily.

36. A 6-month limitation period should apply to all cases mentioned in recommendation 35 hereof.

37. The age of consent to indecent assault should be 15.

38. No person should be convicted of indecently assaulting a male or female aged between 13 and 15 years if the alleged assault is consented to and that person is less than 8 years older than the said male or female.

39. The age of consent to sexual intercourse should be 17 in relation to a person's schoolteacher.

40. In relation to children under 10 years of age a special offence, carrying penalties equivalent to the most serious rape offences, should be complete upon proof only of sexual penetration.

41. The offence of 'attempted carnal knowledge' should be abolished, and all sexual assaults on young children in which penetration is not effected, and which do not fall within any of the categories of aggravated sexual assault, should be treated as 'indecent assault', triable summarily.

42. All complaints of sexual offences involving children under 15 (or under 17 if the offender is the child's mother, sister, parent, adoptive parent, foster parent, step-parent, guardian or schoolteacher, or is the de facto husband or wife of the child's mother or father) which are reported to and accepted by the police should be reported by the police to a child protection service.

43. A child protection service should provide a social worker to work with the child and its family, to provide assistance as recommended in Part V in cases of parental abuse, and, if necessary, to represent and assist the child through the process of the courts.

44. A special tribunal should be established, presided over by a judge, to determine applications that, in the interests of the child victim of sexual offences, no prosecution should lie against the alleged offender, or any existing prosecutions should be discontinued.

45. The tribunal should conduct its proceedings in camera, and should receive only written evidence and submissions.

46. Application should be made to the tribunal by the parents or by a social worker appointed by the child protection service. The police should place a report before the tribunal and reply to the application. The tribunal should have power to call for welfare reports.

47. Subject to appropriate safeguards as to the position of the alleged offender, an application should operate as a stay of all criminal proceedings against him in relation to the alleged offence.

48. Any application to the tribunal should be made prior to the completion of proceedings in the Magistrate's Court (if the offence is an indictable one) or prior to the taking of the victim's evidence in the Magistrate's Court (if the offence is a summary one).

49. The tribunal should have power to recommend that no proceedings should be instituted against the alleged offender, or that any existing proceedings should be discontinued or to refuse the applications.

50. If the child victim of sexual offences is required to attend and give evidence during committal proceedings, the child's social worker should be permitted to remain in court. The magistrate should have power to order that the defendant remain outside court during the taking of the child's evidence, provided his lawyer is present in court.

51. Before the trial of any person for a sexual offence involving a child victim, a conference should be held between the trial judge, the Crown prosecutor, defence counsel and the child's social worker with the purpose of agreeing on a method of minimising the child's role at the subsequent proceedings.

52. The trial judge should have power to make the following orders:

(a) that during the proceedings or any part of them, the wearing of wigs and gowns by the judge and counsel should be dispensed with;
(b) that the child's evidence should be taken in the judge's chambers or some other place outside the court, in the presence of the jury;
(c) that the public should be excluded from the court during the taking of the child's evidence;
(d) that the evidence of the child should be taken in the absence of the accused, provided the latter's counsel is present.

53. Prior to the hearing of any summary offence, being a sexual offence involving a child victim, a similar conference to that proposed in recommendation 51 should be held between the magistrate, the police prosecutor, defence counsel or the defendant and the child's social worker.

54. During the hearing of any summary offence, being a sexual offence involving a child victim, the magistrate should have the same powers as referred to in recommendation 52.

55. Existing provisions making it an offence to have carnal knowledge with an idiot or imbecile should be repealed, and replaced by a provision prohibiting intercourse with a person who is known by the offender to be unable to understand the nature and consequences of the act.

56. Existing criminal prohibitions against incestuous behaviour should be repealed.

57. The age of consent in relation to sexual intercourse and indecent assault should be 17 if the other party is more than 5 years older than the victim and is the victim's brother, sister, parent, stepparent, or guardian, or is the de facto husband or wife of his or her mother or father.

Annexe 1.A

Catalogue of submissions

(additional to those listed in Annexe N of *Interim report*)

Number/Author — Principal topic

1051 Mrs Eva Byrne *schools, migrants; ethnic officers, schools; migrant services*
1052 Mrs A. N. Nys *adoption; unmarried mothers*
1053 Committee of Investigation: Problems of Disabled Women, Womens Electoral Lobby, Brisbane *disabled women; rehabilitation*
1054 Dr R. Montgomery, La Trobe University *sex education; sexuality; schools–sex education*
1055 P & C Association, Westlawn School *corporal punishment in schools*
1056 Dept for Community Welfare, Western Australia *family education; women; aged; health; child abuse; children; community development; social research*
1057 Mr J. Booth *media; country people*
1058 Name withheld *handicapped children; family–handicapped child*
1059 Charlton Catholic Womens League *Christian family; mothers at home*
1060 P & C Association, Drummond Memorial School *corporal punishment in schools*
1061 Mrs C. Haire *abortion; right to life*
1062 Australian Council of State School Organisations *schools; education system; schools– community; students' rights; sex education*
1063 Name withheld *open marriages; interpersonal relationships; jealousy; roles–parents, children*
1064 Mrs M. Lane *family; sex education; abortion*
1065 International Planned Parenthood, United Kingdom *abortion laws in commonwealth countries*
1066 Australian & South Pacific Temperance Council *alcohol*
1067 Mr D. McLeod, Aboriginal Nomads Group *Aboriginals in WA; nomad Aboriginals*
1068 The United Church (NSW & SA) *education for marriage; responsible parenthood; human sexuality*
1069 Name withheld *human rights; rights of the child*
1070 Carol McLean, Christian Women Concerned *homosexuality; church–homosexuality*
1071 Mr J. Heathcote *sex stereotyping; child care, role of male*
1072 Mr W. Thomson *sex education; abortion in NT; homosexuality; Aboriginals; unwanted pregnancies*
1073 National Right to Life Association, 'Rebuttal of evidence' at public hearings *abortion; contraception; unwanted pregnancies; child abuse*
1074 Mrs M. Hoban *family–support of; migrants, languages; interpreters; pregnancy support*
1075 Divine Light Mission *meditation; knowledge*
C1076 Confidential *privacy; child care; divorce; education; mental health*
1077 Mrs B. Rooney *poetry; women; human relationships*
C1078 Confidential *adoption; rights of fathers re adoption; child welfare*
1079 R. J. Barker *children's rights; child welfare; baby battering*
1080 Mrs B. Henderson *migrants; communication; media–migrants*
1081 Name withheld *concubinage; marriage; languages*
C1082 Confidential *corrective services; mental health*
1083 Mr C. Borough *migration; immigration policy*
1084 The Canberra Learning Exchange *education; community involvement; information–exchange of*
1085 Lalbert Branch, Catholic Womens League of Victoria and Wagga Wagga *marriage; family life*
1086 Mr N. Leal *homosexuality, terms of reference*
1087 Country Womens Association of WA *country people; isolated areas; family life education; communication*
1088 Mr S. Demasson *rape; castration*
C1089 Confidential *health*
1090 Ms P. Woolley *discrimination in employment*
1091 Mr A. Johnson *working wives; status of women; family life; education; sex education*
C1092 Confidential *sexual assault*
1093 Mr M. Nolan *humanists viewpoint*
1094 Joan Nelson, Union of Australian Women *women and trade unions; employment–women*
1095 Mrs D. Playoust *sexuality; lesbianism; sex education*
1096 The Josephine Butler League (Sydney) *prostitution; sex slavery; pornography*
1097 Mrs A. Day *unplanned pregnancies; fertility; male-female roles re contraception*
C1098 Confidential *loneliness; isolation; aged persons*
1099 Name withheld *social security system; government departments*
1100 Association for the Welfare of Children in Hospital *hospitals–children*

Number/Author Principal topic

1101 Australian Medical Association *children; sex education; family planning; abortion; rape; handicapped*
1102 Mr P. Fox *mental health; health care*
1103 Mr N. Woodger *sexuality—handicapped persons*
1104 NSW Dept of Education *personal development courses in schools; sex education; sex education in schools; child development*
1105 ACT Right to Life Association *abortion; ACT draft criminal code; law*
C1106 Confidential *domestic violence; alcohol; rape*
C1107 Confidential *marriage—forms of*
1108 Dr A. Györy *ethnic radio programs*
1109 Miss J. Woollard *child welfare; teenage girls; socially maladjusted state wards; institutions*
1110 Mr and Mrs Scrivener *sexual offences; punishment; primary producers*
C1111 Confidential *family relationships*
1112 Mrs J. Chapman *working mothers; child welfare*
1113 Miss M. Magni *working mothers; crèches; migrants, discrimination; sex education; abortion*
1114 Mrs M. Preston, Willoughby Senior Citizens Centre *social welfare; hostel accommodation for needy invalid pensioners*
1115 Mr C. Nethery *court procedures; traffic offences*
1116 Mrs N. Nunan *education for HR; health and nutrition*
1117 Mrs J. Lowth *tubal ligation; vasectomy; schoolchildren*
C1118 Confidential *domestic violence*
1119 United Tasmania Group *environment; children; poverty; unemployment; homelessness; education*
1120 Mrs L. Healy, Federation for Junior Deaf Education (NSW) *deafness—children; education —deaf children*
1121 Mr R. Coady *media; 'classes' in society; the arts*
1122 Catholic Family Welfare Bureau, Perth, WA *unwanted pregnancies; pregnancy; abortion*
1123 Mrs B. Shannon *single parents; schools—sex roles*
1124 Name withheld *sex offences; law; media*
1125 Mrs D. Davies *status of women; abortion; prostitution*
C1126 Confidential *alcoholism; effect of alcohol on family*
C1127 Confidential *loneliness; homelessness; single women*
1128 Mr Lex Watson *homosexuality; law reform; discrimination; sex education*
1129 Mr P. Crisp *Christianity; education—Christian and humanist*
1130 Victorian Commission of Public Health *child development; child welfare; preschool development*
1131 Name withheld *Christian ethics*

Number/Author Principal topic

1132 Mr R. Farmer and Helen Hocking *health education*
1133 Lismore Heights Public School P and C Assoc. *corporal punishment in schools*
1134 Temora High School P and C Assoc. *corporal punishment in schools*
1135 Moruya High School P and C Assoc. *corporal punishment in schools*
1136 Temora Primary School P and C Assoc. *corporal punishment in schools*
1137 National Committee on Discrimination in Employment and Occupation *discrimination in employment*
1138 Ms C. Lingard *infertility; fertility pill*
C1139 Confidential *homosexuality in isolated communities*
1140 Sister E. Heath *families; delinquency; alcoholism; isolated areas*
1141 The Sisters of St Joseph, St Anthony's Home *unmarried mothers; abortion*
1142 Name withheld *forms of marriage; de facto relationships*
1143 Name withheld *illegitimacy*
1144 Name withheld *adoption; illegitimacy*
1145 Mrs H. Enders *natural foods*
1146 Dr J. Billings *natural family planning methods; contraception; abortion*
1147 Australian Festival of Light, NSW *family; youth; pornography; moral pollution*
1148 Mr Darcy Dugan *prisons and prisoners; the law; education; prisoners and their families*
1149 Professor I. C. Lewis *child abuse; adolescents and aggression; teenagers—hostility*
1150 Mrs C. Harland *problems of country life in isolated areas*
1151 Name withheld *sexuality; loneliness; vasectomy*
1152 Mrs J. H. Starkey *aged; pensioners; education in HR*
1153 Mr W. Turnbull *discrimination re age; employment—age*
C1154 Confidential *family property law; marriage; parenthood*
C1155 Confidential *family relationships*
1156 Pastor J. Whitbourn *family; marriage*
C1157 Confidential *aged; support services*
1158 Royal North Shore Hospital, Child Care Centre *child care centres in hospitals; health education; day care; responsible parenthood*
1159 Trundle P and C Assoc. *corporal punishment in schools*
1160 Prospect Public School P and C Assoc. *corporal punishment in schools*
C1161 Confidential *divorce; taxation deductions*
1162 Millbank Public School P & C Association *corporal punishment in schools*
1163 Australian Labor Party Womens Branch, Launceston *alcohol; drug abuse*
1164 Miss W. Faulkes *women & violence; marriage*

1165 'Sola Scriptura' Womens Bible Study Club *Christianity; family; family education*
1166 Rev. K. Ogier *child care; child abuse; family; parenthood*
1167 Miss A. Anderson *care of the aged; aged—nursing homes*
C1168 Confidential *children & sexual offences*
C1169 Confidential *mentally handicapped children*
1170 The Free Reformed Church of Launceston *Christian ethics; abortion; family*
1171 Family Planning Association of Northern Territory *family planning; contraceptives; abortion; unwanted pregnancies*
1172 Rev. Robert Owen *abortion*
C1173 Confidential *homosexuality*
1174 P & C Association, Gosford High School *corporal punishment in schools*
C1175 Confidential *discrimination re finance*
1176 Name withheld *care of the aged*
1177 Name withheld *custody of children; deserted husbands*
1178 Miss Y. Allen *social isolation; loneliness*
1179 Presbyterian Womens Association of Aust. (NSW) *family life; marriage; aged; youth*
1180 International Womens Year Darwin Committee *family life education; law & sexuality*
1181 Mrs H. Boutell *motherhood; migrants; Aboriginal mothers*
1182 Mr M. Croll *family relationships; sex education*
1183 Ms Y. Sullivan *status of women*
1184 Mr R. Webb *privacy; noise pollution*
1185 Mrs C. Brown *support services for mothers at home*
C1186 Confidential *control & care of children under detention*
C1187 Confidential *marriage guidance courses; rights of children; migrants*
C1188 Confidential *prostitution; brothels*
C1189 Confidential *alcoholism; domestic violence; divorce*
C1190 Confidential *incest*
1191 Mrs B. Kramer *school facilities*
1192 Barbara Whiley *discrimination re old age pensioners, married and single*
1193 Miss G. Morris *discrimination against the single woman*
C1194 Confidential *handicapped children*
C1195 Confidential *discrimination in employment due to obesity*
1196 Mrs C. Bass *parent's view of education system; schools—society*
1197 Mrs C. McKenzie *alcoholism in society*
1198 Mrs J. Lange *community centres for women*
1199 Miss N. Edwards *education for living; courses in schools; social health*
1200 Name withheld *child welfare; family life; wives of company executives*
C1201 Confidential *family law; marriage; divorce & maintenance*

Number/Author Principal topic

C1202 Confidential *rights of fathers to custody of children*
1203 National Council of Women of Launceston *women's rights and responsibilities; problems of voluntary womens organisations*
1204 Mrs M. Bottomley *suburban housewives; neurosis; loneliness*
1205 Mrs E. Hancock *motherhood; working women; child care*
1206 Mr H. F. Purnell *rape; sex offences; sex education*
C1207 Confidential *abortion; unwanted pregnancies*
1208 Dr B. Smithurst *venereal disease—surveys*
C1209 Confidential *enforcement of maintenance orders*
C1210 Confidential *homosexuality and sexual discrimination*
1211 Ms Pam Waugh, Division of Guidance and Special Education *sex roles in schools; school counsellors*
C1212 Confidential *migrants*
1213 Mrs J. Lockart, St Johns Mothers Union, Tamworth *employment; sex education; media*
1214 Mr M. Wilson *interpersonal relationships; love & marriage*
C1215 Confidential *human relationships*
C1216 Confidential *the challenge of change*
C1217 Confidential *medical profession*
1218 Mr E. Evans *problems associated with practice of hypnotherapy*
1219 Dr J. Krupinski *setting up of an institute of family studies*
1220 Name withheld *schizophrenia and sexuality; loneliness*
1221 Mr M. Glass *homosexuality*
C1222 Confidential *euthanasia; suicide*
1223 Mrs Frieda Brown *family life; Christian ethics*
1224 Mr W. Dwyer *population and birth control in Australia*
C1225 Confidential *parenthood; marriage; sexuality; family*
1226 Australian Council of Social Service *child care resource centres*
1227 Womens Electoral Lobby Probate group *widows and death, probate & estate duties*
1228 Mr B. Collingburn *sex; rape; sex education; sexuality; mental health; social services*
C1229 Confidential *care of mentally disabled*
1230 Mr & Mrs Verass *spiritual groups, cults & sects; communes*
1231 Mrs F. McConnell *quality of life; child care; single parents*
1232 Mr W. J. Helem *sexuality; coeducation; celibate emancipation*
1233 Peace Institute of Australia *peace; peace education and research*
1234 Mr D. Bau *family; sex crimes; censorship; violence*
1235 Girl Guides Association (NSW) *education and youth; responsible parenthood*

Number/Author	Principal topic

C1236 Confidential *divorce; rights of children; custody and access*
1237 Deaconess Nancy Drew *middle-aged spinsters; single women*
1238 Mr K. Howse *marriage; divorce; family; children; sexuality; abortion*
1239 Mr M. Glass *compulsory blood tests for VD before marriage*
C1240 Confidential *abortion*
1241 Name withheld *discrimination; traffic offence*
C1242 Confidential *smoking; nuisance caused by neighbours; nursing homes*
C1243 Confidential *divorce*
1244 Health Education Association of NSW *health education; community health*
1245 Misses Cannon & Downing & Mr Muldoon *counselling services*
1246 Australian Council, Royal College of Obstetricians & Gynaecologists *abortion statistics in Australia*
1247 Catholic Adoption Agency, NSW (case histories confidential) *adoption—case histories*
1248 Name withheld *lack of employment for young persons*
C1249 Confidential *treatment of patients in hospitals*
1250 Mr D. Burnett *political subversion*
1251 Dr P. Arnold *sex education; counselling in medical schools*
1252 Drs Dunstone, Heddle and Limmer *sex education; medical training and counselling; family planning*
1253 Mrs S. Wilding *country life; communication between city and country people*
1254 Mrs V. Miller *youth and recreation activities*
1255 Name withheld *epilepsy*
C1256 Confidential *rural communities; country women*

Number/Author	Principal topic

C1257 Confidential *cigarette smoking in public places*
1258 Mrs H. James *housing and high rents for persons on low incomes*
1259 Mr D. Boorer *handicapped persons*
C1260 Confidential *second marriages; divorce and maintenance*
C1261 Confidential *abortion*
C1262 Confidential *effect of working mothers on the family*
C1263 Confidential *discriminatory system of health service delivery*
C1264 Confidential *abortion services*

Corrigenda to Annexe N of *Interim report*

Page 47: Submission 61—listed out of sequence
Submission 68—author's surname should read Betts

Page 50: Submission 241—should read Confidential
Submission 244—author should read WEL, Williamstown group
Submission 274—listed twice

Page 52: Submission 403—should read Confidential

Page 54: Submission 548—not confidential, author should read Mr S. G. Johnstone

Page 55: Submission 619—not confidential, author should read Abortion Law Repeal Assoc., NSW

Page 58: Submission 807—should read Confidential

Page 59: Submission 917—not confidential, should read Name withheld

Page 60: Submission 966—should read Name withheld *philosophy of life; working wives*
Submission 967—incorrectly listed as 966, Mrs K. C. Warner

Annexe I.B

List of witnesses giving evidence at public hearings
(additional to those listed in Annexe O of *Interim report*)

Occupation/Affiliation — Principal topics

Sydney: 10-12 February 1976

Dr Stella Dalton Drug and Alcoholic Treatment Centre *drug addiction*

Professor Dexter Dunphy Dept of Behavioural Science, University of New South Wales *work; encounter groups*

Mr John Gilroy, Mr Arthur Martin Total Care Foundation *rehabilitation of the handicapped*

Ms Margaret Barry, Ms Neta McRae, Ms Joy Wallace, Ms Ann Pfingst Inner Sydney Residents Action Group *urban life; urban renewal*

Dr Clair Isbister Paediatrician *education for parenthood*

Mr William Crews Wayside Chapel Crisis Centre *social problems*

Ms Judith McLean Family Planning Association of NSW *womens health centres; contraception*

Ms Margaret Ward, Woman–name withheld *adoption*

Professor Rodney Shearman Dept of Obstetrics and Gynaecology, University of Sydney *contraception; abortion*

Dr Bertram McCloskey Department of Health, Victoria *child welfare*

Ms Audrey Marshall, Ms Pam Roberts NSW Council of Social Service *adoption; rights of children*

Ms Robyn Janssen Women Active Politically *housewives*

Dr Joan Thomas Royal North Shore Hospital, Child Care Centre *child care centres*

Mr Alexander Watson Dept of Government, University of Sydney *homosexuality*

Dr John Helmer Dept of Sociology, University of Melbourne *rape*

Sr Dolor, Sr Annunciata St Anthony's Home *unmarried mothers*

Dr Geoffrey Davis Population Services International *abortion*

Mr William Denney Action for Children *state wards*

Mr Michael Clohesy, Ms Col Eglington, Ms Robyn Kennedy, Man–name withheld CAMP New South Wales *homosexuality*

Sydney: 25 February 1976

Mr Michael Clohesy, Ms Col Eglington, Ms Robyn Kennedy, Man–name withheld CAMP New South Wales *discrimination*

Corrigenda to Annexe O of *Interim report*

Page 62:	Seventh witness–surname should read Vinen
Page 63:	Adelaide: 8-11 July 1975 should appear as a heading between the names Mrs Hanna Enders and Professor George Maxwell
Page 64:	Thirteenth witness, Perth–surname should read Ligtermoet Mr Alan Luxton should be listed as a witness with Mrs Margaret Stevenson, in Perth
Page 65:	The final witness in Perth should be listed–Mr John Foulsham, WA Community Welfare Department, *Custody of children; family law*

Annexe I.C

Offices of Australian Archives where Commission public documents may be inspected

ACT
Australian Archives
Bowen Place
Parkes, 2604

NSW
Australian Archives
Wembley Chambers
104 Hunter Street
Sydney, 2000

NT
Australian Archives
Basement, block 6
Mitchell Street
Darwin, 5790

QLD
Australian Archives
Wynnum Road
Cannon Hill, 4170

SA
Australian Archives
11 Derlanger Avenue
Collinswood, 5081

Tas.
Australian Archives
30 Anglesea Street
Hobart, 7000

Vic.
Australian Archives
Outer Crescent
Middle Brighton, 3186

WA
Australian Archives
Cnr Berwick Street and Hillview Terrace
East Victoria Park
Perth, 6100

Annexe I. D

Consultations, conferences, overseas communication

Conferences and seminars attended by Commissioners (additional to those listed in *Interim report*, pp. 10–11, 15–16)

- (a) Australian Religious Press Assoc., Presentation of awards, Sydney, February 1976
- (b) Rotoract District 268, Annual District Conference, Sydney, February 1976.
- (c) Lord Mayor's Reception, Newcastle, March 1976
- (d) Conference on the Pre-school Intellectually Handicapped Child, Macquarie University, Sydney, July 1976
- (e) Combined View Clubs of Canberra, Annual Meeting, June 1976
- (f) Western Australian Committee on Discrimination in Employment and Occupation, Seminar: IWY and beyond—an assessment of the woman at work, Perth, June 1976
- (g) Family Life Movement of Australia, Golden Jubilee National Seminar, Canberra, September 1976
- (h) NSW Institute of Marriage Counsellors, inaugural meeting, August 1976
- (i) United Associations of Women, annual award luncheon, Sydney, December 1976
- (j) United Nations Association of Australia, NSW Division, United Nations Women's luncheon, Sydney, October 1976
- (k) NSW Child Care Week, Sydney, July 1976
- (l) Australian Council for Health, Physical Education and Recreation, Annual Conference, Brisbane, 12 January 1977
- (m) Womens Trade Union Conference, 6–8 August 1976
- (n) First Australian Conference on Adoption, University of NSW, Sydney, 15–20 February 1976
- (o) Family Planning and the Law seminar, Monash University, July 1976

Overseas communication with individuals and organisations:

- (a) President's Committee on Mental Retardation, Washington, DC
- (b) Physically Handicapped and Able-bodied Association, London, UK
- (c) Central Council for the Disabled, London, UK
- (d) Central Bureau for Educational Visits and Exchanges, Youth and Community Services Dept, London, UK
- (e) Association for Improvements in Maternity Services, UK
- (f) Philadelphia General Hospital, Supportive Child-Adult Network, Philadelphia, USA
- (g) National Center for the Prevention of Child Abuse and Neglect, Denver, Colorado, USA
- (h) The Royal Norwegian Embassy

July–August 1976, Dr Arnott visited:

- (i) Toronto, Canada—Kinsmans Institute, York University (to investigate schemes for the rehabilitation of the handicapped)

(j) London—Family Planning Centre, Tavistock Square

(k) Copenhagen—(various) hospitals, kindergartens, child care centres, schools, old peoples home and working class housing (to compare with similar institutions in Australia)

Annexe I.E

Related Commissions and Committees

(additional to those listed in Annexe A of *Interim report*)

(a) AUST: Australian Government Commission of Inquiry into Poverty
(b) AUST: Royal Commission on Australian Government Administration
(c) AUST: The Law Reform Commission, Chairman Mr Justice M. Kirby
(d) WA: Honorary Royal Commission on Homosexuality, set up in 1974
(e) NSW: Women's Advisory Council, set up in 1975 and now a standing, ongoing review committee of inquiry and advice to the NSW Government
(f) VIC: Special Advisory Committee to the Premier on Mental Retardation
(g) QLD: Commission of Inquiry into the Nature and Extent of the Problems concerning Youth in Australia, set up in 1974, Chairman the Hon. A. G. Justice Demack
(h) UK: Advisory Group on the Law of Rape, the Hon. Mrs Justice Heilbron, DBE, Chairman
(i) CANADA: Law Reform Commission, Ontario
(j) FRANCE: The French Government in 1976 adopted a 5-year program of reform for women as described in *Project pour les femmes 1976–1981* published by the Secrétariat d'état à là Condition Féminine, and following an inquiry conducted by the Minister for Women, Madame Giroud
(k) USA: The President's Commission into the Status of Women, Chairman Eleanor Roosevelt, set up in 1961, reported in 1963
(l) USA: National Commission on the Observance of International Women's Year; report, *Justice for American women,* was released June 1976
(m) USA: The New York City Commission on Human Rights, 1970; report, *Women's role in contemporary society,* published in 1972

Annexe I.F

Commission research reports

(on microfiche except where indicated)

Number	Author	Title
1.[a]	..	Medical education, survey questionnaire
	ANU Survey Research Centre	Medical education, technical report
2.[b]	..	Abortion sequelae
3.	..	Hospital admissions for abortions, survey questionnaire
4.	Mr S. Rigg	Clients of Children by Choice, Brisbane
5.	Ms F. Beighton and Dr J. Cole	Attitudes of young males to contraception
6.	Mr S. Hasleton	Attitudes to sexual issues
7.	Rev. A. J. Scott	Attitudes to sexuality, Melbourne
8.	Ms S. Wills, Ms E. Cox and Ms G. Antolovich	Attitudes to sexuality, Sydney
9.	Dr P. Wilson	The other side of rape
10.	Dr R. Barr and Dr H. Molony	Families with an intellectually handicapped child
11.	Ms C. Gibbeson	Domestic violence
12.	Ms J. Harper and Ms D. Worrell	Young mothers and the workforce
13.	Ms E. Cox and Ms J. Martin	Stress amongst migrant women
14.[c]	Ms L. Richards	Having families
15.	..	Violence against children—interviews with parents

(*a*) Appears as Annexe III.A of Commission report
(*b*) Appears as Annexes IV.P and IV.Q of Commission report
(*c*) Copy with Australian Archives

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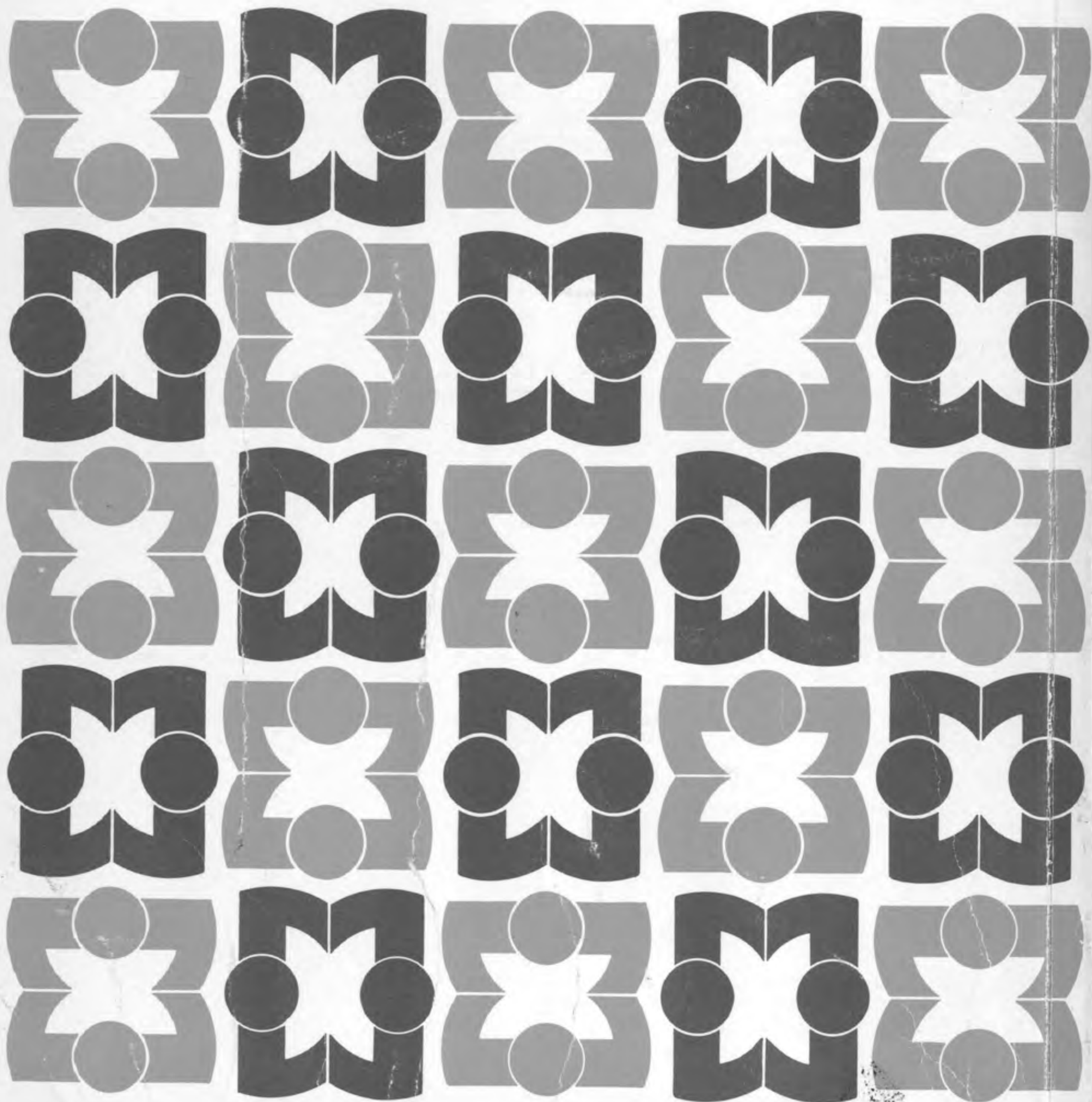

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