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To Whom It May Concern,

**Submission to the Sexual Orientation and Gender Identity Conversion Practices Issues Paper**

The Australian Psychological Society (APS) welcomes the invitation to provide a submission in response to the submission to the Tasmania Law Reform Institute's (TLRI) Sexual Orientation and Gender Identity Conversion Practices Issues Paper.

The APS is the peak professional body for psychology in Australia, representing over 25,000 members nationally. A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing.

The APS has made many statements and submissions relating to sexual orientation and gender identity issues. Most relevant to this inquiry is:

- [Use of psychological practices that attempt to change sexual orientation: Position statement](#) (2016)
- [Mental health practices that affirm transgender people's experiences](#) (2018)
- [Submission to Queensland's Health Legislation Amendment Bill 2019](#)
- [Submission to the Religious Freedom Bills - Second Exposure Drafts](#) (2020)

If the Institute requires further APS input, I may be contacted through my office on (03) 8662 3300.

Yours sincerely



**Zena Burgess FAPS FAICD**  
Chief Executive Officer

## **APS Submission to the TLRI Sexual Orientation and Gender Identity Conversion Practices Issues Paper**

The APS is acknowledged in the Issues Paper, alongside the AMA, as a peak body that considers conversion practices unscientific, ineffective and dangerous. This is correct, and as stated in our [position statement](#), the APS strongly opposes any form of mental health practice that seeks to change a person's sexual orientation or gender identity.

Evidence indicates that sexual orientation and gender identity (SOGI) conversion practices are harmful to all people subjected to them and that these practices lack efficacy. As such, any psychologist attempting to use conversion practices is likely to be in breach of our Code of Ethics.

Legislation such as in that in Queensland, which was an amendment to the Public Health Act 2005, only bans conversion practices by health service providers. This is an important and necessary step to minimise harmful practices by regulated health service providers such as psychologists. However, this is not where the majority of harm caused by conversion practices is occurring.

Conversion practices in Australia primarily (though not solely) occur in the context of religious organisations. Of great concern to the APS is that because many conversion practices occur under the banner of pastoral care, it means they are unregulated. This means that many practices, which may look similar in modality to that provided by psychologists, 'talking therapy' for example, are legally allowed to happen because they occur under the guise of pastoral care but without the necessary safeguards (e.g. evidence-based practices, trained and regulated professionals guided by a code of ethics, informed consent and reflective practice about power dynamics).

The APS therefore looks to the Government to minimise any potential harm as a result of such practices, as well as preserve the integrity of the modality of practices commonly conducted by psychologists.

The APS considers that a unilateral ban on conversion practices is warranted, similar to that which is proposed in Victoria, and should not be mitigated by recourse to claims of religious freedom. It is important to note that a number of significant religious organisations are also in support of this position and have endorsed the [statement by survivors](#) against conversion practices and ideologies.

In this submission, the APS draws on insights from psychological science and practice to respond to the most relevant questions.

### **Q1. After considering the background and working definition (see [1.3.23] on page 13), in your opinion, what are and are not 'sexual orientation and gender identity conversion practices'?**

While the definition in general is sound, part (c) introduces limitations due to the focus on 'dysfunction'. While 1.3.25 suggests that no ideological focus is described, dysfunction is indeed an ideology, and one that may not fully describe all possible forms or logics underpinning SOGI conversion practices. For example, someone may offer conversion practices in the genuine or rhetorical belief that a particular sexuality or gender holds happiness. This does not have to mean that other sexualities or genders are inherently unhappy or dysfunctional, but rather that one sexuality or gender is seen as the most happy. The Institute

would no doubt be aware that advocates of conversion 'therapy' utilise a diversity of language to evade sanction. Limiting the focus to dysfunction may limit the reach of any legislation. As such, part (c) could be reworded to: "are based on a claim, assertion or notion that sexuality or gender diversity can be suppressed or changed".

While 1.3.24 suggests that the definition avoids describing specific acts, one must wonder if the language of SOGI conversion *practices* implicitly creates a focus on purposive acts (again, that are guided by the ideology of dysfunction), that may fail to regulate a more diverse understanding of conversion. Does online rhetoric, for example, that treats diverse SOGI as dysfunctional constitute a conversion practice? So if a media outlet, for example, repeatedly states that trans people are dysfunctional, is that not a form of conversion practice? We know that some trans people do not continue with a gender transition because of the pressure they receive from others to conform. Such pressure comes from family, but also from institutions such as the media. This pressure, while not a formal source of conversion practice, nonetheless serves the same ends.

**Q2. Should people be allowed to consent to SOGI conversion practices? If so, at what age and under what conditions?**

Given the broader ideological context in which conversion practices occur, it is not possible to make the case that an individual could truly give informed consent. Given pressures from family, friends, and institutions such as the media, any 'consent' to conversion practices is intimately enmeshed with broader ideologies. To be able to consent is to be able to assess available information without undue pressure to decide a particular course of action. Given the ideological force of anti-SOGI diversity sentiment, it is difficult to imagine a context in which an individual could make a decision free from this force.

**Q4. Do you think that Tasmanian law should be changed to address SOGI conversion practices? If so, should this be through comprehensive reform, amendment or both (a hybrid)?**

The evidence base shows that conversion practices are harmful regardless of where they are delivered or who they are delivered by. Therefore comprehensive reform is required, as is proposed by Victoria and that which currently exists in ACT.

An amendment, and particularly one added to an existing healthcare bill, limits the reach by focusing on a specific sphere of practice (such as that legislated in Qld). Given the ubiquity of conversion practices across many sectors, a comprehensive approach is required to ensure that all avenues to conversion practices are covered.

**Q8. Are there any other models or approaches that are preferable to, or should complement, changing the law?**

A good evidence-based peer support model could complement changes to the law and prevent and minimise harms. However, as stated in Recommendation 9 of the [APS Response to the Productivity Commission's Inquiry into Mental Health Draft Report](#), from a consumer safety perspective, it should be noted that the use of peer and lived experience workers in the construction or allocation of the psychological workforce, should be appropriately targeted and supervised, to ensure good clinical governance, especially with high risk groups (which

includes people who identify as LGBTQI+). While the APS notes the importance of psychosocial support, we emphasise that this should not occur at the expense of, or at odds with, appropriate clinical mental health care / treatment.

**Q9. Are there any other matters that you consider relevant to this Inquiry and would like to raise?**

The APS believes that the Victorian Change or Suppression (Conversion) Practices Prohibition Bill 2020 is a good example of how legislation should balance harm prevention with religious freedom. Furthermore, a good Code of Ethics, practices that are supported by a sound evidence base, and a set of boundaries in legislation will all help mitigate any risks associated with regulation/criminalisation that may fall short.