



**TASMANIA**  
**LAW REFORM**  
**INSTITUTE**

# **Sexual Orientation and Gender Identity Conversion Practices**

FINAL REPORT NO. 32

APRIL 2022

## **About the Tasmania Law Reform Institute**

The Tasmania Law Reform Institute ('TLRI') is Tasmania's peak independent law reform body. The TLRI was established on 23 July 2001 by agreement between the Government of the State of Tasmania, the University of Tasmania and the Law Society of Tasmania. The TLRI is based at the Faculty of Law at the University of Tasmania. The TLRI undertakes law reform work and research on topics proposed by the government, the community, the University and the TLRI itself.

The work of the TLRI involves the review of laws with a view to:

- The modernisation of the law
- The elimination of defects in the law
- The simplification of the law
- The consolidation of any laws
- The repeal of laws that are obsolete or unnecessary
- Uniformity between laws of other states and the Commonwealth.

The TLRI's Acting Director is Associate Professor Brendan Gogarty. For the purpose of this reference, the members of the Board of the TLRI are: the Honourable Justice Helen Wood (appointed by the Honourable Chief Justice of Tasmania); Professor Michael Stuckey (Faculty of Law at the University of Tasmania appointed by the Vice Chancellor of the University of Tasmania); Associate Professor Brendan Gogarty (Chair); Ms Kristy Bourne (appointed by the Attorney-General); Mr Craig Mackie (nominated by the Tasmanian Bar Association); Ms Ann Hughes (appointed at the invitation of the TLRI Board); Mr Rohan Foon (appointed by the Law Society of Tasmania); Ms Kim Baumeler (appointed at the invitation of the TLRI Board); and Ms Rosie Smith (appointed at the invitation of the TLRI Board as a member of the Tasmanian Aboriginal community).

The Board oversees the TLRI's research, considering each reference before it is accepted, making recommendations and approving publications before their release.

## **Acknowledgements**

This Final Report was prepared for the Board by Associate Professor Brendan Gogarty, Dr Martin Clark and Mx Ashleigh Barnes with the research assistance of Ms Siobhan Galea and Ms Lily Russell.

Disciplinary contributions to the preparation of the Issues Paper and Final Report to this Inquiry were provided by an Expert Advisory Group, Mr Stuart Davey; Dr Brendan Gogarty; Ms Anja Hilke-meijer; Associate Professor Amanda Neil; Professor Margaret Otlowski; and Dr Jessica Roydhouse.

Mr Chris Csabs and Rev Jeff Savage were community members of the Expert Advisory Group who provided guidance and feedback on the Issues Paper leading to this report. In line with

Institute protocol, community members do not participate in the preparation of the Final Report.

Ongoing administration and management of the Inquiry has been provided by Ms Kira White. Proof reading and editorial support was provided by Ms Denice Chang.

The TLRI wishes to thank all those who made submissions in response to the questions asked in the Issues Paper. All submissions were taken into account in formulating those recommendations.

An electronic copy of the Final Report is available at the TLRI website via the permalink <http://utas.edu.au/sogi-conversion-practices>

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## **Ethical Conduct of Research**

This Inquiry has been approved by the University of Tasmania's Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this Inquiry, please contact the Executive Officer of the Human Research Ethics Committee (Tasmania) Network on +61 3 6226 6254 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H0016752

## Executive Summary

This Final Report makes recommendations for reforms to Tasmanian law to address the risks and harms caused by sexual orientation and gender identity ('SOGI') conversion practices — 'conversion practices' for short.

Conversion practices involve a course of conduct that aims to change, suppress or eradicate the sexual orientation or gender identity (which, under Tasmanian law, includes 'gender expression') of another person.

SOGI conversion practices take various forms. All are motivated by common, intersecting beliefs [see 2.6.6–2.6.10]:

- There are fixed 'correct' SOGI attributes (normally heterosexual/cisgender); and
- That people with 'incorrect' SOGI attributes (normally LGBTQA+ attributes) have a fault or dysfunction; and
- That these attributes can and should be changed, suppressed or eradicated.

Conversion practice beliefs were once part of mainstream medicine. Those beliefs supported abusive physical, psychiatric and psychological practices that caused profound and lasting harm to LGBTQA+ people. They also contributed to social stigma and discrimination towards and abuse against sexual and gender minorities.

Conversion practices, and the beliefs that drive them, are now firmly rejected by mainstream science and medicine [see Chapter 4]. The mainstream medical consensus now is that:

- LGBTQA+ attributes are not faults or dysfunctions;
- Conversion practices lack efficacy (they are not successful in doing what they claim to do in a safe or reliable way); and
- Conversion practices involve serious risks of causing serious and lasting harm to those subject to them.

All peak health bodies and public health officers who responded to this Inquiry called for the regulation and prohibition of conversion practices, including the Australian Medical Association Tasmania, Australian Professional Association for Trans Health, Australian Psychological Society, Tasmania's Chief Civil Psychiatrist, the Tasmanian Gender Service, the Mental Health Council of Tasmania, the Royal Australian and New Zealand College of Psychiatrists, and Women's Health Tasmania [see 4.3.1–4.3.12].

Despite the consensus opposition, conversion practices continue, albeit on the fringes of the health profession as a form of medical malpractice, or now, more commonly, as a form of pseudoscientific or pseudo medical practice outside the clinical space. That may involve individual or group 'therapy', 'treatment', 'healing', 'counselling', 'mentoring' or other forms of 'study' programs. Promotion of the practices, or the underlying beliefs that motivate them also continues, despite them being discredited and known to generate risks for subjects.

A range of generalisable international and national studies indicate that conversion practices occur in Tasmania [see 3.2]. Respondent feedback to this Inquiry confirmed this [see 3.3–3.6]. Forty-six submissions reported people being offered or undergoing conversion practices in Tasmania. Some submissions from Tasmanian organisations and individuals stated or implied that they engage in these practices. Respondents also reported that the promotion of disinformation about conversion practices and the beliefs that motivate or support them led to

LGBTQA+ people submitting themselves to or being pressured to submit themselves to interventions which ultimately caused significant mental trauma and harm.

Nineteen submissions reported harmful effects. These effects were consistent with studies on reports of harm [see Chapter 4] and included: isolation from, and loss of trust in, religious leaders or medical professionals, low self-esteem, self-hatred, anxiety, depression, trauma, substance abuse, a reluctance to seek medical treatment, and suicidal ideation, suicide attempts, and suicides. These harms often last for many years and trauma can persist for life for survivors.

The United Nations Independent Expert on Protection Against Violence and Discrimination reported that conversion practices are ‘by their very nature degrading, inhuman and cruel and create a significant risk of torture’.

A large number of international jurisdictions have now proscribed conversion practices, have de facto bans, or are in the process of drafting or debating prohibitions [see 5.2.8]. Queensland, the ACT and Victoria have passed legislation proscribing conversion practices and legislation has been proposed in the other states.

A range of existing Tasmanian laws potentially already apply to conversion practices. However, the current law is unclear in scope and application. Clarifying the law will contribute to sustainable individual, social and systemic risk reduction.

Tasmanian law should be reformed to ensure people in Tasmania are aware of their rights and duties and that public offices are able to meaningfully respond to:

1. **Direct practices**, amounting to medical malpractice by health professionals or unsanctioned purported (conduct that emulates or mimics) health practices that occur outside of the clinical space or by non-health professionals [see 6.3].
2. **Indirect practices**, involving disinformation designed to convince others that certain sexual orientations or gender identities are faulty or dysfunctional and can and should be changed, suppressed, or eradicated [see 7.3].

Given the consensus agreement in the medical profession that sexual orientation is not a mental health disorder, a statutory prohibition on its clinical assessment or treatment is recommended. Gender identity must be similarly legally depathologised; however, law reform must not undermine, or have a chilling effect on supportive, evidence-based medical practice designed to support or treat mental health symptoms relating to gender dysphoria/incongruence.

Assessing and treating gender-related disorders should be regulated by clinical guidelines set by the Chief Civil Psychiatrist under the *Mental Health Act* in consultation with appropriate professional bodies. Accredited and authorised specialist health professionals who apply standards declared by the Chief Civil Psychiatrist in good faith should be exempt from liability other than under existing professional standards regulations. Professionals who do not intend to apply those standards should register a conscientious objection to them and refer a patient to a professional who will. This form of adaptive health service model will ensure the law is reflexive and responsive to advances in scientific understanding and clinical best practice.

People who are unqualified and unauthorised to conduct mental health assessments or care should be prohibited from doing so. That includes conduct that purports to assess the underlying ‘causes’ of a person’s lived or experienced SOGI or emulates treatment of a

person's feelings or functions. Tasmanian health law should be extended to proscribe all persons from engaging in such practices.

The Institute recommends amending the provisions of the *Anti-Discrimination Act* to clarify that indirect conversion practices are a form of incitement of hatred towards, serious contempt for or severe ridicule of another person or group of persons.

Complaint handling about direct conversion practices should be a matter for the Health Complaints Commission. Equal Opportunity Tasmania should handle complaints about indirect conversion practices.

Complainants should have access to civil liability schemes. In addition, criminal offences should be enacted as a last resort for SOGI conversion practices that cause serious harm. In both cases, conversion practices directed towards children should be categorised as a form of child abuse.

These proposed reforms do not affect:

- Legitimate health care, relating to SOGI, conducted by appropriately qualified health professionals, consistent with disciplinary standards declared by the appropriate chief health officer;
- Statements, expressions of faith, interpretations of moral, philosophical or religious doctrine about SOGI unless they involve the direct or indirect conduct set out above;
- Public acts done in good faith for academic, artistic, scientific or research purposes or any purpose in the public interest; or
- Supportive care, guidance, or mentoring of a child by a parent or guardian which are conducted in the best interest of the child.

These rights and duties are protected by existing legal exceptions or defences and/or new exceptions and defences recommended by the Institute to complement its other reform proposals.

In addition to law reform, funding and resources should be made available for educational materials and community organisation initiatives to inform the LGBTQA+ and religious communities and the general population about what SOGI conversion practices are, what they are not, why they are harmful and why they are now unlawful.

Reforming discriminatory systems that have developed around the misconception of gender and sexual normativity is necessary to correct historical injustice. It is fundamental to a more fair and equal society. In the case of conversion practices, reform is necessary to protect the basic rights to life, health and wellbeing of vulnerable members of the community.

## Recommendations

<p><b>1</b> Page 104</p>	<p>Tasmanian law should be reformed to address harms from Sexual Orientation and Gender Identity Conversion Practices.</p>
<p><b>2</b> Page 126</p>	<p>The <i>Mental Health Act</i> should contain an express provision that a person must not purport to or actually undertake an assessment or treatment of another person's sexual orientation.</p>
<p><b>3</b> Page 128</p>	<p>A provision should be added to the <i>Mental Health Act</i> to clarify that a person is not to be taken to have a mental illness by reason only of that person's gender identity or expression.</p> <p>For the avoidance of doubt, this recommendation does not extend to discussions relating to gender identity as part of a legitimate mental health service by an appropriately qualified health professional.</p>
<p><b>4</b> Page 129</p>	<p>Tasmanian health law should prescribe the professionals who may assess and treat mental health conditions relating to gender identity or expression (gender dysphoria/incongruence) and the clinical guidelines which must be adhered to as part of that care. Tasmanian law should prohibit persons who are not qualified professionals from purporting to assess (diagnose) or treat people in relation to their gender identity or expression.</p>
<p><b>5</b> Page 132</p>	<p>Tasmanian health law should be amended to stipulate that a person must not purport to or undertake any assessment or treatment of another person in relation to their sexual orientation* or gender identity unless they are expressly authorised to do so under a Standing Order and they act consistently with Clinical Guidelines under the <i>Mental Health Act</i>.</p> <p>The offence should be aggravated by continuing conduct or conduct directed to a child or vulnerable person.</p> <p>* Note that this will result in the general prohibition of all assessment and treatment of sexual orientation by virtue of the operation of Recommendation 2.</p>
<p><b>6</b> Page 137</p>	<p>A new provision should be included in Tasmanian health law (preferably the <i>Mental Health Act</i>) to allow public health officers, statutory commissions, welfare and guardianship authorities, judicial officers or police to</p>

	<p>receive, refer and report on complaints about unauthorised mental health or mental health-like assessment or treatment of SOGI attributes to the Health Complaints Commissioner or Ombudsman.</p> <p>The <i>Health Complaints Act</i> and <i>Ombudsman Act</i> should be amended to clarify the Commissioner may investigate any matter referred under the <i>Mental Health Act</i>.</p>
<p><b>7</b> Page 138</p>	<p>Direct SOGI conversion practices should be included as a purported health service under the <i>Health Complaints Act 1995</i> (Tas) clarifying, in Schedule 1 of the Act, that health services include ‘a course of conduct which is for, or purportedly for, the mental health assessment or treatment of another person in relation to that person’s sexual orientation or gender identity’.</p>
<p><b>8</b> Page 139</p>	<p>Section 20 of the Health Complaints Act should be amended to specify that:</p> <ul style="list-style-type: none"> <li>• A person is entitled to health care and services free of direct or indirect discrimination on the grounds of sexual orientation, gender identity; and</li> <li>• A person’s sexual orientation and/or gender identity are not pathological conditions, faults or dysfunctions.</li> </ul> <p>The Charter of Health Rights should be updated to include a specific reference to these health rights.</p>
<p><b>9</b> Page 141</p>	<p>The Health Complaints Commissioner should investigate and report all findings of direct SOGI conversion practices to the Chief Civil Psychiatrist.</p>

<b>10</b>	Section 19 of the <i>Anti-Discrimination Act 1998</i> (Tas) should be amended to clarify that a public act promoting conversion practices amounts to incitement of hatred towards, serious contempt for or severe ridicule of another person or group of persons on the grounds of sexual orientation and/or gender identity.
Page 157	
<b>11</b>	Tasmanian anti-discrimination law should be reformed to provide the Anti-Discrimination Commissioner with the discretionary power to cooperate and coordinate with other state offices in investigations into alleged SOGI conversion practices.
Page 158	
<b>12</b>	Section 63(2) of the <i>Anti-Discrimination Act</i> should be clarified to state considerations that may be relevant to the Commissioner’s decision to accept a complaint beyond the 12-month limitation period where the harm from a conversion practice is manifested beyond that 12-month period.
Page 159	
<b>13</b>	The <i>Civil Liability Act</i> should contain a new provision clearly setting out the elements of SOGI conversion practices under tort law.  This provision should clarify that a person acting in good faith and in accordance with Tasmanian health law is not captured by this definition.
Page 168	
<b>14</b>	The <i>Civil Liability Act</i> should be amended to include SOGI Conversion Practices as a form of child abuse for which organisations responsible for the care of a child are vicariously liable if the organisation did not take reasonable precautions to prevent an individual associated with the organisation perpetrating conversion practices on a child. The provision should become operative 24 months after the reform of Tasmanian law.
Page 169	

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A specific offence should be included in the *Criminal Code Act 1924* (Tas) to proscribe SOGI conversion practices that cause (or a person was reckless about causing) serious physical or mental harm.

This provision should clarify that a person acting in good faith and in accordance with Tasmanian health law is not captured by this offence.

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Adequate funding should be provided to community legal centres and medical, LGBTQA+ and religious organisations for education and support campaigns to inform their communities about changes in the law, what is and is not acceptable, and what avenues of redress may be possible for those who have been subjected to SOGI conversion practices.

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## List of Acronyms and Abbreviations

The following is a complete list of acronyms, abbreviations and key terms used in this Final Report:

Conversion practice	Sexual orientation and gender identity (SOGI) conversion practices involving conduct directed to changing, suppressing or eradicating a person or group's sexual orientation or gender identity [see 2.1]
LGBTQA+	Lesbian, Gay, Bisexual, Transgender, Queer, Asexual Plus
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual Plus
SOGI	Sexual Orientation and Gender Identity
SOGICE Survivors	Sexual Orientation and Gender Identity Change Efforts Survivors
TOR	Terms of Reference
TLRI	Tasmania Law Reform Institute



# About this final report

## 1.1. Background

- 1.1.1. This Final Report consolidates the Institute’s research and consideration of community and stakeholder consultation on Sexual Orientation and Gender Identity (SOGI) conversion practices. An explanation of what these practices are and the effects they have is set out below [on definition, see 2.2–2.7 and on effects see 4.5–4.7]. The Report follows the release of an Issues Paper by the Institute in late 2020. Based on that research the Institute makes recommendations for law reform to address the harmful and discriminatory aspects of such practices in Tasmania.
- 1.1.2. The request for an inquiry into SOGI conversion practices matter was first brought to the TLRI Board in 2016 by peak Tasmanian Lesbian, Gay, Bisexual, Transgender, Queer, Asexual Plus (LGBTQA+) stakeholder bodies and representatives. This Reference Group includes:
- Working It Out;
  - Rainbow Communities Tasmania;
  - Martine Delaney (individual);
  - Parents and Friends of Lesbians and Gays (PFLAG Tasmania);
  - Tasmanian Council on AIDS, Hepatitis and Related Diseases (TasCAHRD);
  - Tas Pride;
  - Bi Tasmania; and
  - Tasmanian Gay and Lesbian Rights Group.
- 1.1.3. The community reference process appears to have caused some confusion amongst respondents to the Issues Paper, insofar as some assumed it had been written at those groups’ direction.<sup>1</sup> This is not the case.
- 1.1.4. Requests for the TLRI to undertake a community reference are common. However, the Institute only accepts a limited number of such requests and only where there is demonstrable evidence of a problem that requires review and potentially law reform to respond to that problem. In this case the Board sought further information from both the referring bodies and other relevant public entities before determining to accept a reference and determine its terms. After obtaining

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<sup>1</sup> Submissions 2, 20, 21, 24\*, 31\*, 81, 98\*, 109C.

further evidence, the TLRI Board accepted the reference in July 2018, on the condition that it could be appropriately funded.

- 1.1.5. Once a reference is accepted, reference groups have no input into or influence over an investigation in any way other than making a submission to the Inquiry in the same manner that other persons or organisations are invited to do. Beyond that contribution a reference body has no involvement or influence in the research, writing, consultation, formation of preliminary views, or drafting of either an issues paper or final report, or any recommendations made to the TLRI Board. Nor does the TLRI accept benefits, financial or otherwise, from community reference bodies.
- 1.1.6. This matter is further discussed below in relation to the conduct of this Inquiry [see 1.3.1–1.3.6]

## **1.2. Terms of Reference (TORs)**

- 1.2.1. The accepted Terms of Reference for this Inquiry were to:
  - Define the nature, scope and meaning of SOGI conversion practices;
  - Review and consider peer-reviewed literature about the impact of SOGI conversion practices on people who are subjected to them and/or who have survived them;
  - Consider any other verifiable and authoritative data about the nature and prevalence of SOGI conversion practices in Tasmania;
  - Review and consider statements, policies and laws relevant to SOGI conversion practices in Australia and elsewhere;
  - Evaluate current laws that may be relevant to the prevention or regulation of SOGI conversion practices in Tasmania;
  - Consult with Tasmanians about their understanding, perception and experience of SOGI conversion practices;
  - Where necessary and possible, consult with experts from all relevant sciences about the impact of SOGI conversion practices on people who are subjected to them and/or who have survived them; and
  - Recommend appropriate regulatory and/or legislative responses to the evidence raised in the Inquiry.
- 1.2.2. Community references must be independently funded, either through a public grant, or funding from one of the three founding bodies of the Institute (the Tasmanian Government, the Law Society of Tasmania, or the University of Tasmania). In this case financial support was obtained from the Office of the Vice Chancellor of the University of Tasmania as a Founding

Body of the Institute in 2019. The TLRI Board subsequently framed Terms of Reference and the inquiry process began in 2020.

- 1.2.3. The Institute acknowledges that the process of establishing an evidentiary foundation to justify the Inquiry and its funding took some time. The Institute recognises and thanks the Reference Group and the broader interest groups and community for their patience, understanding and willingness to contribute to this process.

### **1.3. Conduct of Inquiry**

- 1.3.1. Following the acceptance of the reference by the TLRI Board, Institute researchers prepared a literature review, including a review of national and international laws relating to SOGI conversion practices. That review was used to identify the main subject matter areas requiring expert and community input, and the evidence base (including gaps) for the completion of an issues paper for community consultation. These areas of expertise were human rights and equal opportunity law; criminal law, public law and regulation; health science, epidemiology and statistical analysis; religious community leadership; and conversion practices survivor group leadership.
- 1.3.2. Based on the identified subject matters the Institute worked with the Tasmanian legal profession, and the Faculty of Law and the Menzies Institute for Medical Research (‘Menzies Institute’) at the University of Tasmania to form an expert advisory group with understanding, skills or expertise relevant to the Inquiry.<sup>2</sup> To avoid bias or influence no member of the Expert Advisory Group was a member of, or associated with the Reference Group [see above 1.1.2]. The TLRI did not inquire into the sexuality, gender identity or religious affiliation of any disciplinary experts although it did seek assurances there were no conflicts of interest. None were declared.
- 1.3.3. In addition, community representatives from religious and LGBTQA+ backgrounds that had experience in the area (namely having published or been involved in community work) were sought. Because Expert Advisory Group members cannot be part of or affiliated with community Reference Group bodies or entities (to avoid bias or influence), representation from outside of Tasmania — notably from the Brave Network — was sought and received. The Brave Network is a national support and advocacy group for LGBTIQ people of faith and allies.<sup>3</sup>

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<sup>2</sup> The Menzies Institute is a Tasmanian based, internationally recognised research institute that has, among other things, expertise in health science, statistics, epidemiology, and metanalysis. See further Menzies Institute for Medical Research <<https://www.menzies.utas.edu.au/>>.

<sup>3</sup> ‘Brave Network: Faith and LGBTIQ Inclusion’ <<https://thebravenetwork.org/>>.

- 1.3.4. In addition, the Institute sought a representative from the Uniting Church of Australia, the largest faith organisation founded in Australia and the nation's largest non-government provider of community and health services.<sup>4</sup> Notably, the Church is a 'multicultural' body<sup>5</sup> which has been a leading organisation within the Australian interfaith movement and is broadly accepting of Australia's multicultural, multi-faith, and community members of all backgrounds and identities.<sup>6</sup>
- 1.3.5. Community members of the Expert Advisory Group step down after the publication of the Issues Paper and do not participate in the preparation of the Final Report. This protocol is designed to avoid actual or apprehended bias in the review of submissions, and the preparation of draft recommendations for the TLRI Board. That process has been followed in this case.
- 1.3.6. Between July and September 2020 Institute researchers worked with the Expert Advisory Group to prepare an Issues Paper for community consultation. The Paper was reviewed by the TLRI Board and approved for public release in November 2020. The paper:
- Broadly described SOGI conversion practices, seeking community feedback on an appropriate definition of such practices for the purposes of Tasmanian law;
  - Summarised existing evidence, literature and survivor accounts of:
    - various practices aimed at changing, suppressing or eradicating sexual orientation and/or gender identity;
    - the harms such practices cause;
    - the efficacy of such practices;
  - Reviewed Tasmania's laws to consider whether any possible harms from SOGI conversion practices are adequately addressed and regulated;
  - Summarised law reforms in other jurisdictions relevant to SOGI conversion practices; and
  - Set out a series of questions for community consideration and feedback relevant to the formation of recommendations for this Inquiry.
- 1.3.7. A copy of the Issues Paper can be found on the Institute's website.

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<sup>4</sup> The Church identifies as 'the nation's only truly indigenous mainstream Christian movement': Uniting Church in Australia National Assembly, Submission No 1921 to Australian Human Rights Commission, *Freedom of Religion and Belief in the 21<sup>st</sup> Century* (March 2009) 2 <[https://humanrights.gov.au/sites/default/files/content/frb/submissions/Sub1921.Uniting\\_Church\\_National\\_Assembly.doc](https://humanrights.gov.au/sites/default/files/content/frb/submissions/Sub1921.Uniting_Church_National_Assembly.doc)>. See generally Uniting Church, 'About Us' <<https://www.uniting.org/about-us/the-uniting-church>>.

<sup>5</sup> Uniting Church in Australia National Assembly, 'The Uniting Church is a Multicultural Church' (May 1985) <[http://www.unitingjustice.org.au/images/pdfs/issues/community/assembly-resolutions/4\\_multicultural1985.pdf](http://www.unitingjustice.org.au/images/pdfs/issues/community/assembly-resolutions/4_multicultural1985.pdf)>.

<sup>6</sup> Uniting Church in Australia National Assembly, 'Summary of *Living With The Neighbour Who Is Different: Christian Faith In A Multi Religious World* (1997) <<https://www.assembly.uca.org.au/images/Ministries/ROF/images/stories/theology/livingsummary.pdf>>.

- 1.3.8. The TLRI invited responses to the Issues Paper, which could take a number of forms:
- By completing and submitting a survey instrument via the TLRI’s website, which contained optional questions on demographics as well as each of the Issues Paper questions on definitions of SOGI conversion practices and options for law reform.
  - By written response, responding to one or more of the questions set out in the Issues Paper.
  - By meeting with members of the TLRI.
- 1.3.9. The initial community consultation period for this Inquiry was timetabled for a six-week period. After a very high level of public interest in the Inquiry and a number of requests for extensions community consultation was extended to February 2021. Some late or amended submissions and supplementary material were accepted into early March 2021 with prior agreement.
- 1.3.10. After the community consultation closed, Institute researchers began reviewing, coding and analysing all submissions. That process which took several months.
- 1.3.11. In April 2021 the Institute prepared a set of law reform regulatory principles for continuing consultation with experts and public authorities. Over this period a general approach to law reform suitable to the Tasmanian legal system was considered and refined. The Board of the TLRI provided final approval for this report and its recommendations in March 2022.

## **1.4. Submissions to this Inquiry**

- 1.4.1. The Institute ultimately received 256 public submissions (125 written submissions and 131 online survey submissions). A joint submission endorsed by a petition with 377 signatures, calling for the prohibition of SOGI conversion practices, broadly defined, with a series of related submissions was also submitted to the Institute. The petition is included on the TLRI website.
- 1.4.2. After a process of review the final number of unique submissions (not including the 377 petition submissions) accepted was 182. Seventy-four submissions were rejected because they were:
- Empty or lacking any information that was readable or relevant to the topic or questions asked in the Issues Paper;
  - Duplicate to other submissions (including identical or substantially identical submissions made via different means by the same person or organisation, for example submitting both an emailed written submission and a survey response with the same text, or from identical IP addresses or ranges);

- Lacking sufficient basic data to allow the TLRI to determine the source or identity of the respondent, the type of submission, or the veracity of the submission; and
  - Empty, conflicting, or erroneous basic data such as name or address.
- 1.4.3. In particular a number of submissions were made that purported to be submitted by Tasmanian residents but metadata indicated they had been made from outside the state, including from overseas jurisdictions.<sup>7</sup>
- 1.4.4. TLRI undertook all reasonable efforts to resolve any uncertainties or conflicts about the identity of respondents, including contacting respondents and/or confirming electoral records, but where that was not possible the entirety of the submission was excluded.
- 1.4.5. Of the accepted 182 submissions:
- 118 were public;
  - 56 were anonymous; and
  - The remainder were either confidentially made, or did not specify their preference and the TLRI was unable to contact the respondent to confirm their preference.

## **Review process for submissions**

- 1.4.6. Public submissions are listed on the TLRI website. All submissions were reviewed by at least two TLRI staff. A significant number of written submissions were lengthy and not expressly framed as direct responses to the questions asked in the Issues Paper. Given the volume of material to be processed the University of Tasmania provided the Institute with a social science coding specialist, Ashleigh Barnes. The Institute is especially grateful for this expertise and assistance which ensured a large volume of data could be effectively reviewed, considered and integrated into this Final Report and its recommendations.
- 1.4.7. The Institute also recognises the substantial amount of time and effort that all respondents committed to the consultation process. It is clear from many submissions that the task of recounting painful and traumatic experiences imposed a significant emotional toll on many people. It was also clear that the broader subject matter evokes strong feelings for a wide range of community members. The Institute thanks all respondents who took the time to consider the Issues Paper and respond to its questions.

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<sup>7</sup> The Issues Paper and consultation survey instrument made it clear that the consultation was open to members of the Tasmanian community and people outside Tasmania with relevant knowledge, expertise or experience about the subject matter of the Inquiry: Tasmanian Law Reform Institute, *Sexual Orientation and Gender Identity Conversion Practices* (Issues Paper No 31, November 2020) x ('How to Respond') <[https://www.utas.edu.au/\\_\\_data/assets/pdf\\_file/0005/1415669/tlri-sexual-orientation-and-gender-identity-conversion-practices-issues-paper-2020.pdf](https://www.utas.edu.au/__data/assets/pdf_file/0005/1415669/tlri-sexual-orientation-and-gender-identity-conversion-practices-issues-paper-2020.pdf)> ('*TLRI SOGI Conversion Practices Issues Paper*').

## Reference to submissions in this Report

1.4.8. Submissions are referenced here by submission number, ordinarily in a footnote reference. The following nomenclature is used for individual submissions:

- A number without any tailing symbol is public and can be found on the TLRI website;
- An ‘\*’ after the submission number indicates the submission was made anonymously; and
- A ‘C’ after the number indicates the submission was made confidentially.

Consistent with the options outlined in the Issues Paper and on the survey instrument, in this Final Report, public submissions may be directly quoted or referred to and name the source. Anonymous submissions may be directly quoted or referred to but without naming the source. Confidential submissions are not directly referred to or quoted from, but are for general background and/or aggregated statistical data.<sup>8</sup>

Numbers above 125 indicate survey submissions, which are not publicly available. Due to software and licensing issues, data in the survey instrument could not reliably be reproduced online. Survey responses could not be converted to single documents that reflected the responses and comments of each survey respondent.

### *Naming of respondents*

1.4.9. During the course of this Inquiry individuals who were associated with the preparation of or contributions to the Issues Paper were targeted online and by telephone. In one case an Institute staff member’s private telephone appears to have been circulated amongst campaigners. Some attempts at personal communication were hostile, whereas others sought to influence the course of the Inquiry. Some members of the Expert Advisory Group were personally named and impugned in some respondent submissions.

1.4.10. The Institute emphasises that inquiries are a collective undertaking and no one person is responsible for this Report or the prior Issues Paper. Research conclusions are ordinarily settled by a relevant disciplinary expert(s) or the Director in the case of a disagreement. Recommendations are made by the Board by consensus.

1.4.11. Given the nature of submissions to this Inquiry the Institute has determined to not name individual respondents in this report itself. The Institute seeks to avoid the possibility that quotes or opinions listed here might be used as part of any targeted campaign against anyone who participated, regardless of their views or positions. Unfortunately, such campaigns occurred following the Issues Paper and publication of respondent submissions on the TLRI

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<sup>8</sup> See further *TLRI SOGI Conversion Practices Issues Paper* (n 7) x (‘How to Respond’).

website. The TLRI also aims to avoid perceptions of bias for or against certain individuals that might be inferred by the Institute choosing to name some respondents and not others.

- 1.4.12. As such the Institute refers only to respondents by descriptive qualities relevant to the matter being discussed. Submissions by organisations are explicitly named. Where an individual made a submission on behalf of an organisation, and the Institute could confirm that was done in an official capacity, the organisation rather than the individual is named.

#### *Consideration and use of submissions*

- 1.4.13. The Institute did not rank submissions other than to tag and categorise them for authoritative relevance (under a library of relevant keywords). Respondent submissions were chosen to be included in-text in this Final Report via these tags as a first point of assessment, rather than by author.
- 1.4.14. In general, the degree of consideration given to particular submissions on any topic was influenced by the demonstrable experience or expertise of the author relevant to the topic being discussed. Where the respondent was an organisation, particularly a representative one (e.g., a royal college), it was treated as generally authoritative on a topic. Individuals who have qualifications in a field of study relevant to the subject were also given special consideration (e.g., clinical psychiatrists). However, if an author or organisation did not have direct disciplinary expertise or qualifications, but there was evidence that their work or qualifications overlaps or intersects with the topic, their views were also given some weight (e.g., a health law scholar).
- For instance, a person with a PhD in economics who made submissions on the aetiology of gender identity would not be weighted sufficiently to be cited in text as they are not a doctor of medicine specialising in gender care.
- 1.4.15. Where the topic of discussion related to experiences or clearly articulated personal viewpoints, the most relevant consideration was whether the respondent lived in or had a clear connection with Tasmania.
- For instance, online submissions which were made from other states or countries that expressed the opinion that Tasmania should or should not change its laws were given less weight than those made by people living in Tasmanian or by people who had experienced conversion practices here.

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# SOGI CONVERSION PRACTICES: MEANING, NATURE & SCOPE

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Sexual orientation and gender identity (SOGI) conversion practices involve conduct directed to changing, suppressing or eradicating a person or group's sexual orientation or gender identity.

SOGI Conversion practices are driven by three **interrelated** beliefs.

1. Human SOGI is fixed to a normative, dimorphic archetype (normally heterosexual and cisgender);
2. SOGI attributes which diverge from the presumed normative archetype (in 1) *can be* changed, suppressed or eradicated via external or internal intervention;
3. SOGI attributes which diverge from the presumed normative archetype (in 1) *should be* changed, suppressed or eradicated.

SOGI conversion practices may be **direct or indirect** and conducted in a wide range of contexts and domains.

- **Direct conduct** involves interventions, procedures or actions aimed at bringing about change, suppression or eradication of the SOGI of another person or group of people.
- **Indirect conduct** involves actions aimed at convincing:
  - *Others* (i.e., LGBTQA+ people) that they can and should suppress or eradicate their own SOGI attributes.

- *Community members* that certain SOGI attributes can and should be changed so as to generate pressure on people with divergent SOGI to subject themselves to direct practices.

**Legitimate health care**, relating to SOGI, conducted by appropriately qualified health professionals, that is consistent with appropriate disciplinary laws and standards, and that does not pathologise SOGI attributes, *is not* a SOGI conversion practice.

**Statements, expressions of faith, interpretations of moral, philosophical or religious doctrine** about SOGI *are not* SOGI conversion practices unless they involve the direct or indirect conduct set out above.

**Supportive care, guidance, or mentoring** of a child by a parent or guardian which are conducted in the best interest of the child *are not* SOGI conversion practices unless they involve the direct or indirect conduct set out above.

# The meaning of SOGI conversion practices

## 2.1. Overview

2.1.1. The primary and overarching question referred to the TLRI is:

what, if any, reform is necessary to Tasmanian laws to deal with sexual orientation and gender identity ('SOGI') conversion practices?

2.1.2. A necessary precursor to responding to this question is identifying what SOGI conversion practices are and why they have become a subject of law reform.

## 2.2. Background to conversion practices

2.2.1. As discussed in the Issues Paper to this Inquiry, the term SOGI conversion practices (or 'conversion practices' for short) generally describes conduct aimed at changing or suppressing a person's feeling about themselves (commonly, their gender identity) or their feelings towards others (in particular, their sexual orientation). In most cases, the conduct is directed towards people who identify as or exhibit behaviours perceived to be associated with LGBTQA+ identity or orientation.<sup>9</sup> For example, a person might promise that, through meditation, another person could cease having homosexual desires and 'become straight'.

2.2.2. The stated and/or ostensible justification for 'converting' someone's sexual orientation or gender identity varies [see 2.6], but may ultimately be attributed to certain beliefs about biological sex, gender identity, and the behaviours and feelings that certain categories of people 'ought' to have or not have [see 2.6.6]. For example, some groups believe that people who are 'born female' should only be romantically attracted to people who are male, and should act, appear, dress, and adopt certain behaviours which that group expects of, and associates with, the female gender. Those groups may further believe that people who deviate from such expectations do so because they are somehow flawed and require intervention to make the person behave in a manner that is more consistent with the assumed normative gender role. Essentially such groups believe that such intervention is not only possible, but necessary [see

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<sup>9</sup> See, eg, D Haldeman, 'Sexual Orientation Conversion Therapy: Fact, Fiction, and Fraud' in Sari H Dworkin and Mark Pope (eds), *Casebook for Counseling: Lesbian, Gay, Bisexual, and Transgender Persons and Their Families* (Wiley, 2015) 297 <<https://onlinelibrary.wiley.com/doi/book/10.1002/9781119221715>>.

2.6.8–2.6.11]. In summary, all conversion practices are motivated by three intersecting, and intrinsically linked, beliefs.

- There is a normative, archetypal sexual orientation and gender identity for each human biological sex<sup>10</sup> [see 2.6.6]; and
- People whose sexual orientation or gender identity does not conform to the normative archetype (in belief 1) can be changed by intervention [see 2.6.8]; and
- Those people should pursue or accept such interventions to return them to a ‘normal’ or ‘natural’ (archetypal) SOGI status [see 2.6.10].

2.2.3. None of these beliefs are supported by contemporary science or consensus medical opinion in Australia. No peak health bodies that made submissions to this Inquiry supported these propositions. For instance, the Australian Psychological Society emphasised to this Inquiry that they are ‘strongly opposed any form of mental health practice that seeks to change a person’s sexual orientation or gender identity’ partly because there is no evidence base for the efficacy of such activities.<sup>11</sup> The Institute notes that this consensus position is relatively recent in the history of medical and behavioural science.

2.2.4. Beliefs about the normativity of human sexuality and gender identity were dominant in Western society, science and medicine until the latter part of the 20<sup>th</sup> Century.<sup>12</sup> This was, in part, because much research on human behaviour prior to this period began from the biased assumption that SOGI is binary, fixed and archetypal (that is heterosexual and cisgender). People who experienced or expressed attributes which deviated from this archetype were assumed to be suffering a mental or physical impairment due to an underlying fault or dysfunction of the mind or body.<sup>13</sup> The result was to focus historical health practice such as psychiatry towards discovering the causes of and ‘cures’ for SOGI attributes which deviated from the assumed norm. Such approaches reached their crescendo in international health science and clinical practice in the middle part of the 20<sup>th</sup> century.<sup>14</sup> Ultimately the research and medical interventions which arose from such approaches proved to lack efficacy and were unsuccessful in their aims [see 4.2–4.3]. More problematically they caused serious harm to

<sup>10</sup> The TLRI notes that this view automatically ignores the existence of biologically intersex people.

<sup>11</sup> Submission 18 at 2.

<sup>12</sup> Kenji Yoshino, ‘Covering’ (2002) 111 *Yale Law Journal* 769, 790

<sup>13</sup> Yoshino (n 12).

<sup>14</sup> Yoshino (n 12) 797; Jack Drescher, ‘A History of Homosexuality and Organized Psychoanalysis’ (2008) 36 *American Academy of Psychoanalysis and Dynamic Psychiatry* 443; Nancy H Bartlett, Paul L Vasey and William M Bukowski, ‘Is Gender Identity Disorder in Children a Mental Disorder?’ (2000) 43 *Sex Roles: A Journal of Research* 753; Victor Madrigal-Borloz, *Report on Legal Recognition of Gender Identity and Depathologization* (12 July 2018) UN Doc A/73/152  
<<https://www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/LegalRecognition.aspx>>.

subjects and contributed to social stigma and discrimination towards and abuse against sexual and gender minorities [see 4.5].

- 2.2.5. Over the past half century — and especially since the 1990s — biomedical and behavioural research on sexuality and gender has been reviewed and revised to correct for this implicit and cultural bias.<sup>15</sup> Contemporary, evidence-based research — particularly in the fields of sexology, psychology, neuroscience, and population studies — suggests that human gender identity and sexual orientation are complex, divergent, and are not easily capable of simple classification.<sup>16</sup> By consequence, the contemporary scientific view is that LGBTQIA+ attributes are part of natural variation and diversity in human populations. This has led to a significant revision in the approach to the way such attributes are dealt with in clinical settings and within public health policy.
- 2.2.6. Perhaps the most profound reversal in national and international health practice has been the ‘depathologisation’ of homosexuality (and, by proxy, bisexuality). This process was formalised in the declassification of homosexuality as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (which was and still is used by Australian health professionals to assess and treat mental illness) in the 1980s.<sup>17</sup>
- 2.2.7. Gender identity diversity has followed a similar trend of depathologisation to sexual orientation, albeit a more recent and slower one. The slower nature of the trend towards complete depathologisation is in part a consequence of the more complex biomedical and bioethical issues relating to the nature of gender identity, its connection with other disorders like gender dysphoria/incongruence, and the issues around gender reassignment treatments.<sup>18</sup> This is discussed below [see 6.3.18–6.3.19, 6.3.27 and Appendix B] but, put simply, contemporary science and medicine does not consider any gender identity or expression —

<sup>15</sup> Drescher, ‘A History of Homosexuality and Organized Psychoanalysis’ (n 14) 452, citing R Roughton, ‘Overcoming Antihomosexual Bias: A Progress Report’ (1995) 29 *American Psychoanalyst* 15, 15–16; L G Hoffman et al, ‘Homophobia: Analysis of a “Permissible” Prejudice’ (2000) 4 *Journal of Gay and Lesbian Psychotherapy* 5.

<sup>16</sup> C E Roselli, ‘Neurobiology of Gender Identity and Sexual Orientation’ (2018) 30(7) *Journal of Neuroendocrinology* e12; Zhana Vrangalova, Ritch C Savin-Williams, ‘Mostly Heterosexual and Mostly Gay/Lesbian: Evidence for New Sexual Orientation Identities’ (2012) 41 *Archives of Sexual Behavior* 85; Ritch C Savin-Williams, ‘An Exploratory Study of the Categorical Versus Spectrum Nature of Sexual Orientation’ (2014) 51 *Journal of Sex Research* 446; Lisa M Diamond, ‘The New Genetic Evidence on Same-Gender Sexuality: Implications for Sexual Fluidity and Multiple Forms of Sexual Diversity’ (2021) 58 *Journal of Sex Research* 818; Andrea Ganna et al, ‘Large-Scale GWAS Reveals Insights into the Genetic Architecture of Same-Sex Sexual Behavior’ (2019) 365 *Science* eaat7693; Robert Lickliter and Hunter Honeycutt, ‘Biology, Development’ and Human Systems’ in Richard M Lerner Willis F Overton and Peter C M Molenaar (eds), *Handbook of Child Psychology and Developmental Science* (7<sup>th</sup> ed, Wiley, 2015) 162; Melissa Hines, ‘Human Gender Development’ (2020) 118 *Neuroscience and Biobehavioral Reviews* 89.

<sup>17</sup> Homosexuality was removed as a disorder in its own right in the *DSM-III* with only distress about being homosexual (defined as ‘ego-dystonic homosexuality’) retained as assessable condition. Ego-dystonic homosexuality was also removed in *DSM III-R*. See further *Diagnostic and Statistical Manual of Mental Disorders* (3<sup>rd</sup> ed, American Psychiatric Association, 1980).

<sup>18</sup> For an overview of the process of depathologising gender diversity see Madrigal-Borloz (n 14).

including being transgender or non-binary — to be a mental or physical impairment, or a diagnosable disorder.

## **The social/medical/legal interface**

- 2.2.8. The paradigmatic shift in scientific and medical understanding of the human sexuality and gender identity, combined with decades of activism by LGBTQIA+ people, produced a shift in wider social attitudes and led to Australians becoming gradually more accepting, tolerant and protective of LGBTQIA+ people. It is likely that there has also been a reciprocal relationship between changing social, legal and medical attitudes to diversity in sexual orientation and gender identity.<sup>19</sup> Noting this, the shift away from discriminatory treatment of LGBTQIA+ people in all these domains is relatively recent.<sup>20</sup> Sexual and gender minorities continue to face discrimination and adverse treatment.
- 2.2.9. Progress towards equality and the removal of embedded discriminatory attitudes towards minority groups is ongoing across the world, including in Australia.<sup>21</sup> Reforming discriminatory legacy medical, social and legal systems that have developed around the misconception of gender and sexual normativity is part of this process.
- 2.2.10. Over the past decade a range of measures have been taken by international organisations, states (countries), subdivisions of states (e.g. federal states/territories), and international and national medical and health standards bodies to regulate or prohibit conduct aimed at changing or suppressing LGBTQIA+ attributes on the grounds that they are mental or physical impairments, dysfunctions or disorders.<sup>22</sup> The relative recency of this trend means that there is not a consistent approach to reform, or a universally accepted understanding of what conversion practices are.
- 2.2.11. Terminology differs across jurisdictions, as does where each draws the boundary between what might be described as a conversion practice and what might be considered acceptable conduct. As noted in the Issues Paper to this Inquiry,<sup>23</sup> different terms have been used to describe conversion practices; for instance ‘reparative therapy’,<sup>24</sup> which is now viewed as misleading and

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<sup>19</sup> Jack Drescher et al, ‘The Growing Regulation of Conversion Therapy’ (2016) 102(2) *Journal of Medical Regulation* 7, 8.

<sup>20</sup> Yoshino (n 12).

<sup>21</sup> This is reflected in reforms to state and Commonwealth law over the past three decades to protect attributes like sexual orientation and gender identity from discrimination, to provide rights to same-sex couples to be treated equally under law, and to allow people to legally change their gender on official records.

<sup>22</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) 30–36.

<sup>23</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) 8–9.

<sup>24</sup> Yoshino (n 12) 777.

problematic in its own right for both its suggestion that LGBTQIA+ people are in need of or can be ‘repaired’ and for its purported connection to medically-approved ‘therapies’.

- 2.2.12. There are also differing views about how broadly the term should be defined; that is, what sort of conduct and subject matters it covers and what it does not. This was evident in the responses to this Inquiry, more broadly in the literature, and in the differing approaches taken to describing conversion practices in the laws of other jurisdictions and the health policies adopted by national and international organisations.
- 2.2.13. Paradigm shifts in science are rarely absolute, and even less so in social science.<sup>25</sup> New scientific understanding which competes with older theories may ascend to become dominant, but adherence to legacy theories and the ideas which attach to them may remain for generations or longer.<sup>26</sup> Of course, new scientific knowledge may arise to complement or compete with the current paradigm. This is true of our current view of human sexuality and gender identity. The responses to this consultation, and the broader debate about sexuality and gender outside of it, indicate that a plurality of views remain about the nature of such attributes and their individual and social roles.
- 2.2.14. The need to protect and promote legitimate ethical scientific inquiry and debate is an important factor in defining what a conversion practice is (and equally importantly what it is not). So is the need to protect and promote legitimate, ethically appropriate health care practice, including health care that relates to or touches on sexual orientation and gender identity. These matters are discussed at length below [see 5.5.16–5.5.21].
- 2.2.15. Relatedly, describing what is and what is not a conversion practice necessarily involves consideration of fundamental principles such as freedom of expression and freedom of religion. Most mainstream religions set out theological rules relating to sexual conduct, gender roles and social conduct. Different religious groups expect different levels of compliance with rules by their adherents. Certain groups may also be actively involved in promoting their views on sexuality and gender to non-members or within the political domain more generally. The potential for, and concern about, such conduct being described as a conversion practice was raised by several respondents, often in the context of how broadly or narrowly SOGI conversion practices should be defined as a matter of health policy and/or law. Such considerations are not *always* strictly a definitional issue but may instead be a question of

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<sup>25</sup> Sharif Haider, ‘The Philosophy of Sensitive Social Work Research’ in *Sensitive Research in Social Work* (Palgrave MacMillan, 2022) 21, 21–37.

<sup>26</sup> Thomas Kuhn, *The Structure of Scientific Revolutions* (University of Chicago Press, 1962).

appropriate rights balancing.<sup>27</sup> Regardless, the intersection between conversion practices and religious and speech freedoms is evident and is dealt with in detail below [see 5.5.26–5.5.28].

2.2.16. In this Part the Institute sets out the meaning of ‘SOGI Conversion Practices’ based on respondent, expert and stakeholder feedback to its Inquiry and other relevant literature. It is important to note that this exercise is directed to settling upon and defining terminology for the purposes of this report — and by consequence its recommendations for reform — rather than prescribing, at this stage, a proposed legislative definition. That is because the model of any reform will affect how the concept is described and regulated.<sup>28</sup> However, the settled terminology does have a direct relevance to the recommended wording of any reform and questions of consistency and clarity of reform across the corpus of Tasmanian law.

### 2.3. TLRI working definition: terminology, test and elements

- 2.3.1. Describing the subject matter of this Inquiry involves addressing two interrelated definitional questions. The first is the term used to describe the subject matter.
- 2.3.2. ‘Sexual Orientation and Gender Identity (SOGI) Conversion Practices’ was adopted in the Issues Paper to this Inquiry because that terminology had been specified in its Terms of Reference. Nevertheless, the Institute recognised that there are differences of opinion about the appropriate terminology to refer to such practices and sought feedback on its appropriateness.
- 2.3.3. The second definitional question relates to the elements used to identify and classify certain conduct as falling within the meaning of the term.<sup>29</sup> In respect of SOGI conversion practices, the TLRI Issues Paper adopted the following test to identify what might be defined (or not defined) as conversion practices:

- acts or statements;
- that are aimed at changing, suppressing, or eradicating the sexual orientation or gender identity of another person; and

<sup>27</sup> That is, conduct might fall within the definition of a conversion practice, but still be permissible because it is a legitimate exercise of protected political speech.

<sup>28</sup> For instance, the broad concept of trespass is articulated in a variety of ways depending on which statute or common law context it is used (i.e. criminal, civil), and the subject matter to which those laws apply (e.g. land, property, person, and so on).

<sup>29</sup> For example, the term used for certain forms of regulated conduct on land is ‘trespass’, and its elements are a) intentionally entering or remaining on land; b) that is another person’s property; c) without the authority or consent of that person.

- are based on a claim, assertion or notion that non-conforming sexual orientation or gender identity is a physical or psychological dysfunction that can be suppressed or changed.

- 2.3.4. Only a small proportion of respondents specifically addressed the working definition and test directly. The majority of respondents tended to indirectly or partially respond to individual words used in the adopted term, or parts of the proposed test. In the main, respondents were satisfied or did not question the use of SOGI conversion practices as the appropriate term, but wished the definitional test to be broader, so as to capture a wider range of conduct. The Institute notes however, that this general consultative position was influenced by the high level of campaign submissions supporting Tasmania’s adoption of the SOGICE Survivor Statement as the principal basis for law reform.
- 2.3.5. This Section revises the working definition in the context of stakeholder and community feedback. The TLRI has chosen to summarise feedback under each of the conditional words (‘conversion’, ‘practices’) or adjective phrases (‘sexual orientation’, ‘gender identity’) that were specified in the Terms of Reference.

## 2.4. ‘Sexual Orientation and Gender Identity’ (SOGI)

- 2.4.1. The overwhelming majority of respondents agreed with the TLRI’s use of both sexual orientation and gender identity together in a general definition of conversion practices.
- 2.4.2. The definition of each attribute is set out below.

### Sexual orientation

- 2.4.3. Some participants specifically defined ‘sexual orientation’ to mean ‘gay’<sup>30</sup> or ‘homosexual’<sup>31</sup> with minimal or no reference to lesbian, bisexual, or other types of sexual identities.<sup>32</sup> However, the TLRI notes that Tasmanian Law — namely, s 3 of the *Anti-Discrimination Act* — defines sexual orientation to include (meaning the definition is not limited to):

- (a) heterosexuality; and
- (b) homosexuality; and
- (c) bisexuality.

The TLRI adopts this expansive definition.

<sup>30</sup> Submissions 136\*, 34, 105\*.

<sup>31</sup> Submissions 51, 52, 141\*.

<sup>32</sup> Submissions 7, 21, 27, 28\*, 34, 51, 52, 82, 93, 141\*, 142\*.

## Gender identity

2.4.4. A number of submissions were addressed to the inclusion of gender identity within the description (and term) ‘SOGI Conversion Practices’. These are set out below. Notably, no submissions suggested alternative meanings of gender identity. Section 3 of the *Anti-Discrimination Act* defines the term to mean:

the gender-related identity, appearance or mannerisms or other gender-related characteristics of an individual including gender expression (whether by way of medical intervention or not), with or without regard to the individual’s designated sex at birth, and may include being transgender or transsexual.

Under s 3, gender expression means:

any personal physical expression, appearance (whether by way of medical intervention or not), speech, mannerisms, behavioural patterns, names and personal references that manifest or express gender or gender identity.

The Institute adopts these existing Tasmanian legal definitions for this Final Report.

## The inclusion of both sexual orientation and gender identity in a definition

2.4.5. For some respondents, sexual orientation and gender identity were both central to their experiences of SOGI conversion practices in Tasmania, in that they had been subjected to conversion practices targeting both of these aspects of their identity.<sup>33</sup>

2.4.6. Around fourteen per cent of individual submissions to the Inquiry (approximately 4 per cent of total submissions) argued that gender identity should not be included in any definition of conversion practices in Tasmania.<sup>34</sup> A range of arguments were made to justify this position, but most commonly they were based on assertions that:

- Gender identity is ‘ideological’, compared to natal sex, which is a ‘biological reality’;<sup>35</sup> and relatedly
- Gender identity which is incongruent to natal sex is assessed and/or treated as a mental health condition, and that any law directed to changing or suppressing such a characteristic

<sup>33</sup> Submissions 1C, 110\*, 121, 126C, 129\*, 148\*, 159\*, 167\*, 168\*.

<sup>34</sup> Submissions 7, 8, 19, 34, 36\*, 43\*, 47, 50, 51, 52, 71, 72, 73, 74, 75\*, 77\*, 82, 107, 136\*, 140\*, 141, 142, 154, 166\*, 174.

<sup>35</sup> Submissions 12, 47, 52, 57, 66, 75\*, 76\*, 139\*, 174.

would improperly risk or interfere with clinically or otherwise medically acceptable health-care protocols.<sup>36</sup>

- 2.4.7. With respect to the first of these propositions, it is sufficient to note that neither contemporary health science nor the law concern themselves with the underlying bases of sexual orientation or gender identity. Indeed, both characteristics are afforded equal legal status as protected attributes under Tasmanian<sup>37</sup> and Commonwealth law,<sup>38</sup> without reference to the reasons people experience such attributes.
- 2.4.8. As the preamble to the Commonwealth *Sex Discrimination Act* notes, ‘every individual is equal before and under the law, and has the right to the equal protection and equal benefit of the law, without discrimination on the ground of ... sexual orientation, [or] gender identity’. Similarly, Principle 1 of the *Yogyakarta Principles* — which articulate universal human rights norms relating to human sexuality and gender identity — clarify that ‘sexual orientation and gender identity are integral to every person’s dignity and humanity and must not be the basis for discrimination’.<sup>39</sup> *Yogyakarta* Principle 2 defines discrimination to include ‘any distinction, exclusion, restriction or preference based on sexual orientation or gender identity which has the purpose or effect of nullifying or impairing equality before the law or the equal protection of the law’.
- 2.4.9. There is no conventional medical evidence that suggest a person’s experienced or expressed sexual orientation or gender identity have separate or different ‘causes’ that might support distinction or discrimination under law. No peak medical bodies, appropriately qualified medical or scientific experts submitted such evidence to this Inquiry. There is therefore not, in the TLRI’s view, any justification for distinguishing, excluding or restricting one protected characteristic from the scope of a potential legal protection on the purported grounds that each arises from a different source. Doing so would be a discriminatory act, contrary to the present position taken by the law and human rights norms.
- 2.4.10. The second point above [see 2.4.6] raises broader issues, not least because every person has the universal right to enjoy the highest attainable standard of physical and mental health.<sup>40</sup> Law reform should not undermine the right of persons to receive such care, or the capacity of health professionals to exercise their duty of care in accordance with appropriate clinical standards.

<sup>36</sup> See, eg, Submission 21 at 1.

<sup>37</sup> *Anti-Discrimination Act 1998* (Tas) s 16.

<sup>38</sup> *Sex Discrimination Act 1984* (Cth).

<sup>39</sup> *The Yogyakarta Principles: Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity* (March 2007) <[http://yogyakartaprinciples.org/wp-content/uploads/2016/08/principles\\_en.pdf](http://yogyakartaprinciples.org/wp-content/uploads/2016/08/principles_en.pdf)>.

<sup>40</sup> *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12 (‘ICESCR’).

- 2.4.11. Concerns about the potential for any law reform to interfere with appropriate care standards were expressed by peak medical bodies, and medical professionals.<sup>41</sup> For instance, the Royal Australian and New Zealand College of Psychiatrists — which supports legislating to prohibit SOGI conversion practices — noted the concern of some of their members about the need to ensure that ‘legitimate psychiatric treatment and the work of health professionals is not banned by any legislation’, particularly in relation to ‘individuals questioning their gender or considering treatment’ who need to be ‘appropriately counselled and supported using an evidence-based approach with reference to accepted professional standards’.<sup>42</sup> The Royal College explained this position on the grounds that ‘legislation in other jurisdictions could have, under some circumstances, been perceived to include some evidence-based psychiatric practice, even though the intent of the treatment may not be to change, suppress or eliminate an individual’s sexual orientation or gender identity.’<sup>43</sup>
- 2.4.12. Similarly, the Australian Medical Association Tasmania — which also supports legislating to prohibit SOGI conversion practices — emphasised that any legislation ‘must not come at the cost of good patient care’.<sup>44</sup> AMA Tasmania also expressed
- some concern as where the line is drawn on what constitutes conversion practices, when seeing a person with dysphoria ... there must be a safe space for doctors together with their patient to be able to explore issues relating to the patient’s sexual orientation or gender identity.<sup>45</sup>
- 2.4.13. The Institute accepts that gender identity remains a legitimate diagnostic consideration for the assessment of certain disorders in Australia. More generally the Institute accepts that gender divergent people may experience distress and trauma for a range of reasons — not least the ongoing social stigmatisation of them by much of society — which are relevant to certain specialist forms of healthcare (e.g. psychotherapy). People experiencing such trauma require support by suitably qualified and registered professionals, acting under appropriate clinical standards.
- 2.4.14. Noting this, advice from peak psychiatric and psychological bodies emphasised the difference between diagnostic consideration and diagnosable disorders.<sup>46</sup> No clinical standard in Australia

<sup>41</sup> Submission 5, 18 at 4, 90.

<sup>42</sup> Submission 5 at 2.

<sup>43</sup> Submission 5 at 2.

<sup>44</sup> Submission 90 at 3.

<sup>45</sup> Submission 90 at 2.

<sup>46</sup> As with homosexuality, gender identity has been removed as a diagnosable condition from the *Diagnostic and Statistical Manual of Mental Disorders*, which is used by Australian health professionals to assess and treat mental illnesses. It was replaced with ‘gender dysphoria’, which refers to the ‘incongruence between one’s sex assigned at birth and one’s gender identity’ accompanied by ‘clinically significant distress or impairment in

permits the assessment or treatment of gender identity or gender expression as disorders in and of themselves [see Appendix B]. Peak health bodies also expressed serious concern about the dangers of people being subject to medically unsanctioned and dangerous interventions in mental health care by non-specialists.

- 2.4.15. In the Institute’s view, concerns about clinical care and patient wellbeing are legitimate and important, but they are not definitional questions. Rather they are questions of regulatory design, implementation and communication. Recommendations for such reform are set out below [see Chapter 6].
- 2.4.16. In conclusion, the Institute’s view is that there is no basis to exclude either ‘sexual orientation’ or ‘gender identity’ from the definition of conversion practices. Doing so would confuse and conflate a personal attribute with a health condition. The subject of law reform in this instance is the reduction of harm to persons who have certain protected attributes from forced, coerced or unjustified conduct aimed at changing or suppressing those attributes.
- 2.4.17. This Final Report will continue to refer to both protected attributes together as is consistent with the practice in other jurisdictions, along with contemporary national and international policy documents. However, law reform recommendations may differ to ensure the law is appropriately tailored to the differences between each attribute. That includes the different ways in which conversion practices may be directed to each respective attribute and the manner in which they are presently dealt with (or precluded from being dealt with) by contemporary evidence-based health standards.

## 2.5. Conversion

- 2.5.1. The word ‘conversion’ means to ‘change in character, form, or function’.<sup>47</sup> In the context of the present subject the word is commonly used to describe conduct that seeks to bring sexual or gender divergence into conformity with perceived and assumed normativity. Another word that was historically used, especially by proponents and practitioners, was ‘repairing’ (i.e. ‘reparative therapy’).<sup>48</sup> That term is no longer considered appropriate given its implication that LGBTQA+ people are in any way broken and require fixing, and its suggestion that it is a

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social, occupational, or other important areas of functioning’. However, as the American Psychiatric Association (the publisher of the Manual) states ‘Not all transgender or gender diverse people experience dysphoria’ and ‘diverse gender expressions, much like diverse gender identities, are not indications of a mental disorder’: American Psychiatric Association, ‘What Is Gender Dysphoria?’ (November 2020) <<https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>>.

<sup>47</sup> *Macquarie Dictionary* (online at 1 December 2021) ‘conversion’ (n, def 3) <<https://www.oed.com/view/Entry/40777>>.

<sup>48</sup> Jack Drescher, ‘I’m Your Handyman: A History of Reparative Therapies’ (1998) 36 *Journal of Homosexuality* 19.

legitimate medical treatment. No respondent suggested returning to that terminology. Nor did any respondents to the Inquiry dispute the word ‘conversion’ in the descriptive phrase or suggest alternatives.

- 2.5.2. Conversion connotes a form of permanent and inherent change to the state of being of a person, be it their thoughts, feelings or behavioural drives. For instance, conversion may mean an attempt to ‘make a gay person straight’ so that they no longer feel same-sex attraction and only feel opposite-sex attraction. However, some practices reported within the literature, and to this Inquiry, accept that sexual or gender feelings may not be able to be permanently eradicated. In that case a conversion might involve convincing a person not to act on their feelings, for instance to be celibate or gender conforming.<sup>49</sup>
- 2.5.3. As the Institute highlighted in the Issues Paper, it is important to limit the scope of conversion so as only to target acts which genuinely aim to bring about change in another person’s state of sexual orientation or gender identity. The intent to exclude, stigmatise or otherwise treat such a person in a prejudicial way may be highly damaging, and described as discrimination, but that is not, alone and of itself, evidence of ‘conversion’.
- 2.5.4. In the second arm of its working definition, the TLRI set out the elements of ‘changing, suppressing, or eradicating’ to describe the purpose of conversion in relation to the subject matter. In the third arm of the working definition test, the TLRI proposed that conversion practices required evidence of an intent to convert, rather than simply discriminate, namely: ‘a claim, assertion or notion that non-conforming sexual orientation or gender identity is a physical or psychological dysfunction that can be suppressed or changed’.
- 2.5.5. No respondents raised issues with the second arm of the working definition test. However, a range of respondents made submissions about the third arm, and in particular its lack of reference to ‘conversion ideology’.

## **Ideology and belief**

- 2.5.6. Survivors of SOGI conversion practices have emphasised that SOGI conversion practices must be underpinned by a false ‘ideology’ which generally involves claims that being LGBTQA+ is a form of ‘brokenness’, or caused by trauma, and that it can be changed through physical, psychological or spiritual intervention. On this account, ‘conversion ideology’ is central to any definition of a SOGI conversion practice, and it is difficult or impossible to accurately capture the full range of possible SOGI conversion practices without reference to the ideas that underlie them and form a common characteristic to these various practices.

<sup>49</sup> Victor Madrigal-Borloz, *Practices of So-Called “Conversion Therapy”* (1 May 2020) UN Doc A/HRC/44/53, 13 <<https://undocs.org/A/HRC/44/53>>.

- 2.5.7. The Sexual Orientation and Gender Identity Change Efforts Survivors' ('SOGICE Survivors') *SOGICE Survivor Statement* describes this ideology to be that:

Humans are born with the potential of developing into heterosexual people whose gender identity reflects their sex assigned at birth. In [LGBTQA+] people ... this development has been halted or stunted due to ... abuse, neglect, inappropriate parenting dynamics, social influence, and even spiritual issues (including demonic influence) ... [LGBTQA+] people should live celibate lives or seek healing ... [t]hrough consistent long-term [acts of devotion, mentoring, abstinence, group counselling etc] ... a person will either: [e]xperience a change in their sexual orientation and/or gender identity, or [o]vercome the causes or drivers behind their same-sex attraction or trans-identity and remain celibate ... [LGBTQA+] people may not be suited to positions of authority within their faith community.<sup>50</sup>

- 2.5.8. The *SOGICE Survivor Statement* explains that this ideology is distinct from faith-based views as follows:

LGBTQA+ conversion practices can be recognised and distinguished from other practices that occur in faith communities using the [above] ideology as a reference point. Another lens through which to view conversion ideology is the false and misleading claims that it makes, none of which are grounded in factual, psychological, or scientific evidence, and are refuted by medical, psychological and secular bodies as being damaging and unfounded.<sup>51</sup>

- 2.5.9. Many submissions to the TLRI Inquiry supported including parts or the whole of the *SOGICE Survivor Statement*'s description of conversion ideology,<sup>52</sup> or urged that some reference to ideology more broadly should be included in law reform recommendations and any implementation of those recommendations in legislation.
- 2.5.10. Respondents who made such submissions argued that specific reference to ideology (either verbatim from the *SOGICE Survivor Statement*, or a similar formulation), is the most effective way of unifying the broad and disparate forms of conduct that seek to achieve similar ends under one test.<sup>53</sup> For example, the Tasmanian Council of Social Service (TasCOSS) submitted that it:

<sup>50</sup> Sexual Orientation and Gender Identity Change Efforts Survivors, 'SOGICE Survivor Statement' (July 2020) 3 <<http://socesurvivors.com.au/wp-content/uploads/2020/12/Survivor-Statement-A4-Doc-v1-2-Digital.pdf>> ('*SOGICE Survivor Statement*').

<sup>51</sup> *SOGICE Survivor Statement* (n 50) 3.

<sup>52</sup> Submissions 37, 42, 80, 93, 94, 111\*, 113, 168, 169, 175, 177, 179\*.

<sup>53</sup> For example, any practice, activity, or treatment (in any setting) that seeks, or is used, to target an individual's sexual or gendered identity, where that change is deemed necessary due to the instigator's belief in or adherence

acknowledges the SOGICE Survivor Statement definition of what practices are appropriately defined as conversion practices ... TasCOSS would encourage the TLRI to consider including spiritual dysfunction in their definition in order to capture the broadest range of conversion practices.<sup>54</sup>

- 2.5.11. It was similarly argued that specific reference to ideology is necessary to cover any potential gaps in law reform. Hence, one respondent stated:

conversion practices can not be isolated from conversion ideology. Any policy, regulatory, legislative, public health, or survivor support responses that separate the two will not adequately address the conversion movement.<sup>55</sup>

- 2.5.12. In contrast to the above respondents, others read element (c) as effectively targeting ‘ideology’, and argued against any reference to ideology on the grounds that it would infringe freedom of expression or religion. For instance, one respondent submitted:

Of particular concern is the intent within the definition to target specific ideology. Point c) of the working definition looks to a ‘claim, assertion or notion’ which can clearly be a ‘belief’ in traditional sexuality as understood by many members of the Tasmanian community, especially those who are faith-based. This would render normal actions (advice, counsel, or prayer) consistent with those beliefs illegal (refer discussion under Question 9 On Religious Freedom). In so doing the definition is explicitly categorising persons, including or excluding them from the ambit of any proposed legislation, based almost entirely on their belief system (or ideology).<sup>56</sup>

- 2.5.13. The same respondent argued that the inclusion of ideology would mean that any law reform was directed to preferencing some ideologies (i.e. conversion practice ideology) with others (i.e. gender affirming practice, which the respondent considered to be ideological):

This then leads to the incongruous outcome that extremely damaging conversion behaviour is protected purely because the belief or ideology of the person conducting it is inherently supported. An overzealous practitioner who incorrectly encourages a child into significant and life-changing surgery to support a non-conforming sexual orientation is entirely exempted. This is despite the consequences being far more catastrophic and irreversible ...

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to conversion ideology. This included the creation and distribution of misleading and pseudoscientific documents and the promotion, advertising or running of counselling or educational courses, training, retreats, camps, or any form of education, formal or informal, that claims to assist or be able to change someone’s sexual orientation or gender identity: these are and should be covered by the meaning of SOGI conversion practices. Other methods of practices noted by respondents included recommendations and referrals from practitioners for third party conversion ‘therapies’ or removal of children from a jurisdiction for the purpose of conversion practices. Submissions 85, 138, 10, 124, 141\*, 155, 10, 94, 125, 118, 173\*.

<sup>54</sup> Submission 80.

<sup>55</sup> Submission 111\*.

<sup>56</sup> Submission 68\*.

If it is not the intent of the TLRI to blatantly discriminate and target faith-based communities or other groups who hold traditional views of sexuality, then the definition should refrain from targeting specific ‘belief’ or ideology, and instead ensure it applies in an equitable way to conversion practices in any direction. The definition of conversion practices should be limited to those at the narrow end of the scale.<sup>57</sup>

## 2.6. The TLRI’s view on ideology and belief

- 2.6.1. The TLRI acknowledges that identifying the common drivers of disparate behaviour is essential to understanding and designing effective, responsive and evidence-based law, policy and educational responses that sustainably reduce the prevalence and risk of harmful behaviour. That is particularly the case where the drivers of harmful behaviour — such as racism, gender norms, implicit bias, stigma — are culturally entrenched within parts of the community or communities.<sup>58</sup>
- 2.6.2. The TLRI accepts that the *SOGICE Survivor Statement* appropriately identifies the drivers of conversion practices. The statement has also been carefully drafted to distinguish between personal or group beliefs and speech or acts that cause harm. This approach is generally consistent with the protection for religious freedom under Australian law.
- 2.6.3. The Institute prefers to reference the drivers as beliefs *simpliciter*, rather than ideologies. In an academic setting, ‘ideology’ has a number of contested definitions, but in general describes ‘ideas whose purpose is not epistemic, but political’.<sup>59</sup> The word also has strong political connotations in general use, often in a pejorative context to ascribe political motivation to conduct or groups.<sup>60</sup> This was reflected in a number of responses to this Inquiry from both supporters and opponents of law reform.<sup>61</sup> Views which contradicted some respondent’s understanding of sex and gender were described as ideologically motivated and hence politically biased rather than ‘true’.
- 2.6.4. The framing of competing views as ideological also meant that the subject of the Inquiry was sometimes viewed or represented as a clash between politics and religion, politics and science, politics and child welfare, and so on. In the Institute’s view such contests serve to distract from

<sup>57</sup> Submission 68\*.

<sup>58</sup> See further Eldar Shafir, *The Behavioural Foundations of Public Policy* (Princeton University Press, 2013).

<sup>59</sup> Christine Synowich, ‘Law and Ideology’ in Edward N Zalta (ed), *The Stanford Encyclopedia of Philosophy* (2019) <<https://plato.stanford.edu/archives/sum2019/entries/law-ideology/>>.

<sup>60</sup> Emmet Kennedy, ‘“Ideology” from Destutt De Tracy to Marx’ (1979) 40 *Journal of the History of Ideas* 353; Kathleen Knight, ‘Transformations of the Concept of Ideology in the Twentieth Century’ (2006) 100 *American Political Science Review* 619.

<sup>61</sup> See, eg, Submissions 27, 52, 57, 66 (opposing reform) and Submissions 110\*, 113 (supporting reform).

the focus of the Inquiry on evidence-based harm reduction. Ultimately the categorisation and attribution of the source of beliefs are, in the Institute's view, less important than describing the beliefs themselves when establishing a common definitional core to include and exclude certain conduct.

- 2.6.5. Given that is the case, the Institute considers that three intersecting and intrinsically linked beliefs are drivers of conversion practices.

### **Belief 1: Human SOGI is *fixed* to an archetype**

- 2.6.6. The core, foundational, conversion practice belief is the view that human sexuality and gender identity are fixed and normative. Most commonly, conversion practitioners believe that human beings are dimorphically heterosexual and cisgender. As such any sexuality or gender identity that differs from that archetype is abnormal, broken, diseased, disordered or deficient in a medical, moral or spiritual sense.<sup>62</sup>
- 2.6.7. In practice, this belief is manifested by assertions about the underlying 'causes' ('aetiology')<sup>63</sup> of LGBTQA+ sexual orientation and gender identity.<sup>64</sup> In respect of this Inquiry, such claims were predominantly made by respondents who are not recognised disciplinary (psychological, psychiatric, scientific or medical) experts or organisations.<sup>65</sup> This belief may also be evident in assertions or other forms of speech conduct directed to LGBTQA+ people that they need to 'fix', 'cure', 'get help for', or similar language suggesting that their feelings towards themselves or others are the result of a fault or dysfunction. Such pressure often comes from loved ones, close friends, trusted professionals, or religious leaders.<sup>66</sup>

### **Belief 2: SOGI *can* be consciously changed, suppressed, eradicated**

<sup>62</sup> See, eg, Douglas Haldeman, 'Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination' in *Homosexuality: Research Implications for Public Policy* (SAGE Publications, 1991) 149; Douglas C Haldeman, 'The Practice and Ethics of Sexual Orientation Conversion Therapy' (1994) 62 *Journal of Consulting and Clinical Psychology* 221; Kate Bradshaw et al, 'Sexual Orientation Change Efforts Through Psychotherapy for LGBQ Individuals Affiliated With the Church of Jesus Christ of Latter-Day Saints' (2015) 41 *Journal of Sex and Marital Therapy* 391. For practices reportedly in Australia, see Timothy W Jones et al, *Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia* (Human Rights Law Centre, 2018) <<https://www.hrlc.org.au/reports/preventing-harm>> ('*HRLC Conversion Therapy Report*'); *SOGICE Survivor Statement* (n 50)

<sup>63</sup> Aetiology in medical practice and science means an investigation into the causes or origins of a disease. The TLRI uses it here, albeit with the similar caveat to conversion 'therapies' that this inquiry into causes does not relate to a genuine 'diseases', because sexual orientation and gender identity are not diseases.

<sup>64</sup> *SOGICE Survivor Statement* (n 50) 3–4.

<sup>65</sup> For example, one religious leader responding to the consultation stated that as a preacher they are 'like a medical doctor who explains the disease so the patient can understand the need for treatment and be persuaded to take it'. Submission 3. Similar points were made in Submissions 2, 9, 14, 16, 17, 24\*, 26\*, 28\*, 32, 36, 37, 38, 39, 43\*, 44, 45\*, 48, 53, 55C, 57, 63\*, 64\*, 65, 67, 68\*, 70\*, 72, 83C, 88C, 96C, 100\*, 108, 109, 112\*, 124, 125, 138\*, 141, 146C.

<sup>66</sup> Submissions 126C, 155, 163\*, 165.

- 2.6.8. The second, related belief is that people whose sexual orientation or gender identity does not conform to the assumed normative archetype (in foundational belief 1) can be changed, suppressed, or eradicated by intervention. The elements of consciousness and intervention are important. Behavioural scientists have highlighted the fluid and diverse nature of sexuality and gender identity in populations and individuals.<sup>67</sup> That is, some people's sexual orientation and gender identity may naturally change over their lives. However, conversion practitioners adopt the position that such change may be coerced through external means.
- 2.6.9. In practice, this belief is manifested by assertions and representations that changes to a person's feelings are possible and probable through a proposed course of conduct. Such interventions or programs may be externally conducted or self-directed.<sup>68</sup>

### **Belief 3: Certain SOGIs *should* be changed, suppressed, eradicated**

- 2.6.10. Finally, conversion practitioners believe that people who do not experience or express SOGI attributes which conform with the assumed normative archetype (in belief 1) should necessarily change those divergent attributes through intervention (pursuant to belief 2).
- 2.6.11. In practice, this belief is manifested by conduct that encourages, pressures or coerces LGBTQA+ people to change, suppress or eradicate their expressed or experienced sexuality or gender identity. It may also be directed to the community around the LGBTQA+ person, with the aim of convincing that community that conversion is necessary for the health and wellbeing of such people. The result is to generate community pressure on LGBTQA+ people to change, suppress or eradicate their SOGI attributes, or foment discrimination against people who ostensibly choose not to do so. [see 3.4.2–3.4.4]

#### *Convincing others of beliefs is an indirect conversion practice*

- 2.6.12. Whilst the above three beliefs are drivers of the course of conduct which constitutes a SOGI conversion practice, they may also be integrated into the practice itself. That is, part of the process of converting another person often involves convincing that person to accept the beliefs

<sup>67</sup> Brendan P Zietsch et al, 'Genomic Evidence Consistent with Antagonistic Pleiotropy May Help Explain the Evolutionary Maintenance of Same-Sex Sexual Behaviour in Humans' (2021) 5 *Nature Human Behaviour* 1251; Pawel Tacikowski, Jens Fust, H Henrik Ehrsson, 'Fluidity of Gender Identity Induced by Illusory Body-Sex Change' (2020) 10 *Scientific Reports* 14385; Lisa M Diamond et al, 'Who Counts as Sexually Fluid? Comparing Four Different Types of Sexual Fluidity in Women' (2020) 49 *Archives of Sexual Behavior* 2389; A Ventriglio and D Bhugra, 'Sexuality in the 21<sup>st</sup> Century: Sexual Fluidity' (2019) 29 *East Asian Archives of Psychiatry* 30.

<sup>68</sup> Respondents explained that such messaging was often accompanied by representations about interventions or purported services to achieve such ends. These tended to be offered by religious leaders or health professionals who the respondent knew or suspected were associated with a religious entity: Submissions 3, 30, 37, 142, 85, 92, 93, 94, 105, 110\*, 113, 119, 120, 121 (Cases 1 and 2), 126C, 129\*, 136\*, 148\*, 159\*, 165, 167, 168, 173, 175. Some respondents reported experiences with SOGI conversion practices that had no apparent religious connection or motivation, or did not mention any religious connection in their account (predominantly, health practitioners with no clear religious connection): Submissions 1C, 29C, 34, 86, 91, 128, 130\*, 131, 132, 144C, 151, 155, 157\*, 163, 164\*, 165, 169, 177, 179\*, 180, 181.

above in order to voluntarily submit to a program aimed at changing or suppressing their sexuality or gender identity. This Final Report refers to this type of conduct as an indirect conversion practice.

2.6.13. Indirect conversion practices are discussed in detail [see below 3.6.7–3.6.9]. In summary, they involve a course of conduct which promotes false or misleading information about SOGI. That information is promoted to communities or the public at large with the intention of convincing people of conversion practice beliefs. That is, to convince:

- LGBTQA+ people that their experienced or expressed SOGI is the result of a fault or dysfunction and that it can and should be changed, suppressed or eradicated; or
- Others that LGBTQA+ people have a fault or dysfunction that can and should be changed, suppressed or eradicated. This may create social pressure from people who have power or influence over an LGBTQA+ person to convince that person to seek, accept or commit to harmful conversion practices.

An indirect conversion practice is typically conducted over an extended period of time. Children may be exposed to indirect conversion practices and the beliefs set out above, with the result that they are more likely to ostensibly voluntarily subject themselves to direct conversion practice later in life.<sup>69</sup>

*The beliefs are interlinked*

2.6.14. As noted, it is the TLRI’s view that each belief is integrally linked with the other beliefs in driving conversion practice conduct. This is fundamental to maintaining the distinction between harmful behaviour and freedom of conscience, religion and expression. The first belief must be accompanied by the second and third belief and expressed or acted upon in a course of conduct.

2.6.15. For example a person may:

- Believe and preach that sexual divergence from heterosexuality is ‘sinful’. That is not part of a conversion practice unless it is accompanied by assertions that a sexually divergent person can and should subject themselves to intervention to remove the ‘sin’.
- Assert that gender identity is an ideological construct. That is not a conversion practice, unless it is made as part of a purported clinical assessment of a person’s mental health and accompanied by the recommendation that the person undertake treatment to become gender conforming that would not otherwise be supported by contemporary medical professional evidence-based practice standards.

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<sup>69</sup> *SOGICE Survivor Statement* (n 50) 11–12: ‘Most survivors are exposed to conversion ideology from a young age and, although there are some exceptions, usually experience conversion practices when they are young adults or older. Most of the harm observed by SOGICE Survivors has been experienced by adult survivors.’

## The role of beliefs in law reform

- 2.6.16. The Institute does not consider that tailoring law reform to address potentially harmful behaviours that are driven by certain beliefs — or in this case a series of interrelated beliefs — serves to unjustly discriminate or disproportionately target any social, political or religious group. Understanding and articulating the drivers of behaviour, including beliefs, is a common and important part of justifying proportionately tailored laws.<sup>70</sup> For instance, laws on sedition, terrorism, domestic violence, hate speech, discrimination, blasphemy, and so on, are all responses to conduct grounded in ideological, religious or cultural beliefs which parliament(s) have considered are a risk to individuals or the community. Despite such laws burdening and regulating some groups more than others, their legitimacy derives from the targeting of the law to general classes of conduct that arise from a belief, rather than classes of individuals who hold that belief.<sup>71</sup>
- 2.6.17. The diversity of Australian society means that all laws, however generally articulated, will have differential effects on different people and different groups. If the touchstone of invalidity was divergent application alone the Parliament would be incapable of ever passing laws. As Waite CJ stated in the matter of *Reynolds v United States*, ruling that Mormons could not claim First Amendment free exercise of religion exemptions from anti-bigamy laws notwithstanding their genuine religious belief in polygamy;
- Can a man excuse his practices to the contrary because of his religious belief? To permit this would be to make the professed doctrines of religious belief superior to the law of the land, and in effect to permit every citizen to become a law unto himself. Government could exist only in name under such circumstances.<sup>72</sup>
- 2.6.18. This is not to say Parliaments should not be concerned about the unjustified or unforeseen burden of their laws on specified groups or individuals. The question is whether the legal response does only what is appropriate to reduce harm and is sufficiently adapted to avoid, as much as possible, infringement upon the rights and freedoms essential to a democratic, pluralist society. It is for this reason that the Institute acknowledges the beliefs which drive and unify conversion practices, and summarises them here for the purposes of law reform policy, but distinguishes that descriptive policy definition from a legislative one.

<sup>70</sup> *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 19 ('ICCPR').

<sup>71</sup> Hence, a law targeting communist organisations based solely on their political views is invalid, but one proscribing inciting people to overthrow the democratic government is not. That is the case even if the reason those speech acts are conducted is in pursuit of a communist ideology and the latter law was enacted in response to the perceived threat of communism. See *Australian Communist Party v Commonwealth* (1951) 83 CLR 1, 211–2 (McTiernan J).

<sup>72</sup> *Reynolds v United States* (1878) 98 US 145, 166 (1878).

## Understanding the drivers of conduct is important to evidence-based law reform

- 2.6.19. It is the position of the Institute that whilst it is entirely appropriate for a law to be designed around and justified in response to conduct which is driven by certain beliefs, it is not appropriate for the law to target that belief system itself. In practice that means that references to belief or ideology should, wherever necessary, be avoided in law.<sup>73</sup> Rather the law should be directed to general conduct which arise as a manifestation of those beliefs, however they are formed and whomever holds them. As noted in the Issues Paper to this Inquiry,<sup>74</sup> that distinction is consistent with conventional legislative approaches to balancing rights, freedoms and obligations.<sup>75</sup> It is also consistent with the position of the Courts on the need for laws burdening rights and freedoms to focus on conduct, decoupled from the underlying beliefs that such conduct manifests.<sup>76</sup>
- 2.6.20. In the Issues Paper to this Inquiry the Institute emphasised the need for laws (rather than the policies that inform them) to be addressed to conduct rather than the underlying beliefs that motivate it. In particular, the Institute would be concerned about the potential for laws to be too ambiguous and uncertain, and therefore undermine legal certainty for the public and investigative and enforcement bodies. This view was reinforced by Tasmania Police's submission this Inquiry:

It should be noted that offences that require ideological motivations are likely to complicate the process of police investigation and prosecution for activities that otherwise constitute unlawful behaviour. The TLRI is correct, in the view of Tasmania Police, to assert that law

<sup>73</sup> It is not, to the Institute's knowledge, common for the law to describe the metaphysical character of the beliefs which drive or motivate an act. Indeed, the Institute was only able to find scant reference to 'ideology' in Tasmanian or Commonwealth statutes: see, eg, *Terrorism (High Risk Offenders) Act 2017* (NSW) s 10(1A)(a): 'advocating support for a terrorist act or violent extremism includes (but is not limited to) any of the following: (i) making a pledge of loyalty to a person, group of persons or organisation, or an ideology, that supports terrorist acts or violent extremism ...'; *Criminal Code 1995* (Cth) pt 5.3 (terrorism) div 100.1 definitions: '**terrorist act** means an action or threat of action where ... the action is done or the threat is made with the intention of advancing a political, religious or ideological cause'.

<sup>74</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) 1.2.13–1.2.18.

<sup>75</sup> Anti-discrimination law looks to the conduct act of discrimination based on the prescribed characteristics of the person discriminated against. The underlying beliefs of a person that led to that discrimination are not relevant, except to act as an exception for certain forms of employment, education and training. See eg, *Anti-Discrimination Act 1998* (Tas) pt 4 div 1 (discrimination) s 14(3)(c): 'For direct discrimination to take place it is not necessary ... that the person who discriminates has any particular motive in discriminating'. See also at pt 5 (Exceptions and Exemptions) divs 8–9 (exceptions relating to religious belief, affiliation or activity, and exceptions relating to political belief, affiliation or activity).

<sup>76</sup> The law recognises 'a complete freedom of conscience in matters of religion': *A-G (NSW) v Grant* (1976) 135 CLR 587, 600 (Gibbs J) ('*Presbyterian Church Case*'). However, the manifestation of this freedom of conscience and freedom of religion may be limited by legitimate laws aimed at the 'protection of the community and in the interests of social order': *Adelaide Company of Jehovah's Witnesses Inc v Commonwealth* (1943) 67 CLR 116, 155 (Starke J) ('*Jehovah's Witnesses Case*').

enforcement agencies do not have the capacity or expertise to investigate or prosecute matters that require establishment of an ideological basis for an act ...

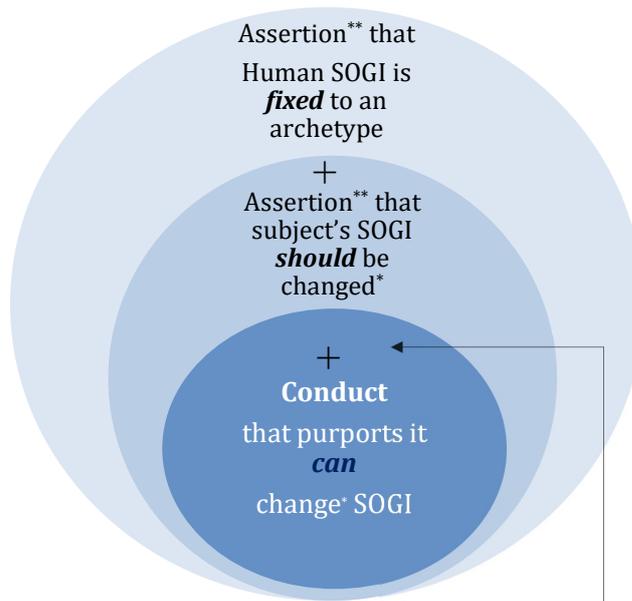
Noting that the TLRI has not reached the stage of defining SOGI conversion practices for the purpose of law reform, Tasmania Police asks the TLRI to continue to be cognisant of the very real difficulties of investigating and prosecuting ideologies.<sup>77</sup>

- 2.6.21. The Institute accepts that understanding the beliefs underlying SOGI conversion practices is essential to understanding their drivers, nature and character.
- 2.6.22. Given the Institute recommends an amendment approach to law reform, this policy definition is relevant to how respective laws are tailored in response to the drivers of harmful behaviour. For instance, the assertion of beliefs, in certain contexts, are directly relevant to discrimination law, but less relevant to criminal law, where harmful conduct alone is the appropriate criteria. Acknowledgement of the beliefs that drive conversion practices may also be important for situating legislative reform within a broader framework of social services, community education and governance. Finally, if the Parliament considered it appropriate, it might also choose to reject the beliefs which drive conversion practices in an objects clause, long title or preambular legislative statement.<sup>78</sup>
- 2.6.23. The TLRI remains convinced, however, that these points about conversion ideology, compelling as they may be in generally defining conversion practices, are not appropriate to include in statutory definitions adapted to the statutory regimes that the TLRI recommends be amended. The Institute emphasises that any law reform should be concerned with the conduct that causes harm, rather than proscribing beliefs which are the underlying drivers of that conduct.
- 2.6.24. In the below diagrams, a conversion practice for the purpose of targeted law reform would be the **conduct**, which is a manifestation of the beliefs which drive that conduct. Each individual belief would fall outside any law reform.

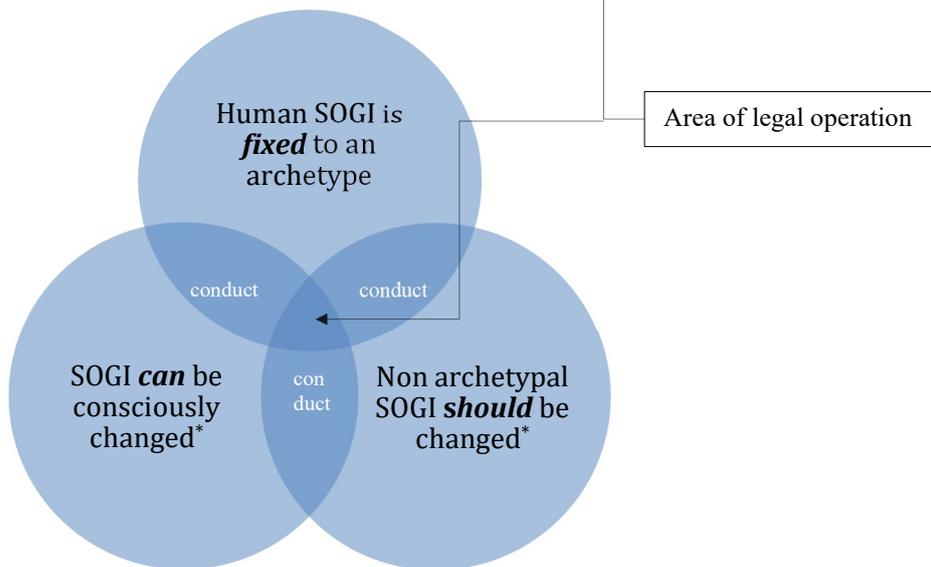
<sup>77</sup> Submission 25, at 2.

<sup>78</sup> This is the case in Victoria, where *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) s 3(2) 'affirms that a person's sexual orientation or gender identity is not broken and in need of fixing' and that 'no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming'. Notably, these rejections of conversion beliefs appear in the objects of the Act, not in the legislative definition of SOGI conversion practices themselves.

### Direct conversion practices



### Indirect conversion practices



\* 'change(d)' includes suppressing or eradicating. \*\* Assertions may be express or implied.

## 2.7. Practices

2.7.1. In defining practices, the TLRI made reference to ‘acts or statements’ in its working definition test [see 2.3]. In its summary of the acts or statements which have been described in literature or law as conversion practices the Institute listed the following conduct:<sup>79</sup>

- **Publications** — in particular publications containing statements in favour of the beliefs about sexuality and gender set out above [see 2.6.6–2.6.11]. These publications seek to stigmatise certain sexualities or gender identities as being the result of an impairment of the mind, body or spirit which requires external or self-directed treatment to correct. They aim to convince LGBTQA+ people they can and should change or suppress their expressed or experienced SOGI. They may also promote misleading information in the community, and generate social pressure on individuals to subject themselves to conversion practices. Such publications have been distributed in Tasmania, both by unsolicited letter box drop,<sup>80</sup> and electronically.<sup>81</sup>
- **One-to-one practices** — the most common conception of a conversion practice is conduct aimed at bringing about an actual change or suppression of another person’s SOGI delivered by one person to another. This may include purported ‘treatment’ regimes, psychological or psychiatric ‘counselling’ and ‘therapies’ by licensed medical practitioners or non-medical practices like faith-based support, spiritual guidance, or other religious ‘development’ activities.<sup>82</sup>
- **Group practices** — these are aimed at the same outcome as one-to-one practice, except that they occur in a collective or group environment. Commonly cited group practices include encouraging, pressuring or forcing subjects to attend prayer groups or scripture study groups that attempt to change or suppress sexual orientation or gender identity. It may also include viewing or listening to sermons, lectures or talks about LGBTQA+ people that are premised upon assertions that LGBTQA+ people are broken, sinful, immoral, pathological, or in need of fixing.<sup>83</sup>

<sup>79</sup> See *TLRI SOGI Conversion Practices Issues Paper* (n 7) [1.2.8]. Note that the material in the Issues Paper on ‘false claims’ is now covered under ‘conversion beliefs’: see [2.6].

<sup>80</sup> During the conduct of the Inquiry publications pathologising homosexuality and claiming that homosexual people can become heterosexual were distributed in Tasmania: ‘Outrage over Newspaper Promoting Anti-Gay Conversion’, *Pink Advocate* (online, 28 October 2020) <<https://pinkadvocate.com/2020/10/28/outrage-over-newspaper-promoting-anti-gay-conversion/>>.

<sup>81</sup> For example, Women’s Health Tasmania noted that ‘the phrase “healing homosexuality Tasmania” returns information about talks delivered in Hobart by the Executive Director of an international ministry working to encourage gay people to be celibate that is associated with the Catholic Church’: Submission 37 at 6.

<sup>82</sup> The TLRI understands from members of the Expert Advisory Group that most religious groups would not agree that such practices would constitute genuine counselling or pastoral care of adherents.

<sup>83</sup> The TLRI notes that prayer or scripture study groups will not necessarily involve SOGI conversion practices, and may cover all kinds of topics around religious doctrine and observance.

- **Intensive practices** — include the above one-to-one or group practices, but in concentrated time periods or delivery methods. These may include organised retreats, camps, online ‘courses’ and ‘conferences’ where intensive or systematic individual and/or group SOGI conversion practices are delivered and engaged in. Some of these activities involve intrastate, interstate or overseas travel to such events.
- **Aversion therapy** — is a discredited, pseudoscientific intervention involving associating a stimulus with unpleasant results, e.g.: electroshocks combined with images of homosexual intimacy.<sup>84</sup> This appears to largely be historical given it involves clear medical malpractice and physical harm.

2.7.2. Based on the feedback from the consultation below and the reports of conduct made in respondent submissions [see 3.3], the Institute considers that this list accurately describes the type of conduct that may amount to conversion practices, depending on the context in which it occurs. A range of negative treatment or discriminatory conduct that relates to sexual orientation or gender identity may not necessarily amount to conversion practices [see 3.6.2].

### **Respondent submissions on practices**

2.7.3. There was no objection to the TLRI’s use of ‘practice’ rather than ‘therapy’ and agreement with the point that ‘practice’ avoids the potential legitimisation that medical language confers. As explained by Women’s Health Tasmania:

Therapy is a word associated with processes and practices which treat or cure a disorder or a disease. Having a diverse sexuality or gender is not a disorder or a disease. Such confusion would be unhelpful in legislation framed to deter harmful practices.<sup>85</sup>

2.7.4. There was close to unanimous agreement among respondents (including those that opposed law reform) that any physically abusive act that attempted to change or suppress sexuality or gender identity, such as aversion therapy, did fall within the definition of conversion practices.

2.7.5. Thirty respondents expressed the view that ‘conversion practices’ should be narrowly defined to describe limited forms of physical conduct only. The common theme within these responses was the emphasis on physical harm or mental ‘abuse’.<sup>86</sup> Examples given were chemical castration, electric shock and forceful medication and aversion ‘therapies’.<sup>87</sup> Respondents in this category tended to emphasise that such conduct was historical and unlikely to be occurring in

<sup>84</sup> The TLRI notes that this is not a recognised medical or psychological therapy, is reportedly extremely rare today, and would be covered by criminal laws on assault or causing injury.

<sup>85</sup> Submission 37.

<sup>86</sup> Submissions 3, 7, 19, 20, 27, 45\*, 48, 65, 88C, 82, 60\*, 61, 63\*, 64, 65, 95\*, 99, 100\*, 116, 148\*.

<sup>87</sup> Submissions 3, 7, 19, 20, 21, 27, 28\*, 41, 43\*, 45\*, 48, 52, 60\*, 61, 63\*, 64\*, 65, 68\*, 72, 76\*, 82, 88C, 95\*, 99, 100\*, 109C, 116, 125, 141\*, 148\*.

contemporary Australia.<sup>88</sup> As a result their position was that either law reform was not necessary, or would need to be limited to a very narrow bandwidth of physical act.<sup>89</sup> For instance, the Australian Association of Christian Schools (AACS) submitted:

AACS is not aware of any Tasmanian Christian school having been involved in, or having offered or supported, any form of coercive SOGI conversion practices. It is important to clearly state that AACS does not support any coercive and abusive gay conversion practices. They are abhorrent. We acknowledge that some people have been deeply hurt through these terrible practices and they have no place in modern Australia. Whether there is a need for the Tasmanian Parliament to introduce new legislation to address these archaic practices is, however, questionable. There has been no compelling evidence provided by the TLRI that these abusive practices remain in use in Tasmania. And if they were, they would be covered by existing health regulations and professional standards, as stated in the Issues Paper.<sup>90</sup>

- 2.7.6. Whilst there was a general consensus that physically abusive practices should be illegal, there were differing views of what other conduct might be included in a definition (legislative or otherwise). This meant that some respondents considered ‘acts’ or, more appropriately ‘practices’, to be too broad without a suitable clarifying qualifier to limit the scope of the word to only that form of conduct.<sup>91</sup>

## Acts and statements

- 2.7.7. Many respondents were generally supportive of using ‘acts or statements’ in relation to conversion practices, noting that contemporary conversion practices take place almost entirely through oral communication (counselling, prayer groups) and thus statements are the general activity.
- 2.7.8. Some respondents who supported the inclusion of ‘statements’ believed this would help ensure the definition would include any suggestion, inducement or advertisement for SOGI conversion practices.<sup>92</sup> Those who considered it essential that ‘statements’ remain part of a definition highlighted the ‘deep harm’ caused by speech or publications that are ‘imbued with the ideology that LGBTIQ+ people are broken and can be fixed’.<sup>93</sup> Others made suggestions that the use of statements be qualified by a term like ‘ongoing’, ‘sustained’ or ‘continuing’.<sup>94</sup> This was demonstrated by a number of submissions that explain that it is the repetition of statements

<sup>88</sup> Submissions 63\*, 64\*, 88C, 99, 100\*.

<sup>89</sup> Submissions 48.

<sup>90</sup> Submission 44 at 5.

<sup>91</sup> See, eg, Submissions 27, 44 at 3, 57, 81 at 5.

<sup>92</sup> Submissions 80, 124.

<sup>93</sup> Submission 124 at 8.

<sup>94</sup> Submission 80.

and messages about sexual orientation and gender identity that lead to the sustained shaming and misinformation about the ‘causes’ or ‘nature’ of gender or sexual identity, which in turn causes long-term harm.<sup>95</sup>

- 2.7.9. Other respondents argued that the term ‘statements’ was too broad and needed further refining on what a ‘good’ or ‘bad’ ‘statement’ was, either by content or intent, and in what context.<sup>96</sup> The Civil Liberties Alliance pointed out that ‘statements’ is ‘vague and may be overly broad’ and suggested that the use of ‘practice’ or ‘treatment’ or ‘service’ or ‘sustained effort’, as in Canada, Malta, Victoria, the ACT and Queensland, would be preferable.<sup>97</sup> One submission stated that statements or conversations are not or should not be seen as harmful:

Statements can be ignored [*sic*]. If someone feels like they are trying to be convinced or changed by something said by another, they don’t have to listen. They can disagree and argue or debate it. Talking is not a conversion practice.<sup>98</sup>

- 2.7.10. Finally, some respondents were deeply opposed to the language of ‘statements’, mostly due to concerns about religious freedom of expression.<sup>99</sup> These respondents tended to note that ‘statements’ would increase the risk that any law on SOGI conversion practices would infringe on religious freedom and self-expression. They also expressed fears that simply talking about religious beliefs around sexuality and gender would be considered a conversion practice.

### *Course of conduct*

- 2.7.11. The TLRI agrees that broadly referring to ‘acts and statements’ without further definitional shaping may lead to legal uncertainty and potential overreach. As noted, the basis of the working definition was to start from a general position that allowed respondents to help shape any discrete, legally appropriate, definition. The TLRI notes that other recent State level reforms in Australia use the language of ‘practice’ (Queensland, ACT, Victoria), ‘conduct’ (Victoria only), or ‘treatment’ (ACT only), and none of these jurisdictions use ‘acts or statements’. As noted below [see 4.2.4 and 4.3], ‘treatment’ is best avoided because SOGI conversion practices are not recognised medical treatments.
- 2.7.12. For the final general definition, the TLRI has opted for ‘course of conduct’. The plural ‘acts or statements’ was used to indicate that a sustained series of acts and/or statements would usually be required; a single statement is not likely sufficient for a ‘practice’, partly because the harms of SOGI conversion practices is a function of their sustained application to a person. ‘Course of

<sup>95</sup> Submissions 1C, 42, 72, 85, 92, 113, 121, 163\*, 165.

<sup>96</sup> Submissions 43\*, 44, 65, 68\*, 86, 90, 97, 104, 109C, 116, 144C.

<sup>97</sup> Submission 86.

<sup>98</sup> Submission 33.

<sup>99</sup> Submissions 33\*, 43\*, 57, 97, 147C.

conduct’ captures the need for sustained conduct, but in a clearer way, particularly because ‘acts or statements’ might be read as referring to a wide variety of acts or statements, rather than also the repetition of them. ‘Course of conduct’ also has the advantage of being used in other areas of the law, namely criminal, consumer and industrial relations law, among other areas.

- 2.7.13. Notably, a course of conduct may include both acts and statements, but the focus is on the conduct as a whole. This avoids perceived overreach into expression of belief or opinion, and while a SOGI conversion practice could be entirely a series of statements, conduct emphasises that they be taken as a whole, and with a purpose in mind, which is perhaps less clear with the phrase ‘acts or statements’. ‘Course of conduct’ in a criminal statute has been defined as protracted or repeated acts,<sup>100</sup> though a single serious act may be sufficient.<sup>101</sup>
- 2.7.14. ‘Course of conduct’ also corresponds to criminal offences like ‘stalking and bullying’ in Tasmania. That provision is intended to apply to a wide range of possible acts, statements and behaviours that are linked by their harmful effects, where that harm is compounded by their sustained nature: a single offensive remark is not likely to amount to bullying, while a course of offensive remarks over a period of 12 months might.<sup>102</sup>

### **Conduct that should be expressly included**

- 2.7.15. Many respondents made reference to ‘formal’ and ‘informal’ contexts, using them to indicate ‘formal’ medical, psychological and counselling environments as well as ‘informal’ religious meetings or discussion groups.<sup>103</sup> Generally these respondents argued that specifying the wider situational contexts in which conduct may occur is essential to ensuring the broadest scope of any possible law.<sup>104</sup> For example, one submission explicitly encouraged a broad definition to capture practices within informal religious settings, which included ‘counselling, prayer, scripture reading, fasting, retreats and “spiritual healing”’.<sup>105</sup> Respondents mentioned other examples of SOGI conversion practices beyond individual or small group counselling or prayer sessions, including external religious support groups, conferences, rallies, online coursework, and online mentorship programs,<sup>106</sup> all of which specifically aim to change or work towards

<sup>100</sup> *Gunes v Pearson* (1996) 89 A Crim R 297.

<sup>101</sup> *Police v Nunn* [2021] TASM 3 (14 May 2021) at [38], regarding *Family Violence Act 2004* (Tas) s 9, ‘emotional abuse or intimidation’, which uses ‘course of conduct’.

<sup>102</sup> *Criminal Code 1935* (Tas) s 192. Note s 192(2), defining ‘course of conduct’ as follows: ‘a person pursues a course of conduct if the conduct is sustained or the conduct occurs on more than one occasion; and if the conduct occurs on more than one occasion, it is immaterial whether the actions that make up the conduct on one of those occasions are the same as, or different from, the actions that make up the conduct on another of those occasions.’

<sup>103</sup> Submissions 10, 42, 80, 85, 79, 111\*, 121, 124, 144, 153, 179\*.

<sup>104</sup> Submissions 93, 80, 111, 110\*, 124\*.

<sup>105</sup> Submissions 42, 144, 153\*.

<sup>106</sup> Submissions 37, 42, 111, 105\*, 121, 165.

more ‘acceptable’ sexual or gendered behaviours.<sup>107</sup> Similarly, a range of respondents urged the TLRI to specifically refer to informal, non-clinical and/or unregulated counselling in its definition of conversion practices.<sup>108</sup>

- 2.7.16. The TLRI acknowledges that conversion practices may occur in a range of formal and informal contexts, and sometimes move between these domains. However, TLRI considers that focusing broadly on conduct will serve to ensure that the broadest range of activity is captured, regardless of the context it occurs in.

### **Conduct that should be expressly excluded**

- 2.7.17. A range of submissions argued for the tailoring or explicit exclusion of certain conduct from any future legal definition of SOGI conversion practices. As discussed above, these arguments related to the confinement of conversion practices to conduct which was not:

- The provision of counselling, psychological support or health care;<sup>109</sup> and/or
- An expression of a religious, philosophical or personal/political view; and/or
- The exercise of parental/guardian rights to nurture or care for a child or guide a child’s development.<sup>110</sup>

- 2.7.18. For example, one respondent argued that:

Intentionally or not, [the TLRI definition] captures helpful counselling and psychological support for children, teens and adults struggling with gender dysphoria. It also captures spiritual counselling around sexual ethics and identity. Any proposal to ban conversion therapy must clarify that these practices are not conversion therapy, nor is religious instruction promoting healthy sexuality in line with biblical teaching. Any ban on conversion therapy must not lump the helpful with the harmful.<sup>111</sup>

- 2.7.19. As noted above the Institute agrees that there is a need to protect and promote evidence-based health care practices. That is especially true for vulnerable people or those who are experiencing distress, trauma or mental health symptoms. All people have the fundamental right to the enjoyment of the highest attainable standard of physical and mental health.<sup>112</sup> The Institute also agrees that the state has an obligation to protect freedom of religion and freedom

<sup>107</sup> Submission 42.

<sup>108</sup> Submissions 10, 41, 80, 82, 114, 122, 124, 138\*, 156, 167.

<sup>109</sup> Submissions 20, 41, 42, 79, 120, 121.

<sup>110</sup> ‘It appears that [under the TLRI’s working definition] even the children’s parents, grandparents, health professionals and others could face criminal charges if they, out of love and concern try to dissuade their love [sic] ones from going down the gender conversion therapy path.’: Submission 53 at 1.

<sup>111</sup> Submission 20.

<sup>112</sup> *ICESCR* (n 40) art 12.

of conscience, and only limit the manifestation of religion or belief in a justified and proportionate manner.<sup>113</sup> Finally, the Institute acknowledges the essential role of parents and guardians as carers and mentors of children. The state must respect the right of parents and guardians to educate their children in accordance with their religious and moral convictions.<sup>114</sup> However, the Institute does not consider that any of these rights, freedoms and responsibilities, or the associated state responsibilities, mean that conduct is not a conversion practice simply because it occurs within one or more of these broad domains.

- 2.7.20. As was discussed at length above [see 2.4.8–2.4.9, 2.6.18–2.6.19, 2.7.19], no right is absolute, particularly insofar as it is relied upon to justify conduct which the state considers harmful. To allow persons to claim their conduct is helpful rather than harmful based simply on their beliefs, their status as a parent,<sup>115</sup> or even their professional opinion is not sufficient to justify a practice, or take it outside the confines of ethical, clinical or legal responsibility.
- 2.7.21. As was also discussed above [see 2.2.3], the Institute shares the concern of peak medical bodies about the need to limit harm from unethical and unsanctioned conduct that is misrepresented as being medically sound or scientifically supported. That is, conduct should not fall outside the definitional scope of conversion practices simply because a practitioner claims that it is medically or scientifically sanctioned. The same applies to the legitimacy, efficacy and proportionality of claims that conduct is being conducted for parental or religious purposes.
- 2.7.22. Hence in the Institute’s view, no domain or area of conduct should be excised from the definition of conversion practices. Rather the question is whether the conduct is legitimately and principally pursued in the exercise of a protected right or duty rather than with the aim of bringing about a result that the state considers harmful. If it is, then the question is whether or not the conduct goes only so far in pursuit of the right or duty that is appropriate and adapted to the risk it poses to others. As noted, these considerations are most appropriately addressed as part of the exceptions or clarifications to law, rather than a matter of limiting the definitional scope of conversion practices more generally [see 6.4.19 and 6.4.25]

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<sup>113</sup> *ICCPR* (n 70) art 18.

<sup>114</sup> *ICCPR* (n 70) art 18(3).

<sup>115</sup> The Commissioner for Children and Young People in Tasmania stated that ‘[i]n light of the evidence of the harmful effects of SOGI conversion practices and authoritative human rights statements ... I cannot perceive a situation in which it could ever be in a child’s best interests to undergo SOGI conversion therapy. Accordingly, I would not support a situation where a parent of a child or a mature minor could consent to SOGI conversion practices.’: Submission 120 at 5.

# Are conversion practices occurring in Tasmania?

## 3.1. Overview of this part

- 3.1.1. The community consultation for this Inquiry provided strong evidence that SOGI conversion practices are taking place in Tasmania today. A total of forty-six submissions reported people being offered or undergoing conversion practices in Tasmania.<sup>116</sup>

## 3.2. Prevalence

- 3.2.1. As acknowledged in the Issues Paper, no data about the nature and prevalence of SOGI conversion practices in Tasmania exists. No scientific study has been published on the prevalence of SOGI conversion practices in Tasmania or Australia [see 3.2.6].
- 3.2.2. It is important to emphasise that ‘prevalence’ is used in its scientific and epidemiological, rather than everyday sense. A scientific study of ‘prevalence’ attempts to establish what proportion of a given population had been exposed to some practice or harm. Surveying people or collecting data on harm is not necessarily a prevalence study.
- 3.2.3. In place of scientific studies of prevalence, one Australian report offered an estimate of prevalence. The Human Rights Law Centre’s 2018 Report suggested that prevalence studies in the United Kingdom provide a fair comparison for likely prevalence in Australia.<sup>117</sup> That is because of similar demographic conditions with respect to religious observance and LGBTQA+ people.<sup>118</sup> Using the UK data the Centre considered the proportion of Australians who were

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<sup>116</sup> Submissions 1C, 3, 30, 37, 38, 42, 58, 60\*, 85, 89, 91, 92, 93, 94, 102\*, 105\*, 110\*, 111\*, 113, 119, 120, 121, 123, 126C, 130\*, 131, 132, 136\*, 141\*, 147C, 148\*, 151, 153\*, 154\*, 155, 157\*, 163\*, 164\*, 165, 169, 173\*, 175, 177, 180\*, 181.

<sup>117</sup> *HRLC Conversion Therapy Report* (n 62) 16.

<sup>118</sup> The comparison was based on statistics from the UK’s 2018 National LGBT Survey that showed that 2 per cent of respondents had undergone conversion practices and a further 5 per cent had been offered conversion practices. Respondents from ‘multicultural and multifaith’ backgrounds in the UK were up to three times more likely to be have experienced conversion practices than white and non-religious respondents. Government Equalities Office, *National LGBT Survey: Research Report* (2018) 83–94 <[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/721704/LGBT-survey-research-report.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf)>.

active members of conservative religious bodies that promote or are likely to promote conversion practice literature or services.<sup>119</sup> Based on these comparators, the Centre estimated that ‘up to 10% of LGBT Australians are still vulnerable to harmful conversion therapy practices’,<sup>120</sup> and the same percentage of Australians as a general population may be subject to the promotion of conversion practice ‘ideology’.<sup>121</sup>

- 3.2.4. The Centre’s estimates were questioned by a number of respondents.<sup>122</sup> This was based both on the method the Centre used to arrive at its estimate and assertions that the Centre is an ‘advocacy group’ for sexual and gender minorities.<sup>123</sup>
- 3.2.5. The Institute recognises that the Human Rights Law Centre’s estimate of prevalence is based on the overlap between the general estimate of ‘extremely or very active’ religious people in Australia, and the general percentage of LGBTQA+ people in Australia. This is a choice made by the Centre for the purposes of estimation and in the absence, at that time, of sufficiently specific population data. As a result that estimate may not necessarily capture the precise cohort of people likely to be exposed to SOGI conversion practices. Rather, it provides a probable upper limit for *possible* exposures. The probabilistic nature of the Centre’s estimate was made clear in the Issues Paper to this Inquiry.<sup>124</sup> In particular, the TLRI noted that such estimates suggested that such practices may be taking place in Tasmania, given the general structural and social homogeneity of the Australian population across the federation.
- 3.2.6. Since the Issues Paper was released, national reports and studies have provided more robust estimations. Jones et al (2021) provides a better account based on a large sample survey to suggest that SOGI conversion practices are taking place in Australia.<sup>125</sup> As noted below [see 4.4.48–4.4.51] that study advances our understanding of hidden practices in Australia, but would not meet the criteria of a prevalence study. Rather it is better categorised as a large nationwide survey.
- 3.2.7. Most importantly, the need for assumptions based on general population estimates in the Issues Paper has been reduced by evidence submitted to this Inquiry. Respondents have provided strong evidence through personal testimony that SOGI conversion practices are taking place in

<sup>119</sup> *HRLC Conversion Therapy Report* (n 62) 16.

<sup>120</sup> *HRLC Conversion Therapy Report* (n 62) 3.

<sup>121</sup> *HRLC Conversion Therapy Report* (n 62) 19.

<sup>122</sup> Submissions 12, 21, 27.

<sup>123</sup> Submission 21.

<sup>124</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.3.2]–[2.3.3] and accompanying footnotes.

<sup>125</sup> Tiffany Jones et al, ‘Religious Conversion Practices and LGBTQA+ Youth’ [2021] *Sexuality Research and Social Policy* <<https://link.springer.com/content/pdf/10.1007/s13178-021-00615-5.pdf>>.

Tasmania. This is not the same as a prevalence study, and as noted in the Issues Paper the TLRI was not resourced or competent to undertake such an investigation.

3.2.8. In the Institute's view, law reform should not be contingent upon identifying the exact number of people in the community who are affected by harmful behaviour. That is especially the case when that behaviour is understood to be subverted or hidden within subsets or units of the population. Rather, the most important considerations are:

- Whether harmful behaviour is likely to have occurred or may be still occurring;
- What the nature and degree of harm, or risk of that harm, is;
- What law reform is necessary to remedy or prevent that harm.

3.2.9. In the Institute's view there is sufficient evidence from the literature and this Inquiry that conversion practices are taking place in Tasmania, that they have caused harm to people in Tasmania, and that they will continue to take place and risk causing further harm if they go unregulated.

### **3.3. Evidence that conversion practices are taking place in Tasmania**

3.3.1. Respondents to the Issues Paper were invited to provide personal, anecdotal evidence about the existence of SOGI conversion practices in Tasmania. Question 3 asked if a respondent had been involved in, offered, or heard about others being involved in or offered SOGI conversion practices, and if so what the harms were.

3.3.2. Forty-six submissions reported people being offered or undergoing conversion practices in Tasmania.<sup>126</sup> Submissions which directly addressed this question provided a detailed picture of how and by what methods SOGI conversion practices are conducted in Tasmania.

3.3.3. Submissions by both practitioners and survivors are presented in two categories. First, the experiences of SOGI conversion practices by non-medical practitioners, predominantly religious leaders. Second, the experiences of SOGI conversion practices by healthcare professionals. Respondents' accounts of the efficacy and effects of SOGI conversion practices on people in Tasmania will be covered in Parts 4.5 and 4.6.

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<sup>126</sup> Submissions 1C, 3, 30, 37, 38, 42, 58, 60\*, 85, 89, 91, 92, 93, 94, 102\*, 105\*, 110\*, 111\*, 113, 119, 120, 121, 123, 126C, 130\*, 131, 132, 136\*, 141\*, 147C, 148\*, 151, 153\*, 154\*, 155, 157\*, 163\*, 164\*, 165, 169, 173\*, 175, 177, 180\*, 181.

### 3.4. Practices outside of clinical settings

- 3.4.1. Many pseudonymous, anonymous or confidential submissions provided experiences of SOGI conversion practices in Tasmania, primarily undertaken by non-medical practitioners.<sup>127</sup> These were generally conducted by people in positions of power or influence, such as religious leaders, educators or other community leaders who were believed to have responsibility for the care of young people. A common theme was the promotion and conduct of conversion practices within pseudo-medical contexts (counselling, psychological support and care) by people who are not appropriately qualified health professionals. Some submissions reported loved ones, friends, professionals, or religious leaders pressuring them to ‘fix’ or ‘correct’ their LGBTQA+ feelings or status on the grounds that they are unnatural, dysfunctional and the product of a mental, physical or spiritual impairment.<sup>128</sup> Submissions from survivors and their friends and relatives confirmed this connection or overlap between spiritual guidance and pseudo-health practice.

#### Pressure to treat or fix SOGI

- 3.4.2. Some submissions reported confiding in loved ones, friends, professionals, or religious leaders about the person’s sexuality or gender identity, which led to significant pressure from those people to undergo some form of ‘treatment’ or ‘therapy’ to ‘fix’ or ‘correct’ those identities or orientations, instead of being affirmed or supported by these trusted people.<sup>129</sup> For example, one anonymous submission stated:

I have been offered (but not accepted) forms of SOGI conversion practices in Tasmania ... An evangelical priest who considered my exorcism would lead to my ‘saving’ and conversion, leading me to be ‘a happily married man with children’. It happened at the [struck Hobart church]. I had been in a car accident and had injured my neck. Noting my brace, the priest said that my ‘sexuality’ is the cause of sin and he could take the sin from me restoring me to full health. I was stressed as at this stage I was still struggling to come to terms with who I was, let alone be a practicing gay man. I am not aware I had actually ‘come out’ to anyone. It left me feeling exposed, frightened and probably led to another few years of being closeted and depressed.<sup>130</sup>

<sup>127</sup> Submissions 2, 3, 9, 14, 16, 17, 24\*, 26\*, 28\*, 32, 36, 37, 38, 39, 43\*, 44, 45\*, 48, 53, 55C, 57, 63\*, 64\*, 65, 67, 68\*, 70\*, 72, 83C, 88C, 96C, 100\*, 108, 109, 112\*, 124, 125, 138\*, 141, 146C.

<sup>128</sup> Submissions 126C, 155, 163\*, 165.

<sup>129</sup> Submissions 126C, 155, 163\*, 165.

<sup>130</sup> Submission 173\*.

- 3.4.3. Transforming Tasmania provided the following anonymous account of a 25-year-old trans person, who experienced exclusion from his religious community during secondary school, presumably approximately seven to ten years ago. His faith community encouraged the suppression of his gender identity by a demand to remain ‘abstinent’ from expressing that identity, or face exclusion from the community:

My faith is a huge part of who I am. It’s the foundation of me. Back when I was at [struck education provider], I wanted to join a social group for my faith, and since service to others and the community is a core value of my faith, I wanted to be an active part of that group. For a while, it was great — I was part of the group’s music crew and volunteered at events, and it seemed to be a really warm, loving community dynamic.

And then they found out I was trans.

Suddenly I got booted out of the music crew and got banned from volunteering. I was told by the group’s leadership that I could still be a member, but only if I ‘abstained’ from being who I am and didn’t ever mention it again. They prayed for me to be ‘healed’.

The sense of whiplash was incredible. Being cut off from my faith community so suddenly, it was like I couldn’t breathe. They said I could rejoin the music crew, on the condition that I denounced my identity publicly and went to regular ‘healing’ prayer sessions. For a while I tried to continue attending the group’s events, pretending I was a good little cis-het girl just to be there, but I couldn’t keep it up. Everyone had suddenly become so cold, and knowing that my acceptance in that community was contingent on me lying about who I am — that damage was done. I couldn’t be at home there anymore, and I couldn’t trust any of those people. It hurt so bad, like my family had died but was somehow still standing around making small talk with each other.

It totally destroyed my self worth, I hated myself. I started drinking myself into oblivion every night, sleeping with strangers compulsively and putting myself in unsafe situations. I thought I deserved to suffer, and I was going to hell anyway, so I might as well get there a bit quicker.

I guess I’m one of the lucky ones, in that it didn’t end up actually stopping me transitioning, and I made it to a better place eventually. But I lost so much.

Honestly, I still don’t trust any faith groups. I haven’t been able to be part of any since. I don’t know how to find a church community where I’ll be able to feel safe, and not like they might suddenly turn on me. My faith is still the core of my identity, but trying to find other people to share that with is too much for me most of the time.<sup>131</sup>

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<sup>131</sup> Submission 121 ‘Ben’.

- 3.4.4. Survivors reported that messages about the need to fix or correct SOGI from persons of trust and authority usually occurred over long periods of time. A 28-year-old trans person reported through Transforming Tasmania that they had confided in a trusted pastor that she was trans, and received pastoral counselling and focused bible study to ‘fix’ her.

When I — utterly terrified — finally told my pastor I was trans and asked him if there was any hope for me, his tone didn’t really change. He’d always been worried for me, and he stayed as gentle and kind as he’d always been. But gently, kindly, he told me that queerness was a kind of spiritual brokenness, and I needed to be healed—and it was part of his calling to help me find my way back to ‘what God intended’ for me.

To have the main authority and parental figure in my life tell me that who I was was fundamentally wrong, and corrupted by the Devil? Saying out loud all the things my anxiety and depression had been saying inside my head? I can’t explain what that felt like. Multiple times a week, we would have one on one ‘bible studies’ that were all about convincing me to change my sinful heart and let God heal me. The other emotional and material help my pastor had been giving me all stopped.

My girlfriend got taken in for compulsory ‘faith counselling’, too. They told her she had to break up with me, that she wasn’t the right person to guide me back to righteousness, and that if she wanted to stay at that church she wasn’t allowed to talk to me or sit with me during services any more. She needed the church community, so she stopped talking to me. I don’t blame her.

A month into my ‘rehabilitation’ I tried to kill myself. I left the church after that.

I actually tried to kill myself a few times over the next few years. I guess I was pretty bad at it.

I’d like to say I’m all better these days, but I’m not. I’m still totally fucked up. I can’t hold down a relationship. My faith is a source of constant pain. I’m scared of Christians, but I am a Christian still, so I can’t practice my own faith. I feel safest around other queer people who hate Christianity because of how it’s treated them, but then, I end up feeling like they hate that part of me and I have to keep that secret. I can’t be my whole self anywhere. Deep down I think I still believe I deserve to suffer.

I don’t know if things will ever get better for me. But any laws that could stop that happening to someone else are a good thing as far as I’m concerned.<sup>132</sup>

## Places where conversion practices are occurring

<sup>132</sup> Submission 121 ‘Chloe’.

- 3.4.5. Conferences, prayer groups and counselling were the most common SOGI conversion practice activities for those exposed to SOGI conversion practices within faith-based communities.<sup>133</sup> One respondent noted how his ‘voluntary’ participation in SOGI conversion practices in Tasmania occurred over a number of years and in different ways, such as online conferences, private counselling, group prayer and training retreats which were costly emotionally and financially:

I even participated in a 10-week course with [struck — a conversion practitioner] via Skype sessions when I was living in Launceston. In 2012 and 2013, [an] international ‘ex-gay’ leader [struck — name redacted] visited [struck — place redacted] for conferences ... [The Speaker used] terms like ‘sexual brokenness’. Regardless, these conferences were run as conversion gatherings, focussing heavily on all aspects of conversion practices and ideology outlined in the TLRI issues paper.

Between 2009 to 2013, I was introduced to, and met with, members of [struck] three times for the purpose of prayer ministry. I was desperate for healing and wholeness, and drove from Launceston to a house in South Hobart ... where I underwent nine hours of prayer ministry, including an exorcism, in the hope of healing from my same sex attraction. Two years later, I again met for prayer ministry that lasted five hours at a church in [struck — Launceston suburb] with members of this group, and finally in 2013, I drove up to [struck — reference to rural town] to have 2.5 hours of prayer ministry, all in the hope of finding healing. Each time I was urged by the leadership in this group to attend training weekends that were very costly, and I didn’t have the money, and when I reached out a fourth time for prayer, it was suggested I do the weekend training retreat, where I could also receive prayer, but my delay to find the finances meant I missed out as they were ‘booked out’, and I never contacted them again. In 2013–2014, I would drive from Launceston to [struck — Hobart location] to see a Christian counsellor [who] used prayer ministry and talk therapy to try to deal with the issues in my life, including the ‘underlying issues’ behind my same-sex attraction. This was, obviously, not successful.<sup>134</sup>

- 3.4.6. Other submissions highlighted that conduct may be divided across religious organisations, such as churches, schools, camps and retreats:

I had been exposed to LGBTQA+ conversion ideology (see SOGICE Survivor Statement) from a very young age. The messages about ‘gay people’ that I received over many years convinced me that LGBT+ people were perverted and suffered from a broken form of sexuality. These messages were present in my home life, my (Christian) school-life and my

<sup>133</sup> Submissions 85, 93, 105\*, 110\*.

<sup>134</sup> Submission 105\*.

church life.

By the time I was in junior high school, I strongly believed that I was ‘broken’ and possibly demon-possessed, which was terrifying. ‘came out’ to my pastor at 16, who told me that he knew people who had been ‘healed’ of homosexuality and that he would introduce me to them. I already believed I needed to be healed, so I was more than willing to go along with anything that I thought may ‘fix’ me. Whilst I waited for these meetings, I went to an informal Christian counselling session through a church, which involved discussing my sexual orientation and my desire for healing, as well as past trauma and relational issues to determine possible influencing factors in my sexuality ...

when I was 17, my parents took our family to an isolated village in Tasmania to complete a week-long Christian ‘course’ ... The leaders of the organisation that ran the course (and the village) heard that I was gay and I was approached by one of them. They told me that they would allow me to participate in the course but that I would have to keep my sexuality a secret. I hazily recall them telling me that the view of the organisation was that homosexuality was a sin and that it was not God’s plan for my life. I was given the choice to join in and comply or to hang around the village on my own for the week whilst everyone else in the village participated in the course (it was nowhere near a town and I had no transport). I decided to join in....The next year, I moved to Tasmania to live in the same Christian community and study ... I lived in Tasmania for six months. During that time, I was informally exposed to what SOGICE Survivors refer to as ‘conversion ideology’ — claims about the nature of LGBTQA+ people or identities (including sexual brokenness, dysfunction or sickness etc), or about the ‘cause’ of LGBTQA+ identities (including past trauma, abuse, sin, etc). was not well — I suffered crippling anxiety and obsessive religiosity. I believed that my life couldn’t truly begin until my homosexuality was gone. [These] were self-directed efforts that were a result of years of exposure to conversion ideology and the subsequent inner belief that I was broken, sick, perverted, dysfunctional and that I needed to seek healing for that. I became aware of other ‘ex-gays’ in Tasmania who had also been exposed to the same ideology. Some were married or in heterosexual partnerships and were not open to discussing it. This indicated to me that the ‘ex-gay’ movement was absolutely present in Tasmania.<sup>135</sup>

- 3.4.7. One respondent detailed his many experiences with a variety of conversion practices, including exorcisms, in various Launceston area churches:

I was involved from the age of 16–36 with churches in the Launceston area... through many years I went through many different types of conversion therapy from counselling, prayer

<sup>135</sup> Submission 111\*.

groups. Exorcism through prayer by strong Pentecostal believers that I had demons and the only way that I can rid myself was to have them prayed out. That would involve multiple sessions hours on end, with shouting, shaking and making the ‘demons’ manifest, call them by their names and try to rip them out of my being. None of this of course worked and I was blamed and told that it was my fault that you were not delivered of the demons.... Over the years I was subjected to different forms of spiritual abuse, from counselling in many different forms, lectures, ostracized to full on: ‘having demons’ expelled from my body in which ever form that the particular movement believed in. This would occur over ma[n]y sessions, I only did it to want to do the right thing.<sup>136</sup>

- 3.4.8. Rainbow Communities Tasmania stated that SOGI conversion practices were occurring in both Tasmanian schools and in targeted campaigns by churches recruiting homeless youth:

I have been aware and advocated against CT [conversion therapy] practices by the Catholic Church insisted on by the hierarchy of all, religious and teachers to students in Catholic schools. This is in the doctrinal insistence on teaching that LGBTI people are unnatural, immoral ... If teachers or students or teachers reject or refuse they are evicted from teaching or studying. ... I am also aware in my work with homeless and unemployed youth that fundamental Christian organizations like [struck] are inducting LGBTI young people into C/V therapy ... [struck] actually paid for LGBTI youth in the municipality to be inducted into a C/T program.<sup>137</sup>

- 3.4.9. One Tasmanian clinical psychologist stated that some of their clients encountered SOGI conversion practices within religious educational institutions:

I have also assisted young people who have been advised by members of the Catholic education system that they require counselling within the church to ‘address their confusion’. Language is a subtle form of conversion that needs to be addressed within our medical and education system.<sup>138</sup>

- 3.4.10. Other submissions suggested the long history of these practices in Tasmania. A Tasmanian LGBTQIA+ advocate and community leader provided his account of the history of SOGI conversion practices, both through his own experience and the stories of others:

As I came out in the late 1980s, I quickly became aware of aversion practices based on behaviouralist ideas about operant conditioning. Older gay men passed down stories of aversion practices, including electric shock treatment, inflicted on them in the 1960s and 1970s. I also became aware of the subsequent generation of change and suppression efforts -

<sup>136</sup> Submission 165.

<sup>137</sup> Submission 123.

<sup>138</sup> Submission 159\*

ex-gay groups like Exodus International - which relied less on behaviouralism [sic] and more on pseudo-psychoanalysis and Bible study ...

A person with whom I had a pre-existing relationship sought to persuade me to undergo conversion practices through their church. They provided personal testimonies of other people we knew who were now 'ex-gay'. I am fortunate that I firmly believed my sexual and romantic orientation was natural, fixed and unchanged-able so the approach did not cause me any inner conflict or distress. But I can imagine how difficult it would be for people who are unsure why they are same-sex attracted, feel shame about it, and are approached by people in authority they respect or rely on. ...

'For a Caring Tasmania' was established in Launceston ... In the early 1990s it hosted more subdued rallies against decriminalisation. It also hosted a conversion conference in the northern suburbs of Launceston where high-profile American 'ex-gays' spoke about their 'escape from the homosexual lifestyle'.<sup>139</sup>

## Anecdotal reports

- 3.4.11. Finally, other networks stated that they had contact with people who had experienced SOGI conversion practices in Tasmania. The Brave Network and SOGICE Survivors submitted eight stories of Australians who had been exposed to SOGI conversion practices, stating that these stories included 'survivors from within Tasmania',<sup>140</sup> albeit (for reasons of anonymity) without any mention of how many of the eight were Tasmanian, or any Tasmanian place names or other clear connections. The Uniting Church LGBTIQ+ network stated that

While some of the members of the Uniting Network executive have experienced conversion practices and are aware of practices happening in Tasmania, we do not have specific stories to share.<sup>141</sup>

- 3.4.12. The community leader and LGBTQIA+ advocate quoted above [3.4.10] also reported that Tasmanian survivors had contacted him to relay their recent experiences:

My chief contact with conversion practices is now through those Tasmanian survivors who have contacted me and provided me with details of their experiences. There are several notable patterns within this personal testimony: Overwhelmingly survivors are under 30, have been part of evangelical Protestant, or traditionalist Catholic or Orthodox congregations, and have worshipped in an environment saturated with conversion ideology and with antagonism to LGBTIQ+ equality.<sup>142</sup>

<sup>139</sup> Submission 113 at 2, 3.

<sup>140</sup> Submission 93 at 17.

<sup>141</sup> Submission 94 at 4.

<sup>142</sup> Submission 113 at 6.

- 3.4.13. Community organisations, such as Relationships Australia Tasmania, stated that their clients had reported experiences of SOGI conversion practices in informal religious settings that aimed at developing core beliefs that their sexuality was ‘evil or defective’.<sup>143</sup>
- 3.4.14. Another anonymous respondent submitted an anonymous account of a person writing in support of conversion practices that stated ‘I spend time regularly in Tasmania. If I cannot find the ongoing help and support I need there as a result of changes in law relating to therapy then I, like others, will have to cease doing work and visiting there’,<sup>144</sup> suggesting that that person is involved in conversion practices when they visit Tasmania.

### Voluntary reports

- 3.4.15. Some respondents accepted that the TLRI’s working definition would capture their present or future activities. None of these people were health professionals. For instance, one respondent, who works in compliance and public policy stated:

I am personally invested in this proposal to the extent that the more extreme suggestions, if adopted, would likely see me in prison.<sup>145</sup>

- 3.4.16. A Tasmanian Reverend submitted that:

... our church preaches and teaches what the Bible says, including what it says about sexual orientation and gender identity. We do this out of our ultimate commitment to God, our love for him, and out of love for the people around us. We counsel accordingly. We pray publicly and privately accordingly. According to the working definition the Issues Paper provides, we are involved in SOGI conversion practices. We make no apologies for that. Moreover, as stated above, this is non-negotiable for our church since we believe what the Bible says. For us to do otherwise would be unloving and disingenuous.<sup>146</sup>

- 3.4.17. The Reverend stated that ‘I also respectfully provide this submission to alert you to the fact that Christian churches like ours will not change our practices.’<sup>147</sup> He anecdotally reported that similar beliefs and practices occurred in aligned religious schools:

While it is not operated or governed by our church, members of our church community operate a Christian school in Launceston. This Christian school is also unreservedly committed to what the Bible teaches about SOGI. The children who attend this school are taught accordingly, because their parents want their children to be taught in a way which

<sup>143</sup> Submission 85

<sup>144</sup> Submission 110\*.

<sup>145</sup> Submission 34 at 1.

<sup>146</sup> Submission 3 at 3.

<sup>147</sup> Submission 3 at 1.

corresponds with their Christian faith. In fact, the parents have all made public vows to this effect — this is taken very seriously in our community. There are several similar Christian schools throughout Tasmania.<sup>148</sup>

- 3.4.18. No school or school organisation stated that they endorsed or permitted conversion practices. However, some religious education providers expressed concern that the broad working definition adopted by TLRI would affect some of their faith-based policies and practices. The Australian Association of Christian Schools, affiliated with ten Tasmanian schools, provided statements around their educational practices around sexuality and gender identity. The Association stated that:

... our schools do not attempt to forcibly change, suppress or eradicate the sexual orientation or gender identity of any child, nor do we support this practice. We do promote a Biblical worldview on these topics consistent with the religious teachings of the Christian faith. Our schools believe that God designed two biological genders, male and female, and that families are formed through marriage which is a commitment between one man and one woman, to the exclusion of all others for life and is the rightful place for sexual activity and procreation.

...

Staff do not attempt to force their beliefs and values upon any student in relation to these deeply personal matters which go to the heart of someone's identity and faith. We do, however, seek to lovingly support young people as they explore questions about their identity in the context of their faith in Christ on a broad range of topics including gender, sexuality and personal relationships.<sup>149</sup>

- 3.4.19. A joint submission by Christian Schools Australia and Adventist Schools Australia took a broader view of the role of faith-based counselling for students:

As educators who care for the wellbeing of our students, we know that childhood and adolescence can be a time of confusion and exploration. For generations young people have sought the advice of teachers and other staff in matters far beyond the subject matter of a classroom. Schools of all types, including faith-based schools, must be able to continue to have open and honest conversations with students in their care ... Amongst the very different results is a marked reduction in suicidal ideation by those who have received treatment to deal with unwanted same sex attraction or gender identity issues ... Support for the people wanting to take these pathways being effectively eliminated if the ban is adopted ... On behalf of the parents who choose a faith-based education, and the church and faith

<sup>148</sup> Submission 3 at 4–5.

<sup>149</sup> Submission 44 at 2, 5.

communities that deliver it, schools represented in this submission are overt and particular about the beliefs and values that underpin curriculum, culture and practice. This includes orthodox Christian teaching on personhood, identity and sexuality. It would be a grave infringement of these fundamental rights if any ban of ‘conversion practices’ had the result, directly or indirectly, of impacting what is taught within a Christian, Adventist or other faith-based school.<sup>150</sup>

- 3.4.20. The TLRI notes that these statements may be interpreted primarily as objections to the breadth of the TLRI’s definition, or its consequences, rather than as statements that these bodies and schools do engage in SOGI conversion practices. However, the submissions do suggest a lack of certainty about the appropriate boundary line between legitimate expressions of opinion and faith and conduct amounting to a conversion practice.
- 3.4.21. While it is reassuring that educational providers do not undertake ‘forceful’ practices, that is not the only form of conduct which is used to convert someone’s sexual identity or gender identity. Harmful conduct may be physical and non-physical, direct or indirect, immediate or prolonged. Conversion practices may occur through a range of non-coercive means, such as improper pressure, persuasion, coercion, inducement or by convincing a person or group to uncritically accept a set of beliefs about themselves or others.
- 3.4.22. It is the Institute’s view that religious schools should be permitted to instruct on matters of doctrine and faith. It is also the view of the Institute that schools have an active and important role in supporting and promoting the wellbeing of children in their care. However, there are limits to these rights and duties. There are also disciplinary limitations on the form of counselling and health support educators and religious leaders are able to provide to students.
- 3.4.23. It is acceptable to teach and express beliefs of faith. It is less acceptable to make children believe they are dysfunctional, faulty or broken because of how they feel or express themselves. It is dangerous to convince children they can and must change their state of being and state of mind when there are demonstrable risks from such conduct. While there may be no bright line between these things, the more persistent and systematic the conduct, the less likely it can be proportionately defended as a manifestation of religious belief rather than an attempt to subject a child to conversion practices.
- 3.4.24. The Institute considers that law reform may assist in clarifying where the appropriate boundary line is between educating on matters of faith and inappropriate non-forceful conduct that is likely to cause harm.

<sup>150</sup> Submission 27 at 6, 13, 15 and 16.

### 3.5. Practices in clinical settings

- 3.5.1. A range of submissions, some public but predominantly anonymous or confidential, reported SOGI conversion practices by medical professionals in Tasmania.<sup>151</sup> These included general practitioners, psychiatrists, psychologists and hospital staff subjecting clients/patients to undertake medical intervention or hospitalisation, or giving a ‘diagnosis’, ‘assessment’ or ‘treatment’ that aimed to change, suppress or eradicate their sexual orientation or gender identity.<sup>152</sup> These experiences have occurred to people across varying ages and stages of their lives, and some do not indicate when the practices occurred. For example, one respondent wrote ‘[w]hen I first came out as transgender to the family GP I had been seeing for years, his response was that it was a symptom of my mental illnesses and that I needed to be fixed immediately’.<sup>153</sup>
- 3.5.2. A number of these submissions related to historical health practices. For example, one respondent reported a historical experience of SOGI conversion practices from more than three decades ago:

At the age of 16 I had a huge crush on a girl at school. I was sent for hypnotherapy to ‘support me through my confusing time’ ... I had 8 sessions. She had said that gay people are harmful to children and it is part of their gay agenda to recruit young people to their way of life.<sup>154</sup>

A similarly historical case from the 1960s was recounted by an anonymous respondent.

I was somewhat concerned about my sexual orientation and went to see a university doctor. He suggested I should have aversion therapy. I asked him what this involved and he described a process to me involving electric shock treatment which I thought barbaric. Even if it stopped my homosexual feelings, I asked what guarantee there was that I would develop heterosexual feelings. The doctor said there were no guarantees. I left feeling totally unsatisfied but decided if that was what was on offer I would rather stay as I was.<sup>155</sup>

- 3.5.3. Some confidential submissions provided information of historical pathologisation of SOGI by public health authorities leading to, in at least one case, commitment to mental health facilities because of same sex or gender attraction.<sup>156</sup>

<sup>151</sup> Submissions 1\*, 110\*, 119, 121, 126C, 144C, 155, 161\*, 163\*, 173\*, 180\*.

<sup>152</sup> Submissions 180\*, 126C, 159\*, 163\*.

<sup>153</sup> Submission 155.

<sup>154</sup> Submission 130\*.

<sup>155</sup> Submission 161\*.

<sup>156</sup> Aggregate confidential information only used.

- 3.5.4. A limited number of submissions did report more recent conduct (within the past five years), particularly in relation to non-homosexual attributes. One respondent reported:

My last psychologist told me that being agender and asexual was ‘fundamentally wrong’ and suggested that I start treatment for it, despite never telling me what that ‘treatment’ involved. I was made to feel like my identity and sense of self was something unusual or perverse... [the psychologist] told me that I should start treatment to ‘fix’ my sexuality and gender identity. I refused but felt very pressured in the next 4 sessions that we had. It was because of this that I stopped seeing her and have moved to another doctor[']s care.<sup>157</sup>

- 3.5.5. Another respondent reported that a psychologist had offered cognitive behavioural therapy to ‘treat’ their report of being transgender, which led to them stopping all treatment for mental health issues and being reluctant to seek treatment in the future:

I have been offered (but not accepted) forms of SOGI conversion practices in Tasmania... I was seeing a local psychologist for mental health stuff and came out to them as trans. The psychologist then offered me CBT [cognitive behavioural therapy] to ‘make it go away’. I declined and changed psychologists. That hurt a lot and made me feel unsafe. It stopped me accessing any mental health care for a while, because I was afraid the next psychologist would try to ‘cure’ me as well.<sup>158</sup>

- 3.5.6. Transforming Tasmania provided an anonymised account of a nonbinary person’s encounter with a psychiatrist who used cognitive behaviour therapy to ‘treat’ their gender identity:

Shortly after I came out to myself as nonbinary, and started coming out to the world, I was dealing with a lot of depression — not from my identity, but from unrelated health and disability issues. I saw a psychiatrist to try and get some help.

After we did introductions in the first session, the psychiatrist immediately started in on me. ‘You’re not transgender. Nonbinary isn’t a real thing; that’s just a mental illness. You’re damaged, and what you need is therapy and then you’ll realise you’re just a girl who’s [sic] attention-seeking because you need to feel special.’

The psychiatrist put me on a course of CBT [cognitive behavioural therapy] to try and ‘train’ me back towards being cis and straight. When it didn’t seem to be working, he told me I was deliberately deluding myself and that I wasn’t trying hard enough, that I didn’t want to ‘get better’. At the time, I was devastated by it all, but the full damage of it didn’t really become clear to me until years later. I’m still unpicking it. I had never before, and have never since, been so systematically undermined and invalidated and traumatised by someone who was meant to be helping me.

<sup>157</sup> Submission 163\*.

<sup>158</sup> Submission 180\*.

...

The next couple of years after that were a hellish storm of suicidality.

... and here I am, someone whose mental illness is defined entirely by the way he, the respected medical professional, describes it. That sort of power dynamic is basically insurmountable.

I didn't go back to a psychiatrist for years after that, even though I needed to. Eventually I was forced to, after a couple of instances of becoming so suicidal I had to go to the ER [emergency room]. By that point, I'd finally just managed to start HRT [hormone replacement therapy], but was having a lot of trouble coming to terms with it because part of me still believed what that first psychiatrist had tried to train me to—that my transness wasn't real, that I was just wrong and broken and attention-seeking.

The new psychiatrist I was referred to told me she wouldn't review my medications or treat me unless I stopped taking my HRT. At least that time it made me so angry I walked out and decided I was going to live, if only out of spite to prove her wrong. She made it clear that my stopping being trans was more important than making sure I was going to survive.<sup>159</sup>

- 3.5.7. Some submissions presented accounts of SOGI conversion practices appearing in more subtle, suggestive ways.<sup>160</sup> For example, one Tasmanian clinical psychologist stated that some of their clients have experienced both overt and subtle forms of SOGI conversion practices in medical settings in Tasmania:

I have also supported young people who have been advised by general practitioners that their questions relating to their gender are 'ridiculous' and to 'stop just trying to be part of a trend'. These comments are extremely concerning as they have resulted in an increase in suicidal ideation for the young person and a reluctance to access medical care when needed.<sup>161</sup>

### 3.6. Conversion practices are taking place in Tasmania

- 3.6.1. Submissions to the Inquiry provided a collective account of longstanding prejudice, discrimination and maltreatment of sexual and gender diverse minorities that continues to this day. Those submissions were compelling and at times disturbing. While Tasmania has become a much more tolerant and inclusive society over recent decades, LGBTQA+ people continue to

<sup>159</sup> Submission 121 'Rae'.

<sup>160</sup> Submissions 122, 126C, 159\*, 163\*, 173\*, 111\*, 121.

<sup>161</sup> Submission 159\*.

experience discriminatory treatment across all areas of life, simply because of who they are, what they feel and how they express themselves.

- 3.6.2. Not all reports of negative treatment of LGBTQA+ people made in submissions to this Inquiry would, in the Institute's view, amount to conversion practices. For instance, excluding persons from participating in religious, social or educational events based on SOGI attributes is clearly discriminatory — and may very well be regulated or proscribed by anti-discrimination law — but it is not, without more, evidence of an intent to convert those who are excluded. Similarly, dismissive and discriminatory conduct by health professionals may have amounted to unethical practice or misconduct — and may have given rise to disciplinary complaints against the relevant professional — but may not purport to assess or treat the person's sexuality or gender identity as an impairment or dysfunction that needed correcting. Disowning a child who comes out as gay or transgender may amount to a failure of the parental duty to act in a child's best interests, but it is not, by itself and without more, evidence of an intent to change the fundamental attributes that person has revealed.
- 3.6.3. A significant number of reports of negative treatment of LGBTQA+ people by respondents to this Inquiry did, in the Institute's view, amount to a targeted, focused attempt to change, suppress or eradicate sexual orientation or gender identity. Personal and anecdotal reports from multiple respondents met such a threshold. Some individuals and organisations also strongly suggested, or in some cases explicitly stated, that they consider certain SOGI attributes to be the result of an impairment, personal dysfunction or fault and/or that they actively seek to change, suppress or eradicate such attributes.
- 3.6.4. The bulk of these accounts relate to non-medical settings, specifically churches, religious schools and other religious community activities. Some accounts relate to medical practitioners, particularly mental health practitioners, engaging in SOGI conversion practices. Stories extend as far back as the 1960s. Most accounts relate to recent conduct (within the past 5–15 years) that meets the criteria of SOGI conversion practices. Notably, while the nature of these practices has changed over time, their broader intent and the beliefs that drive them appear to have remained consistent.
- 3.6.5. Whilst there were no recent reports of physically abusive practices in recent time, historical accounts of abusive practices, both personal and anecdotal, were provided. There is also a documented history of such practices being sanctioned and occurring inside and outside clinical contexts in the recent past.
- 3.6.6. What was reported to the TLRI was a very wide range of ongoing non-physical practices aimed at changing, suppressing or eradicating SOGI attributes. As set out above, these direct acts were often described by practitioners as a course of therapy, counselling, or 'healing' (psychological

or spiritual) sessions. This is consistent with evidence about SOGI conversion practices occurring in Australia from other secondary sources. The TLRI is therefore satisfied there is evidence of a direct form of conversion practices occurring in Tasmania which extend well beyond the scope of freedom of expression, religion or legitimate health care.

- 3.6.7. What was also evident in both the relevant literature and the reports to this Inquiry was that direct conversion practices (e.g., purported therapy) are only a small part of a much broader continuum of conduct directed towards LGBTQA+ people. More indirect acts, usually (but not always) conducted over a prolonged period of time, are used to convince people to submit to direct acts, or undertake self-directed acts to change, suppress or eradicate their SOGI attributes. This continuum of conduct involves seeking to convince LGBTQA+ people that:
- They are suffering a dysfunction or fault as the result of a physical impairment because of their expressed or experienced SOGI; and
  - It is possible to change, suppress or eradicate their SOGI attributes, and
  - They should do so for reasons of health, wellbeing, morality, social acceptance and so forth.
- 3.6.8. Such indirect conduct extends beyond reasonable expression of faith or belief about SOGI attributes and instead becomes an intentional effort to convert someone's state of mind and/or state of being. In the Institute's view they amount to SOGI conversion practices and are consistent with reports of such conduct occurring in Australia in other literature sources.
- 3.6.9. Respondent submissions also highlighted the pressure brought to bear upon them or others to change, suppress or eradicate their SOGI attributes by people around them who were convinced that it was necessary and possible to do so. This was made possible by a perpetuation of the conversion beliefs set out above [see 2.6] through persistent messaging or publications to target LGBTQA+ or religious communities or the broader Tasmanian community.
- 3.6.10. As noted above [see 2.7.1], a circular promoting conversion practice beliefs, including claims that people had successfully changed their SOGI and were living happier, healthier, more normal and fulfilled lives was circulated in Tasmania during this Inquiry. A range of publications, materials and manuals were also submitted to the Institute which indicated concerted campaigns to convince members of the community that LGBTQA+ people were dysfunctional or faulty as the result of an impairment of mind (developmental delay, trauma), or body (hormonal or other physical imbalance) or spirit. Those publications purported to show ways in which any person could change, suppress or eradicate their SOGI attributes. In the Institute's view these materials went well beyond expressions of faith, legitimate reporting, or medical or scientific research. Rather they were platforms to convince LGBTQA+ people that they should submit to conversion practices, or to create community pressure on LGBTQA+

people to submit to conversion practices. In the Institute's view some of these forms of messaging and publication amount to an indirect SOGI conversion practice.

Finally, the Institute emphasises its caution about assuming conversion practices have reduced in incidence or impact in Tasmania in recent years. Clinical evidence and testimony from survivors' advocacy groups suggest that many harms and traumas linked to SOGI conversion practice experiences often do not manifest until several years later. That would suggest that persons who have recently been or who currently are being subject to conversion practices will not report the conduct for some time. This is consistent with submissions to this Inquiry, the most recent of which relate to practices that took place approximately five to seven years ago, around 2015.

Part II

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**RISKS, GAPS AND THE NEED FOR  
REFORM**

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# What are the risks and harms of conversion practices?

## 4.1. Overview of this part

- 4.1.1. This Part examines the data on the risks and harms of SOGI conversion practices. It reiterates the Issues Paper’s findings on the scientific and clinical evidence on the risks and harms of conversion practices, assesses submissions made to the Inquiry on risks and harms, and in particular those of peak medical bodies, considers criticisms of the TLRI’s approach to the scientific and clinical literature, and provides details of further relevant studies published since November 2020. It then presents testimony from respondents about the risks and harms that they, or people they know, had suffered and attributed to their exposure to SOGI conversion practices in Tasmania.
- 4.1.2. Overall, these sources show that SOGI conversion practices pose significant risks and harms to individuals subjected to them. For that reason, it is appropriate to consider ways in which the law may be reformed to reduce these risks and harms.

## 4.2. What data exists?

- 4.2.1. The Issues Paper reviewed the literature on SOGI conversion practices as it existed in November 2020. In preparation for the Issues Paper, the TLRI gathered and analysed 35 scientific studies. These sources were gathered through keyword searches in major research databases,<sup>162</sup> and by following up citations in the studies found in these searches to find additional sources on the harms caused by SOGI conversion practices that were missed in the initial keyword search.

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<sup>162</sup> Keywords included ‘conversion practices’, as well as related terms, older terms or other descriptions of practices equivalent to SOGI conversion practices, specifically ‘conversion therapy’, ‘reorientation therapy’, (‘change’ AND ‘sexual orientation’), in *MEDLINE/PubMed*, *Google Scholar*, and *EbscoHost Megasearch*. From these 35 studies and following up citations within them, the TLRI had an initial literature collection of 42 journal articles and chapters. From that 42, only 17 studies were discussed in the Issues Paper itself: the remainder either did not contain new data on evidence of effectiveness or harms, or did not include discussions of other issues relevant to the Issues Paper (eg non-peer reviewed papers discussing and critiquing the analysis in other studies). See *TLRI SOGI Conversion Practices Issues Paper* (n 7).

- 4.2.2. As noted in the Issues Paper, these studies emphasise the difficulty of assessing the harms or benefits of SOGI conversion practices.<sup>163</sup> This is partly because they rely on self-reporting and retrospective statements by people who were subjected to SOGI conversion practices,<sup>164</sup> rather than clinical observation of participants before and after the application of the practices (which, given the self-reports of harm, would likely be unethical to conduct).
- 4.2.3. As the Issues Paper stated, the overall conclusions of these studies can be summarised as follows.

### **SOGI conversion practices are ineffective**

- 4.2.4. Studies of SOGI conversion practices concluded that there was no evidence that these practices fulfilled their aims. These studies found little evidence that SOGI conversion practices can change a person's SOGI status, with most subjects reporting they were ineffective and/or harmful. Consequently, there is no base of clinical evidence that would support SOGI conversion practices being recognised as legitimate medical practices or treatments.<sup>165</sup>

### **SOGI conversion practices are harmful**

- 4.2.5. Studies suggest that SOGI conversion practices cause harm to those subject to them. Harms include higher rates of low self-esteem, depression, alienation, loneliness, social isolation, internalised homophobia, sexual dysfunction, relationship problems, drug abuse, post-traumatic stress disorder, suicidal ideation, and suicide attempts.<sup>166</sup> Recent studies suggest the long-term effects of SOGI conversion practices can be serious.<sup>167</sup> While there is limited research on the effects of SOGI conversion practices on children, one recent study showed an association between exposure to SOGI conversion practices and negative health outcomes in young adults.<sup>168</sup>

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<sup>163</sup> See Judith M Glassgold et al, *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* (2009) 35–43. <<http://www.apa.org/pi/lgbcc/publications/therapeutic-resp.html>>; Jack Drescher, 'Can Sexual Orientation Be Changed?' (2015) 19 *Journal of Gay and Lesbian Mental Health* 84, 89.

<sup>164</sup> Elaine M Maccio, 'Self-Reported Sexual Orientation and Identity Before and After Sexual Reorientation Therapy' (2011) 15 *Journal of Gay and Lesbian Mental Health* 242; Robert J Cramer et al, 'Weighing the Evidence: Empirical Assessment and Ethical Implications of Conversion Therapy' (2008) 18 *Ethics and Behavior* 93.

<sup>165</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.5]–[2.2.7].

<sup>166</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.8].

<sup>167</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.9].

<sup>168</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.10].

### 4.3. Consultation responses on TLRI’s literature review

4.3.1. Medical experts and peak medical bodies that made submissions to the Inquiry agreed with TLRI’s evaluation of the scientific literature on the efficacy and likely harms of SOGI conversion practices.

4.3.2. The submission by the **Australian Psychological Society (APS)** stated that it

considers conversion practices unscientific, ineffective and dangerous ... 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 ... any psychologist attempting to use conversion practices is likely to be in breach of our Code of Ethics.<sup>169</sup>

4.3.3. The Society stated that the ‘evidence base shows that conversion practices are harmful regardless of where they are delivered or who they are delivered by’.<sup>170</sup> In February 2021, the Society published an updated position statement on SOGI conversion practices, which stated:

Approaches to mental health practice variously referred to as ‘reparative’, ‘conversion’ or ‘ex-gay’ ‘therapy’ are based on the assumption that being lesbian, gay, bisexual, transgender or queer (LGBTQ+) is indicative of psychological dysfunction, and that this can be ‘cured’.

No professional health organisation in Australia supports these approaches, for the following reasons:

1. There is no clinical evidence demonstrating that approaches that claim to change or suppress a person’s sexual orientation or gender are effective.
2. There is, however, a considerable body of evidence documenting the negative effects of stigma associated with being a member of LGBTQ+ communities, including higher rates of depression.
3. There is also clinical evidence that change or suppression practices are harmful and can compound the challenges already faced by LGBTQ+ communities.<sup>171</sup>

<sup>169</sup> Submission 18 at 2.

<sup>170</sup> Submission 18 at 3.

<sup>171</sup> Australian Psychological Society, ‘Use of Psychological Practices that Attempt to Change or Suppress a Person’s Sexual Orientation or Gender: Position Statement’ (February 2021) <[https://psychology.org.au/getmedia/7bb91307-14ba-4a24-b10b-750f85b0b729/updated\\_aps\\_position\\_statement\\_conversion\\_practices.pdf](https://psychology.org.au/getmedia/7bb91307-14ba-4a24-b10b-750f85b0b729/updated_aps_position_statement_conversion_practices.pdf)> (*‘Australian Psychological Society 2021 Position Statement’*).

4.3.4. The **Australian Medical Association Tasmania** stated that it had:

consulted with our membership on the TLRI Issues Paper. There was a strong view that Sexual Orientation and Gender Identity (SOGI) conversion practices are harmful and should be banned.<sup>172</sup>

4.3.5. The **Royal Australian and New Zealand College of Psychiatrists** similarly stated:

[t]here is no scientific evidence that sexual orientation can be changed and sexual orientation change efforts risk causing significant harm to individuals as well as contributing to the misrepresentation of alternative sexualities as mental disorders.<sup>173</sup>

4.3.6. The **Mental Health Council of Tasmania** endorsed the Australian Psychological Society's 2015 position statement and quoted from it in support of its view that SOGI conversion practices have 'no evidence' to support them, and that they 'can cause psychological harm leading to self-harm, mental ill-health and subsequent economic disadvantage'.<sup>174</sup>

4.3.7. The **Australian Professional Association for Trans Health** stated that:

The evidence on SOGICE, available in the testimonies of sexual and gender minority community members and healthcare providers, as well as research studies, reveals that such efforts have little if any impact on sexual orientation or gender identity. Rather, any impact they have is generally limited to individuals' sexual and gender expression, with such impact largely due to great anxiety and shame these efforts promote in its victims ... Recent research by Turban et al highlights the clearly harmful impact of such practices specifically upon trans people of all genders. In view of all the above we regard SOGICE as a threat to health.<sup>175</sup>

4.3.8. **Tasmania's Chief Civil Psychiatrist**, reiterated that the Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners and the Royal Australasian College of Physicians 'do not support SOGI [conversion] practices' because they are 'unethical, harmful and not supported by medical

<sup>172</sup> Submission 90 at 1.

<sup>173</sup> Submission 5 at 1. Regarding gender identity-related healthcare practices, the Royal Australian and New Zealand College of Psychiatrists recommended that assessment and treatment related to gender identity should be partly regulated as specific clinical conditions, and that that regulation should not interfere with evidence-based psychiatric practice: 'It is important that individuals questioning their gender or considering treatment can be appropriately counselled and supported using an evidence-based approach with reference to accepted professional standards': Submission 5 at 2.

<sup>174</sup> Submission 10 at 1.

<sup>175</sup> Submission 114 at 1–2.

evidence'.<sup>176</sup> The Chief Civil Psychiatrist endorsed those positions, stating that they are 'well informed by evidence-based data and literature, both nationally and world-wide'.<sup>177</sup>

4.3.9. A respondent who is a clinical psychiatrist specialising in children and adolescents with more than 15 years' experience in transgender health, and currently the **Clinical Lead at the Tasmanian Gender Service**, submitted several points on clinical practice and evidence base. These included his professional opinion that:

- 'I do not believe conversion practices are ethical, evidence based, helpful or lawful';
- '[C]onversion practices are non-affirming (which is in direct contrast to evidenced based practice) and therefore stigmatising to trans and gender diverse individuals who already have one of the worst mental health records, including suicide, mostly related to social stigma'; and
- 'The suggestion that banning conversion practices will make sexually diverse individuals identify as trans makes no sense to me; I have never experienced this in clinical practice over 15 years and this claim has no scientific basis as far as I can see'.<sup>178</sup>

4.3.10. Medical bodies also tended to reiterate the distinction between genuine medical assessments and treatments that do have a base of clinical evidence to support their efficacy and benefits, and those, like SOGI conversion practices, that do not. For example, the **Royal Australian and New Zealand College of Psychiatrists** stated that:

It is important that individuals questioning their gender or considering treatment can be appropriately counselled and supported using an evidence-based approach with reference to accepted professional standards.<sup>179</sup>

4.3.11. The **Royal College** also emphasised that in dealing with the 'definition and meaning of proscribed treatments', any law reform should ensure

that all conversion therapies are captured, while removing any association with evidence-based mental health care and support. Initial legislation in other jurisdictions could have, under some circumstances, been perceived to include some evidence-based psychiatric practice, even though the intent of the treatment may not be to change, suppress or eliminate an individual's sexual orientation or gender identity.<sup>180</sup>

4.3.12. Similarly, the **Tasmanian Chief Civil Psychiatrist** stated:

<sup>176</sup> Submission 104 at 1.

<sup>177</sup> Submission 104 at 1.

<sup>178</sup> Submission 40 at 1.

<sup>179</sup> Submission 5 at 2.

<sup>180</sup> Submission 5 at 2.

I also support the thinking around avoiding any language around these practices that suggests they are therapies or educational programs of any kind or based on any medical evidence, best practice or shared philosophy, there is simply no compelling evidence that this is the case.<sup>181</sup>

## 4.4. Literature not included in the Issues Paper

### ‘Missing’ or selective Literature

- 4.4.1. Several respondents stated that the TLRI had not considered relevant publications in its literature search. A list of publications suggested by respondents is included in Appendix E.
- 4.4.2. The TLRI thanks these respondents for these suggestions and has reviewed them. Many were not relevant to the specific question of conversion practices, but dealt with wider questions of sexuality and gender that the Inquiry need not examine. Others were not peer-reviewed, or were further critical commentaries on other studies: those can be of value in scientific discussions, but the TLRI search is restricted to peer-reviewed literature for the reasons explained in the Issues Paper.<sup>182</sup>
- 4.4.3. One frequently cited example was Lawrence S Mayer and Paul R McHugh’s ‘Special Report: Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences’ published online at *The New Atlantis* website.<sup>183</sup> This suggestion serves as an example to illustrate why it was not included in the original Issues Paper, as a means of clarifying the points in the original paper about how and what literature was selected for the review.
- 4.4.4. The Mayer and McHugh ‘Special Report’ is not a peer-reviewed publication, and *The New Atlantis* states on its website: ‘We are not an academic journal but a public journal of ideas’.<sup>184</sup> This report was not identified in the TLRI’s literature search because that search did not extend beyond scholarly sources and research databases.
- 4.4.5. The standard for an academic search of scientific literature is to narrow the examination to peer-reviewed publications only. In this instance, that narrowness meant that no scientific studies provided evidence to support the claim that SOGI conversion practices either worked or were not harmful. In order to examine the only material that did make such claims, the TLRI did include the non-peer-reviewed research published in the main outlet for SOGI conversion

<sup>181</sup> Submission 104 at 2.

<sup>182</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.12] n 61.

<sup>183</sup> Lawrence S Mayer and Paul R McHugh, ‘Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences’, *The New Atlantis* (2016) <<https://www.thenewatlantis.com/publications/executive-summary-sexuality-and-gender>>.

<sup>184</sup> ‘About’, *The New Atlantis* (2022) <<https://www.thenewatlantis.com/about>>.

practice advocates, the *Journal of Human Sexuality*. Papers from this journal had been cited in a range of secondary sources and in peer reviewed refutations at the time of the Issues Paper literature review. The Issues Paper outlined a number of papers published there and explained why their claims were not reliable.

- 4.4.6. A small number of submissions suggested the Issues Paper lacked scientific rigour and needed to broaden its ‘scientific scope’ in order to correct its ‘biases’.<sup>185</sup> For example, some respondents stated that the Issues Paper was not informed by or did not include ‘reliable science’, such as evidence where conversion practices have ‘worked’ or have been ‘beneficial’.<sup>186</sup> Consequently, the scientific literature was ‘selective’ or inappropriately interpreted, for example in the use of anecdotal accounts of SOGI conversion practices that are not ‘hard evidence’ and should not be used as the basis for generalisations.<sup>187</sup> None of these submissions were made by respondents who identified their expertise in medicine, mental health or empirical research.
- 4.4.7. The Issues Paper did in fact cite studies that reported small numbers of participants who reported positive outcomes.<sup>188</sup> The Issues Paper also dealt in detail with several sources claiming to report positive outcomes, and explained the reasons why these were not clinical studies that provided evidence of positive outcomes, but instead commentaries on studies that claimed to show evidence of harm.<sup>189</sup> Similarly, on the issue of ‘anecdotal accounts’, the Issues Paper provided an extensive explanation of the methodologies of these studies and their use of self-reporting, stating that while these methods had limitations, they are clinically valuable and scientifically robust, and that other methods like clinical observation and intentional exposure, which some may wrongly perceive as the only source of ‘hard evidence’, would be unethical.<sup>190</sup>

### **Can sexuality and gender data be used together?**

- 4.4.8. Some respondents stated that the TLRI had erroneously assumed that sexual orientation and gender identity is fixed and immutable, and suggested literature related to this theme. For example, one respondent, who is a religious leader, and a Doctor of Ministry, provided citations to several studies that they claimed showed people who were gender fluid might ‘settle into a heterosexual relationship’:

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<sup>185</sup> Submissions 21, 27, 83C.

<sup>186</sup> Submissions 9, 2, 14, 19, 65.

<sup>187</sup> Submissions 12, 49\*, 65, 77\*.

<sup>188</sup> For example, the Issues Paper’s account of Shidlo and Schroeder’s 2002 study stated in the footnote providing details of that study that: ‘A minority (13%) perceived themselves as having been successful’: *TLRI SOGI Conversion Practices Issues Paper* (n 7) 18 n 53, citing Ariel Shidlo and Michael Schroeder, ‘Changing Sexual Orientation: A Consumers’ Report’ (2002) 33 *Professional Psychology: Research and Practice* 249.

<sup>189</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) 19–20 [2.2.11]–[2.2.13].

<sup>190</sup> *TLRI SOGI Conversion Practices Issues Paper* (n 7) 19–20 [2.2.2]–[2.2.4].

These are a sample of the several well respected academics and scholars in this field who challenge the notion of fixed sexual orientation and argue instead for sexual attraction being desires-based, and that over time these desires can be fluid even among those who formerly identified themselves as same-sex attracted.<sup>191</sup>

This respondent also noted that academics had provided examples of ‘women who lived as lesbians who later settled into a heterosexual relationship’.

- 4.4.9. The TLRI is not of the view that sexuality or gender are fixed and immutable. The TLRI accepts studies which indicate these attributes may be fluid in individuals and across populations. The Institute does not consider that the submitted papers<sup>192</sup> or any other rigorous literature provide evidence that it is possible for another person to cause that change in orientation (i.e., about the efficacy of SOGI conversion practices) and the accounts submitted by respondents to this Inquiry do not involve any report of another person attempting to have that effect on these subjects.
- 4.4.10. That sexual orientation or gender identity may change over time, or adopting a ‘desires-based’ account of the nature of sexual orientation or gender identity, does not mean that external human interventions can influence those desires. Nor does it mean that attempting to do so is not likely to cause harm. That would include the potential harm of interventions in a sexually or gender fluid person to try to make their SOGI fixed and immutable.
- 4.4.11. Some submissions made a similar claim around the conflation of sexual orientation and gender identity: namely that while sexual orientation conversion practices lack a medical basis and should not be protected, gender identity-related assessments and treatment, for example for conditions like gender dysphoria/incongruence, are legitimate medical practices and should not be covered by SOGI conversion practices.

<sup>191</sup> Submission 41 at 4–5.

<sup>192</sup> Submission 41 provided citations to the following peer-reviewed journal articles: Sari M van Anders, ‘Beyond Sexual Orientation: Integrating Gender/Sex and Diverse Sexualities via Sexual Configurations Theory’ (2015) 44 *Archives of Sexual Behavior* 1177; R F Baumeister, ‘Gender Differences in Erotic Plasticity: The Female Sex Drive as Socially Flexible and Responsive’ (2000) 126 *Psychological Bulletin* 347; Lisa M Diamond, ‘What Does Sexual Orientation Orient? A Biobehavioral Model Distinguishing Romantic Love and Sexual Desire’ (2003) 110 *Psychological Review* 173; Thomas D Steensma et al, ‘Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-Up Study’ (2011) 16 *Clinical Child Psychology and Psychiatry* 499. Submission 45 also provided references to two books: Lisa M Diamond, *Sexual Fluidity: Understanding Women’s Love and Desire* (Harvard University Press, 2009) and Ritch C Savin-Williams, *Mostly Straight: Sexual Fluidity among Men* (Harvard University Press, 2017). Finally, Submission 45 provided references to two short talks and one interview: Lisa Diamond, ‘Why the “Born This Way” Argument Doesn’t Advance LGBT Equality’, *TEDx Salt Lake City* (19 December 2018) <<https://youtu.be/RjX-KBPm4g4>>; Paula Johnson, ‘His and Hers Healthcare’, *TED Women2013* (December 2013) <[https://www.ted.com/talks/9paula\\_johnson\\_his\\_and\\_hers\\_health\\_care?language=en](https://www.ted.com/talks/9paula_johnson_his_and_hers_health_care?language=en)>; Julie Zaugg, ‘Paula Johnson: “We Need a Better Understanding of the Differences between the Sexes”’, *In Vivo Magazine* <[https://www.invivomagazine.com/en/mens\\_sana/interview/article/116/paula-johnson-we-need-a-better-understanding-of-the-differences-between-the-sexes%3E](https://www.invivomagazine.com/en/mens_sana/interview/article/116/paula-johnson-we-need-a-better-understanding-of-the-differences-between-the-sexes%3E)>.

- 4.4.12. The TLRI acknowledges that there are a range of assessments and treatments for conditions related to gender identity, such as gender dysphoria/ incongruence, that do not have analogies with sexual orientation. The TLRI accepts that genuine medical assessments and treatments are not SOGI conversion practices.
- 4.4.13. The Australian Psychological Society’s 2015 position statement on psychological practices that attempt to change sexual orientation (note, at this point, not also extending to gender identity), is a useful indication of what is and is not acceptable and why:

It is, of course, appropriate for psychologists to provide clinical services to clients who experience distress in regards to their sexual orientation. It is also appropriate for psychological research to be undertaken on this topic. However, the Australian Psychological Society advises that such practice and research should seek to understand *the reasons for* distress and how it may be alleviated. Evidence-based strategies to alleviate distress do not include attempts at changing sexual orientation, but could include challenging negative stereotypes, seeking social support, and self-acceptance, among others.<sup>193</sup>

- 4.4.14. Similarly, treatments for gender identity-related disorders do not attempt to change or suppress a person’s gender identity, but instead to treat the symptoms of distress. This may require discussion of the causes of that distress, but that is not an inquiry into the ‘causes’ of a person’s gender identity or a change in that identity [see Appendix B].
- 4.4.15. In a more recent version of this statement, published in February 2021, the Society stated:

As a professional organisation committed to evidence-based practice, the Australian Psychological Society (APS) strongly opposes any form of mental health practice that tries to change or suppress someone’s sexual orientation or gender. Any psychologist attempting to do so is likely to be in breach of the APS Code of Ethics.

Instead, in response to an individual client who may be exploring their sexual orientation or gender and who may be struggling to reconcile it with their beliefs or those of significant others in their lives, the APS recommends psychological approaches that attempt to:

- Challenge negative stereotypes
- Develop affirming social supports
- Promote self-acceptance

<sup>193</sup> Australian Psychological Society, ‘APS Position Statement on the Use of Psychological Practices that Attempt to Change Sexual Orientation’ (2015) 2 (emphasis in original) <[http://admin.psychology.org.au/Assets/Files/APS%20Position%20Statement%20on%20Psychological%20Practices%20that%20attempt%20to%20change%20Sexual%20Orientation\\_Members.pdf?\\_ga=1.58087530.1714916510.1434345901](http://admin.psychology.org.au/Assets/Files/APS%20Position%20Statement%20on%20Psychological%20Practices%20that%20attempt%20to%20change%20Sexual%20Orientation_Members.pdf?_ga=1.58087530.1714916510.1434345901)>.

- Increase mental health literacy<sup>194</sup>

4.4.16. The existence of genuine medical treatments for gender identity-related disorders does not mean, however, that SOGI conversion practices conflate these two areas. It is entirely possible for a person to attempt a SOGI conversion practice on a person with gender dysphoria/incongruence, for example:

- A counsellor without any medical training or professional accreditation who attempts to ‘treat’ another person’s feelings of anxiety or distress around that person’s gender identity by a course of meditation.
- A religious leader attempting to convince a young congregant that their possible gender dysphoria/incongruence (even where that assessment would be accurate if performed by a trained and licensed medical practitioner) has been caused by childhood trauma and can be remedied by prayer.
- A medical professional engaging in a purported assessment and treatment of a person with potential gender dysphoria/incongruence in a manner that is not supported by current professional understandings and best practice treatment standards, for example, an accredited psychologist stating to a patient that being non-binary is ‘not real’ and is a function instead of another mental illness.

4.4.17. A submission by a legal scholar who did not list medical qualifications made a series of claims around the health science literature on gender identity conversion practices:<sup>195</sup>

- That transgender identification was once rare but that people, particularly adolescents, now identify as transgender in numbers comparable to or exceeding those identifying as same-sex attracted, citing a study by Baams published in 2018.<sup>196</sup>
- That the number of people presenting to clinics with gender identity concerns have increased ‘exponentially’, and that this is especially common in girls, many of whom also have autism or a mental health condition.
- That the TLRI claims a connection between long-discredited aversion therapies used on homosexuality with treatments of gender identity disorders, and then conflates data on the effects of sexual orientation conversion practices with the effects of gender identity treatments, with data on the latter being much more limited. Because Salway et al’s study

<sup>194</sup> *Australian Psychological Society 2021 Position Statement* (n 171).

<sup>195</sup> Submission 21.

<sup>196</sup> Laura Baams, ‘Disparities for LGBTQ and Gender Nonconforming Adolescents’ (2018) 141 *Pediatrics* e20173004.

had only 12 transgender participants,<sup>197</sup> it cannot accurately be used to evaluate the negative effects of gender identity conversion practices.

- That there is value in therapeutic counselling for adolescents who claim to be transgender, citing a study by Churcher Clarke and Spiliadis.<sup>198</sup>

4.4.18. The Institute uses these points to clarify and further investigate the literature that may be relevant for gender identity disorders and their relationship to SOGI conversion practices.

4.4.19. Baams describes an analysis using data from the Minnesota Student Survey 2016, a large anonymous survey of students in the US State of Minnesota. Although this survey is a rich resource and can facilitate analyses such as those performed by Baams, the interpretation here goes beyond Baams' analysis and indeed the data itself. Baams sought to examine childhood adversity in adolescents, with a focus on disparities for LGBTQ adolescents using data from the 2016 cross-sectional survey. This survey has an 85.5 per cent response rate. Table 1 provides the demographic characteristics of the sample, and as stated 2.68 per cent of the full sample are transgender and 1.27 per cent are gay or lesbian. Broader extrapolation of these findings would require further adjustment (e.g., weighting for survey non-response). Therefore, the statement above goes beyond what can be interpreted from the data.

4.4.20. It is correct that there have been increases in presentation of transgender individuals to specialist clinics.<sup>199</sup> The findings from these studies indicating an increase in transgender reporting, namely, Delahunt et al, do not support the statement that 'it is mostly girls', nor the statements about comorbidities. In Delahunt et al's work, an increase in female presentation was seen, however the number of males presenting was larger. As Delahunt et al appropriately note in their paper, their work was an audit of a single specialist clinic and is not necessarily generalisable. Although these studies can provide valuable information, they focus on specific population subsamples; in this example, individuals seeking care. It is not scientifically valid to extrapolate such findings to the broader population at large, because such subsamples likely differ systematically depending on key characteristics. Generalisation based on such results will not yield an accurate population estimate.

<sup>197</sup> Travis Salway et al, 'Prevalence and Exposure to Sexual Orientation Change Efforts and Associated Sociodemographic Characteristics and Psychosocial Health Outcomes among Canadian Sexual Minority Men' (2020) 65 *Canadian Journal of Psychiatry* 502.

<sup>198</sup> Anna Churcher Clarke and Anastassis Spiliadis, "'Taking the Lid Off the Box": The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties' (2019) 24 *Clinical Child Psychology and Psychiatry* 338.

<sup>199</sup> See, eg, Delahunt et al's audit of an endocrine specialist service in New Zealand: John W Delahunt et al, 'Increasing Rates of People Identifying as Transgender Presenting to Endocrine Services in the Wellington Region' (2018) 131 *New Zealand Medical Journal* 33.

- 4.4.21. Meerwijk and Sevelius sought to estimate the size of the transgender population in the US.<sup>200</sup> As they appropriately note, this estimate should not be generalised internationally as social acceptance is a critical factor in self-reporting of sensitive issues such as transgender identity and thus estimates of population size may show striking international variation. Nonetheless, the Institute discusses this paper to underscore the importance and challenge of deriving population-based estimates. Based on data solely from national surveys using probability sampling (e.g., population-based studies), they estimate that 390 per 100,000 adults are transgender, and did find an increase in self-reporting of transgender identity over time. The authors note the role of greater societal acceptance and anticipate future increases. Importantly, they discuss the variability in questions used to assess self-reported gender identity pose challenges for such analyses, and emphasise that the use of standardised approaches to elicit self-reporting of gender identity will improve accuracy.
- 4.4.22. In summary, while the Institute does agree that there is evidence from specialist clinics regarding increases in presentation, the Institute does not agree that such evidence can be presented as described above, and note that future population-based estimates using standard questions will be better positioned to provide the evidence required. Most essentially, the Institute emphasises that an increase in presentation cannot be correlated or associated with mental health conditions in the general population. As Meerwijk and Sevelius noted, any statistical variation over the last two decades is likely to be heavily influenced by changing cultural and social attitudes to gender identity, especially in the relevant jurisdictions reported on.
- 4.4.23. The Institute is also concerned that much of the language and arguments about increases in reporting of gender dysphoria/incongruence repeats and reflects historical, and now discredited, arguments for homosexual conversion practices. For instance, in the 1955 psychiatric text *Sex and Morality* — a foundational conversion practice text used to promote and was used to justify the practices in psychotherapy over the next decades<sup>201</sup> — Kardiner argued that:

Homo-sexuality is a part of the price exacted by the pressures of Western civilization today and it cannot be treated as a local excrescence; it is a systemic disease and requires systemic treatment.

...

<sup>200</sup> Esther L Meerwijk and Jae M Sevelius, 'Transgender Population Size in the United States: A Meta-Regression of Population-Based Probability Samples' (2017) 107 *American Journal of Public Health* <<https://doi.org/10.2105/AJPH.2016.303578>>.

<sup>201</sup> See, eg, Irving Bieber et al, *Homosexuality: A Psychoanalytic Study of Male Homosexuals* (Basic Books, 1962) 44–117; Albert Ellis, *Homosexuality: Its Causes and Cure* (Lyle Stuart, 1965); Lionel Ovesey, *Homosexuality and Pseudohomosexuality* (Science House, 1969); Sandor Rado, *Adaptational Psychodynamics: Motivation and Control* (Science House, 1969); Charles W Socarides, *Homosexuality: Psychoanalytic Therapy* (Jason Aronson, 1978); Charles W Socarides, *The Overt Homosexual* (Grune and Stratton, 1968).

In view of the great increase in homosexuality we are obliged to search for other contributory causes in the total adaptation of the modern male

...

As we have seen, there are people who believe that homosexuality is a biological variant. But no biological variant can increase one hundred per cent in a period of thirteen years. No animal species could survive such an abrupt change or mutation.

...

Evidently there is a voluntary element operating here that we have not hitherto suspected.

What can influence this voluntary factor? It must have something to do with fear, with collapse of pride and confidence, with the fact that homosexuality must have the character of a restitutive device and also one of defiance and rage.<sup>202</sup>

- 4.4.24. Such arguments were both discriminatory and culturally biased, insofar as they began from the assumption about the normative character of human sexuality and ‘procreative objective’.<sup>203</sup> That is, the authors began from the presumption that homosexuality was a fault of character and/or mental dysfunction. As such they incorrectly correlated an increase in reporting of homosexuality with an increase in mental dysfunction in the general population. That is, a social contagion. The objective facts were, however, that homosexuality had only recently been identified as a taxonomical category of human sexuality, and as such had only become the subject of medical and popular attention.<sup>204</sup> It also had been subject to increasing tolerance amongst different parts of the scientific, political and general communities. These factors, rather than an increase in mental or social dysfunction meant that homosexuality was being reported, labelled and investigated more than it had before.<sup>205</sup>
- 4.4.25. The Institute is concerned that contemporary arguments about the increase in presentation of non-cisgender persons in clinical contexts in the 21<sup>st</sup> Century is largely analogous to those made in the mid to late 20<sup>th</sup> Century about homosexuality. It would appear that such arguments, like their predecessors, begin from the assumption that such gender identities are faulty or dysfunctional and make unjustified assumptions and correlations as a result. This is despite the fact that those who make such assertions tend to distance themselves from long discredited homosexual aversion therapies. The Institute does not — and did not in the Issues Paper to this

<sup>202</sup> Abram Kardiner, *Sex and Morality* (Routledge and Kegan Paul, 1955) 180, 153, 159.

<sup>203</sup> Kardiner and contemporary psychoanalysts based their work on that of Rado, who had opposed the notion of natural human bisexuality proposed by Freud; insisting that there was only natural heterosexuality, and all other homosexual/bisexual variants were abnormal and evidence of pathological dysfunction brought about by mental impairment. See Sandor Rado, ‘A Critical Examination of the Concept of Bisexuality’ (1940) 2 *Psychosomatic Medicine* 459.

<sup>204</sup> Vern L Bullough, ‘Homosexuality and the Medical Model’ (1976) 1 *Journal of Homosexuality* 99; Karl Heinrich Ulrichs, *The Riddle of Man—Manly Love*, tr Michael Lombardi-Nash (Prometheus Books, 1994 [1864]).

<sup>205</sup> Jack Drescher “A History of Homosexuality and Organized Psychoanalysis” (2008) 36(3) *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 443 <https://doi.org/10.1521/jaap.2008.36.3.443>

Inquiry — seek to rely on data about aversion therapies to come to any substantive conclusions about prevalence.

- 4.4.26. Regarding the criticisms of Salway et al (2020), the authors' Table 1 compares conversion experiences by subgroups in their sample, and the size of the self-reported transgender subgroup in this paper does limit the conclusions that can be drawn. Salway et al do, however, clearly introduce their definition of 'sexual orientation change efforts'/'conversion therapy' as being 'pseudoscientific practices' and highlight that they use 'discredited methods including aversion therapy.'<sup>206</sup>
- 4.4.27. Regarding gender identity, Salway et al note so-called 'reparative practices' and the question used to assess experience of SOGI conversion practices is quite specific: 'Have you ever attended sexual repair/reorientation counselling?'<sup>207</sup> This is not a description of conduct which would fall under reasonable, contemporary standards of health care relating to gender dysphoria/incongruence. As noted above [see 2.2.3], no peak mental health body in Australia supports programs which promise to 'reorient' or 'repair' someone's gender identity. It seems unlikely, therefore, that this study conflates gender identity conversion practices with genuine 'treatment program[s] responding to [people] with gender identity concerns'.
- 4.4.28. In their description of their study, Churcher, Clarke and Spiliadis note that the aims were to understand individuals who no longer desired medical intervention 'during the course of assessment'.<sup>208</sup> This is underscored by their inclusion criteria, specifically that individuals had to have entered clinical evaluation wanting medical intervention and then moved away from this.<sup>209</sup>
- 4.4.29. The authors are therefore reporting on a very specific population subsample. Extrapolating from such a specific subsample to the broader population would not be valid, as discussed in the response to point 2. Furthermore, given the small numbers involved (n=12) in Churcher Clarke and Spiliadis, on the respondent's own standards it is inconsistent that this study provides 'strong evidence', but the same sample size for Salway et al is 'far too small a number to be making any claims' and that 'such small cell sizes have little or no statistical power'. In the TLRI's view, both are informative provided proper acknowledgement is made of these limits. Salway et al's utility is to describe a small sample from a larger general population of transgender people. Clarke and Spiliadis is useful to understand the specific subset of that

<sup>206</sup> Salway et al, 'Prevalence and Exposure' (n 197) 503.

<sup>207</sup> Salway et al, 'Prevalence and Exposure' (n 197) 504.

<sup>208</sup> Churcher Clarke and Spiliadis (n 198).

<sup>209</sup> Ibid, 342.

population, namely transgender teenagers who had sought medical transition but then decided not to opt for hormone treatment following counselling.

- 4.4.30. Finally, the Institute was supplied a paper by D’Angelo et al<sup>210</sup> criticising a study by Turban et al.<sup>211</sup> The TLRI did not cite or rely on Turban et al in the Issues Paper to this report, or in continuing consultation documents.<sup>212</sup> However, some respondents did cite that report.
- 4.4.31. Turban et al’s 2020 study of recalled exposure to ‘gender identity conversion efforts’ and psychological distress and suicide attempts among transgender adults found suggestions that lifetime and childhood exposure to gender identity conversion practices were associated with adverse mental health outcomes in adulthood. Using data from a 2015 cross-sectional survey of 27,715 transgender respondents, Turban et al found that of the 19,751 respondents who had discussed their gender identity with a professional, 3,869 (19.6 per cent) reported being exposed to ‘gender identity conversion efforts’, and approximately 35 per cent of that group stated those conversion practices were carried out by a religious advisor.<sup>213</sup> Adjusting for demographic variables, exposure to gender identity conversion practices was ‘significantly associated with multiple adverse outcomes, including severe psychological distress during the previous month and lifetime suicide attempts’.<sup>214</sup> The authors noted that exposure to conversion practices was ‘highly prevalent’ among the cohort: 14 per cent of the 27,715 respondents, and 19.6 per cent of those who had discussed their gender identity with a professional.<sup>215</sup>
- 4.4.32. D’Angelo et al’s central objection to Turban et al is that their ‘problematic analysis and flawed conclusions’ are used to ‘justify the misguided notion that anything other than “affirmative” psychotherapy for gender dysphoria is harmful and should be banned’.<sup>216</sup> D’Angelo et al raise issues about a ‘biased data sample’, poorly worded survey questions, the lack of any control variable on subjects’ baseline mental health, and what D’Angelo et al argue was the most problematic aspect of the study: insisting on a ‘binary’ of “affirmation” versus “conversion”’,

<sup>210</sup> Roberto D’Angelo et al, ‘One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria’ (2020) 50 *Archives of Sexual Behavior* 7.

<sup>211</sup> Jack L Turban, Noor Beckwith, Sari L Reisner, Alex S Keuroghlian, ‘Association between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults’ (2020) 77 *JAMA Psychiatry* 68.

<sup>212</sup> Turban et al ‘Recalled Exposure’ (n 211) was not found among TLRI’s results for its literature search for the Issues Paper. That is because the authors use the term ‘gender identity conversion efforts’: while the TLRI used ‘change efforts’ and ‘conversion therapy’ among other terms, the combined phrase ‘conversion efforts’ was not used, and the relative recency of the study meant it was not picked up in examinations of the citations in other studies, most of which pre-date Turban et al’s publication. The TLRI has used that phrase in its more recent searches.

<sup>213</sup> Turban et al, ‘Recalled Exposure’ (n 211).

<sup>214</sup> Turban et al, ‘Recalled Exposure’ (n 211) 73.

<sup>215</sup> Turban et al, ‘Recalled Exposure’ (n 211) 73.

<sup>216</sup> D’Angelo et al (n 210).

that meant any study participant who had encountered non-affirmative reactions to their gender identity from a professional would say they had been subject to a gender identity conversion practice.<sup>217</sup>

- 4.4.33. As a broad observation, the TLRI agrees that Turban et al overstate the generalisability of their claims, and that Turban et al's question does not seek to clarify the contexts in which that encounter took place, the precise form of this reaction by a professional, or how many times it might have been repeated, which may be significant for classifying something as a conversion practice or not. Nonetheless, Turban et al indicate that exposure to gender identity conversion practices is associated with negative mental health outcomes for gender diverse people.
- 4.4.34. The TLRI's position is that the line at which that assessment or treatment might become a conversion practice depends on whether a healthcare professional has offered an assessment and/or treatment that accords with current ethical and professional standards of evidence-based healthcare [see 6.1]. The central problem is the lack of certainty around the context of the encounters reported by participants in Turban et al's study. At the least, however, for the group of study subjects who reported a religious leader trying to make them identify as not trans (which was 35 per cent of the group stating they had encountered conversion practices), and on the assumption that those religious leaders lacked any relevant qualifications or accreditation in healthcare and that these efforts took place in a sustained manner, these would indeed gender identity conversion practices. As to the healthcare professionals that the Turban et al study participants reported had attempted to make them identify as 'not trans', whether that conduct amounted to a conversion practice would depend on the content and context of each of those encounters, and ultimately whether the conduct of those healthcare professionals accorded with ethical, professional, and clinical standards. D'Angelo et al themselves make this point.<sup>218</sup> The conduct of these healthcare professionals cannot automatically be labelled gender identity conversion practices, but nor can they automatically be assumed to be genuine healthcare. Further, while comment and discussion pieces are useful in evaluating scientific studies, at most D'Angelo et al's article provides good reasons to be cautious about, and limitedly accept or even entirely reject the findings of Turban et al's study: it is not itself a clinical study that provides evidence for the proposition that no significant correlations exist, and no such studies have been identified in the TLRI's literature review or by respondents to this Inquiry. Finally, Turban et al's general conclusions are consistent with more recent studies that do distinguish

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<sup>217</sup> D'Angelo et al (n 210).

<sup>218</sup> See D'Angelo et al (n 210) 2–4, especially at 2: '[the] lack of context and detail [in Turban et al's survey question] renders the question incapable of differentiating between ethical non-affirmative (neutral) encounters and unethical conversion therapy.'

between single and sustained encounters with gender identity conversion practices [see, e.g., 4.4.40].

## Studies published since November 2020

- 4.4.35. A number of studies potentially relevant to this Inquiry have been published since the Issues Paper was published in November 2020, and were either raised by respondents in February 2021, or have been identified in later searches to ensure the literature for this Final Report is up to date. The most recent of those searches was conducted in March 2022. Sixteen further clinical or scientific studies and articles potentially relevant to this Final Report were identified and reviewed.<sup>219</sup>
- 4.4.36. The new additions to the scientific and clinical literature are consistent with and provide more detailed support for the conclusions derived from the literature examined in the Issues Paper. They are also consistent with the reports of respondents to this Inquiry on the nature of conversion practices and their effects.
- 4.4.37. Two additional studies were relevant to questions of the prevalence of conversion practices. One assessed prevalence in the United States and the other detailed a plan for a systematic

<sup>219</sup> New scientific and clinical studies were Jones et al (n 125); Madison Higbee, Eric R Wright and Ryan M Roemer, 'Conversion Therapy in the Southern United States: Prevalence and Experiences of Survivors' (2022) 69 *Journal of Homosexuality* 612; Trevor Goodyear et al, "'They Want You to Kill Your Inner Queer but Somehow Leave the Human Alive": Delineating the Impacts of Sexual Orientation and Gender Identity Expression Change Efforts' [2021] *Journal of Sex Research* <<https://doi.org/10.1080/00224499.2021.1910616>>; David J Kinitz et al, "'Conversion Therapy" Experiences in Their Social Contexts: A Qualitative Study of Sexual Orientation and Gender Identity and Expression Change Efforts in Canada' [2021] *Canadian Journal of Psychiatry* <<https://doi.org/10.1177/07067437211030498>>; Ana Mariá del Río-González et al, 'Sexual Orientation and Gender Identity Change Efforts and Suicide Morbidity among Sexual and Gender Minority Adults in Colombia' (2021) 8 *LGBT Health* 463; Travis Salway et al, 'Experiences with Sexual Orientation and Gender Identity Conversion Therapy Practices among Sexual Minority Men in Canada, 2019–2020' (2021) 16 *PLoS ONE* <<https://doi.org/10.1371/journal.pone.0252539>>; David J Kinitz et al, 'The Scope and Nature of Sexual Orientation and Gender Identity and Expression Change Efforts: A Systematic Review Protocol' (2021) 10 *Systematic Reviews* <<https://doi.org/10.1186/s13643-020-01563-8>>; John R Blomsich et al, 'Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt Among Sexual Minority Adults, United States, 2016–2018' (2020) 110 *American Journal of Public Health* 1024; Amy E Green et al, 'Self-Reported Conversion Efforts and Suicidality Among US LGBTQ Youths and Young Adults, 2018' (2020) 110 *American Journal of Public Health* 1221; Turban et al, 'Recalled Exposure' (n 211); Jack L Turban et al, 'Psychological Attempts to Change a Person's Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015' (2019) 109 *American Journal of Public Health* 1452. Articles that were not scientific or clinical studies but dealt with issues related to conversion practices, clinical practice and/or law reform were Patrick Parkinson and Philip Morris, 'Psychiatry, Psychotherapy and the Criminalisation of "Conversion Therapy" in Australia' (2021) 29 *Australasian Psychiatry* 409; Christopher J Ryan and Sascha Callaghan, 'New Laws that Prohibit Conversion Therapy Pose No Material Risk to Evidence-Based and Clinically Appropriate Practice' [2022] *Australasian Psychiatry* <<https://doi.org/10.1177/10398562211057070>>; Florence Ashley, 'Homophobia, Conversion Therapy, and Care Models for Trans Youth: Defending the Gender-Affirmative Approach' (2020) 17 *Journal of LGBT Youth* 361; Marcus Evans, 'Freedom to Think: The Need for Thorough Assessment and Treatment of Gender Dysphoric Children' (2021) *British Journal of Psychology Bulletin* 285; Lucy Griffin et al, 'Sex, Gender and Gender Identity: A Re-Evaluation of the Evidence' (2021) 45 *British Journal of Psychology Bulletin* 291. As noted at 4.4.30, Turban et al 'Recalled Exposure' (n 211) was raised and discussed by several respondents to the Inquiry.

review of, among other things, prevalence data on conversion practices throughout the world. Consequently, these studies are of no use to assessing Australian or Tasmanian prevalence.<sup>220</sup>

- 4.4.38. Several studies examined suicidality and concluded that exposure to conversion practices correlated with a significantly increased risk of suicidal ideation, planning and attempts.
- 4.4.39. Blosnich et al’s July 2020 study examined potential links between sexual orientation change efforts and suicide morbidity after controlling for adverse childhood experiences.<sup>221</sup> Using data in a survey of 1,518 non-transgender sexual minority adults, the study found that 7 per cent (approximately 105 respondents) had experienced sexual orientation conversion practices, and that 80 per cent of those were in a religious setting. Those who had been subjected to conversion practices had nearly twice the levels of lifetime suicide ideation, a 75 per cent increase in the likelihood of planning suicide, and an 88 per cent increase in the likelihood of a suicide attempt, compared with those who had not experienced conversion practices.
- 4.4.40. Green et al’s August 2020 study also examined the potential links between SOGI conversion practices and suicidality among young LGBTQA+ people exposed to them.<sup>222</sup> Unlike Blosnich et al (2020), this study included gender identity conversion practices and transgender people. Using cross-sectional survey data of 25,791 LGBTQA+ people aged 13–24 in the United States, the authors found that two thirds of respondents had encountered someone who had tried to convince them to change their sexuality or gender identity.<sup>223</sup> Of that cohort, 1,088 or 4 per cent of respondents had experienced focused, structured and sustained conversion practices. Adjusting for a range of variables, those exposed to focused, structured and sustained conversion practices were more than twice as likely to report having attempted suicide and engaging in multiple suicide attempts. There was no statistically significant difference in these adverse outcomes related to whether the respondent was transgender or cisgender.<sup>224</sup>

<sup>220</sup> Turban et al, Psychological Attempts to Change a Person’s Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015’ (n 219) examined the data in the 2015 US Transgender Survey of 27,716 transgender people across the United States, and found that 13.5 per cent of the sample indicated they had been exposed, at some point in their lives, to psychological attempts to change their gender identity from trans to cisgender, suggesting the practice is widespread in every US state from 2010 to 2015 [see discussion of this study’s limits at 4.4.34]; Kinitz et al, ‘The Scope and Nature of Sexual Orientation and Gender Identity and Expression Change Efforts: A Systematic Review Protocol’ (n 219) was a systematic review protocol article that outlined the early stages and plan of a systematic review that will attempt to collate and review the international data on conversion practices around the world, including on prevalence, nature of the practices, and their effects. The results of this systematic review have not yet been published, and the article provides no suggestion of expected findings.

<sup>221</sup> Blosnich et al (n 219).

<sup>222</sup> Green et al (n 219).

<sup>223</sup> Green et al (n 219) 1225 (noting that the broad phrasing of this question meant it was unlikely that all of this cohort had encountered ‘formal SOGICE’, but rather, to use the terms of this Report, two-thirds reported exposure to conversion beliefs and/or practices.

<sup>224</sup> Green et al (n 219) 1225: ‘There is also a need to separately examine the associations of sexual orientation change efforts and gender identity change efforts with suicidality among young LGBTQ individuals. Although our question did not allow us to examine these differences, segmentation of our adjusted logistic regression models by gender identity did not reveal any significant differences’.

- 4.4.41. del Río-González et al's 2021 study examined the effects of conversion practices and specifically suicidality in Colombia.<sup>225</sup> Using a short survey of 4,160 sexual and gender minority adults, the authors found a high prevalence of suicidal ideation (56 per cent), suicide planning (54 per cent), suicide attempt (25 per cent) and conversion practice experiences (22 per cent).<sup>226</sup> Exposure to conversion practices was associated with a 69 per cent increase in the odds of suicidal ideation, a 55 per cent increase in the odds of suicide planning, and a 76 per cent increase in the odds of suicide attempt.<sup>227</sup> Exposure to conversion practices further exacerbated the already very high suicide risk in Colombian sexual and gender minority adults.<sup>228</sup>
- 4.4.42. Other new studies reported results consistent with earlier studies showing negative health outcomes, particularly mental health conditions, of people exposed to conversion practices. Some of these studies also delineate between people subjected to sexual orientation conversion practices and gender identity conversion practices [on the separability of this data see 4.4.8]. Some of these studies also suggest that transgender people may be more closely targeted for contemporary conversion practices.<sup>229</sup>
- 4.4.43. Higbee, Wright and Roemerman's 2022 study of prevalence and experiences of 475 conversion practices survivors in the Southern United States involved a quantitative analysis of a major regional study to estimate the prevalence of conversion practices and their effects.<sup>230</sup> The authors' findings were consistent with other previous studies: that there was a strong correlation between exposure to conversion practices and poor mental health outcomes. The authors also concluded that 'respondents who are younger, transgender, non-binary, Hispanic, less educated, and less religious at the time of taking the survey are more likely to have experienced conversion therapy in their youth', and that respondents who underwent conversion practices prior to the age of 18 'were significantly more likely to experience serious mental illness'.<sup>231</sup> The authors emphasise that transgender youth in their cohort seemed to be more closely targeted for conversion practices in the Southern United States.<sup>232</sup>

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<sup>225</sup> del Río-González et al (n 219).

<sup>226</sup> Ibid, 465.

<sup>227</sup> Ibid, 465–6.

<sup>228</sup> Ibid, 470–1.

<sup>229</sup> Green et al (n 219) 1225: 'our elevated reports of SOGICE among transgender or nonbinary young people extend previous findings showing that young adults who report greater gender nonconformity during adolescence are more likely to experience SOGICE'.

<sup>230</sup> Higbee, Wright and Roemerman (n 219).

<sup>231</sup> Ibid, 624.

<sup>232</sup> Ibid, 625: 'The finding that transgender and non-binary respondents also are more likely to report having experienced conversion therapy is consistent with previous studies supporting the finding that gender minority individuals are more likely to undergo the practice than cisgender individuals'.

- 4.4.44. Salway et al's 2021 study,<sup>233</sup> which has a similar focus to Salway et al 2020,<sup>234</sup> used survey data on 9,214 Canadian sexual and gender minority men about their experiences with conversion practices and the effects of exposure. 21 per cent reported that they themselves or a person with authority had at some point tried to change their sexual orientation or gender identity, and 910 respondents (10 per cent) had been involved in 'conversion therapy practices'. Salway et al here define 'conversion therapy practices' as a subset of broader 'sexual orientation and gender identity or expression change efforts', specifically as structured, sustained individual or group sessions that attempt to change sexuality or gender identity.<sup>235</sup> Of these 910 respondents, 77.3 per cent stated that the conversion practices targeted their sexual orientation only, 5.9 per cent stated it targeted their gender identity only, and 16.8 per cent reported it targeted both.<sup>236</sup> Two thirds experienced conversion practices in a religious setting, 30 per cent with a licensed health care practitioner, and 20 per cent with an unlicensed healthcare practitioner.<sup>237</sup> Seventy-two per cent experienced conversion practices before the age of 20.<sup>238</sup> Almost a quarter attended for more than 1 year and 30 per cent attended more than five sessions.<sup>239</sup> Those exposed to conversion practices were more likely to report isolation, feeling left out, greater involvement and connection to the 'GBQ community' and more likely to access mental health services.<sup>240</sup>
- 4.4.45. The studies above tended to use large surveys that often use voluntary social media recruiting, as opposed to selected and weighted samples. This limits the generalisability of their conclusions beyond those cohorts [see further below 4.4.50]. Other recent studies used semi-structured interviews of small groups of participants to examine the nature and effects of conversion practices. As noted above regarding other small group studies [see 4.4.29], this approach can yield rich qualitative data, but its generalisability to a larger population is limited.
- 4.4.46. Goodyear et al's April 2021 study of 22 'Two Spirit' LGBTQ+ people<sup>241</sup> who had undergone SOGI conversion practices through in-depth interviews examined the effects of those practices. The authors found common reports of feelings of shame and brokenness that respondents

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<sup>233</sup> Salway et al, 'Experiences' (n 219).

<sup>234</sup> Salway et al, 'Prevalence and Exposure' (n 197), discussed in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.9] and n 56.

<sup>235</sup> *Ibid*, 2.

<sup>236</sup> *Ibid*, 9.

<sup>237</sup> *Ibid*, 9.

<sup>238</sup> *Ibid*, 9–11.

<sup>239</sup> *Ibid*, 11.

<sup>240</sup> *Ibid*, 11.

<sup>241</sup> 'Two Spirit' is difficult to define precisely, and its use differs among Indigenous nations, but in general it means North American Indigenous LGBTQ+ people, predominantly in Canada, whose gender identity involves both a masculine and feminine spirit.

reported were strongly shaped by their experience with conversion practices, as well as effects like social isolation, mental distress, anxiety, depression and suicidality.<sup>242</sup> The vast majority of these participants saw the effects of these practices as ‘negative and severe to a point of being life threatening’.<sup>243</sup> One participant reported positive experiences with SOGI conversion practices, though also stated that they had not been ‘effective’ in his case.<sup>244</sup>

- 4.4.47. Kinitz et al’s 2021 study used semi-structured interviews with 22 people to examine Canadian experiences with SOGI conversion practices and provide a detailed picture of why, where, how and when Canadians encountered conversion practices.<sup>245</sup> This study intentionally did not focus on effects, but provided a similar account of the types of conversion practices reported to this Inquiry: they include formal and informal methods, offered by religious leaders, healthcare professionals, peers and family members, occurred in religious, medical or social settings, usually began when participants were teenagers or young adults and continued for several years in various forms, and were motivated by participants’ inculcated social and religious expectations that being sexually or gender diverse was not compatible with living a good life.
- 4.4.48. One new study is of particular relevance for questions of prevalence and effects in Australia. Jones et al (2021) used data from the Australian Research Centre in Sex, Health and Society at La Trobe’s 2019 survey *Writing Themselves in 4*, which surveyed 6,412 LGBTQA+ Australians aged 14–21 years and included questions on their experiences with SOGI conversion practices. Jones et al conclude that 4 per cent of this cohort (approximately 216 people) had attended SOGI conversion practices as counselling, group work, programs or interventions that aimed to change their sexuality or gender identity.<sup>246</sup>
- 4.4.49. Jones et al noted a correlation between exposure to SOGI conversion practices and being personally religious or being from a religious household. The authors also noted a correlation between exposure and poorer well-being outcomes, including increased levels of harassment, homelessness, drug-use, mental health conditions, suicidal ideation and attempts, and self-harm. 3.5 per cent of the overall sample was from Tasmania, though there is no further breakdown of how many respondents who reported being exposed to SOGI conversion practices were from Tasmania.
- 4.4.50. For the TLRI’s purposes in this Final Report, the Jones et al study is limited. The article aims to ‘explore prevalence’,<sup>247</sup> though it is not best described as a prevalence ‘study’ insofar as

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<sup>242</sup> Goodyear et al (n 219).

<sup>243</sup> Ibid, 4.

<sup>244</sup> Ibid, 4.

<sup>245</sup> Kinitz et al, ‘“Conversion Therapy” Experiences in Their Social Contexts’ (n 219).

<sup>246</sup> Jones et al (n 125) 4.

<sup>247</sup> Ibid, 2.

prevalence studies tend to use a selected and weighted sample. Rather it is a self-reporting study of a large voluntary sample recruited via social media and online networks. The Institute also notes that the paper uses a broader definition for SOGI conversion practices than that used in this report. Specifically, that definition includes remarks and actions that express a rejection of gender non-conforming behaviour. As with Turban et al (2020) [see above 4.4.33], the Institute's view is that this definition would not sufficiently delineate between discriminatory conduct and conversion practices in all situations, but certainly any conversion practice would involve such remarks and actions.

4.4.51. While Jones et al is limited in the above ways for the TLRI's purposes in this Final Report, it remains valuable for a range of reasons:

- It indicates that SOGI conversion practices are being reported by Australians under 21, indicating that young Australians continue to be exposed to SOGI conversion practices.
- It provides stronger evidence of the estimated levels of participation in SOGI conversion practices within a convenience sample of LGBTQA+ youth than, for example, the estimation approach used by the Human Rights Law Centre.
- Its results around religious belief or religious households being correlated with higher exposure to SOGI conversion practices, and that exposure being correlated with poorer health and wellbeing outcomes are consistent with similar international evidence, namely Meanley et al, Salway et al (2020) and Ryan et al.<sup>248</sup>
- Its results on effects are consistent with the newer studies examined above.

4.4.52. Finally, the five articles identified in the updated literature search did not provide detailed discussions of scientific or clinical studies around conversion practices, but covered other issues relevant to them and their regulation. Two short pieces examined law reform in Australia and its connection to clinical practice and the treatment of gender dysphoria.<sup>249</sup> Three further articles dealt with questions of whether and when gender affirmation is or is not a conversion practice. The first article contended that gender affirmation should not be considered a conversion therapy.<sup>250</sup> The second contended that attempts to understand the increase in

<sup>248</sup> On these studies, see *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.5]–[2.2.10].

<sup>249</sup> Parkinson and Morris (n 219): Parkinson and Morris is a short article that contends that gender identity conversion practices are controversial, that recent Australian reforms assume that these are ineffective and harmful, and conflating gender dysphoria treatment with gender identity conversion practices. This is mostly focused on the law and implications for practitioners, not on evidence or otherwise of the effects of either gender dysphoria treatments or conversion practices in general. Ryan and Callaghan (n 219) provided a short response to Parkinson and Morris, arguing that the ACT and Victorian laws pose no risk for psychiatrists who are engaged in evidence-based and clinically appropriate practice, particularly in assisting patients seeking help for gender identity questions or possible gender dysphoria, would not be vulnerable to prosecution. That is because no current supportable practice could aim at changing or suppressing gender identity.

<sup>250</sup> Ashley (n 219) 369–77, arguing that gender affirmation is not a 'conversion therapy', and contended that conversion therapy has historically and today focused on preventing trans youth from growing up trans. Ashley

presentations to UK gender clinics is complex and difficult to debate, and argued for clinician freedom in treating gender dysphoria.<sup>251</sup> The third article also examined the increase in referrals to UK gender clinics and the distinctions between ‘conversion therapy’ and gender identity-related disorder treatments.<sup>252</sup>

## 4.5. What are the effects of SOGI conversion practices?

- 4.5.1. As noted above [see 4.2.4], the Issues Paper concluded that clinical research on SOGI conversion practices supports two central points, which the Institute reiterates here:

### **SOGI conversion practices are ineffective**

- 4.5.2. Studies of SOGI conversion practices concluded that there was no evidence that these practices fulfilled their aims. These studies found little evidence that SOGI conversion practices can change a person’s SOGI status, with most subjects reporting they were ineffective and/or

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draws on clinical studies and anecdotes of harm to gender diverse people from conversion therapy, but this is not itself a clinical study.

<sup>251</sup> Evans (n 219) assessed the ‘3264% increase’ in referrals to two London gender identity services, contending that understanding the reasons for this increase is complex and difficult to debate due to the ‘politically charged’ nature of the topic and accusations of ‘transphobia’ (at 285). Evans contends that the ‘Memorandum of Understanding on Conversion’, first published in 2015 and signed by many healthcare professionals and the Royal College of Psychiatrists, is often seen as reducing clinician ‘freedom to examine and explore the various pathways that have led to gender dysphoria’, but in fact acknowledges that a therapist should try ‘to help the patient discover and come to terms with who they really are’, and that the Memorandum itself is ‘symptomatic’ of the ‘political agendas that have influenced this area of clinical practice’. (at 286) Much of the article considers the complexities of gender dysphoria treatment, adolescent development and ‘regrets’ and ‘detransitioning’. The only other point in relation to conversion practices is Evans’ mention of the case of Kenneth Zucker, the clinical lead of a Toronto gender identity clinic who Evans states was ‘sacked from his post after being accused of conducting “conversion therapy” because of the centre’s policy of ‘first trying to help the individuals deepen their understanding of themselves before recommending medical interventions’, and who was later ‘exonerated’ by an investigation (at 288). Note that Kenneth Zucker is the editor-in-chief of the peer-reviewed sexology journal *Archives of Sexual Behavior*, which published several articles and studies mentioned in this Final Report. Evans’ article provoked several letters supporting and opposing it, and Evans issued a corrigendum of various amendments, clarifications and additional references.

<sup>252</sup> Griffin et al (n 219) examine and criticise the UK Royal College of Psychiatrists’ position statement on treating transgender people, which notes that ‘any approach that aims to persuade trans people to accept their sex assigned at birth’ is a ‘conversion therapy’, which the authors argue might suggest that full transition is the ultimate goal in treating gender diverse patients, or the tendency of children to have gender dysphoria feelings remit during adolescence (at 292). Relevant to this Final Report is the authors’ discussions of what aspects of psychiatric treatment should not be considered ‘conversion therapy’. The authors stated that examinations of causal factors are now not explored, for example childhood traumas, for fear that they would be considered conversion therapies (at 294–5). The authors contend that transition should not necessarily be the key goal of treating gender dysphoria, but perhaps other outcomes such as ‘improved quality of life and reduced morbidity’: ‘When the phenomena related to identity disorders and the evidence base are uncertain, it might be wiser for the profession to admit the uncertainties. Taking a supportive, exploratory approach with gender-questioning patients should not be considered conversion therapy’ (at 295). The authors also note that while psychiatrists are supposed to ‘journey with’ patients and ‘provide support’, psychiatrists remain unsure if ‘addressing psychological and social antecedents’ for gender dysphoria ‘will lead to accusations of conversion therapy’, which would otherwise ‘be good practice in other conditions involving body image disturbance, such as anorexia nervosa’ (at 295).

harmful. Consequently, there is no base of clinical evidence that would support SOGI conversion practices being recognised as legitimate medical practices or treatments.<sup>253</sup>

### **SOGI conversion practices are harmful**

- 4.5.3. Clinical studies indicate that SOGI conversion practices are highly likely to have a serious negative effect on the health and wellbeing of people subjected to them. These effects include higher rates of low self-esteem, depression, alienation, loneliness, social isolation, internalised homophobia, sexual dysfunction, relationship problems, drug abuse, post-traumatic stress disorder, suicidal ideation, and suicide attempts. Recent studies suggest the long-term effects of SOGI conversion practices can be serious. A recent study showed an association between exposure to SOGI conversion practices and negative health outcomes in young adults.<sup>254</sup>
- 4.5.4. As noted above [4.4], more recent scientific literature presented similar studies and results that are consistent with these conclusions. Some articles disputed the reliability or generalisability of some of these studies. However, no study reviewed by the TLRI or suggested to it by any respondent to this Inquiry provided any claims or clinical evidence that SOGI conversion practices were either effective or did not pose a risk of harm.

### **Submissions reporting inefficacy and negative effects of SOGI conversion practices**

- 4.5.5. Parts 3.4–3.6 examined the accounts of respondents who had been exposed to SOGI conversion practices in Tasmania with a focus on the meanings and types of activities that they were exposed to. Those accounts also provided reports of a range of harms consistent with those reported in the scientific literature.
- 4.5.6. Reports by respondents to this Inquiry were consistent with the types of negative effects reported in studies set out above [see 4.2–4.3] and in the Issues Paper.<sup>255</sup> Nineteen separate submissions<sup>256</sup> reported negative effects following exposure to SOGI conversion practices in either themselves or others (in most cases an organisation’s clients or a medical practitioner’s patients), and some submissions reported the accounts of multiple people. These negative effects relate to people who were subject to conversion practices for their sexual orientation

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<sup>253</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.5]–[2.2.7].

<sup>254</sup> See the discussion and study details provided in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [2.2.8]–[2.2.10].

<sup>255</sup> *Ibid.*

<sup>256</sup> Submissions 1C, 37, 42, 85, 92, 93, 119, 120, 121, 123, 126C, 129\*, 148\*, 167, 168, 169, 177, 179\*, 180\*.

and/or gender identity, which undermines the suggestion by some respondents that gender identity conversion practices are not harmful or not likely to be harmful [see 4.4.17].

4.5.7. These negative effects included community-related harms, such as:

- A loss of trust in religious leaders and other congregants;<sup>257</sup>
- A loss of emotional and/or material support from a religious community;<sup>258</sup>
- Threatened, feared or actual exclusion from a religious community;<sup>259</sup>
- An inability to feel comfortable or accepted in a religious community;<sup>260</sup>
- Problems with/distancing self from families, (religious) communities or intimate relationships;<sup>261</sup>
- A loss of trust in medical practitioners and/or feeling reluctant to seek medical advice for fear of further exposure;<sup>262</sup>

4.5.8. Negative effects also included individual harms, including some extremely serious physical and mental health effects:

- A loss of self-worth or low self-esteem;<sup>263</sup>
- Self-hatred;<sup>264</sup>
- Alcohol and drug abuse;<sup>265</sup>
- Risky sexual behaviour;<sup>266</sup>
- Depression;<sup>267</sup>
- Anxiety;<sup>268</sup>
- Emotional distress, trauma, harm or hurt;<sup>269</sup>
- Feeling unsafe,<sup>270</sup> invalidated, traumatised or undermined;<sup>271</sup>
- Exacerbation or compounding of pre-SOGI conversion practice mental health issues;<sup>272</sup>

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<sup>257</sup> Submissions 42 at 4, 121 ‘Ben’.

<sup>258</sup> Submission 121 ‘Chloe’.

<sup>259</sup> Submissions 85 at 9, 93 at 10, 121 ‘Ben’.

<sup>260</sup> Submission 121 ‘Ben’.

<sup>261</sup> Submissions 37 at 6, 42 at 4, 85 at 9, 148\*, 167, 168, 179\*.

<sup>262</sup> Submissions 1C, 92 at 21, 180\*, 1C.

<sup>263</sup> Submissions 42 at 4, 121 ‘Ben’, 169, 179\*.

<sup>264</sup> Submissions 42 at 4, 121 ‘Ben’, 177.

<sup>265</sup> Submission 121 ‘Ben’.

<sup>266</sup> Submissions 85 at 9, 121 ‘Ben’.

<sup>267</sup> Submissions 42 at 4, 85 at 7, 121 ‘Chloe’, 169, 179\*.

<sup>268</sup> Submissions 42 at 4, 85 at 7, 111\*, 121 ‘Chloe’, 169, 179\*.

<sup>269</sup> Submissions 1C, 85 at 7, 92, 119, 120, 121, 126C, 129\*, 168, 169, 179\*, 180\*.

<sup>270</sup> Submission 180\*.

<sup>271</sup> Submissions 85 at 9, 121 ‘Rae’, 1\*.

<sup>272</sup> Submissions 1C, 121 ‘Rae’, 168.

- Suicidal ideation,<sup>273</sup> and/or
- Suicide attempts, and suicides by friends or loved ones.<sup>274</sup>

4.5.9. A first, strong theme amongst respondents who reported being subjected to conversion practices was community-related harms: feeling isolated from, disconnected from, or distrustful of their family, their religious community or healthcare professionals. They also lost trust in persons in positions of care and authority. For those who were exposed to conversion practices in faith-based communities, the threat of being shunned by or excommunicated from people they love for living authentically was ever present and caused considerable anguish. Respondents who had encountered SOGI conversion practices from medical practitioners often suggested they were reluctant to return to or seek further treatment for other physical or mental health problems. Respondents gave examples of being persuaded to suppress their sexual orientation or gender identity if they wanted to remain connected to their faith-based community and relationships. One respondent who was raised Mormon expressed these difficulties:

Very repressed about any sexuality. Lots of pressure to get married and start a family. There was a need to confess any sexual sins (including thoughts) in order to be able to be considered worthy before God ... I am aware that religious groups offer to run prayer groups and guided support to people whether or not they want to change. The opportunity to participate in a strong, welcoming, loving religious community is very appealing but to be a part of that, you have to renounce LGBTIQA behaviours, including thoughts.<sup>275</sup>

- 4.5.10. Submissions to the community consultation revealed a range of personal experiences with the ineffectiveness of SOGI conversion practices that illustrated the way that repeated ‘failure’ may compound and exacerbate negative effects like self-hatred, depression and anxiety. SOGI conversion practices were presented to these respondents as services that could ‘heal’ their perceived brokenness or deficiency. That positioned the individual subjected to them as central to their effectiveness. Consequently, when these practices were ‘unsuccessful’, that failure was the fault of the subject and their lack of ‘willingness’ or ‘commitment’ to changing, rather than the practitioner. This aligns with the clinical reports on feelings of worthlessness and hopelessness from the inefficacy of SOGI conversion practices, leading these respondents to blame themselves.
- 4.5.11. A respondent who had been subject to life-long discriminatory conduct and conversion practices directed to their sexual orientation summarised the impact on their life as follows:

<sup>273</sup> Submissions 92, 121 ‘Chloe’ and ‘Rae’, 177, 179\*.

<sup>274</sup> Submissions 93 at 17, 121 ‘Chloe’, 123, 126C, 129\*, 159\*.

<sup>275</sup> Submission 148\*.

I am now 50 and have found help over those years but there are parts of me which are still broken and has influence still on my decisions in my life. ... what I would hear from the pulpits was that my [sexual orientation was a] physical illness ... so I under went over the years various forms of ‘help’ ... [but] Nothing changed, it[’]s your fault nothing has changed because you do not want to let it go and fully repent ... When I was overcome with depression and anxiety I felt I had no hope that my life should end because of who I am. ... I’m still scarred I had twenty years of spiritual abuse it does not all heal over night.<sup>276</sup>

4.5.12. Another respondent whose mother sent her for eight hypnotherapy sessions to suppress same-sex attraction, where the therapist ‘had said that gay people are harmful to children and it is part of their gay agenda to recruit young people to their way of life’, only came out fully at 30 and ‘spent years in therapy trying to undo what [w]as done to me’.<sup>277</sup>

4.5.13. Repeated exposures, for example in prayer ministries, deliverance or exorcisms, tended to compound the internalisation of a feeling of failure.<sup>278</sup> The respondent subjected to many sessions of conversion practices, including prayer groups and exorcisms [see 3.4.5 and 3.4.7], stated that he was blamed when they did not work, and that the combined effect of these conversion practices included exclusion from his faith community, anxiety and depression:

When it did not work I was pushed aside, ostracized and told I was going to burn in hell unless I stop living this ‘lifestyle’. ... I am now 50 it has scarred me emotionally [I] suffer anxiety and depression which I can trace back to these practices, when I was in the midst of it and played the game and spoke the mantra I knew no different I had been brainwashed and it still affects me in ways today in my daily life.<sup>279</sup>

4.5.14. The Brave Network and SOGICE Survivors submitted eight stories of Australians who had been exposed to SOGI conversion practices and reported negative effects matching those mentioned above — alienation, depression, anxiety, self-loathing, threatened or actual exclusion from a community, risky sexual behaviour, suicidal ideation and attempts. For example,

I was married with 5 children when I was involved in my church community. I had traumatic memories of abuse and I knew I was attracted to women, which I kept secret. At the time, I asked a fellow Christian friend to suggest a therapist and she recommended one with a specialty in abuse and homosexuality. Our meetings were in a church building and involved a prayer group to support me in my process of healing. Within weeks of therapy I

<sup>276</sup> Submission 165.

<sup>277</sup> Submission 130\*.

<sup>278</sup> Submission 85, 93, 165, 173\*.

<sup>279</sup> Submission 165.

mentioned my same sex attraction and I was told by my therapist that I needed to pray when feelings surfaced. If I succumbed in any way, physically or mentally, my therapist would organise a group prayer session. Unable to hide my feelings, I succumbed to prayer sessions and 10 hour deliverance sessions, with my therapist checking on me 3 times a day to see that I hadn't succumbed to any same sex relationships in any way. My therapist constantly told me God would abandon me for this terrible sin. The pressure led me to attempt to take my life.

4.5.15. The Brave Network and SOGICE Survivors stated that these accounts included 'survivors from within Tasmania' but without clear indication of which or how many accounts related to Tasmania.<sup>280</sup>

4.5.16. Submissions from friends and relatives of survivors also identified harms to subjects of conversion practices. One respondent expressed sadness when discussing how they assisted a young man who attempted suicide due to the harm caused by conversion practices, suggesting that while parents and those in faith communities often want to 'support' others, this can come at a great cost to those people, in particular a loss of trust and faith and connection to their faith communities and/or families:

[they used] religious and superstitious practices (i.e., 'witchcraft') to have their son 'cured.' This included an exorcism. The damage that the young man received at the hand of this was considerable. His faith journey and fundamental beliefs were destroyed.<sup>281</sup>

4.5.17. Another anonymous respondent relayed this story:

The person receiving the 'treatment' was told that their sexuality was an illness that could be cured. They were told that if they prayed hard enough and often enough, and if they were obedient and devoted worshippers of god, they would no longer be homosexual. This person suffered years of believing they were being punished for something they couldn't control and that they weren't trying hard enough to suppress their sexuality. Before the age of 18, they attempted suicide twice.<sup>282</sup>

4.5.18. TLRI received submissions from counsellors, officials and other professionals who had met or worked with Tasmanian conversion practice survivors.

4.5.19. One respondent stated:

I have worked with and supported people who have experienced conversion practices and the effects of these practices last for a life time. They result in low levels of self-esteem,

<sup>280</sup> See further examples in Submission 93 at 17–20.

<sup>281</sup> Submission 173\*.

<sup>282</sup> Submission 129\*.

anxiety, depression and significant trauma which they carry with them throughout their lives.<sup>283</sup>

- 4.5.20. The Commissioner for Children and Young People relayed this experience of speaking with someone who had been subjected to conversion practices:

I recently had the privilege of speaking with an adult survivor of SOGI conversion practices, elements of which occurred during this person's adolescence via Christian counselling underpinned by an ideology that LGBTQA+ people are damaged or 'broken' and can be 'fixed'. The profoundly harmful effects experienced by this person have greatly assisted to provide me with insight into the insidious and unethical nature of SOGI conversion practices and their effects.<sup>284</sup>

- 4.5.21. A Tasmanian public servant stated that they had been involved in discussions with individuals and their families about the effects of conversion practices. The respondent described this as

extreme and ongoing trauma inflicted on both the individuals involved and their families. Expressions such as 'self-hatred', 'coercion', 'bullying' [and] 'CP [conversion practices] presented as only way to fix their abnormality' and 'driven to feel suicidal' were common phrases used in these discussions.<sup>285</sup>

- 4.5.22. Another anonymous respondent wrote that

I have provided assistance to family members who have been advised that their willingness to assist their child/teen to transition amounts to child abuse. They have been refused ongoing treatment and support by their general practitioner. I have also supported young people who have been advised by general practitioners that their questions relating to their gender are 'ridiculous' and to 'stop just trying to be part of a trend'. These comments are extremely concerning as they have resulted in in [sic] an increase in suicidal ideation for the young person and a reluctance to access medical care when needed.<sup>286</sup>

- 4.5.23. Tasmanian community and counselling services provided reports of harms caused by conversion practices to their clients. Some submissions noted that they had many clients who were survivors of SOGI conversion practices in Tasmania.<sup>287</sup> Community organisations went into considerable detail about the effects common to people who had encountered SOGI

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<sup>283</sup> Submission 169.

<sup>284</sup> Submission 120 at 5.

<sup>285</sup> Submission 177.

<sup>286</sup> Submission 159\*.

<sup>287</sup> Submissions 91, 42.

conversion practices and used their services. For example, Relationships Australia Tasmania (RA Tas) stated:

SOGI conversion practices not only do not achieve their stated aims but are harmful with survivors experiencing severe anxiety, depression, guilt[,] and shame. ... As a counselling service, RA Tas has seen the impact of SOGI conversion practices on staff and clients. [including] long-lasting depression, anxiety and trauma, guilt and shame about their sexuality or gender identity, dissociating or suppressing their identity and sexuality (which may result in a belief that they are cured, but in a belief that they are cured, but ultimately has the same traumatic impact as any other form of dissociation), and a resulting impact on the ability to seek, build and sustain healthy interpersonal relationships. Additional observations in other contexts include outcomes of individuals undergoing conversion therapy engaging in compulsive and unsafe sex as a response to trauma symptoms.<sup>288</sup>

- 4.5.24. Working It Out, Tasmania's sexuality, gender and intersex status support and education service, also submitted accounts of clients recovering from exposure to SOGI conversion practices that illustrated harms:

As Tasmania's primary LGBTIQ+ support service, our staff have and do provide support to people who have experienced conversion practices. Our practice-based evidence shows that the effects of these practices can last for many, many years, if not a lifetime. They result in low levels of self-esteem, anxiety and depression. For some people, these experience[s] represent a significant trauma which they carry with them daily. In addition to the harmful narrative that a person is defective and unacceptable in the eyes of their god and community, these practices can alienate people from their faith and their faith communities, causing further trauma and psychological distress.<sup>289</sup>

- 4.5.25. The accounts provided by Transforming Tasmania and extracted above to illustrate conversion practice methods in Tasmania [see 3.4.3, 3.4.4 and 3.5.6] also provide details of harmful effects like the loss of family and religious connections, as well as personal harms like self-loathing, trauma, alcohol and drug abuse, risky sexual behaviour, suicidal ideation and suicide attempts. 'Ben' [see 3.4.4], who was excluded from his church music group after they found out he was trans, reported that being cut off from his church was 'like I couldn't breathe', that he lost trust in the church congregants and leaders, and suffered serious effects:

It hurt so bad, like my family had died but was somehow still standing around making small talk with each other.  
It totally destroyed my self worth, I hated myself. I started drinking myself into oblivion

<sup>288</sup> Submission 85.

<sup>289</sup> Submission 42 at 4.

every night, sleeping with strangers compulsively and putting myself in unsafe situations. I thought I deserved to suffer, and I was going to hell anyway, so I might as well get there a bit quicker.

I guess I'm one of the lucky ones, in that it didn't end up actually stopping me transitioning, and I made it to a better place eventually. But I lost so much.

Honestly, I still don't trust any faith groups. I haven't been able to be part of any since. I don't know how to find a church community where I'll be able to feel safe, and not like they might suddenly turn on me. My faith is still the core of my identity, but trying to find other people to share that with is too much for me most of the time.<sup>290</sup>

- 4.5.26. 'Chloe' [see 3.4.4], a 28-year-old trans woman whose trusted pastor convinced her to undergo conversion practices, detailed exacerbated mental health issues, abandonment by her girlfriend and church, and ultimately suicidal ideation and attempts that followed her exposure to conversion practices:

When I was 17, my family kicked me out — we'd never had good relationships. I was on my own, depressed, anxious, living in totally gross conditions, couldn't afford to eat properly. What kept me going was the support of my pastor and my girlfriend at the time. My pastor made so much time for me — he always checked in, counselled me about so many things, listened to me, helped me out with food and care packages. Our church — my girlfriend and I went to the same one — became my real home.

I'd secretly known I was trans for a long time, but I was too scared to do anything about it. I grew up hearing all the terrible things that get said about gay folks in churches, and I'd lain awake at night for years trying to work out if God had a place for me, if I could ever really be forgiven or if my sin was too great for God to love me.

When I — utterly terrified — finally told my pastor I was trans and asked him if there was any hope for me, his tone didn't really change. He'd always been worried for me, and he stayed as gentle and kind as he'd always been. But gently, kindly, he told me that queerness was a kind of spiritual brokenness, and I needed to be healed—and it was part of his calling to help me find my way back to 'what God intended' for me.

To have the main authority and parental figure in my life tell me that who I was was fundamentally wrong, and corrupted by the Devil? Saying out loud all the things my anxiety and depression had been saying inside my head? I can't explain what that felt like. [Details of conversion practices that Chloe and her girlfriend were involved in] They told her [Chloe's girlfriend] she had to break up with me, that she wasn't the right person to guide me back to righteousness, and that if she wanted to stay at that church she wasn't allowed to

<sup>290</sup> Submission 121 'Ben'.

talk to me or sit with me during services any more. She needed the church community, so she stopped talking to me. I don't blame her.

A month into my 'rehabilitation' I tried to kill myself. I left the church after that.

I actually tried to kill myself a few times over the next few years. I guess I was pretty bad at it.

I'd like to say I'm all better these days, but I'm not. I'm still totally fucked up. I can't hold down a relationship. My faith is a source of constant pain. I'm scared of Christians, but I am a Christian still, so I can't practice my own faith. I feel safest around other queer people who hate Christianity because of how it's treated them, but then, I end up feeling like they hate that part of me and I have to keep that secret. I can't be my whole self anywhere. Deep down I think I still believe I deserve to suffer.

I don't know if things will ever get better for me. But any laws that could stop that happening to someone else are a good thing as far as I'm concerned.<sup>291</sup>

- 4.5.27. Finally, 'Rae' [see 3.5.6], whose psychiatrist offered her cognitive behavioural therapy to change and suppress her nonbinary status, reported severe trauma, invalidation, a longstanding mistrust of health professionals, and multiple episodes of suicidality:

At the time, I was devastated by it all, but the full damage of it didn't really become clear to me until years later. I'm still unpicking it. I had never before, and have never since, been so systematically undermined and invalidated and traumatised by someone who was meant to be helping me. When I told my dad about what had happened — a man of fierce and fearless Christian faith — he cried, because of how they'd hurt me.

The next couple of years after that were a hellish storm of suicidality.

...

I didn't go back to a psychiatrist for years after that, even though I needed to. Eventually I was forced to, after a couple of instances of becoming so suicidal I had to go to the ER [emergency room]. By that point, I'd finally just managed to start HRT [hormone replacement therapy], but was having a lot of trouble coming to terms with it because part of me still believed what that first psychiatrist had tried to train me to- that my transness wasn't real, that I was just wrong and broken and attention-seeking.<sup>292</sup>

- 4.5.28. Working It Out also provided case studies illustrating a range of harms from conversion practices which had previously been mentioned in its annual reports:

Alex spent much of their adult life in 'gay conversion therapy' processes. Alex came to Working It Out experiencing a crisis of meaning and identity. In their first session Alex

<sup>291</sup> Submission 121 'Chloe'.

<sup>292</sup> Submission 121 'Rae'.

spoke almost non-stop of the religious belief they grew up with ... that same sex attraction was evil and wrong. Alex wept as they described the impact that this had had on their life. As Alex's own same sex attractions developed, they internalised intense personal shame and self-hatred. This lifelong denial became too much, and Alex had their first same-sex encounter. Once again Alex wept and using almost religious language, Alex described this act as 'making them whole', 'I was broken and this experience was healing', 'a hole has been filled in my life'. In WIO Alex finally has a safe place where they could ask and reflect on these questions of meaning and purpose. Alex spoke of feeling 'understood and accepted' within our service and of hoping that with the support of WIO they can come for the first time to love and accept themselves.<sup>293</sup>

- 4.5.29. The Chair of the South Australian Rainbow Advocacy Alliance relayed this story about a Tasmanian survivor:

I have met one person whose experiences occurred when they used to live in Tasmania ... Their experience took place in a religious setting and were deeply traumatic, to the point that even discussing these practices briefly in a group setting was enough to bring them to tears. This individual described their experience as stopping them from accepting their sexuality for several years, and that they effectively had to learn to love their self again in their 30s and 40s after being told there was something wrong with them for so many years. This impacted on their intimate relationships, and it's only in the last few years that they feel they've healed enough to be able to maintain a stable relationship.<sup>294</sup>

- 4.5.30. The TLRI acknowledges that many of these reports are anecdotal or pseudonymous, and that some have been submitted by advocacy groups. They are difficult to verify, even where respondents provided specific details such as locations or the names of people (which have been redacted here). Nonetheless, the variety, details and number of these reports, combined with the 42 submissions reporting conversion practices occurring in Tasmania, are strong reasons in favour of them reflecting the harms that people in Tasmania have likely experienced from conversion practices.

## 4.6. Submissions reporting effectiveness of SOGI conversion practices

- 4.6.1. Several submissions stated that SOGI conversion practices had helped people who had participated in them and had positive effects.

<sup>293</sup> Submission 42 at 4–5.

<sup>294</sup> Submission 167.

- 4.6.2. Some positive experiences reports were general statements that there were people who had found SOGI conversion practices useful, or that they were beneficial to LGBTQA+ people in general, without details or specific accounts of individuals who had benefited from them.<sup>295</sup> For example, one respondent wrote:

You refer to those ‘who are subjected’ to conversion practises. You deliberately ignore, and are not prepare[d] to consider the fact, that some people have found them helpful. ... LGBTIQA+ status is disordered and dysfunctional, because it denies the self evident truth about the human body.<sup>296</sup>

- 4.6.3. Another respondent provided this account, which seems to suggest they thought there may be both positive and negative effects for conversion practices, though without explicitly stating they had undergone conversion practices:

I have no doubt that some people have been and will be harmed by some gay conversion practices. Undoubtedly, others will be helped. At one time in my life I was part of a legalistic religious group. The discipline was hugely beneficial to people with otherwise out of control dysfunctional lives, but it was simplistic. The teaching around human sexuality was narrow and condemning. I can to some extent relate to the sentiment of a life un-lived. Was I harmed? Perhaps. I was also helped.<sup>297</sup>

- 4.6.4. The only respondent who submitted detailed accounts of positive experiences was an anonymous person who is not Tasmanian but who is an active campaigner and promoter of conversion practices in Australia. This submission relayed three accounts: the respondent’s own experiences and those of ‘Male, 28, Single’ and ‘Female, 36, Single Aboriginal’. The respondent’s own account stated:

I learnt to look more deeply into my history and to own the dysfunction, trauma and brokenness for what it really was, and to permit myself to gently enter onto a pathway of healing, conversion and restoration. The Christian Churches were the only ones that would support me ... I have only ever met one person who has regularly undergone electric shock treatment ... As for the often-quoted aversion therapies of ice baths, heterosexual rape, bashings and exorcisms casually branded about on all forms of media, I have never heard of, or know of, one case where this has happened. I do know, however, that counselling, support groups, prayer, insightful retreats and camps and peer support has tremendously helped, and is helping, very many of my fellow Australians to take charge of their lives and to live in accordance with their values and beliefs, all for the overall betterment of Australia

<sup>295</sup> Submissions 3, 30, 34, 99, 110\*, 147C.

<sup>296</sup> Submission 30 at 2–3.

<sup>297</sup> Submission 34 at 4.

as a nation ... A great deal of contemporary therapy today, which is now being brandished as conversion therapy, is actually saving lives, decreasing suicides and causing individuals to make successful autonomous therapeutic and spiritual journeys.<sup>298</sup>

4.6.5. The second account stated:

My heart is miraculously changing thanks to ongoing therapy and prayer. I am being fine-tuned into the man that I now see I was created to be. Today, life just keeps getting better. ... Where I was caught up in sex addiction, having sex anywhere in public, I am now reaping the benefits of pursuing purity and being affirmed by God and not by other men. My hunger for fatherly attention, affection, and affirmation is now being healthily met. In place of wearing makeup and doing drag, I now embrace my true identity as a man. Instead of constantly binge drinking, I have learnt to moderate my alcohol consumption. Where I was highly promiscuous and sexually depraved, I now pursue chastity and others' dignity. My underlying nauseous anxiety has been replaced with an underlying peace. ... I spend time regularly in Tasmania. If I cannot find the ongoing help and support I need there as a result of changes in law relating to therapy then I, like others, will have to cease doing work and visiting there.<sup>299</sup>

4.6.6. The third account stated:

Today I am in the best place I have ever been. I am beginning to see how the many wounds inflicted upon me as a teenager through sexual abuse pushed me away from daring to trust men. And yet I need a place of emotional connection and compassion, and so I fell time and again into the arms of another women — but this only made my pain worse, not better. ... Please, I beg you as a committee, on behalf of Aboriginal women and children, do not mess with the therapy, support and prayer that is finally bringing hope to so many confused in their sexual identity, attraction and in their gender. I do not believe you can have any idea how many lives have already been saved by the type of therapy, support and prayer I have received and how many might just be saved in the future. The Aboriginal community needs the opportunity to heal from its traumas, its dysfunction and brokenness. It doesn't need what is working well to be taken away from it. Thank you for letting me voice my concerns to you in this way.<sup>300</sup>

<sup>298</sup> Submission 110\*.

<sup>299</sup> Submission 110\*.

<sup>300</sup> Submission 110\*. The TLRI reiterates that it has not made attempts to investigate the veracity of these accounts, and must assume that these are genuine accounts. The Institute acknowledges that this final account involves a suggestion that the traumatic legacies of Australian settler violence and dispossession of Indigenous peoples and nations (and/or impliedly, LGBTQA+ Indigenous people) might be remedied by the purported benefits of conversion practices. The Institute acknowledges that that suggestion may be offensive to some readers.

- 4.6.7. Another submission did not contain any testimonies, but did include links to videos and testimonies of those who have ‘successfully left the LGBT+ lifestyle’ and stated they had met some of these people,<sup>301</sup> and also included links to sites like [www.freetochange.org](http://www.freetochange.org), an Australian SOGI conversion practices website that includes 76 ‘ex-LGBT’ testimonials.<sup>302</sup>
- 4.6.8. Apart from the one anonymous submission quoted above,<sup>303</sup> the TLRI did not receive any submissions where a respondent stated that SOGI conversion practices had worked for them personally. That submission relayed accounts of themselves and two other anonymous people, which are difficult to verify and lack any stated connection to Tasmania (besides the point on using conversion practices while visiting Tasmania in the second account). The TLRI received other submissions that detailed negative effects of conversion practices that did not have a clear connection to Tasmania, and for that reason did not rely on them in Part 4.5.
- 4.6.9. The accounts quoted and cited above are the total of personal accounts of positive effects of SOGI conversion practices received in the submissions to this Inquiry. Importantly, no medical practitioner submitted any account of patients or clients who had positive experiences with SOGI conversion practices. That is significant because, even in reporting anecdotal experiences, expertise in clinical efficacy and harm would be important for accepting the possibility of either effectiveness or positive benefits. Given the reports of medical practitioners offering SOGI conversion practices within Tasmania, it is possible that at least one of these practitioners might have attested to their successes or the positive benefits on their clients. Such a submission could have been made anonymously and/or under a pseudonym. No such submission was made.

## **4.7. Conclusion on efficacy and harm**

- 4.7.1. As noted above [see 3.4–3.6], the TLRI is satisfied that SOGI conversion practices are currently occurring in Tasmania. This Part has demonstrated that SOGI conversion practices are not recognised medical treatments and are not effective, and that they cause harm. That is supported by clinical studies examining effectiveness and harm, and numerous accounts submitted to this Inquiry detailing the harmful effects suffered by people in Tasmania, submitted by people who have undergone SOGI conversion practices and those who have cared for or treated them. The TLRI is satisfied that conversion practices have harmed people in Tasmania and pose a risk of future harm to people in Tasmania.

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<sup>301</sup> Submission 99 at 1.

<sup>302</sup> Submission 110\*.

<sup>303</sup> Submission 110\*. Submission 34 [see 4.6.3] may have undergone conversion practices and suggested they had positive effects on others, however, this is not clearly stated as a personal experience.

Part III

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**RECOMMENDATIONS FOR LAW  
REFORM**

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## Chapter 5

# Approach to law reform

## 5.1. Conversion practices and Tasmanian law

- 5.1.1. The Issues Paper noted that Tasmanian law does not presently address SOGI conversion practices as a specific category of offence. However, a range of Tasmanian laws may proscribe some forms of SOGI conversion practices.
- 5.1.2. The Issues Paper laid out other law reform approaches taken in different jurisdictions in Australia, in foreign jurisdictions, and under international law.<sup>304</sup> Readers may wish to revisit the Issues Paper Parts 3.3–3.5 for background on these options. The text of the Victorian, ACT and Queensland reforms, all of which have now passed into law in those jurisdictions, are contained in Appendix D to this Final Report.

### Tasmanian law has not been applied to conversion practices

- 5.1.3. No Tasmanian laws have yet been applied to a matter involving SOGI conversion practices. The Institute is not aware of any complaints being raised under existing laws. Nor is the Institute aware of any complaints about SOGI conversion practices being considered by a court or tribunal in Australia.<sup>305</sup> Without further evidence it is not possible to draw conclusions about

<sup>304</sup> TLRI SOGI Conversion Practices Issues Paper (n 7) 30–37.

<sup>305</sup> Westlaw AU — ‘conversion practice’ returned two judgments: *ACN 074 971 109 Pty Ltd v National Mutual Life Association of Australasia Ltd* (2013) 41 VR 476, an insurance matter involving price conversions, no relevance; *Singtel Optus v Almad* [2013] NSWSC 1427, a matter on the tort of conversion, no relevance. Westlaw AU — ‘conversion therapy’ returned three cases: *Secretary, Department of Social Security v SRA* (1993) 43 FCR 299, a social security/family law case on a transgender husband to wife, Black CJ at 337 noting the use of expert expressions ‘sex conversion therapy’ in relation to transgender people, but meaning what today would be called gender re-assignment surgery, not relevant to SOGI conversion practices; *A-G (Cth) v Kevin* (2003) 172 FLR 300, a constitutional law and family law case on the meaning of marriage where one party was transgender, using ‘sex conversion therapy’, quoting Black CJ in *SRA* above, not relevant to SOGI conversion practices; *Nicholas v Jimenez* [2020] NSWDC 71, a tort personal injury/motor vehicle accident case involving whether the plaintiff suffered from a psychiatric/neurological condition called a ‘conversion disorder’ as a result of the accident, no relevance. Lexis Advance — ‘conversion practice’ returned the same two judgments as WestlawAU and ‘conversion therapy’ returned the same three judgments as WestlawAU. AustLII — ‘conversion practice’ returned the same two judgments as Westlaw AU as well as *1113757* [2012] RRTA 955, a refugee protection visa matter, quoting (at [96]) an Indian government report mentioning religious ‘conversion practices’ (ie, rituals for converting a person’s religion, not linked to sexual orientation or gender identity). AustLII — ‘conversion therapy’ returned the same three judgments as Westlaw AU, as well as several refugee cases at the Australian Administrative Appeals Tribunal, each of which related to reports of ‘conversion therapy’ that was relevant to changing sexual orientation or gender identity, but which was occurring outside of Australia and relevant to the applicant’s homosexuality. None of these cases involved a definition or analysis of the meaning of ‘conversion therapy’, and the term was used in passing: *1601459* [2017] AATA 2005; *1509885* [2017] AATA 3924; *1709743* [2020] AATA 970; *1705390* [2020] AATA 1661; *1700793* [2019] AATA 6743; *17005353* [2019] AATA 6825; *2010249* [2020] AATA 3638; *1704734* [2020] AATA 1214. One submission made reference to a possible legal process related to conversion practices in Tasmania. Submission 123 stated ‘[redacted] actually

the lack of public complaints, prosecutions or judgments. As noted in the Issues Paper, four factors suggest the current law is not appropriately directed and tailored to the nature and scope of SOGI conversion practices and their risks and harms.

**I. No statement that SOGI conversion practices are contrary to community interests.**

The law lacks a clear, objective articulation by the State Parliament that SOGI conversion practices are harmful and contrary to public interests or personal rights.

**II. No declaratory statement that SOGI conversion practices are wrong.** Relatedly (to point 1 above), the absence of a specific offence means that the law is not clear and precise about the wrongness of SOGI conversion practices. This means there is no signal to those engaging in the practices that they are harmful or wrong. Nor is it clear to those who are vulnerable, or who have been subjected to harmful practices, that there are lawful means for addressing the harm.

**III. No principle to measure legal effectiveness in reducing harm from SOGI conversion practices.** Because there is no clear statement in the law about SOGI conversion practices, it is not possible for the TLRI to state whether the law ‘effectively’ deals with the practices. In the simplest and broadest terms, the effectiveness of a legal system is tested by reference to whether ‘it ensures that the chosen policy goal is achieved in practice’.<sup>306</sup> From a regulatory perspective there is no statutory objective against which to measure the effectiveness of the law. At best, Tasmanian law may be said to be inferentially addressed to reducing the harms caused by SOGI conversion practices, but the exact forms of practices, the degree of protection and the exact rights of those subjected to them remain unclear.

**IV. The law is inappropriate and inefficient to deal with a common class of SOGI conversion practices and their harms.** Assuming the present law can be interpreted to proscribe harmful SOGI conversion practices, it is arguably inefficient in achieving that end. To the extent that disparate parts of the law might be relevant to SOGI conversion practices, their application is likely to be ad hoc, unpredictable and difficult for victims and complainants to access. The diffuse and uncertain nature of the present law is likely to produce inefficiencies in detection, management and enforcement.<sup>307</sup> In a broader setting it

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won a case against [redacted — Tasmanian council] for engaging [redacted] and thereby [sic] this practice’. This seems to be a reference to a conciliation or other tribunal process related to conversion practices, but no further details were provided or could be found in public reports.

<sup>306</sup> Karen Yeung, ‘Towards an Understanding of Regulation by Design’ in Roger Brownsword and Karen Yeung (eds), *Regulating Technologies: Legal Futures, Regulatory Frames and Technological Fixes* (Hart Publishing, 2008) 79, 91.

<sup>307</sup> Ronald H Coase, ‘The Problem of Social Cost’ (1960) 3 *Journal of Law and Economics* 1, 2.

means the law lacks transparency, accessibility and congruence which are criteria of effective legal design.<sup>308</sup>

## 5.2. Consultation arguments for and against reform

5.2.1. Respondents to the consultation overwhelmingly supported reforming the law to respond to conversion practices. Sixty-one individual respondents to Question 4,<sup>309</sup> as well as the petition signed by 377 Tasmanians and submitted to the TLRI<sup>310</sup> supported law reform (78 per cent of respondents). Ninety individual submissions opposed law reform (16 per cent of respondents).<sup>311</sup>

### Support for law reform

5.2.2. Respondents who supported reforming the law to respond to SOGI conversion practices tended to focus on three principal arguments. These are that conversion practices:

- **Violate the dignity and human rights** of LGBTQA+ people;
- Are **ineffective** and not genuine medical practices; and
- Are **harmful** to subjects and the community.

5.2.3. For example, the petition to the Inquiry called for conversion practices to be prohibited because they ‘create profound distress, trauma and harm to those they are inflicted on, and have resulted in self-loathing, self-harm and suicide’ and that a law against them will ‘have a positive impact on preventing these practices and the ideology behind them’.<sup>312</sup>

5.2.4. The petition supported the creation of a new standalone law, an indictable criminal offence that is justified on the severity of the harms of conversion practices, a scheme that would treat institutions that fail to prevent SOGI conversion practices from taking place in a similar manner to accountability for ‘sexual abuse of people in [the institution’s] care’.<sup>313</sup> The petition also stated that the new law must not infringe freedom of expression, religion or parenting rights,

<sup>308</sup> Colin Diver, ‘The Optimal Precision of Administrative Rules’ (1983) 93 *Yale Law Journal* 65, 67.

<sup>309</sup> Submissions 4, 5, 10, 18, 37, 38, 40\*, 42, 58, 67, 79, 80, 82, 85, 86, 89, 90, 91, 93, 94, 104, 105\*, 111\*, 113, 115, 117, 118, 119, 120, 121, 122, 124C, 127, 129\*, 130\*, 131, 134\*, 135\*, 138\*, 150, 153\*, 154\*, 156, 157\*, 158C, 159\*, 161\*, 162, 163\*, 164\*, 165, 167, 168, 169, 170, 173\*, 175, 177, 179\*, 180\*, 182\*.

<sup>310</sup> Submission 136.

<sup>311</sup> Submissions 2, 3, 7, 8, 9, 11, 12, 13\*, 14, 16, 17, 19, 20, 21, 22\*, 23\*, 24\*, 25, 26\*, 27, 28\*, 29C, 30, 31\*, 32, 33\*, 34\*, 35\*, 36, 39, 41, 43\*, 44, 45\*, 46, 48, 50, 51, 52, 54\*, 56, 57, 60\*, 61, 62, 63\*, 64\*, 65, 66, 67, 68\*, 69\*, 70\*, 71, 72, 73, 74, 76\*, 78\*, 81, 83C, 84\*, 87C, 88C, 95\*, 96C, 97, 99, 100\*, 101\*, 102\*, 103\*, 106, 107, 108, 109C, 110\*, 112\*, 116, 125, 133\*, 136\*, 137\*, 139\*, 141\*, 142\*, 143\*, 144C, 145\*, 146C, 147C, 149C, 152\*, 166\*, 171\*, 172\*, 176\*, 181C, 183\*. The remaining 6 per cent of respondents did not express a view on this question.

<sup>312</sup> Submission 136 at 1.

<sup>313</sup> Submission 136 at 2.

and must balance those rights with the right of LGBTQA+ people ‘to be free from premeditated harm’.<sup>314</sup>

5.2.5. Several peak medical and professional bodies supported law reform to prohibit and regulate SOGI conversion practices:

- the Royal Australian and New Zealand College of Psychiatrists,
- the Mental Health Council of Tasmania,
- the Australian Psychological Society,
- Women’s Health Tasmania,
- the Tasmanian Council on Social Services,
- Australian Medical Association Tasmania,
- the Australian Lawyers Alliance, and
- Community Legal Centres Tasmania.<sup>315</sup>

5.2.6. A range of relevant statutory office holders also voiced their support for reform to this Inquiry:

- the Health Complaints Commissioner,
- the Chief Civil Psychiatrist,
- the Anti-Discrimination Commissioner, and
- the Commissioner for Children and Young People.<sup>316</sup>

5.2.7. Beyond respondents to this Inquiry, a range of international organisations have called on states to regulate and prohibit harmful SOGI conversion practices.<sup>317</sup> In May 2020, the United Nations Independent Expert on Protection Against Violence and Discrimination reported to the United Nations Human Rights Council that SOGI conversion practices are ‘by their very nature degrading, inhuman and cruel and create a significant risk of torture’. He found that depending on how these practices are manifested, they may be in breach of international human rights laws, including the:

- Right to health;<sup>318</sup>

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<sup>314</sup> Submission 136 at 2.

<sup>315</sup> Submissions 5, 10, 18, 37, 80, 90, 118, 122.

<sup>316</sup> Submissions 38, 104, 117, 120.

<sup>317</sup> See the discussion in *TLRI SOGI Conversion Practices Issues Paper* (n 7) [3.5].

<sup>318</sup> ‘Every person, without distinction, should be able to enjoy the highest attainable standard of physical and mental health and freedom from non-consensual medical treatment. Furthermore, the right to sexual and reproductive health encompasses the right of persons to be fully respected for their sexual orientation and gender identity. In that regard, the Committee on Economic, Social and Cultural Rights found that regulations requiring that lesbian, gay, bisexual transgender and intersex persons be treated as mental or psychiatric patients or requiring that they be “cured” by so-called “treatment”, were a clear violation of their right to sexual and reproductive health.’: Madrigal-Borloz, *Practices of So-Called ‘Conversion Therapy’* (n 49) [60].

- Prohibition on torture and ill-treatment;<sup>319</sup> and
- Rights of the child.<sup>320</sup>

Consequently, the Independent Expert recommended that states ban SOGI conversion practices through legal or administrative means, with appropriate sanctions for non-compliance.<sup>321</sup>

5.2.8. As the Issues Paper also discussed, a number of other jurisdictions, national bodies and international organisations have passed prohibitions or urged them. At the time the Issues Paper was published in November 2020, Germany [see Appendix 0], Malta [see Appendix D.7], Albania, Ecuador, Brazil, Taiwan, and 20 states in the US had criminalised, banned or regulated SOGI conversion practices. Since November 2020, Canada [see Appendix D.5],<sup>322</sup> France,<sup>323</sup> and New Zealand [see Appendix D.4]<sup>324</sup> have also proscribed the practice. India’s Madras High Court has also found that SOGI conversion practices are a breach of constitutional rights and made orders for the state and federal governments and agencies to investigate, regulate and prosecute such practices.<sup>325</sup> On 9 December 2021 the United Kingdom Government renewed its commitment to prohibiting conversion practices through a proposed set of amendments to existing UK laws.<sup>326</sup> On 14 February 2022, the Israeli Health Ministry

<sup>319</sup> ‘United Nations entities and human rights mechanisms have expressed concern about practices of “conversion therapy”, and the United Nations anti-torture machinery has concluded that they can amount to torture, cruel, inhuman or degrading treatment. ... The Independent Expert observes that all practices of “conversion therapy” take as a point of departure the belief that sexually diverse or gender-diverse persons are somehow inferior — morally, spiritually or physically — than their heterosexual and cisgender siblings and must modify their orientation or identity to remedy that inferiority. ... All practices of “conversion therapy” however share the premise that sexual orientation and gender identity can be extricated — expelled, cured or rehabilitated — as if they were alien to the person, a most inhuman understanding of human existence. The overwhelming evidence available on the psychological and physical suffering inflicted on victims, as well as its lasting effects, leads the Independent Expert to conclude that perpetrators must act on callous disregard for human suffering.’: Madrigal-Borloz, *Practices of So-Called ‘Conversion Therapy’* (n 49) [62]–[64].

<sup>320</sup> ‘The Independent Expert recalls States’ obligations to protect children from violence, harmful practices and cruel, inhuman or degrading treatment and torture, to respect the right of the child to identity, physical and psychological integrity, health and freedom of expression and to uphold the core principle of the best interests of the child at all times. Moreover, the Committee on the Rights of the Child has clarified that the right of the child to identity, which includes sexual orientation and gender identity, must be respected and taken into consideration when assessing the child’s best interests. ...The Independent Expert therefore concludes that the imposition of practices of “conversion therapy” on children runs counter to States’ obligation to protect them from violence, harmful practices and cruel, inhuman or degrading treatment, to respect the right of the child to identity, physical and psychological integrity, health and freedom of expression and to uphold the core principle of taking the best interests of the child as a primary consideration at all times.’: Madrigal-Borloz, *Practices of So-Called ‘Conversion Therapy’* (n 49) [72]–[74].

<sup>321</sup> Madrigal-Borloz, *Practices of So-Called ‘Conversion Therapy’* (n 49) 21 [83].

<sup>322</sup> *An Act to Amend the Criminal Code (Conversion Therapy)*, RSC 2021, c 24. See Appendix D.5.

<sup>323</sup> ‘France Passes Law Banning “Conversion Therapy” for LGBTQ People’, *France24* (online, 26 January 2022) <<https://www.france24.com/en/europe/20220126-france-passes-law-banning-conversion-therapy-for-lgbtq-people>>.

<sup>324</sup> *Conversion Practices Prohibition Legislation Act 2022* (NZ). See Appendix D.4.

<sup>325</sup> Center for Law and Policy Research, South Asian Translaw Database, ‘*S Sushma and Ors vs Commissioner of Police, Greater Chennai Police and Ors*’ (Case Summary, 2021) <<https://translaw.clpr.org.in/case-law/s-sushma-and-ors-v-commissioner-of-police-greater-chennai-police-and-ors/>>.

<sup>326</sup> UK Government, *Open Consultation: Banning Conversion Therapy* (Command Paper CP 535, 29 October 2021) <<https://www.gov.uk/government/consultations/banning-conversion-therapy/banning-conversion-therapy#summary-of-proposals>>.

banned conversion practices by medical professionals.<sup>327</sup> Many more states have de facto bans and/or are drafting or debating prohibitions.<sup>328</sup> Within Australia, Queensland, the ACT and Victoria have proscribed SOGI conversion practices. The Western Australian government<sup>329</sup> and the South Australian opposition (now government)<sup>330</sup> have made commitments to ban SOGI conversion practices but have not yet introduced legislation.

## Opposition to law reform

5.2.9. The main reasons given by respondents for opposing law reform were:

- SOGI conversion practices are not taking place in Tasmania;
- Existing laws already cover and prohibit SOGI conversion practices; or
- Parental or religious rights would be impermissibly infringed by any law on SOGI conversion practices.

5.2.10. The TLRI considers that there is clear evidence that conversion practices are in fact occurring in Tasmania and are likely to continue in various forms into the future [see 3.4–3.6].

Respondents provided ample evidence that SOGI conversion practices are currently taking place in Tasmania in both non-medical religious and educational settings and among some medical practitioners.

5.2.11. Whilst various laws in Tasmania may cover conversion practices, the TLRI's view is that these laws are not sufficiently tailored or specific. There are also various gaps. This is particularly true of direct and indirect non-physical forms of conversion practice, which appear to constitute the main form of practice in Tasmania.<sup>331</sup> As detailed in Part 2.7 [and see 2.7.6 and 3.6.5], the general consensus in Australia and around the world is that almost all contemporary SOGI

<sup>327</sup> Stuart Winer and Times of Israel Staff, 'Health Ministry Bans "Conversion Therapy" by Medical Professionals', *The Times of Israel* (online, 14 February 2022) <<https://www.timesofisrael.com/health-ministry-bans-conversion-therapy-by-medical-professionals/>>.

<sup>328</sup> UK Government, 'Research and Analysis: Appendix 3: Measures Taken by Country' in *Conversion Therapy: An Evidence Assessment and Qualitative Study* (29 October 2021) <<https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/appendix-3-measures-taken-by-country>>

<sup>329</sup> Hamish Hastie, 'McGowan Commits to Gay Conversion Therapy Ban', *WA Today* (online, 12 March 2021) <<https://www.watoday.com.au/politics/western-australia/mcgowan-commits-to-gay-conversion-therapy-ban-20210312-p57aak.html>>.

<sup>330</sup> Stephanie Richards and Angela Skujins, 'SA Move to Outlaw Conversion Therapy', *In Daily* (online, 16 July 2020) <<https://indaily.com.au/news/2020/07/16/sa-move-to-outlaw-conversion-therapy/>>.

<sup>331</sup> This Inquiry received no clear accounts of physically abusive SOGI conversion practices occurring within the past decade. One possible exception to this is the process of 'exorcisms', which may have involved physical force and/or may require activity for a prolonged period of time which might be physically harmful. Respondents who reported being subject to exorcisms in Tasmania did not provide extensive details on how these rituals work, or explicitly state these rituals involved physical harm, but noted they involved 'shouting' and 'shaking': see 3.4.7.

conversion practices are non-physical, and the clinical evidence shows that serious harm may follow from non-physical SOGI conversion practices.

- 5.2.12. The TLRI also considers that there is a lack of legal certainty about the promotion of materials encouraging or promoting conversion practices, recent examples of which were provided to the Inquiry. The TLRI is concerned about the potential for such materials to mislead vulnerable people to commit to harmful activities, or for misinformation to develop about such activities in communities around them, bringing pressure to bear on those people to commit to conversion practices. Tasmanian law is at best unclear on the legality of such harmful and discriminatory conduct.
- 5.2.13. Parental and religious rights infringement is a serious concern. Any law on SOGI conversion practices must ensure that religious freedom is not unduly burdened. However, as has been discussed throughout this report [see 2.2.15 and 2.6.19], the potential for a law to burden such rights does not act as a barrier to its introduction, but rather is a matter of its calibration and balancing. That is, the balance between rights and responsibilities is a common and central feature of legal design, and judicial and administrative interpretation. For instance, Tasmania's anti-discrimination law contains several limitations on conduct (including speech) that are directed to attributes such as sexual orientation or gender identity.<sup>332</sup> However, these restrictions are balanced by a range of exceptions that protect discrimination which is, for instance, related to gender and 'required by the doctrines of the religion of the institution',<sup>333</sup> or related to religious belief, affiliation or activity and is 'carried out in accordance with the doctrine of a particular religion; and is necessary to avoid offending the religious sensitivities of any person of that religion'.<sup>334</sup>
- 5.2.14. Law reform in this space should be clear about the rights of parents to provide care, mentoring, support and religious guidance in those circumstances [see 2.7.19]. Parents and guardians have the right to express views on sexuality or gender identity issues to their children and family and to guide their moral and spiritual development. The Institute reiterates that expressing views about sexuality and gender identity, or disapproving of certain sexualities or gender identities, is not, of itself, a conversion practices [see 2.5.3 and 3.6.2]. Further, the Institute is not convinced that there are any compelling reasons why SOGI conversion practices warrant a special exemption from the law where they occur in a familial setting. In a General Comment<sup>335</sup>

<sup>332</sup> *Anti-Discrimination Act 1998* (Tas) ss 17, 19, 20.

<sup>333</sup> *Anti-Discrimination Act 1998* (Tas) s 27.

<sup>334</sup> *Anti-Discrimination Act 1998* (Tas) s 52(d).

<sup>335</sup> A General Comment is a treaty body interpretation of the content of rights in an international human rights law treaty. They are not legally binding, but are authoritative: they aim to clarify international human rights law, guide States in their application of that law, and may provide examples of violations by States.

on the child's best interests in international human rights law, the United Nations Committee on the Rights of the Child emphasised:

Although preservation of religious and cultural values and traditions as part of the identity of the child must be taken into consideration, practices that are inconsistent or incompatible with the rights established in the Convention are not in the child's best interests. Cultural identity cannot excuse or justify the perpetuation by decision-makers and authorities of traditions and cultural values that deny the child or children the rights guaranteed by the Convention. ... an adult's judgment of a child's best interests cannot override the obligation to respect all the child's rights ... there is no hierarchy of rights in the Convention; all the rights provided for therein are in the 'child's best interests' and no right could be compromised by a negative interpretation of the child's best interests.<sup>336</sup>

5.2.15. Noting these things, the Committee emphasised in another General Comment that:

The Committee emphasizes the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy. It condemns the imposition of so-called 'treatments' to try to change sexual orientation and forced surgeries or treatments on intersex adolescents. It urges States to eliminate such practices.<sup>337</sup>

5.2.16. This was echoed in a domestic setting by the Commissioner for Children and Young People in Tasmania, submitted to this Inquiry:

In light of the evidence of the harmful effects of SOGI conversion practices and authoritative human rights statements ... I cannot perceive a situation in which it could ever be in a child's best interests to undergo SOGI conversion therapy. Accordingly, I would not support a situation where a parent of a child or a mature minor could consent to SOGI conversion practices.<sup>338</sup>

### **Recommendation 1. Tasmanian law should be reformed**

Tasmanian law should be reformed to address harms from Sexual Orientation and Gender Identity Conversion Practices.

<sup>336</sup> Committee on the Rights of the Child, *General Comment No 14: On the Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration*, UN Doc CRC/C/GC/14 (29 May 2013).

<sup>337</sup> Committee on the Rights of the Child, *General Comment No 20: On the Implementation of the Rights of the Child During Adolescence*, UN Doc CRC/C/GC/20 (6 December 2016) [34].

<sup>338</sup> Submission 120 at 5.

## 5.3. Law reform principles

5.3.1. After considering the nature of harm from conversion practices, the evidence about their drivers and context, and the views of respondents, the TLRI recommends that any law reform is framed with reference to the following principles:

**I.** The primary object of SOGI conversion practices law reform should be individual, social and systemic harm reduction.

**II.** Law reform must accommodate Tasmanian circumstances. In particular it should utilise existing statutory regimes to regulate SOGI conversion practices.

**III.** Law reform should adopt a proactive, preventative and proportionate approach to harm reduction from SOGI conversion practices.

**IV.** Regulatory powers should be self-initiated (i.e. they should not solely rely on complainants or victims coming forward).

**V.** Where possible and practical these authorities should coordinate, within specific areas of competency, to reduce the prevalence of harm from SOGI conversion practices in the Tasmanian community.

**VI.** Law reform should modernise, standardise, and, where clinically appropriate, depathologise language relating to sex and gender.

**VII.** Punitive (criminal) measures should be measures of last resort and restricted to wilful, reckless, repeated or malicious breaches of the law that cause harm and/or contempt for statutory agencies and courts responsible for its enforcement.

**VII.** Civil liability compensation for harms caused by SOGI conversion practices should be provided for after a transition period of not more than 24 months from the date of proscription of the practices by law.

These principles are integrated into the law reform approach set out below.

## 5.4. Approach to reform

### Individual, social and systemic harm reduction

5.4.1. The Institute considers that there is a real and genuine risk to LGBTQA+ people — and especially children in that cohort — from conduct purporting to have a basis in science, medicine or health practice which is not supported or sanctioned by contemporary scientific,

medical or professional healthcare standards. The Institute considers the two primary risks to arise from:

**I. Medical** (or pseudo-medical) malpractice. Being either:

- i. Practices conducted by health professionals contrary to contemporary, evidence-based standards of medical or mental health care; or
- ii. Unsanctioned and unjustified **pseudo-medical or pseudo-scientific practice**: practices which purport to have medical and/or scientific bases undertaken by persons who are not registered, qualified or otherwise competent to assess or treat health — and in particular mental health — conditions.

**II.** The Institute considers a secondary risk to LGBTQA+ people is the **promotion of disinformation** about the aetiological bases of sexual orientation or gender identity, which has the aim of convincing people that they *can* and *should* change those characteristics. The Institute accepts the evidence provided to it that such speech and publications may mislead some LGBTQA+ people to undertake practices which can cause significant mental trauma and harm.

- 5.4.2. In the Institute’s view the object of reform should be the reduction of individual, social and systemic risks and harms.

## 5.5. Reform in a non-Charter context

- 5.5.1. TLRI recommends adopting an approach to law reform which is suited to Tasmanian circumstances.
- 5.5.2. Of particular note is that Tasmania would be the first non-Charter jurisdiction (i.e., a Charter of Rights and Responsibilities or Human Rights Charter) to enact conversion practices legislation. This means that the State lacks an existing statutory human rights framework to connect new legislation to as states such as Victoria have. The State is also the smallest in terms of population and Gross State Product,<sup>339</sup> which limits the likelihood of financial and political commitment to a standalone statutory regime to deal with conversion practices. Indeed, the various attempts to enact a Charter of Rights for Tasmania have consistently faced resistance on (amongst other things) financial grounds.

<sup>339</sup> See Australian Bureau of Statistics, ‘Australian National Accounts: State Accounts’ (20 November 2020) <<https://www.abs.gov.au/statistics/economy/national-accounts/australian-national-accounts-state-accounts/2019-20>>.

- 5.5.3. Tasmania has a robust anti-discrimination framework, and an established healthcare regulation and healthcare complaints framework which incorporates a Charter of Health Rights.
- 5.5.4. Whilst Tasmania has a relatively recent history of laws which directly and indirectly discriminated against LGBTQIA+ people, these have been subject to significant law reform over the past few decades, with the aim of repairing harm and facilitating legal equality.<sup>340</sup> In the main this has been achieved through an amendment approach to law reform. A similar approach is recommended here.

## Amendment model

- 5.5.5. Twelve submissions and the joint written petition submission with 377 signatories endorsed a stand-alone act.<sup>341</sup> Most respondents who supported law reform simply stated their preference without specifying a particular form of law reform.<sup>342</sup> Those who expressed a preference on form provided two approaches:
- First was support for a single-standalone act that encompassed all law reform around conversion practices (e.g., a definition, new offences).<sup>343</sup>
  - Second was support for a stand-alone act with consequential amendments to other legislation as required.<sup>344</sup>
- 5.5.6. Those who gave reasons felt that a standalone act would:
- Send the ‘strongest possible message’ that conversion practices were unacceptable to the community;<sup>345</sup>
  - Be a more ‘comprehensive’ response than amendments;<sup>346</sup>
  - Allow for an explanation of the new law’s purpose within the statute,<sup>347</sup> provide a clear legal definition of conversion practices;<sup>348</sup>
  - Outline exceptions or defences to any offence provision,<sup>349</sup> or

<sup>340</sup> See Alexandra Purvis and Joseph Castellino, ‘A History of Homosexual Law Reform in Tasmania’ (1997) 16 *University of Tasmania Law Review* 12; Rodney Croome, ‘Gay Law Reform’ in *The Companion to Tasmanian History* (2006)

[https://www.utas.edu.au/library/companion\\_to\\_tasmanian\\_history/G/Gay%20Law%20Reform.htm](https://www.utas.edu.au/library/companion_to_tasmanian_history/G/Gay%20Law%20Reform.htm).

<sup>341</sup> Submissions 115, 121, 122, 127, 131, 136, 159\*, 162, 164\*, 165, 167, 173\*, 180\*.

<sup>342</sup> Submissions 127, 131, 159\*, 162, 164\*, 165, 167, 173\*.

<sup>343</sup> Submissions 121, 122.

<sup>344</sup> Submissions 115.

<sup>345</sup> Submission 121, 136, 177, 180\*.

<sup>346</sup> Submissions 115, 122, 167, 175, 177.

<sup>347</sup> Submission 122.

<sup>348</sup> Submission 122.

<sup>349</sup> Submission 122.

- Be necessary because the respondent felt no current laws were relevant or could be effectively amended to address conversion practices.<sup>350</sup>
- 5.5.7. The TLRI's view is that law reform should be directed to simplifying the law and removing defects, uncertainties, and conflicts. Consolidation of laws within subject matter omnibus statutes lead to those outcomes whereas de-consolidation undermines them.<sup>351</sup> Consolidation serves to:
- Reduce 'inconsistency and duplication in the statute book';
  - Ensure that the 'courts, the legal profession and the police [are] able to deal more effectively with a limited number of omnibus offence provisions with which they would become familiar than a much greater number of provisions in particular Acts';
  - Ensure 'matters [that] are of such significance in the administration of law and justice ... be governed by general provisions carefully thought out in advance rather than provisions drafted ad hoc for the purpose of each particular statute'; and
  - Reduce the 'total number' of criminal offences, ensure textual coherence, clarity and ease of access for people and public officers in Tasmania so that they can easily identify and understand the rights, duties, powers and obligations created by law.<sup>352</sup>
- 5.5.8. In the Institute's view these objectives should be pursued as a matter of legal convention, the rule of law and the promotion of human rights within criminal law reform. Given the broad range of forms of conversion practices, and the wide range of contexts in which conversion practices occur, a single Act would necessarily be required to be voluminous and complex. It would also replicate an existing range of laws, rather than clarifying or amending them. That fractures the corpus of Tasmanian law, risks creating inconsistencies in principle and approach, and makes further progressive law reform more difficult. The Institute does not recommend a standalone Act.
- 5.5.9. None of this is to say that the Bill which carries amendments into effect cannot contain a long-title, preamble or objects clause declaring and setting out the purposes of the Bill and the intentions of the enacting Parliament. For instance, the Bill might proclaim that people in Tasmania have a right to be and express all forms of sexual orientation or gender identity, that

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<sup>350</sup> Submission 170.

<sup>351</sup> Tasmania Law Reform Commission, *Report on Powers of Arrest, Search and Bail* (1977); Tasmania Law Reform Institute, *Consolidation of Arrest Laws in Tasmania* (2011).

<sup>352</sup> Sir Harry Gibbs, *Review of Commonwealth Criminal Law: Interim Report — Principles of Criminal Responsibility and Other Matters* (Commonwealth Attorney General's Department, 1990) 436 [50.8]. See also *Review of Commonwealth Criminal Law, Discussion Paper No 14: Omnibus Provisions to Replace Provisions in Common Form in Particular Acts* (1988) 6.

LGBTQIA+ attributes are not faults or dysfunctions, and that the Bill serves to reduce the harms and risks of conduct which is unacceptable to the community. Those parts of the subsequent Act need not be repealed on the incorporation of amendments into other consolidated laws. Even if they were repealed, they still remain on the legislative record and may be referred to in the interpretation of any provisions which give effect to parliamentary intention, regardless of which principal act they are ultimately situated in. Alternatively, if Parliament preferred to avoid an entirely vestigial Act, a standalone provision which does not naturally fit within a consolidated statute might be retained so that the resultant law became a consequential amendment. One possible provision is a law proscribing the removal of a child from Tasmania so as to subject them to a conversion practice in another jurisdiction — which at present the Institute has recommended be incorporated into the *Criminal Code*.

- 5.5.10. If the Parliament does decide to include a long-title, preambular statement, or objects clause to any amending act, the Institute would encourage that it is drafted in consultation with and reflects the collective voices of survivors of conversion practices and LGBTQIA+ people in Tasmania, particularly young people for whom such an act would mark a new step towards equality and reconciliation.

## Focus of amendments

- 5.5.11. The community consultation showed that SOGI conversion practices in Tasmania take place in both medical and non-medical settings.
- 5.5.12. In the medical setting, whether a health practitioner has engaged in conversion practices is primarily a question of whether that person has breached their professional, legal, and ethical obligations by offering a form of assessment, treatment or care that is not supported by clinical evidence and is harmful.
- 5.5.13. In the non-medical setting, the risk derives from unqualified, untrained and unlicensed people making pseudoscientific representations and undertaking pseudo-medical conduct on highly vulnerable people in a particularly sensitive area of health practice. Indeed, the harm is likely to be amplified by the conduct occurring outside of a clinical setting, without appropriate supervision, complaints or disciplinary mechanisms.
- 5.5.14. These factors suggest that amendments should be directed to Tasmanian health law and anti-discrimination law. As the Tasmanian Chief Civil Psychiatrist submitted to this Inquiry:

I support the amendment approach ... to prevent any SOGI [conversion] practices occurring in registered or unregistered healthcare settings, community settings, or religious groups. In the Tasmanian context, this ... could use existing legislative frameworks such as the *Public Health Act 1997* (Tas) or the *Anti-Discrimination Act 1998* (Tas) to include definitions of SOGI [conversion] practices within these Acts, and to also insert a new criminal offence into the *Criminal Code Act 1924*. This option, as you have suggested within your Issues Paper, would be simpler than creating a new stand-alone statutory instrument.<sup>353</sup>

- 5.5.15. The Institute agrees with the Chief Civil Psychiatrist that an adaptive law reform approach is the most appropriate way to respond to the harms from SOGI conversion practices.

## Adaptive health service model

- 5.5.16. The Institute has worked closely with peak medical bodies in and outside of Tasmania as part of this Inquiry. As noted, those bodies are supportive of law reform in this space. Those bodies have already pursued a program of self-regulation by updating health policy and standards to ensure conversion practices are not sanctioned or permitted in the healthcare professions. Any law reform should complement rather than override such self-regulation, not least because the specialist healthcare professions are in the best position to ensure that clinical practice is evidence-based, ethically appropriate and patient-centred.

<sup>353</sup> Submission 104.

- 5.5.17. An adaptive law reform approach would provide a legal framework for such regulation, strengthening and clarifying the role of the registered professional and standards bodies, but not interfere with their standards setting role, or attempt to override their professional competencies. However, this is not to say that health professionals would or should be immune from any proposed law reforms.
- 5.5.18. Despite SOGI conversion practices being declared unethical and unjustified by peak bodies — and in many cases tantamount to malpractice — evidence to this Inquiry was that some Tasmanian health professionals continue to represent sexual orientation and gender identity as dysfunctions requiring treatment. There was also evidence of cooperation between religious entities and health professionals (or at least persons that respondents believed to be accredited healthcare professionals).<sup>354</sup> This involved religious bodies referring vulnerable people to ostensible psychological counselling or other purported treatments which were claimed to be able to change or suppress sexual orientation or gender identity. If the people involved were indeed licensed healthcare professionals, they would likely be breaching their professional duties and acting contrary to professional guidelines applicable to their area(s) of expertise.
- 5.5.19. Given the opposition of contemporary health science to conversion practices, the most common environment that such practices persist in Tasmania appears to be outside, or on the periphery of, legitimate clinical practice. In the cases reported to the Institute, such conduct occurs in ways that mirror the assessment, diagnosis and treatment of mental illness under current Tasmanian mental health legislation.<sup>355</sup> That is, it involves purportedly identifying or diagnosing the ‘cause’ of a person’s feelings towards others or themselves. Such conduct is predominantly justified by unsupported pseudoscientific claims about the aetiological (specifically the cause of a disease or disfunction) bases of SOGI attributes. It is often also accompanied by conduct which purports to ‘prevent or remedy’ or ‘manage and alleviate’ same sex attraction, gender identity or gender expression as if it is a cognitive fault or dysfunction even though such attributes are not mental illnesses and indeed are protected attributes under Tasmanian law.
- 5.5.20. Whatever importance sexuality and gender identity may have as a social and political issue, it is not for members of the public who lack any qualification, accreditation or professional recognition or oversight to engage in any quasi-medical ‘assessment’ or ‘treatment’ of another person. Crucially, the likelihood of harm, demonstrated by clinical studies, justifies restricting health and medical assessments in this area to appropriate health professionals only, within the confines of professional standards.

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<sup>354</sup> See [3.4.5].

<sup>355</sup> See *Mental Health Act 2013* (Tas) ss 5 and 6.

## **Assessing and treating sexual orientation should be proscribed**

- 5.5.21. Because the mainstream medical community wholly rejects the possibility that same-sex attraction could be a medical disorder, it is already the case that no practitioner is permitted to clinically diagnose, assess, or treat sexual orientation as a mental health condition. As such the Institute recommends:
- That the consensus position on mental health diagnoses of homosexuality be proscribed by Tasmanian legislation; and
  - That legislation should apply to both health and non-health professionals as a clear indication of unacceptable conduct in any domain.

## **Assessing and treating gender related disorders should be regulated**

- 5.5.22. The TLRI acknowledges that the scientific and clinical understanding of and approach to gender identity questions and disorders like gender dysphoria/incongruence is not settled and continues to develop. Given that is the case, and given the particular vulnerability of people experiencing distress, anxiety and other mental health disorders, it is especially important that only qualified health professionals — who are required to maintain a contemporary understanding of health science and clinical guidelines — be legally authorised to provide health care. The *Mental Health Act* and national healthcare law framework impliedly makes this already the case: untrained and unlicensed people cannot hold themselves out as ‘psychologists’ or ‘psychiatrists’ or engage in conduct that purports to be a genuine assessment or treatment. Conversion practices reform should make that implication clear.
- 5.5.23. The Institute recommends regulating the assessment and treatment of any condition relating to gender identity to ensure it is only conducted within an appropriate professional environment.

## **Harmful indirect public acts that coerce, mislead, or pressure should be regulated**

- 5.5.24. The Institute considers that clarity is needed about the potential for certain public acts relating to SOGI conversion practices to amount to incitement to hatred, serious contempt or ridicule of LGBTQA+ people. Specifically, the *Anti-Discrimination Act* should expressly proscribe acts which pathologise sexual orientation and gender identity and imply that such attributes can and should be ‘cured’ (i.e., changed, suppressed, eradicated). The Institute accepts that such public acts are misleading and potentially harmful towards LGBTQA+ people. In anti-discrimination terms, such false, misleading and harmful conduct may serve to:

- Induce, pressure or encourage LGBTQA+ people to undertake or participate in harmful acts on the incorrect assumption that they are efficacious;
- Generate hatred, serious contempt or ridicule towards LGBTQA+ people who ostensibly ‘choose’ not to undertake such practices;
- Generate hatred, serious contempt or ridicule towards LGBTQA+ people for whom such practices ultimately prove ineffective; or
- Generate self-hatred, self-contempt or self-ridicule in LGBTQA+ people for whom such practices ultimately prove ineffective.

5.5.25. The Institute recommends clarifying that such behaviour amounts to a form of incitement under the *Anti-Discrimination Act*.

### **Freedom of expression and religion preserved within proportionate limits**

5.5.26. Importantly, these reforms to Tasmanian anti-discrimination law do not prevent individuals, community leaders, educators or organisations, whether religious or secular, from forming or promoting their views on homosexuality, gender identity, transgender people or any other matter related to sexual morality and society. They may express those views directly to people who they perceive to be sinful, impure or immoral, and urge them to change their lives to whatever standards their religious or social values require. That conduct remains within the bounds of freedom of expression and association.

5.5.27. It is essential that there is a clear distinction between the assertion of those religious belief or personal opinion with medical or scientific assertions and pseudo-medical practices. There is also a distinction between freedom of expression and conduct which is harmful or which coerces or persuades another person to self-harm.

5.5.28. Freedom of expression (including freedom of religious expression) does not authorise dangerous medical or pseudo-medical conduct, whether in the guise of counselling, pastoral care, scriptural study or anything else. To the extent that any person seeks to convince another that they can and should change or suppress their personal attributes, the conduct stops being religious expression and becomes harmful conduct. That is because it amounts to a false claim about the ability of a person to change their mental and/or physical state. That is the province of evidence-based medicine, not religion, politics or philosophy, regardless of which person is saying it or the platform they use to promote those beliefs.

## 5.6. Relevant Tasmanian authorities

- 5.6.1. Given the broad nature of conversion practices and that they likely represent a small proportion of harmful behaviours in Tasmania, the Institute does not recommend establishing a standalone body or legal regime. As noted, Tasmania also does not have a general human rights commission framework to vest competency for dealing with conversion practices, as has occurred in the ACT and Victoria. The Institute therefore recommends that existing laws should be modified to better address harms from SOGI conversion practices and existing Tasmanian authorities be given responsibility for regulating, investigating, sanctioning and educating about harmful conduct.
- 5.6.2. In the Institute's view the most appropriate existing bodies which have or should have statutory responsibility for SOGI conversion practices are the Tasmanian Chief Civil Psychiatrist, the Health Complaints Commission, Equal Opportunity Tasmania and Tasmania Police.
- 5.6.3. The Tasmanian **Chief Civil Psychiatrist** is the statutory office that deals with the mental health profession in Tasmania. That office should have responsibility for receiving and investigating complaints made by members of the public about health practitioners who the person believes may be offering SOGI conversion practices, in breach of professional legal and ethical standards.
- 5.6.4. Regarding SOGI conversion practices occurring in medical contexts, the Chief Civil Psychiatrist is the officer most competent to deal with such complaints, and best able to understand and apply relevant professional regulation and current standards of evidence-based professional best practice, and to keep up to date with those professional standards as they change. This is particularly important for ensuring that gender identity related assessments and treatments do remain within the boundaries of professional practice and do not veer into SOGI conversion practices.
- 5.6.5. Regarding SOGI conversion practices occurring in non-medical contexts, the Chief Civil Psychiatrist is again the officer most competent to assess whether a course of conduct by a non-licensed person constitutes an unlicensed purported assessment or treatment of another person. Similar activities are already implicitly regulated by the *Mental Health Act*. The TLRI recommends these powers be clarified in their application to non-licensed people who are purporting to offer assessments or treatments of, among other things, sexual orientation or gender identity.
- 5.6.6. The **Health Complaints Commissioner** is the statutory office that deals with public complaints about the provision of healthcare services in Tasmania. The Tasmanian Health Rights Charter, made under the *Health Complaints Act 1995* (Tas) should be clarified to specify

that a person has a right to healthcare free from discrimination, and that a person's sexual orientation and experienced gender identity are not pathological conditions or dysfunctions. The Health Complaints Commissioner should perform a supporting investigative role in conjunction with the Chief Civil Psychiatrist and/or the Anti-Discrimination Commissioner.

- 5.6.7. The **Anti-Discrimination Commissioner**, and **Equal Opportunity Tasmania**, should be empowered to act in a supporting role to deal with wider public harms in the expression of support for SOGI conversion practices and conversion ideology as a form of incitement to hatred under s 19. Whereas the Chief Civil Psychiatrist and Health Complaints Commissioner are best suited to investigate and assess the medical, clinical and professional legal and ethical responsibilities of alleged SOGI conversion practitioners, whether licensed or not, the Anti-Discrimination Commissioner is best suited to responding to indirect conversion practices.
- 5.6.8. Equal Opportunity Tasmania's mechanisms of dispute resolution by investigation, conciliation or inquiry is best placed to ensure justice and procedural fairness is accorded to both complainants and alleged SOGI conversion practitioners and/or institutions, organisations and corporations that promote or permit SOGI conversion practices to take place within them. The Anti-Discrimination Commissioner should be empowered to work with the Chief Civil Psychiatrist and Health Complaints Commissioner, at their discretion and where appropriate.
- 5.6.9. Tasmania Police should be responsible for investigating and laying charges for breaches of offence provisions.

## **Self-initiated and coordinated jurisdictions**

- 5.6.10. Statutory powers relating to SOGI conversion practices should be self-initiated: that is, they should not solely rely on complainants, victims, or other members of the public coming forward. This approach should include powers to investigate, set standards, make declarations, and issue corrective orders in relation to SOGI conversion practices.
- 5.6.11. Where possible and practical these authorities should coordinate, within specific areas of competency, to reduce the prevalence of harm from SOGI conversion practices in the Tasmanian community. This coordinated role should be designed to reduce regulatory burden and overlap. Most essentially it should ensure that complainants and victims do not ‘fall between the gaps’ of different statutory jurisdictions, or have to carry and repeat their complaints across various agencies. A whole of system, trauma-informed approach should be used.

## **5.7. Civil liability and criminal offences as backstop positions**

- 5.7.1. In the TLRI’s view civil remedies for harms caused by SOGI conversion practices should be provided for after a transition period of not more than 24 months from the date of proscription of the practices by law. Furthermore, punitive (criminal) measures should be a backstop measure of last resort for responding to SOGI conversion practices which cause serious harm as a result of wilful or reckless conduct. In order to ensure that is the case, any conduct should only be proceeded against under conversion practice specific Code provisions with the consent of the Director of Public Prosecutions. Noting this, derivative criminal sanctions are available to prosecute contempt for the statutory agencies, tribunals and courts responsible for the enforcement of laws relevant to SOGI conversion practices. This would remain the case with respect to any amendments to clarify the scope of those laws and their applicability to conversion practices.

## **5.8. Consumer protection not in need of reform**

- 5.8.1. General principles of consumer and contract law might already apply to SOGI conversion practices as a form of counselling or healthcare service that is misleading and deceptive,<sup>356</sup>

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<sup>356</sup> *Competition and Consumer Act 2010* (Cth) sch 2 s 18 (*‘Australian Consumer Law’*).

unconscionable,<sup>357</sup> or involves undue harassment or coercion in connection with the ‘service’.<sup>358</sup> The major regime is the *Australian Consumer Law*, a federal statutory regime that is implemented within Tasmania by State law.<sup>359</sup>

- 5.8.2. The *Australian Consumer Law* regime provides that a person acquires services as a consumer if, and only if, the amount paid for the services does not exceed \$40,000 or if the services were of a kind ordinarily acquired for personal, domestic or household use.<sup>360</sup> SOGI conversion practices that are not provided for a fee (e.g., offered by a religious leader as part of free youth counselling) would not be considered a consumer service, and thus some forms may not be covered by the *Australian Consumer Law*. The TLRI understands that in religious settings, SOGI conversion practices are predominantly delivered free of charge.<sup>361</sup> The *Australian Consumer Law* applies to services offered by healthcare professionals carrying on a business,<sup>362</sup> so any medical practitioner offering conversion practices would be providing a service under the *Australian Consumer Law*.
- 5.8.3. Among other things, the provider of a service guarantees that they render those services with ‘due care and skill’,<sup>363</sup> and that the service be reasonably fit for purpose or be reasonably expected to achieve a result desired by the consumer.<sup>364</sup> Offering a ‘service’ to ‘cure’ homosexuality or gender diversity, or discover and treat their ‘causes’ (e.g., past trauma and abuse), when such assessments and treatments are discredited by Australian medical bodies and not supported by a body of clinical evidence might likely contravene the guarantees around due care and skill and fitness for a particular purpose.
- 5.8.4. Only a handful of respondents mentioned consumer protection law as a useful possible pathway for responding to SOGI conversion practices. These submissions tended to focus on SOGI conversion ideology and practices as a form of false and misleading claims that could be targeted through legislative, regulatory, and educational intervention.<sup>365</sup> Consumer affairs and

<sup>357</sup> *Australian Consumer Law* (n 356) ss 20–21.

<sup>358</sup> *Australian Consumer Law* (n 356) s 50. This requirement could potentially relate to coercing or harassing another person into undergoing conversion practices for a fee.

<sup>359</sup> *Australian Consumer Law (Tasmania) Act 2010* (Tas); *Australian Consumer Law (Tasmania) Regulations 2012* (Tas).

<sup>360</sup> *Australian Consumer Law* (n 356) s 3(3).

<sup>361</sup> Only one respondent providing details of their experiences with SOGI conversion practices in Tasmania mentioned that they could not afford to attend a SOGI conversion practice retreat: the retreat was ‘booked out’ while the respondent was attempting to find enough money to cover it; presumably the other attendees did pay money to attend this retreat: Submission 105\*. The remainder of reports of religious conversion practices did not mention charging fees for informal meetings with religious leaders and/or prayer groups. Other respondents reporting SOGI conversion practices offered by healthcare professionals presumably paid for these services.

<sup>362</sup> See further Australian Competition and Consumer Commission, ‘Medical Professionals’ <<https://www.accc.gov.au/business/industry-associations-professional-services/medical-professionals>>.

<sup>363</sup> *Australian Consumer Law* (n 356) s 60.

<sup>364</sup> *Australian Consumer Law* (n 356) s 61.

<sup>365</sup> Submission 93.

consumer protection laws were suggested to assist in regulating pseudo-scientific publications that promote SOGI conversion practices.<sup>366</sup>

- 5.8.5. The TLRI agrees that these practices and the promotion or advertisement of them may contravene already existing consumer law. As the *Australian Consumer Law* is contained in a Commonwealth statute, the Tasmanian Government could, at most, advocate for reforms at the Commonwealth level, or issue a code of practice under pt 4 of the *Australian Consumer Law (Tasmania) Act 2010* (Tas).
- 5.8.6. Because the *Australian Consumer Law* is already likely sufficiently wide in scope to cover SOGI conversion practices performed for a fee, and does not operate by specifying particular services that do or do not contravene its provisions, no additional provision to clarify that SOGI conversion practices would contravene its provisions is necessary.
- 5.8.7. Finally, consumer law is likely to be less useful than a clarification of healthcare law.
- First, while many of these practices are not offered for fees and thus are not services for the purposes of consumer law, purported assessments and treatments like informal SOGI conversion practices would still likely be covered by healthcare law. The TLRI makes recommendations to clarify that application.
  - Second, because the question of whether those that are offered for fees will fall foul of guarantees of due care and skill and fitness for a particular purpose will turn on an expert assessment of whether the services provided contravened the standards of healthcare professionals in assessment and treatment, the more appropriate means of doing that is through healthcare law, and relevant statutory offices that can make those expert assessments, rather than the mechanisms and offices related to the *Australian Consumer Law*.
- 5.8.8. Consequently, the TLRI does not recommend legislative changes to consumer law.

## 5.9. A minimal amendment model

- 5.9.1. The approach recommended by the Institute does not require a substantial amount of reform. In the Institute's view existing statutory regimes already partly or impliedly extend to and incorporate SOGI conversion practices. Reform would seek to clarify and, where necessary, expand the jurisdiction of relevant authorities to ensure they are properly equipped to respond to the harms from conversion practices in line with the principles set out above [see 5.4].

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<sup>366</sup> Submission 153\*.

5.9.2. In particular the Institute's principal recommendations are focused on clarifying, strengthening and expanding:

- Health law to deal with direct SOGI conversion practices and some indirect practices [see Part 6.3];
- Anti-discrimination law to deal with indirect, public acts that go beyond mere discrimination [see Part 7.3];
- Civil law to compensate persons who have suffered damages from conduct that occurred after the introduction of law reforms (i.e., after practitioners have been put on statutory notice) [see Part 8.4]; and
- Criminal law to sanction conduct which causes serious and clearly foreseeable harm [see Part 9.1].

## Chapter 6

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# Responding to direct conversion practices

## 6.1. Reforming Tasmanian health law

- 6.1.1. The TLRI's starting position is that any Tasmanian law reform to respond to conversion practices should include a broad and clear exemption for legitimate assessment and treatment by authorised health professionals.
- 6.1.2. The TLRI recommends that law reform to respond to SOGI conversion practices should approach the problem as primarily one of responding to the harms likely to be caused by a form of pseudo-scientific or pseudo-medical practice or conduct. By this the Institute means that SOGI conversion practices can be seen as conduct that is:
- Not supported by contemporary health care standards; and/or
  - Not undertaken by appropriately trained and registered health professionals; and
  - Likely to cause harm, regardless of who it is conducted by.
- 6.1.3. The TLRI considers that in the circumstances, Tasmanian law requires further clarification to restrict who may make assertions, assessments and deliver healthcare in relation to gender identity, namely the assessment and treatment of gender dysphoria/incongruence, and the standards to which such services must be delivered.

## 6.2. Consultation responses on healthcare law

- 6.2.1. While the regulation of healthcare practices was an important discussion for many respondents, those submissions largely focused on excluding genuine healthcare practices from either a definition of conversion practices or any potential criminal offence provision [see 2.4.11 and 9.2.10]. Few respondents dealt with the national or Tasmanian legislative regimes for the regulation of healthcare.
- 6.2.2. Some respondents suggested that amendments to Tasmanian health practitioner laws could be used to deal with SOGI conversion practices. One suggestion was to incorporate the mandatory deregistration of any health practitioner who directly or indirectly offers, refers or conducts SOGI conversion practices.<sup>367</sup> This suggestion took the form of a suggested new clause in the

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<sup>367</sup> Submission 94.

*Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) to specifically target and regulate transphobic ideology by framing it as ‘medical malpractice’ in addition to categorising it as a SOGI conversion practice.<sup>368</sup> One submission suggested that any law reform should be explicitly limited to apply only to health practitioners.<sup>369</sup>

6.2.3. Some healthcare professional bodies and individual healthcare practitioners expressed support for regulating conversion practices through professional agencies, bodies and codes.<sup>370</sup> This would involve baseline prohibitions for professionally inappropriate care, but would otherwise leave the evaluation of what was appropriate healthcare to the present professional associations, namely the Royal Colleges.<sup>371</sup> Other respondents who were not medical practitioners also mentioned and supported the involvement of healthcare regulators.<sup>372</sup>

6.2.4. Several peak health bodies suggested that current professional regulations would apply to SOGI conversion practices. The Australian Psychological Society stated that SOGI conversion practices are:

harmful to all people subjected to them and ... lack efficacy. As such, any psychologist attempting to use conversion practices is likely to be in breach of our Code of Ethics’.<sup>373</sup>

6.2.5. The Australian Medical Association Tasmania’s members would prefer that any investigation of health professionals for possible SOGI conversion practices take place through the Australian Health Practitioners Regulation Agency procedures for ‘further investigation and sanction’.<sup>374</sup>

6.2.6. The Australian Psychological Society noted that because most conversion practices take place in religious contexts and under a banner of ‘pastoral care’, they are unregulated and may ‘look similar in modality to that provided by psychologists’, such as ‘talking therapy’, albeit without the necessary professional training, accreditation, oversight, code of ethics, or informed consent requirements.<sup>375</sup> The Society thus endorses avoiding harm caused by practices while also ‘preserv[ing] the integrity of the modality of practices commonly conducted by psychologists’; consequently a unilateral ban is warranted.<sup>376</sup>

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<sup>368</sup> Submission 93.

<sup>369</sup> Submission 66.

<sup>370</sup> Submissions 18 at 4, 114.

<sup>371</sup> Submission 90 at 3.

<sup>372</sup> Submission 93 at 5–6.

<sup>373</sup> Submission 18 at 2.

<sup>374</sup> Submission 90 at 2.

<sup>375</sup> Submission 18 at 2.

<sup>376</sup> Submission 18 at 2.

- 6.2.7. No respondent to the community consultation mentioned Tasmanian public health law as an appropriate vehicle for law reform. Tasmania Police noted the Queensland approach to amending its *Public Health Act 2005* (Qld) in order to discourage taking any similar approach to the *Public Health Act 1997* (Tas), because these two acts are ‘different in their focus and content’.<sup>377</sup> No respondent examined the *Mental Health Act 2013* (Tas) in relation to law reform.<sup>378</sup>
- 6.2.8. Following the community consultation, TLRI developed a series of regulatory proposals as part of a continuing consultation with peak medical bodies and statutory health officers [see 1.3.11]. Feedback from that continuing consultation was integrated into the final report and recommendations for legislative reform set out below.

### **6.3. Principal amendments should be situated in the *Mental Health Act***

- 6.3.1. The *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas), which implements the National Health Practitioner Regulation Law in Tasmania, is the main statute on the accreditation and regulation of registered health practitioners. Its complaints mechanisms would likely offer one means to investigate health practitioners who offered SOGI conversion practices as treatments.
- 6.3.2. The Tasmanian *Health Practitioner Regulation National Law* does not expressly define or prohibit SOGI conversion practices, but they may be covered under the broader obligations to provide evidence-based, professional and non-discriminatory health services. Health practitioners offering SOGI conversion practices in Tasmania might also contravene other professional standards and obligations set by peak medical bodies.
- 6.3.3. There is an existing body of Tasmanian health law and professional standards regulation that intersects with and implements national health standards within the State.<sup>379</sup> This law is predominantly situated in the *Public Health Act*, the *Mental Health Act* and the *Health Complaints Act*. Law reform should complement and be incorporated into these existing statutes, rather than as an additional standalone Tasmanian health law statute [see the principles in Part 5.3].

<sup>377</sup> Submission 25 at 2. Submission 122 similarly discouraged amendments to the *Public Health Act 1997* (Tas), albeit in favour of a standalone statute.

<sup>378</sup> Submission 49 provided the sole mention of the *Mental Health Act 2013* (Tas), albeit to suggest that ‘gender identity’ should be a ‘psychological illness given gender dysphoria causes severe distress in individuals’.

<sup>379</sup> Namely the *Health Practitioner Regulation National Law Act 2009* (Qld) and associated rules made by the Australian Health Practitioner Regulation Agency and various National Boards: see further AHPRA <<https://www.ahpra.gov.au/>>.

- 6.3.4. The Institute recommends law reform principally be situated within amendments to the *Mental Health Act* rather than the *Public Health Act*. This is because the *Public Health Act* is primarily concerned with community health risks like notifiable diseases, public health emergencies, immunisation, water quality, and tobacco control, which pose health risks to the public in general.<sup>380</sup> Specifically, the *Public Health Act* does not deal with health at the level of clinical practice.
- 6.3.5. Direct conversion practices are predominantly targeted at specific subsets of the general population, namely LGBTQA+ people, rather than the general population. Moreover, SOGI conversion practices are based on implicit or overt assertions about impairments of person's state of being or state of mind as a result of their expressed or experienced SOGI. Consequently, while a significant proportion of the Tasmanian population are more likely to be at risk from conversion practices, those risks are manifested at the individualised or clinical-level, rather than at the public or community level.
- 6.3.6. The *Mental Health Act*, on the other hand, is a framework for the regulation of mental health treatments by healthcare professionals, and thus focuses on the individual and clinical-level space where conversion practices might take place. It provides a series of definitions that are useful for narrowing down the kind of conduct that conversion practices, as pseudo-medical practices, involve, namely, legislative definitions of 'assessment', 'treatment' and 'mental illness'. Using the *Mental Health Act* places direct conversion practices within the province of mental health healthcare practice, albeit as purported mental health practices unsupported by contemporary scientific, medical or professional healthcare standards.

### **False and misleading mental health assessments and treatments**

- 6.3.7. For the purposes of Tasmanian health law, direct conversion practices can be approached as a form of false and misleading assessments and treatments.
- 6.3.8. The *Mental Health Act* currently describes an 'assessment' as:
- the clinical process involved in *diagnosing* the condition of a person's mental health and, where necessary, identifying the most appropriate treatment.<sup>381</sup>
- 6.3.9. A 'treatment' is defined by the Act as
- the *professional intervention* necessary to —
- (a) prevent or remedy mental illness; or
- (b) manage and alleviate, where possible, the ill effects of mental illness; or

<sup>380</sup> For example, notifiable diseases, public health emergencies, immunisation, water quality, tobacco control etc.

<sup>381</sup> *Mental Health Act 2013* (Tas) s 5 (emphasis added).

- (c) reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or
- (d) monitor or evaluate a person’s mental state.<sup>382</sup>

6.3.10. Under the same Act, a person is taken to have a mental illness if that person

- experiences, temporarily, repeatedly or continually —
- (i) a serious *impairment of thought* (which may include delusions); or
- (ii) a serious impairment of *mood, volition, perception* or cognition; ...<sup>383</sup>

6.3.11. The Act clarifies that:

- a person is not to be taken to have a mental illness by reason only of the person’s –
- ...
- (d) current or past expression of, or failure or refusal to express, a particular sexual preference or orientation; or
- ...
- (f) current or past engagement in a particular sexual activity or sexual promiscuity<sup>384</sup>

6.3.12. Notably the *Mental Health Act* does not currently contain any reference to ‘gender identity’.

6.3.13. Direct conversion practices emulate or mimic mental health assessment and treatment by **purporting to:**

- **Diagnose** (i.e. ‘classify’, or ‘determine, by examination’ the source, ‘nature and identity’ of a disease, fault or dysfunction<sup>385</sup>) sexual orientation or gender identity as a mental illness;
- On the basis that certain sexual orientation or gender identity attributes are the result of an **impairment of thought** (how a person *thinks* about themselves or others); *perception* (how they identify themselves or how they perceive others’ attractiveness); **mood** (how a person *feels* about themselves or others) or **volition** (how a person *chooses to act* or express themselves in relation to others or themselves);<sup>386</sup> and
- Undertake to **prevent** (*eradicate/change*), **remedy** (*eradicate/change*), or **alleviate** (*suppress*) that impairment of thought, mood or volition; and
- **Reduce** the claimed **risks** of LGBTQA+ status to the person or others; and

<sup>382</sup> *Mental Health Act 2013* (Tas) s 6 (emphasis added).

<sup>383</sup> *Mental Health Act 2013* (Tas) s 4(1) (emphasis added).

<sup>384</sup> *Mental Health Act 2013* (Tas) s 4(2).

<sup>385</sup> Diagnosis is not defined in the *Mental Health Act* or *Public Health Act*. The *Macquarie Dictionary* defines it to refer to ‘the process of determining, by examination of the patient, the nature and identity of a diseased condition; the decision reached from such an examination’: *Macquarie Dictionary* (online at 4 March 2022) ‘diagnosis’.

<sup>386</sup> Being ‘the act of willing; exercise of choice to determine action’: *Macquarie Dictionary* (online at 4 March 2022) ‘volition’.

- **Monitor** or **evaluate** a person’s mental state (a purported treatment as a continuing *course of conduct*).

6.3.14. However, unlike legitimate clinical assessment and treatment of genuine mental health conditions, SOGI conversion practices:

- Improperly categorise SOGI attributes as a disease, dysfunction or fault [see 2.2.3]; and
- Are predominantly undertaken outside the clinical context [see 3.4]; and
- Are conducted in a manner which is contrary to accepted standards of mental health care [see 4.3]; and
- Create, rather than alleviate, mental health risks for the subject and risks to the community through the perpetuation of false and misleading claims about mental health and mental illness [see 4.5].

6.3.15. It is the view of the Institute that the *Mental Health Act* should not only regulate appropriate health care, but proscribe inappropriate conduct which emulates, mimics or otherwise purports to be mental health care and is known to create risks to the mental health and wellbeing of people in Tasmania.

#### *Expanded jurisdiction to non-clinical contexts*

6.3.16. The Institute considers that the *Mental Health Act* provides an existing legislative basis for an adaptive, evidence-based, health service model [see 5.5.16] for regulating direct SOGI conversion practices. The Act currently provides for the regulation of ‘clinical or non-clinical procedure[s] or matter[s]’ by ‘medical practitioners, nurses or other persons’ through standing orders or clinical guidelines issued by a Chief Psychiatrist.<sup>387</sup> However, the *Mental Health Act* is currently predominantly clinical in focus. It would therefore require minor amendments to clearly and precisely proscribe harmful conduct which emulates or purports to be clinical mental health assessment and treatment of SOGI. The Institute recommends reforming the Act so that:

- Certain forms of actual or purported mental health care conduct which are considered clinically inappropriate by all peak health bodies — such as pathologising sexual orientation — would be proscribed by the Act [requires amendment];
- Greater clarity about what all peak health bodies agree is not a mental illness or dysfunction — such as gender identity (which includes gender expression) — and that this be statutorily clarified in the Act [requires amendment];

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<sup>387</sup> *Mental Health Act 2013* (Tas) s 152(1).

- In all other circumstances — such as the assessment or treatment of gender dysphoria/incongruence — the Chief Civil Psychiatrist (under existing statutory powers) would issue clinical guidelines for the assessment and treatment conditions relating to SOGI [no amendment needed];
- The Chief Civil Psychiatrist (under existing statutory powers) would issue standing orders specifying the class and qualifications of health professionals who may assess and treat people for mental health conditions relating to SOGI [no amendment needed];
- Clinical health professionals would be bound under the current provisions of the *Mental Health Act* to observe the issued guidelines and standing orders relating to SOGI and would be subject to professional or occupational disciplinary action if they breached those guidelines or orders [no amendment needed];
- Purported mental health care conduct or the ‘assessment’ or ‘treatment’ of a person’s mental health in relation to their SOGI, by *any other person*, would be an offence under the Act [requires amendment];
- To reduce regulatory burden on the Chief Civil Psychiatrist, unlawful assessments or treatments related to SOGI that occurred outside the clinical health space should be investigated by existing Tasmanian public officers or commissions and reported to the Chief Civil Psychiatrist [requires amendment].

6.3.17. These recommendations are expanded below.

### **Pathologisation of sexual orientation should be proscribed**

6.3.18. The Institute notes the support of all peak health authorities in Tasmania and nationally for the strict prohibition of practices which seek to pathologise, diagnose, change, suppress or eradicate a person’s sexual orientation [see 4.3]. The Institute recommends that a person may not be assessed or treated for a mental health condition on the grounds of sexual orientation.

6.3.19. Practitioners would still be permitted to discuss sexual orientation as part of the legitimate and clinically sanctioned assessment and treatment of other mental health conditions, so long as there was no express or implicit pathologisation of sexual orientation as part of that process.

**Recommendation 2. Purported or actual mental health assessment or treatment of sexual orientation should be proscribed.**

The *Mental Health Act* should contain an express provision that a person must not purport to or actually undertake an assessment or treatment of another person’s sexual orientation.

### **Assessment and treatment of gender dysphoria/incongruence**

- 6.3.20. The Institute notes that no peak health authorities in Tasmania or nationally consider a person's experienced gender identity to be a pathological fault, dysfunction or disorder. Nor does any such body describe non-cisgender identity as the basis or justification for any form of medical or psychological intervention. It is also the Institute's view that people who are *Gillick* competent should be free to make decisions about surgery to change or suppress their sex characteristics without having to be assessed as having a mental illness.<sup>388</sup>
- 6.3.21. However, the Institute understands that gender dysphoria/incongruence is frequently accompanied by significant distress and psychiatric morbidity. As such gender dysphoria/incongruence remains a diagnosable mental health condition in Australia. Gender identity expression and experience are relevant diagnostic criteria but are not permitted to be sole determinants of a diagnosis of gender dysphoria/incongruence [see Appendix B].
- 6.3.22. The Institute accepts that legitimate assessment and treatment of such symptoms (in particular psychotherapy) may involve discussions about a person's past, present and potential experienced gender identity.
- 6.3.23. In particular, some submissions emphasised that mental healthcare professionals' use of talk therapy methods and 'inclusive treatments' might fall within the proposed definition of 'conversion practices' [see 2.7.21]. Inclusive treatments involve a psychiatrist or psychologist exploring the 'causes' of a patient's discomfort, distress or mental health problems by exploring the patient's own rationalisation of where the harm comes from.
- 6.3.24. In cases of gender dysphoria/incongruence, clinical health professionals might ask the patient to reflect on their experiences and feelings about themselves, including their gender, and how that relates to their discomfort or distress. That may involve talking about traumatic childhood experiences. The specific concern would be that this might count as suggesting there is a 'cause' to the patient's gender dysphoria/incongruence, or linking being transgender with other traumas or mental health conditions. This could fall into a similar category to some SOGI conversion practices and conversion beliefs, most notably the false belief that LGBTQA+ status is caused by past trauma.
- 6.3.25. The Institute acknowledges the concerns of peak health bodies that broadly worded criminal sanctions might deter healthcare professionals from assessing and treating patients with gender dysphoria/incongruence in accordance with professional standards.

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<sup>388</sup> *Gillick* competence refers to circumstances where a person under the age of 18 is held to be capable of consenting to a medical intervention, treatment or procedure without parental/guardian consent. See further *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112; *Secretary of the Department of Health and Community Services v JWB* (1992) 175 CLR 218 ('*Marion's Case*').

- 6.3.26. Nevertheless, the Institute is concerned about the serious risk to gender dysphoric/incongruent people (especially children) from illegitimate, unsanctioned and unregulated conduct which purports to assess or treat gender dysphoric/incongruent people on mental health grounds. Specifically, conduct which purports to describe the aetiological basis of a person's gender identity or expression, associate it with a cognitive or physical impairment or treat it as a fault, dysfunction or disorder is contrary to best-practice professional standards. Any debate about the correct approach to assessing and treating gender dysphoric/incongruent patients does not displace the need for any such assessments to be carried out by appropriately qualified, accredited and regulated mental healthcare professionals, to the best standards of current professional practice.
- 6.3.27. The TLRI also notes and agrees with the wider principle of depathologisation of gender dysphoria/incongruence, reflected in the International Classification of Diseases 11<sup>th</sup> revision (ICD-11). The Manual revised its 10<sup>th</sup> edition by renaming 'gender dysphoria' to 'gender incongruence' and also moving it from the 'mental and behavioural disorders' chapter to a new chapter entitled 'conditions related to sexual health'. These changes reflect the contemporary understanding that transgender and gender diverse identities are not mental health conditions.
- 6.3.28. Making the *Mental Health Act* the principal legislative framework for the regulation of conversion practices should not be taken to imply that sexual orientation or gender identity has any association with mental health. Rather it signals that, with the exception of a very narrow bandwidth of healthcare activities, sexual orientation and gender identity are not mental health issues, and their mischaracterisation as being caused by disease, dysfunction or fault is harmful and socially unacceptable. The TLRI also emphasises that the regulation of mental health care for gender dysphoria/incongruence does not necessarily imply gender dysphoric/incongruent people need to be assessed or treated.
- 6.3.29. Given that:
- There is unanimous agreement amongst peak health bodies that a person's gender identity is not a mental health disorder; and
  - Both classifications for mental disorders clearly state that a person who is gender dysphoric/incongruent may not have mental health symptoms or require mental health treatment,

The Institute makes the following recommendation:

**Recommendation 3. The *Mental Health Act* should clarify that gender identity and gender expression are not mental illnesses**

A provision should be added to the *Mental Health Act* to clarify that a person is not to be taken to have a mental illness by reason only of that person's gender identity or expression.

For the avoidance of doubt, this recommendation does not extend to discussions relating to gender identity (including gender expression) as part of a legitimate mental health service by an appropriately qualified health professional.

6.3.30. However, given that:

- Peak medical bodies generally recognise the need to assess, treat and care for gender dysphoric/incongruent people who are distressed as a result of the dysphoria/incongruence; and
- Those people are vulnerable and require highly specialised care by appropriately trained and qualified health professionals; and
- Those professionals require the freedom to discuss the patient's sexual orientation and gender identity in a manner that is consistent with appropriate clinical guidelines,

The Institute makes the following recommendation:

**Recommendation 4. Tasmanian law should require that the assessment and treatment of gender dysphoria/incongruence comply with appropriate professional standards.**

Tasmanian health law should prescribe the professionals who may assess and treat mental health conditions relating to gender identity or expression (gender dysphoria/incongruence) and the clinical guidelines which must be adhered to as part of that care. Tasmanian law should prohibit persons who are not qualified professionals from purporting to assess (diagnose) or treat people in relation to their gender identity or expression.

## **Professional standards for gender dysphoria/incongruence**

6.3.31. The Institute notes that the Family Court of Australia has confirmed that the appropriate Australian Standards for the care of trans and gender diverse people in Australia requires a 'gender affirming' approach to clinical intervention [see Appendix B].<sup>389</sup> The TLRI is not a medical authority and accepts that the present gender affirming model is evidence-based and designed to ensure the best standard of care for gender dysphoric/incongruent patients. However, the Institute acknowledges that appropriate assessment and treatment pathways for gender related disorders are complex and evolving.

<sup>389</sup> *Re: Imogen [No 6]* [2020] FamCA 761.

6.3.32. The TLRI agrees that any legislation on SOGI conversion practices must be adaptive to advances in scientific and medical knowledge, clinical practice and professional standards. It would not be appropriate to fix clinical standards in primary legislation. Rather the Institute recommends Tasmanian law empower an appropriate public health authority to declare, revise and update appropriate clinical standards for the assessment, treatment and care of gender dysphoric/incongruent people in Tasmania. The most appropriate existing Tasmanian authority for that role is the Chief Civil Psychiatrist.<sup>390</sup>

## 6.4. Chief Civil Psychiatrist should be responsible for issuing SOGI related guidelines and orders

- 6.4.1. Chapter 3 pt 1 div 3 of the *Mental Health Act* empowers the Chief Civil Psychiatrist to issue:
- **Clinical guidelines** for controlling authorities, medical practitioners, nurses or other persons in the exercise of their responsibilities in respect of any treatment, clinical procedure or other clinical matter;<sup>391</sup>
  - **Standing orders** for controlling authorities, medical practitioners, nurses or other persons regarding the exercise of their responsibilities in respect of any clinical or non-clinical procedure or matter.<sup>392</sup>
- 6.4.2. Both standing orders and clinical guidelines are binding on the people or roles to whom they are directed, and those people/roles must comply with their provisions.<sup>393</sup> A health professional who fails to comply with standing orders or clinical guidelines is liable for professional or occupational disciplinary action.<sup>394</sup>
- 6.4.3. The Institute recommends the Chief Civil Psychiatrist develop and issue clinical guidelines relating to the assessment, treatment and care of persons who have or may have a gender related disorder, in consultation with the:
- Royal Australian and New Zealand College of Psychiatrists;
  - Australian Psychological Society;
  - Australian Medical Association Tasmania;
  - Australian Professional Association for Trans Health; and
  - Any other expert bodies the Chief Civil Psychiatrist considers relevant.

<sup>390</sup> *Mental Health Act 2013* (Tas) ch 3 pt 1 ‘Chief Psychiatrists’.

<sup>391</sup> *Mental Health Act 2013* (Tas) s 151.

<sup>392</sup> *Mental Health Act 2013* (Tas) s 152.

<sup>393</sup> *Mental Health Act 2013* (Tas) ss 151(4) and 152(4).

<sup>394</sup> *Mental Health Act 2013* (Tas) ss 151(5) and 152(5).

- 6.4.4. The Institute suggests that these clinical guidelines be based on, reference or incorporate:
- International Statistical Classification of Diseases and Related Health Problems 11<sup>th</sup> Revision (ICD-11); and
  - Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents 2020.
- 6.4.5. The Institute further recommends that the Chief Civil Psychiatrist issue standing orders to specify the professions or professionals who are competent to provide health services to:
- Persons with gender related disorders; and
  - Persons who are being assessed or treated for a mental health condition, or mental health symptoms, in which the person's SOGI may be discussed or explored.
- 6.4.6. The Institute recommends that these standing orders be made in consultation with the:
- Royal Australian and New Zealand College of Psychiatrists;
  - Australian Psychological Society;
  - Australian Medical Association; and
  - Any other professional or regulatory bodies the Chief Civil Psychiatrist considers appropriate.

### **Unauthorised and purported assessment and treatment should be proscribed**

- 6.4.7. At present clinical guidelines and standing orders under the *Mental Health Act* bind specific classes of individuals, which may include persons who are not health professionals and conduct which involves a non-clinical procedure or matter. However, these guidelines and orders are not exclusionary, insofar as they do not make it an offence for persons who *are not* proscribed to exercise certain responsibilities under the Act to exercise the responsibilities of a person who is proscribed to do so.
- 6.4.8. The Institute recommends extending the operation of the *Mental Health Act* (either by provisions in that Act, or the *Public Health Act*) to make it an offence to assess or treat a person for, or relating to, sexual orientation or gender identity, if that person is not authorised to do so by a standing order. This will avoid questions of jurisdiction and claims that persons who are not clinicians may provide 'alternative' practices which are similar to mental health healthcare (i.e. conduct which emulates, mimics or otherwise purports to be mental health services) outside of the Act. The Institute notes that such a provision may be situated in the *Public Health Act* or the *Mental Health Act*. While there are benefits to both approaches, the Institute prefers to situate such a general prohibition on unauthorised mental health or mental health like

practices in the *Mental Health Act*, for the reasons set out above [see 6.3] and for the purposes of legislative clarity and accessibility.

- 6.4.9. Regardless, the provision should be in the form of a statutory offence with a penalty equivalent to the present offence of unlawful treatment under s 213 of the *Mental Health Act*, namely a maximum of 100 penalty units or imprisonment for a term not exceeding one year. Unlike that provision, a new provision would apply to unlawful assessment or treatment of ‘any other person’ (rather than to a ‘patient’). It would also include a ‘purported assessment or treatment’.

#### *Notices*

- 6.4.10. Noting the risk posed by continuing conduct, the Institute recommends including provisions in Tasmanian health law (preferably the *Mental Health Act*) for a relevant statutory officer to issue a notice to any person or entity that their conduct is suspected of contravening a statutory prohibition on direct conversion practices and that the conduct must cease until an inquiry is made under the *Health Complaints Act* [see 6.5]. Those officers should also be permitted to issue a notice following a report by the relevant body of inquiry that the conduct amounts to a direct conversion practice under the Act and that the conduct must cease.
- 6.4.11. The Institute recommends that statutory officers who may issue a notice include: a Chief Psychiatrist, the Director of Public Health, and the Minister for Health.

#### *Aggravating Factors*

- 6.4.12. The Institute recommends that a person who continues to undertake conduct that is subject to a notice ordering them to cease that conduct is subject to an aggravated penalty if the principal offence is made out. The Institute recommends the aggravated penalty be two times the standard penalty.
- 6.4.13. Given their particular vulnerability to conversion practices, the Institute also recommends that there be an aggravated offence of unlawful mental health assessment or treatment of a child or vulnerable person under the Division. The Institute recommends the aggravated penalty be four times the standard penalty.

**Recommendation 5. Unauthorised mental health or mental health like assessment or treatment of SOGI attributes should be an offence**

Tasmanian health law should be amended to stipulate that a person must not purport to or undertake any assessment or treatment of another person in relation to their sexual orientation\* or gender identity unless they are expressly authorised to do so under a Standing Order and they act consistently with Clinical Guidelines under the *Mental Health Act*.

The offence should be aggravated by continuing conduct or conduct directed to a child or vulnerable person.

\* Note that this will result in the general prohibition of all assessment and treatment of sexual orientation by virtue of the operation of Recommendation 2.

### *Definition of purported assessment or treatment*

- 6.4.14. To properly capture misleading or deceptive conduct which emulates mental health assessment or treatment, the Institute recommends including provisions in Tasmanian health law which describe what ‘purported’ assessments or treatments of sexual orientation or gender identity are. Such conduct would be ‘purported’ because it is not carried out by an authorised person and is contrary to clinical guidelines (and therefore is not an evidence-based mental health practice).
- 6.4.15. A ‘**purported assessment** of sexual orientation or gender identity’ would be a course of conduct which:
- Asserts or infers another person’s sexual orientation or gender identity:
    - Is the result of psychiatric or pathological brokenness, mental illness, disease, dysfunction or disorder; or
    - Is the cause of the person’s mental health symptoms; and
  - Is conducted by a person who is not authorised to undertake mental health assessment relating to SOGI by standing orders made under the Act.
- 6.4.16. A provision describing a purported assessment should make it clear that ‘infers’ includes asserting a person’s sexual orientation or gender identity ‘can and should be fixed, cured, repaired, or otherwise treated’.
- 6.4.17. The Institute also recommends that a provision should also be added to the *Mental Health Act* to describe a ‘**purported treatment** of sexual orientation or gender identity’ as a course of conduct which:
- Seeks or claims to change, suppress or eradicate another person’s sexual orientation or gender identity; and
  - Is conducted by a person who is not authorised to undertake mental health treatments relating to sexual orientation or gender identity by standing orders made under the Act.
- 6.4.18. The Institute recommends including provisions relating to proscribed and purported assessment and treatment of SOGI in a standalone division of the *Mental Health Act* (or the *Public Health*

*Act* if that is preferred) for clarity, unity and utility. The reform should clearly state that ‘purported’ includes conduct that occurs outside the clinical setting.

## Exceptions

- 6.4.19. The TLRI recommends that a broad exemption for healthcare services complying with prescribed clinical guidelines be included in any proposed legislative change. The TLRI believes that maintaining exemptions congruent with the National Law would be preferable to using the less clear ‘reasonable professional judgement’ standard used in the legislation of other Australian jurisdictions that have proscribed conversion practices [see Appendix A]. This would ensure clarity, consistency and health profession-led adaptive governance in the best interests of patients.
- 6.4.20. The Institute recommends that the following exceptions to proscribed assessments or treatment (including purported assessments or treatments) be clearly articulated in any law reform:
- Clinical practices which are conducted in good faith and consistent with the provisions of the *Mental Health Act* and any standing orders or clinical guidelines made under that Act; or
  - Health practices which are expressly authorised, or which a health professional reasonably believes to be expressly authorised under any other Act; or
  - Providing care, assistance or support to a person to:
    - Undergo a gender transition;
    - Develop mental or emotional resilience, coping skills, or identity exploration and development; or
    - Explore, develop or express their sexual orientation or gender identity — without trying to change, suppress or eradicate that sexual orientation or gender identity; or
  - Conduct which involves no more than:
    - The expression of an opinion, idea or belief, or
    - Support, acceptance, or understanding of a person.

## Conscientious objection

- 6.4.21. The Institute is of the view that all patients should receive the best possible standard of care, based on contemporary, evidence-based clinical guidelines. However, there is a potential risk that strongly held philosophical, moral, and religious beliefs about sexual orientation or gender identity may undermine the objectivity, trust or professional–patient relationship essential to many forms of healthcare, especially in relation to gender dysphoria/incongruence. The Institute considers that risk to outweigh any benefits of mandating specific care pathways for all health professionals.
- 6.4.22. In the circumstances, the Institute recommends that health professionals be able to conscientiously object to clinical guidelines relating to sexual orientation and gender identity. However, the needs of the patient are paramount, so any exception for conscientious objection must be balanced by provisions that ensure the patient is referred to a suitably qualified professional who does not have such objections. Furthermore, the law should ensure that an appropriate record of conscientious objectors is kept to ensure future patients are not sent to health professionals who are not willing or able to treat them according to declared clinical guidelines.
- 6.4.23. The Institute considers that it would be appropriate for a health professional who has a conscientious objection to assessing or treating a person in conformity with an issued clinical guideline to, within seven days:
- If the person is not currently a patient of the health professional, then
    - notify any referring professional of the conscientious objection; or
  - If the person is a patient of the health professional, then
    - notify the patient and refer them to another professional who does not have a conscientious objection, and
    - note in the patient’s medical record the reasons for the refusal to provide health care; and
    - notify the Office of the Chief Civil Psychiatrist of the basis of the refusal and the action that was taken to refer the patient to another health professional.
- 6.4.24. Following the notification, the Chief Civil Psychiatrist should update any Standing Orders to include the health professional in a list of persons who are not authorised to provide mental health services to gender dysphoric/incongruent people.

## Proportionate expression of opinion, religion and parental rights unaffected

6.4.25. Beyond the conscientious objection provisions above, the Institute does not consider that exceptions for freedom of expression, religious expression, or parental or guardian rights are necessary or appropriate for direct conversion practices. Actual or purported assessment or treatment of mental health is a subject that falls outside of reasonable expression of opinion or faith. The above recommendations allow for:

- The voicing and publication of personal or doctrinal views on sexual orientation and gender identity attributes, provided that they are honestly and clearly distinguished from assertions and claims about aetiology (causes), pathology and mental health symptoms of such attributes; and
- Parents, guardians, religious and other leaders to provide supportive care and counselling for another person, provided that the care or counselling does not seek to convince the subject they have a fault or dysfunction that requires correction.

## **6.5. Existing statutory officers and commissions should receive, investigate and report**

6.5.1. At present, suspected contraventions of the *Mental Health Act* and any clinical guidelines and standing orders are, under ch 3 divs 2–4:

- Primarily received by, referred to and reported on by ‘Official Visitors’ to approved facilities and any premises from which patients are provided with services;<sup>395</sup> and
- Investigated by the Health Complaints Commissioner (private entities) or Tasmanian Ombudsman (public entities);<sup>396</sup> and
- Where the contravention involves an offence, prosecution by Tasmania Police.

6.5.2. The Institute recommends adopting a similar approach for unauthorised mental health or purported mental healthcare-like assessment or treatment of SOGI attributes. In particular the Institute recommends that the body which retains principal responsibility for the investigation and reporting on direct SOGI conversion practices is the Health Complaints Commission. However, the complaint process under ch 3 of the *Mental Health Act* is presently concerned with the receipt, referring and reporting of complaints by patients who use approved facilities and any premises at which patients are provided with healthcare services under the Act.

6.5.3. Because SOGI conversion practices occur both inside and outside clinical settings, the Institute recommends that a broader range of public authorities be empowered to receive, refer and

<sup>395</sup> *Mental Health Act 2013* (Tas) ss 156 (functions of principal official visitor), 160 (visits) 161 (complaints), 165 (operational and monthly reporting).

<sup>396</sup> *Mental Health Act 2013* (Tas) s 165(1).

report on complaints of direct SOGI conversion practices to the Health Complaints Commissioner. These would be:

- A Chief Psychiatrist, the Director of Public Health, or the Official Visitor (public health officers);
- The Anti-Discrimination Commissioner; the Commissioner for Children (statutory commissioners);
- The Secretary responsible for administering the *Children, Young Persons and Their Families Act 1997* (Tas); the Public Guardian (welfare and guardianship authorities);
- A judge, associate judge or magistrate (judicial officers);
- A police officer.

6.5.4. Whereas the *Mental Health Act* currently specifies the Health Complaints Commissioner and Ombudsman as the appropriate bodies to investigate suspected contraventions of the Act,<sup>397</sup> there is no stipulation in the *Health Complaints Act 1995* (Tas) or *Ombudsman Act 1978* (Tas) that an investigation may commence upon reference or referral under the *Mental Health Act*.<sup>398</sup> The Institute recommends that, for the sake of clarity the *Health Complaints Act* s 40 and *Ombudsman Act* pt 2 div 2 be amended to make it clear that the Health Complaints Commissioner and Ombudsman may inquire into any matter referred or reported under the *Mental Health Act*.

**Recommendation 6. Health Commissioner or Ombudsman should investigate direct SOGI Conversion Practices**

A new provision should be included in Tasmanian health law (preferably the *Mental Health Act*) to allow public health officers, statutory commissions, welfare and guardianship authorities, judicial officers or the police to receive, refer and report on complaints about unauthorised mental health or mental health-like assessment or treatment of SOGI attributes to the Health Complaints Commissioner or Ombudsman.

The *Health Complaints Act* and *Ombudsman Act* should be amended to clarify the Commissioner may investigate and report on any matter referred under the *Mental Health Act*.

<sup>397</sup> *Mental Health Act 2013* (Tas) s 165(1).

<sup>398</sup> Under the *Health Complaints Act 1995* (Tas) the Commissioner is only required to investigate on a written direction given by the Health Minister (s 40). There is no requirement or power for the Ombudsman to investigate a reference or referral under the *Mental Health Act 2013* (Tas) s 16 at all.

## 6.6. Amendments to the *Health Complaints Act*

- 6.6.1. Under the present *Health Complaints Act 1995* (Tas) the Health Complaints Commissioner has a wide range of powers to investigate, conciliate, and report on health service complaints under that Act, or under other statutes, including the *Mental Health Act*. A ‘health service’, includes:
- A service provided to a person for, or *purportedly for*, the benefit of human health,<sup>399</sup> and
  - Any other service provided by a provider for, or *purportedly for*, the care or treatment of another person.<sup>400</sup>
- 6.6.2. The Act’s schedule relevantly specifies that services delivered at or by hospitals or health institutions, and medical, mental health, community health, psychotherapy, therapeutic counselling, social work, welfare, recreational or leisure services (if provided as part of a health service) are health services for the purpose of the Act.<sup>401</sup>
- 6.6.3. These definitions arguably cover the broader range of contexts in which SOGI conversion practices occur, including outside of clinical contexts where they are *purportedly* for the benefit of human health, care or treatment. However, there is a potential for uncertainty around some forms of conversion practices which may not have been represented or understood by the subject to be a ‘health service’ *per se*. For instance, they may have been represented as a faith-based support (although labelled as ‘care’, ‘healing’ and other terms which are healthcare-like). While service is generally defined as ‘an act of helpful activity’ (which would, under the statutory definition include a ‘purportedly’ helpful activity),<sup>402</sup> it involves a connotation of a request or demand for that activity. Conversion practices may involve a unilateral course of conduct that may have not been requested or demanded but imposed or coerced.
- 6.6.4. There is potential for ambiguity and uncertainty about whether all forms of direct SOGI conversion practices are services covered by the Act. This uncertainty may serve to reduce reporting, referrals and investigations and undermine the potential for claimants to access justice. As such, the Institute makes the following recommendation to clarify the meaning of health service in relation to SOGI conversion practices:

**Recommendation 7. The *Health Complaints Act* should be amended to clarify that SOGI conversion practices fall under the jurisdiction of the Act**

<sup>399</sup> *Health Complaints Act 1995* (Tas) s 3 (emphasis added).

<sup>400</sup> *Health Complaints Act 1995* (Tas) sch 1, pt 1, cl 8 (emphasis added).

<sup>401</sup> *Health Complaints Act 1995* (Tas) sch 1, pt 1.

<sup>402</sup> *IW v City of Perth* (1997) 191 CLR 1, 11 (Brennan CJ and McHugh J).

Direct SOGI conversion practices should be included as a purported health service under the *Health Complaints Act 1995* (Tas) clarifying, in Schedule 1 of the Act, that health services include ‘a course of conduct which is for, or purportedly for, the mental health assessment or treatment of another person in relation to that person’s sexual orientation or gender identity’.

## Allowing health complaints about conversion practices by health service users

- 6.6.5. Independent of any reference made under the Mental Health Act, the Health Complaints Commissioner may inquire into any matter relating to health services (or purported health services) which discriminate against LGBTQA+ people. That includes investigating breaches of the Tasmanian Charter of Health Rights and Responsibilities. Under the present Charter a person has the right to health services free from discrimination on the grounds of, amongst other things, gender, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, or social status.<sup>403</sup> The Charter also explains that a person has the right to health services free of abuse, deception or fraud.<sup>404</sup>
- 6.6.6. Notably the Charter does not currently stipulate that a person has the right to health care that is free from discrimination on the basis of a person’s gender identity or gender expression. Nor does it emphasise that gender identity is not a mental health condition or dysfunction. The Institute recommends including provisions in s 20 of the Health Complaints Act — which sets out the general principles upon which the Charter is developed — to make this clear.

**Recommendation 8. The *Health Complaints Act* and *Charter* should clarify the protected and depathologised nature of gender identity attributes**

Section 20 of the Health Complaints Act should be amended to specify that: a person is entitled to health care and services free of direct or indirect discrimination on the grounds of sexual orientation or gender identity; and a person’s sexual orientation and gender identity are not pathological conditions, faults or dysfunctions.

The *Charter of Health Rights and Responsibilities* should be updated to include a specific reference to these health rights.

<sup>403</sup> *Tasmanian Charter of Health Rights and Responsibilities* Right 2.

<sup>404</sup> *Tasmanian Charter of Health Rights and Responsibilities* Right 2.

- 6.6.7. The inclusion of the above rights will clarify that any person may complain to the Health Complaints Commissioner about discriminatory conduct in relation to their mental health on the grounds of their gender identity. They will also permit the Commissioner to consider whether certain conduct referred under the Mental Health Act was motivated by discrimination.
- 6.6.8. As noted above [see 3.6] a number of reports to this Inquiry involved discriminatory conduct by health professionals which may not have amounted to direct conversion practices, but which was less favourable because of SOGI attributes. Other reports involved discriminatory conduct which arguably amounted to direct conversion practices. In both cases, the Commissioner is able to contribute to social and systemic harm reduction from discriminatory, abusive, deceptive or fraudulent conduct affecting the health and wellbeing of LGBTQA+ people in Tasmania [see Law Reform Principle I at 0]. This is because the Commissioner's functions include not only resolving complaints under the Act, but reviewing wider issues arising from those complaints and suggesting ways of improving health rights for LGBTQA+ people in Tasmania. In particular, the role of the Commissioner involves making recommendations for systemic reform. Clarifying the protected character of gender identity and its status in contemporary health science within the Act is a simple amendment which will ensure that any legacy misconceptions about SOGI attributes may be appropriately responded to within Tasmanian health services.
- 6.6.9. If a complaint against a health service is not resolved, or if the matter has been referred to the Health Complaints Commissioner by a public officer or authority under the provisions of the Mental Health Act [see 6.5], the Commissioner may, under the current provisions of the *Health Complaints Act*, conduct an investigation into the conduct. Under the current Act, the Commissioner has the powers to:
- Conduct an investigation in 'such manner as the Commissioner considers appropriate': s 43;
  - Obtain and use records or information from any person: s 45;
  - Examine witnesses under oath or affirmation: s 46;
  - Obtain warrants to aid investigation or obtain a document or other thing relevant to an investigation: s 47;
  - Refer a matter to the Ombudsman, a registration board or another person that has functions under any law of Tasmania, another State, a Territory or the Commonwealth, such as the Australian Health Practitioner Regulation Agency or the Health Practitioners Stream of the Tasmanian Civil and Administrative Tribunal: ss 46, 56A; and
  - Make a report containing information, comments, opinions and recommendations for action: s 55(3).

- 6.6.10. The Institute considers these powers and duties are adequate to investigate direct conversion practices. They are generally expressed (i.e. they apply to persons rather than health practices or health professionals) and therefore may be used to investigate conduct that is alleged to have occurred in both clinical and non-clinical settings. However, the reporting process assumes the existence of a health service provider that may implement recommendations. SOGI conversion practices are pseudo-medical and pseudoscientific in character. They may emulate, mimic or otherwise purport to be health services, but in many cases it is unlikely that there will be an entity which is able or willing to implement recommendations in a meaningful way. Furthermore, the Commissioner does not have binding powers in relation to recommendations and no power to implement penalties.
- 6.6.11. Under the Health Complaints Act, the Commissioner may report to any person who ‘under a law of Tasmania ... has a function exercisable in relation to a matter raised in the report’.<sup>405</sup> However, the Commissioner is not obliged to report back on referrals made under other Acts, such as the Mental Health Act (despite that Act providing for referrals to inquire into whether its provisions have been breached).
- 6.6.12. The Institute recommends that the *Health Complaints Act* be amended to clarify that the Commissioner should report back to the referring officer and the Chief Civil Psychiatrist under the *Mental Health Act*. Such a requirement would be consistent with s 55(2)(g) of the Act, which specifies that a report be provided back to any registration board that referred a matter for inquiry. The Act should be further amended to specify that the Commissioner should report to the relevant Chief Psychiatrist, Director of Public Health and Health Minister if the Commissioner believes a provision of the *Mental Health Act* has been breached. Such an amendment would ensure that findings of direct conversion practices which are made as a result of a complaint (rather than a referral) are raised with the appropriate statutory officer.

**Recommendation 9. The Health Complaints Commissioner should investigate and report all findings of direct SOGI conversion practices to the Chief Civil Psychiatrist.**

<sup>405</sup> *Health Complaints Act 1995* (Tas) s 55(2)(e).

# Responding to indirect conversion practices

## 7.1. Tasmanian anti-discrimination law

7.1.1. In the previous chapter, the Institute considered and made recommendations on the reform of Tasmanian health law to proscribe direct conversion practices. Indirect conversion practices are driven by the same beliefs as direct practices, but are of a different categorical form and serve a different function [see 3.6.7–3.6.9] placing them mainly outside the health law space. In summary, such practices involve a course of conduct that aims to convince:

- LGBTQA+ people that they can and should change, suppress or eradicate their SOGI attributes; or
- Others that LGBTQA+ people have a fault or dysfunction that can and should be changed, suppressed or eradicated, so as to create social pressure for people with those attributes to accept or commit to harmful conversion practices.

7.1.2. Such conduct is a precursor to direct conversion practices. The person or persons who conduct the indirect practice may not be the same person who conducts a subsequent direct conversion practice. Indeed, a subject may ultimately undertake a self-directed conversion practice due to indirect conversion practices. Many if not most indirect practices will occur outside of the jurisdictional scope and remit of health law, even to the extent that that law applies to pseudoscientific and pseudo-medical practices.

7.1.3. Because indirect conversion practices are a form of speech act directed to the characteristics of a class of people, the Institute considers they are most appropriately described and regulated as discriminatory conduct. In general terms, discrimination is any conduct which differentiates based on specific attributes ‘in favour of or against a person or thing, especially when arising from prejudice’.<sup>406</sup> All conversion practices (direct and indirect) can therefore be properly described as discrimination towards SOGI attributes. That means that direct practices may fall under the subject matter jurisdiction of both health and anti-discrimination law. In contrast, indirect practices fall only under the latter. Both forms may additionally fall under other laws, such as consumer, civil or criminal law.

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<sup>406</sup> *Macquarie Dictionary* (online at 4 March 2022) ‘discrimination’.

- 7.1.4. As discussed above, not all discrimination against LGBTQA+ people amounts to a conversion practice [see 3.6.2]. Nor are all discriminatory statements about LGBTQA+ people an expression of a conversion belief or a conversion practice [see 2.2.8–2.2.10]. For instance, a person may make homophobic comments, or exclude a homosexual person from a group activity, but not believe that that person can change their sexual orientation, nor assert they should change that attribute. The discrimination in such cases involves treating the person less favourably *because of* their SOGI attributes. Conversion practices on the other hand involve the less favourable treatment *directed to* a person’s SOGI attributes.
- 7.1.5. An analogy to the different ways in which discrimination can differentiate based on SOGI attributes is racial discrimination. Racism may involve segregationist beliefs and acts — which admit racial diversity but direct prejudice towards certain people because of their race. Racism may also involve assimilationist beliefs and acts — which seek racial homogeneity and are directed to changing, suppressing or eradicating certain people’s racial characteristics. These two forms of racism are not always distinct, and often intersect with each other. The same is true of discrimination directed towards SOGI characteristics. Nevertheless, it is only the aspects of the discrimination which are directed to SOGI characteristics with the aim of changing, suppressing or eradicating them that are conversion practices.
- 7.1.6. As was discussed in the Issues Paper to this Inquiry, Tasmania has a robust anti-discrimination regime that is concerned with reducing harmful forms of discrimination on the grounds of, amongst other things, SOGI attributes. An overview of the Tasmanian *Anti-Discrimination Act* is set out in the next section of this chapter.
- 7.1.7. The Issues Paper to this Inquiry described how the *Anti-Discrimination Act* might regulate and proscribe conversion practices. It also highlighted some definitional and operational issues that mean that the present act may not entirely — or at the very least clearly — address the harms from the particular form of discrimination that conversion practices involve. The Institute sought community feedback on these issues and the appropriateness of the anti-discrimination regime to regulating conversion practices. The Institute also undertook a continuing consultation with public bodies, including Equal Opportunity Tasmania, the statutory office responsible for administering the Tasmanian *Anti-Discrimination Act*. Responses to the Inquiry relevant to discrimination law are set out in this chapter [see 7.2].
- 7.1.8. In the Institute’s view, the *Anti-Discrimination Act* is well suited to the regulation of indirect conversion practices. However, some reform is necessary to cover the gaps and uncertainties identified in the Issues Paper and in the community and continuing consultation. In particular, reform is required to clarify what provisions of the Act are relevant to conversion practices both as a matter of law and declaratory transparency. Reform is also recommended to ensure that

discriminatory conduct that is more appropriately regulated by health law (i.e. direct conversion practices) is directed to appropriate authorities by the State rather than the complainant. This will reduce burdens and ensure that people who have raised complaints about conversion practices do not ‘fall between the gaps’ of State laws and agencies.

## Prohibited discrimination and related conduct

7.1.9. The *Anti-Discrimination Act* prohibits various forms of discriminatory conduct, including: ‘direct’ and ‘indirect’ discrimination on the grounds of attribute;<sup>407</sup> offending, humiliating, intimidating, insulting or ridiculing another person on the basis of an attribute;<sup>408</sup> sexual harassment;<sup>409</sup> and incitement of hatred towards, serious contempt for, or severe ridicule of a person or group relating to certain attributes, among them sexual orientation and gender identity.<sup>410</sup>

### *Direct and indirect discrimination*

7.1.10. The *Anti-Discrimination Act* does not provide a general definition of discrimination for the purposes of Tasmanian law, rather it describes the term by including specified forms of conduct regulated under the Act. As noted these are direct and indirect forms of discrimination.

7.1.11. Direct discrimination is defined as follows:

- (2) Direct discrimination takes place if a person treats another person on the basis of any prescribed [ie SOGI] attribute, imputed prescribed attribute or a characteristic imputed to that attribute less favourably than a person without that attribute or characteristic.
- (3) For direct discrimination to take place, it is not necessary –
  - (a) that the prescribed attribute be the sole or dominant ground for the unfavourable treatment; or
  - (b) that the person who discriminates regards the treatment as unfavourable; or
  - (c) that the person who discriminates has any particular motive in discriminating.<sup>411</sup>

7.1.12. Indirect discrimination is defined as follows:

- (1) Indirect discrimination takes place if a person imposes a condition, requirement or practice which is unreasonable in the circumstances and has the effect of disadvantaging a member of a group of people who –
  - (a) share, or are believed to share, a prescribed attribute; or

<sup>407</sup> *Anti-Discrimination Act 1998* (Tas) ss 14–16.

<sup>408</sup> *Anti-Discrimination Act 1998* (Tas) s 17(1).

<sup>409</sup> *Anti-Discrimination Act 1998* (Tas) s 17(2).

<sup>410</sup> *Anti-Discrimination Act 1998* (Tas) s 19(c) and (e).

<sup>411</sup> *Anti-Discrimination Act 1998* (Tas) ss 14(2)–(3).

(b) share, or are believed to share, any of the characteristics imputed to that attribute – more than a person who is not a member of that group.

(2) For indirect discrimination to take place, it is not necessary that the person who discriminates is aware that the condition, requirement or practice disadvantages the group of people.<sup>412</sup>

7.1.13. Direct and indirect discrimination are different types of differentiation.<sup>413</sup> The former involves active and conscious differentiation. The latter is ‘facially neutral’.<sup>414</sup> That means that a condition, requirement or practice is one that seems to apply to everyone equally, but in practice adversely differentiates against certain people with specific attributes.<sup>415</sup>

7.1.14. ‘Indirect discrimination’ — even where it relates to the imposition of ‘practices’ — should not be confused with indirect conversion practices. Conversion practices are not facially neutral. Instead, they are, in practice, targeted at SOGI characteristics. The practices are *directed to* and confined to SOGI characteristics rather than practices of a general character, applying to all persons, which only produce discriminatory outcomes *because of* some people’s SOGI characteristics.

7.1.15. Both direct and indirect conversion practices may, in some circumstances, amount to ‘direct discrimination’ under the *Anti-Discrimination Act*. However, this will not always be clear or certain. That is because of the requirement that the practice is demonstrably ‘less favourable’ when applied to people with specific attributes. Direct conversion practices tend only to be offered to and conducted on people with those attributes. They are expressly directed to changing, suppressing or eradicating those attributes. There cannot, therefore, be said to be a differentiation between classes of SOGI that gives rise to an assessment of favourability. As indirect practices promote such conduct, they are subject to similar definitional uncertainty.

### *Offending, humiliating, intimidating or ridiculing*

7.1.16. Section 17(1) of the *Anti-Discrimination Act* provides that a person ‘must not engage in any conduct which offends, humiliates, intimidates or ridicules another person’ on the basis of,

<sup>412</sup> *Anti-Discrimination Act 1998* (Tas) ss 15(1)–(2).

<sup>413</sup> It has been stated that direct and indirect discrimination were mutually exclusive: see *Lindisfarne R & S L A Sub-Branch and Citizen’s Club Inc v Buchanan* [2004] TASSC 73, [14]. However, the High Court has highlighted the potential for overlap in certain circumstances: see discussion of *Purvis v New South Wales* (2003) 217 CLR 92 by Bromberg J in *Sklavos v Australasian College of Dermatologists* [2017] FCAFC 128 [15]–[20].

<sup>414</sup> *Waters v Public Transport Corporation* (1991) 173 CLR 349, 402 (McHugh J); *Commonwealth Bank of Australia v Human Rights and Equal Opportunity Commission* (1997) 80 FCR 78 at 97 (Sackville J); *Australian Iron and Steel Pty Ltd v Banovic* (1989) 168 CLR 165, 175 (Deane and Gaudron JJ); *New South Wales v Huntley* [2017] FCA 581, [96] (Perry J).

<sup>415</sup> For instance, a rule prohibiting all animals in a commercial or public building indirectly discriminates against people who require the assistance of assistance dogs.

among other things, sexual orientation, lawful sexual activity or gender identity.<sup>416</sup> The standard is objective. The conduct is prohibited if a reasonable person, having regard to all the circumstances, would have anticipated that the person subjected to the conduct would be offended, humiliated, intimidated, insulted or ridiculed.<sup>417</sup> Section 17 focuses on feelings experienced as a result of exposure to discriminatory language or behaviour directed at a person's sexuality or gender identity.

- 7.1.17. Direct or indirect conversion practices that involve depicting or speaking about LGBTQA+ status in a way that is offensive, humiliating, intimidating, or insulting to LGBTQA+ people or ridicules LGBTQA+ status would contravene s 17.
- 7.1.18. Many forms of direct conversion practices would not, however, likely contravene s 17. While the beliefs underlying conversion practices may indeed be offensive, humiliating, intimidating or insulting to LGBTQA+ people, or would ridicule them, the reported forms of direct conversion practices involve a number of elements that make it less clear that these practices do indeed involve that kind of conduct.
- First, SOGI conversion practices are often presented as being 'helpful', 'constructive', or 'healing'.
  - Second, engagement may be 'voluntary', even though genuine consent is impossible, and the subject may genuinely believe that engaging in the practices are in their best interests.
  - Third, as with s 16, the harms from the practices are manifested after exposure, sometimes years later, whereas typical s 17 harms are immediate and obvious.
  - Fourth, and most importantly, the possible harms that conversion practices cause are not best described in terms of emotions, feelings or reactions to conduct, but rather as the manifestation of serious physical or psychological conditions like post-traumatic stress disorder, anxiety, depression, and suicidal ideation and attempts.

### *Hatred, Serious Contempt, Severe Ridicule*

- 7.1.19. Section 19 of the *Anti-Discrimination Act* prohibits a 'public act' that 'incite[s] hatred towards, serious contempt for or severe ridicule of a person or group of persons on the ground of' among other things, sexual orientation, lawful sexual activity or gender identity.<sup>418</sup> The meaning of public act includes 'any form of communication to the public' or 'any conduct observable by the public' or 'the distribution or dissemination of any matter to the public'.<sup>419</sup>

<sup>416</sup> *Anti-Discrimination Act 1998* (Tas) s 17(1). The attributes mentioned here are contained in ss 16(c), (d), (ea).

<sup>417</sup> *Anti-Discrimination Act 1998* (Tas) s 17(1).

<sup>418</sup> *Anti-Discrimination Act 1998* (Tas) ss 19(c) and 19(e).

<sup>419</sup> *Anti-Discrimination Act 1998* (Tas) s 3.

- 7.1.20. Section 19 is unlikely to apply to direct conversion practices. While direct conversion practices are harmful and are often motivated by discriminatory beliefs about LGBTQA+ people, they are generally offered and accepted as ‘helpful’, ‘constructive’, or ‘healing’. Therefore, they are unlikely to meet the threshold of incitement to ‘hatred, serious contempt or ridicule’ required by s 19. Additionally, direct conversion practices generally do not involve ‘public acts’, as required by s 19. They are ordinarily conducted in private, either as individual counselling or small group events. Consequently, these would not be covered by s 19.
- 7.1.21. Indirect conversion practices may fall within the scope of s 19. Statements that LGBTQA+ people can or should change, suppress or eradicate their sexual orientation or gender identity may constitute incitement of hatred towards, serious contempt for, or severe ridicule of:
- LGBTQA+ people who ostensibly ‘choose’ not to undertake such practices; and
  - LGBTQA+ people for whom such practices ultimately prove ineffective.
- 7.1.22. Indirect practices may also produce self-hatred, self-contempt and serious self-ridicule *in* LGBTQA+ people for whom such practices ultimately prove ineffective. However, this is not express in the wording of the Act. Because it requires an understanding of the social and individual implications and long-term consequences of indirect conversion practices, it is not immediately obvious on the face of the statute that it is applicable to such conduct.

#### *Advertisement and promotion*

- 7.1.23. Some parts of the current *Anti-Discrimination Act* may apply to the advertisement and promotion of conversion practices. For example, s 20 prohibits a person from publishing or displaying signs, notices or advertisements that promote, express or depict ‘discrimination or prohibited conduct’. This would likely apply to public advertisements of SOGI conversion practices or promotional material like newspapers or fliers promoting conversion beliefs. However, the provision requires it to be established that such practices are directly or indirectly discriminatory under the Act, which at present is not always clear. Furthermore, s 20 does not cover word of mouth recommendations, referrals, or other private communications directed to potential SOGI conversion practice subjects.

#### *Aiding discrimination or prohibited conduct*

- 7.1.24. The *Anti-Discrimination Act* may also regulate organising conversion practices or convincing another person to undergo them. Section 21 prohibits aiding a contravention of the Act, providing that a person must not knowingly cause, induce or aid another person to contravene the Act. Doing so makes a person jointly and severally liable for the contravention. This may be relevant to SOGI conversion practices: for example, where a person promotes or supports an

incitement under s 19. As with s 20, whether s 21 would cover such conduct would depend on whether the *Anti-Discrimination Act* does indeed prohibit conversion practices.

## Exceptions for legitimate speech, religion, public interest etc.

- 7.1.25. The *Anti-Discrimination Act* also moderates the unnecessary overreach of the law into legitimate speech and acts by providing a range of exceptions.<sup>420</sup>
- 7.1.26. Sections 51, 51A and 52 provide several exceptions on the grounds of religious belief or affiliation for conduct that would otherwise be prohibited, including religious requirements for employment, enrolment as a student, or participation in activities or rituals. Sections 51, 51A and 52 are unlikely to provide an exception relevant to conversion practices. They allow for requirements that employees, students, or participants in religious activities profess certain religious beliefs: for example, that a teacher at a Catholic school is themselves Catholic. Or, conversely, they allow a religious organisation not to employ, enrol or allow the participation of a person who is not a member of that religion. Participants in religious conversion practices are likely to meet those requirements already. These exceptions are narrowly focused on these situations. They are not a general religious exemption that might justify discrimination against characteristics like sexual orientation or gender identity based on religious belief.
- 7.1.27. One exemption that may likely apply to some aspects of conversion practices is s 55. That section provides that ss 17(1) and 19 do not apply if a person's conduct is (among other things) a public act done in good faith for academic, artistic, scientific or research purposes or any purpose in the public interest.<sup>421</sup> For example, a person publishing an opinion piece criticising the contemporary approach to gender affirming health-care that uses language that might offend LGBTQA+ people would be exempt under s 55.

## Dispute resolution process

- 7.1.28. Finally, Tasmanian anti-discrimination law operates through a dispute resolution process that is relevant to its usefulness in addressing SOGI conversion practices.<sup>422</sup> The process can start in two ways.
- First, a person who believes they have been subjected to discrimination or prohibited conduct lodges a complaint (or various persons or organisations may do so on the person's behalf).

<sup>420</sup> *Anti-Discrimination Act 1998* (Tas) ss 51 (employment based on religion), 51A (admission of person as student based on religion), 52 (participation in religious observance), 53 (employment — political belief exemption). Section 27 provides that 'A person may discriminate against another person on the ground of gender (a) in a religious institution, if it is required by the doctrines of the religion of the institution'. However, 'gender' is a different characteristic from 'gender identity', and thus 'gender identity' is not relevant to the s 27(a) exception.

<sup>421</sup> *Anti-Discrimination Act 1998* (Tas) s 55.

<sup>422</sup> See *Anti-Discrimination Act 1998* (Tas) pt 6.

- Second, if the Commissioner believes there are reasonable grounds to do so, the Commissioner may commence an investigation without a complaint first being lodged.<sup>423</sup>

7.1.29. The Commissioner then investigates that complaint/situation, and may then proceed to conciliation or an inquiry.<sup>424</sup> A conciliation is a private conference run by Equal Opportunity Tasmania that involves the complainant, the person who is alleged to have engaged in the discrimination or prohibited conduct, and other persons whom the Commissioner has directed to attend.<sup>425</sup> An inquiry takes place if the conciliation is unsuccessful, or if the Commissioner believes the complaint cannot be resolved by conciliation, or is of a nature that it should be referred for inquiry.<sup>426</sup> Conciliation of complaints (albeit by a human rights commission) is a central mechanism in both the ACT and Victorian legislation on SOGI conversion practices.<sup>427</sup>

## 7.2. Consultation responses on anti-discrimination law

- 7.2.1. Many respondents commented on whether anti-discrimination law might be an appropriate mechanism for responding to SOGI conversion practices.
- 7.2.2. The language of ‘discrimination’ was used in approximately 40 submissions. Most of these respondents used the concept in its general meaning [see 7.1.3], rather than its specifically legal meanings [see 7.1.10–7.1.12], and only a few submissions mentioned or examined Tasmania’s *Anti-Discrimination Act*. ‘Discrimination’ was invoked by submissions that supported or opposed SOGI conversion practices alike.
- 7.2.3. Some submissions also mentioned the general harms of discrimination and stigmatisation of LGBTQA+ people in connection with conversion practices.<sup>428</sup> One anonymous respondent wrote:

The impact of discrimination and stigma on LGBTIQ+ people is real and contributes to some of the worst mental health outcomes of any group in Australia (Private Lives 3 Report, 2020). Harmful practices continue to flourish and therefore it can be expected that it is highly likely this issue will create significant controversy and backlash. Messaging needs to be clear, strong and affirming and focus on the lived experience of survivors and the welfare

<sup>423</sup> *Anti-Discrimination Act 1998* (Tas) s 60(1) and (2).

<sup>424</sup> *Anti-Discrimination Act 1998* (Tas) s 71.

<sup>425</sup> *Anti-Discrimination Act 1998* (Tas) s 75.

<sup>426</sup> *Anti-Discrimination Act 1998* (Tas) s 78.

<sup>427</sup> *Sexuality and Gender Identity Conversion Practices Bill 2020* (ACT) sch 1, amending *Human Rights Commission Act 2005* (ACT); *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) pt 3 (using the language of ‘facilitating outcomes’ for dealing with reports).

<sup>428</sup> Submissions 10, 42, 86, 153\*.

of the LGBTIQ+ communities. It is vital the legislation is properly explained and understood and adhered to at all times.<sup>429</sup>

- 7.2.4. Similarly, the Royal Australian and New Zealand College of Psychiatrists stated in its submission that

The RANZCP is supportive of the intent behind such legislation which seeks to prohibit the practice of conversion therapies. Members of the LGBTIQ+ community are valued members of society with rights to equal access to health care, marriage and procreation and bringing up children. They should experience life free from harassment or discrimination in any sphere and a right to protection from therapies that are potentially damaging, particularly those that purport to change sexual orientation.<sup>430</sup>

- 7.2.5. Several respondents invoked discrimination and human rights concepts in their domestic and international forms to argue in support of banning or regulating SOGI conversion practices, emphasising that in addition to a healthcare issue, SOGI conversion practices are more broadly a human rights and anti-discrimination issue.<sup>431</sup>
- 7.2.6. Many respondents who discussed Tasmania's *Anti-Discrimination Act* noted that amending it would be a simple or easy option for law reform.<sup>432</sup> Most respondents who were supportive of law reform and also supported amending anti-discrimination law did not state precisely how that change should be effected.<sup>433</sup>
- 7.2.7. Several respondents pointed out that one possible benefit of amending Tasmania's *Anti-Discrimination Act* would be to empower the Anti-Discrimination Commissioner to investigate and potentially conciliate and remedy cases of conversion practices through the aid of third parties, with or without a specific complaint from a survivor to prevent re-traumatisation.<sup>434</sup> For instance, Equality Tasmania submitted:

a body such as the Anti-Discrimination Commission [should] be given powers to investigate, and potentially conciliate and remedy, instances of conversion practices. The Commission should be able to exercise the powers regardless of whether a complaint is made. This parallels the existing power of the Commission to investigate discrimination. The Commission could also be responsible for educating the public about conversion

<sup>429</sup> Submission 179\*, citing Adam O Hill et al, 'Private Lives 3 2020: A National Survey of the Health and Wellbeing of LGBTIQ People in Australia' (2020) <[https://www.latrobe.edu.au/\\_\\_data/assets/pdf\\_file/0009/1185885/Private-Lives-3.pdf](https://www.latrobe.edu.au/__data/assets/pdf_file/0009/1185885/Private-Lives-3.pdf)>.

<sup>430</sup> Submission 5.

<sup>431</sup> Submissions 4, 42, 80 at 5, 82 at 3, 85 at 6, 86 at 1, 114 at 2, 115 at 2, 120 at 3–4, 122 at 2.

<sup>432</sup> See, eg, Submission 165.

<sup>433</sup> Submissions 117, 127, 131, 148\*, 154, 158C, 168, 169, 170, 175.

<sup>434</sup> Submissions 85, 91, 79, 124C.

practices, which would, again, be consistent with its current role educating about discrimination. We note that the Victoria Human Rights and Equal Opportunity Commission has been vested with similar powers in that state. However, these amendments are not suggested as alternatives to conventional criminal and civil procedures and remedies under a principle [sic] conversion practices Act. They are suggested as additional legislative measures to send the strongest possible message, and to provide survivors with the broadest range of protections and complaint options.<sup>435</sup>

- 7.2.8. Some respondents expressed wary support for anti-discrimination law and indicated that a general Human Rights Act would be needed. For instance,

I'm not convinced that amendments, even to the existing Anti-Discrimination laws, is sufficient, other than consequential amendments flowing from a new primary Act. Ideally Tasmania will introduce a new Human Rights Act, which may also provide a workable mechanism by which to address and prohibit CPs.<sup>436</sup>

- 7.2.9. Of respondents opposed to law reform in general, only four mentioned anti-discrimination law. This was often to state that banning or regulating SOGI conversion practices would discriminate against religious people. For example, one anonymous respondent wrote:

The suggested law reforms in relation to SOGI will give opportunity for discrimination and vilification of the Christian Church and other religious institutions. Potentially criminalizing teachings central to multiple systems of faith.<sup>437</sup>

A senior pastor wrote:

[S]ome of the religious practices which the IP [Issues Paper] implies as needing regulation is the religious activity of 'prayer' for those with desires or attractions that are seen by the faith community as 'incompatible with the faith and inclusion in the religious community' (1.2.6.2). This implied suggestion fails to distinguish between a religious group's unfair discrimination of an individual (bigotry) and a view of human sexuality that is grounded in a moral code and is therefore, instead, an ethical concern.<sup>438</sup>

- 7.2.10. Some respondents writing in support of using anti-discrimination law anticipated and responded to this point. The Tasmanian Council on Social Service, for example, pointed to the restrictions on religious freedoms in international human rights law to protect, among other things, public safety, health and the rights and freedoms of others:

<sup>435</sup> Submission 124 at 11.

<sup>436</sup> Submission 177.

<sup>437</sup> Submission 133\*.

<sup>438</sup> Submission 41.

TasCOSS does not believe this legislation threatens religious freedom because it does not prohibit religious or spiritual activity, only those practices which seek to change or suppress an individual's sexual orientation or gender identity and cause harm or injury to that individual. Nowhere in Australian law or in international human rights covenants does there exist an absolute right to act on religious conviction in any circumstance; the International Covenant on Civil and Political Rights, to which Australia is a signatory, recognises 'that the right to manifest religious or other beliefs may be subject to limitations that are prescribed by law and necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others.' International human rights law seeks to ensure that individuals are subject to both freedom of, and freedom from discrimination based on, 'religion or belief'.<sup>439</sup>

- 7.2.11. While most respondents did not provide technical suggestions about how changes to anti-discrimination law should proceed, statutory bodies provided close analysis of how Tasmanian anti-discrimination law might apply to SOGI conversion practices.
- 7.2.12. The Tasmanian Chief Civil Psychiatrist wrote in support of using anti-discrimination law (and criminal law) as a backstop for forms of conversion practices which are not properly described as health or purported health practices.<sup>440</sup>
- 7.2.13. Equal Opportunity Tasmania submitted a detailed examination of how anti-discrimination law might apply to SOGI conversion practices. Equal Opportunity Tasmania identified several barriers to people affected by indirect SOGI conversion practices — the promotion of harmful beliefs about the nature of SOGI and whether those attributes can or should be changed — obtaining justice in the present *Anti-Discrimination Act 1998* (Tas).
- 7.2.14. First, Equal Opportunity Tasmania noted interpretive, contextual and temporal issues relating to indirect SOGI conversion practices. This was because, first:

A significant barrier for individuals is the identification of the treatment they are subject to during SOGI conversion practices as being 'less favourable', let alone unlawful. The same can arguably be said for prohibited conduct under section 17(1) [*Anti-Discrimination Act*], where a person must subjectively feel offended, humiliated, intimidated, insulted or ridiculed in order to allege a breach of this provision. SOGI conversion practices are generally presented to individuals as helpful, supportive and coming from a place of compassion, and the conduct is not framed as being harmful or detrimental to an individual's health. Additionally, as I understand it, such practices are generally

<sup>439</sup> Submission 80 at 5.

<sup>440</sup> Submission 104.

recommended by people an individual trusts, further impacting their ability to identify the conduct as harmful.<sup>441</sup>

- 7.2.15. Second, the harms from SOGI conversion practices often do not manifest for several years, which may mean the time limitations on bringing anti-discrimination claims may preclude the Commissioner from investigating a complaint:

At the time SOGI conversion practices are experienced they may not be interpreted as being injurious to a person. Evidence shows that the negative effects of such practices can emerge some years after experiencing them. A person undergoing SOGI conversion practices would therefore experience certain barriers to seeking justice under the Act before even lodging a complaint, the first being identification of the conduct as potentially unlawful, and the second being lodging the complaint within the time constraints ... The Act places limitations on the Commissioner's ability to accept a complaint for investigation within a certain time period.

63 Time limit on complaints:

- (1) A complaint is to be made within 12 months after the alleged discrimination or prohibited conduct took place.
- (2) The Commissioner may accept a complaint made after the 12-month time limitation has expired if satisfied that it is reasonable to do so.

As set out in the Issues Paper, evidence shows that SOGI conversion practices have long term negative effects, including guilt, shame, severe anxiety and depression, internalised homophobia and PTSD [post-traumatic stress disorder]. These effects all create barriers for a person lodging a complaint within 12 months. Identification of the conduct as being grounds for a complaint under the Act may take years. The Commissioner's discretion to extend time can only be exercised where certain criteria is met.<sup>442</sup>

- 7.2.16. Third, recognising the ability to 'consent' to SOGI conversion practices, where the risk of harm is well-documented, but the effect on an individual difficult or impossible to predict, could complicate the application of anti-discrimination law:

In circumstances where the effects are largely harmful and the extent to which a person may be negatively affected by SOGI conversion practices is unknown, [i]t is difficult to see how informed consent can be given ... It would be legally problematic if a person could consent to a service which another person may make a complaint under the [*Anti-Discrimination*

<sup>441</sup> Submission 117.

<sup>442</sup> Submission 117.

*Act*] about. It is inconsistent to label the service discriminatory in some circumstances, but not others. Insofar as people can purportedly consent to SOGI conversion practices existing discriminatory attitudes regarding LGBTIQ+ people will continue to be upheld making social change and equality far more difficult to achieve.<sup>443</sup>

### 7.3. Clarifying why indirect public conversion practices may be incitement

- 7.3.1. The Institute agrees with respondents who submitted that SOGI conversion practices are discriminatory. The Institute's view is that where the discriminatory conduct is also represented as, or conducted within, a health practice, it properly falls primarily within the province of Tasmanian health law. Repeated, reckless or egregious direct SOGI conversion practices that cause serious harm to a person will almost certainly also involve discrimination, but are best dealt with through criminal sanctions.
- 7.3.2. For the reasons set out by Equal Opportunity Tasmania [see 7.2.14–7.2.15], anti-discrimination law is a less useful regulatory instrument to deal with direct conversion practices. Amendments to make ss 16, 17 or 19 cover direct conversion practices would require a significant restructuring of those sections, making them less effective in dealing with the forms of discrimination to which they are currently addressed. People who have been subjected to direct conversion practices may still raise complaints with the Anti-Discrimination Commissioner. People who have been subjected to forms of segregationist discrimination on the grounds of their LGBTQA+ status also have clear grounds for making a complaint under the Act.
- 7.3.3. The TLRI believes, however, that anti-discrimination law is an important and useful option for dealing with indirect conversion practices [see 2.6.12 and 3.6.7–3.6.8]. Such practices promote and encourage LGBTQA+ people to seek out or agree to harmful acts. The evidence submitted to the Inquiry was that such conduct takes the form of public acts like speech or publications that promote the belief system that underlies and motivates direct conversion practices. That conduct is harmful and dangerous and, in the Institute's view, tantamount to incitement to hatred, serious contempt or ridicule of LGBTQA+ people and should be made clearly unlawful. Whilst Tasmanian anti-discrimination law implicitly prohibits such conduct, it is the Institute's view it does not do so in a sufficiently clear manner [see 7.1.22].
- 7.3.4. The Institute also recommends amending the *Anti-Discrimination Act* to allow the Anti-Discrimination Commissioner and Equal Opportunity Tasmania to resolve complaints about SOGI conversion practice promotional speeches and publications to reduce the personal and

<sup>443</sup> Submission 117.

social harm they may cause. Importantly, indirect conversion practices should only be dealt with under the procedures and structures of Tasmanian anti-discrimination law, namely balanced by the current exemptions [see 7.1.25–7.1.27] and through an investigative or conciliatory approach to mediating and resolving conflicts that may include compensation [see 7.1.28–7.1.29].<sup>444</sup>

- 7.3.5. The Institute emphasises that Tasmanian anti-discrimination law does not provide for criminal penalties.
- 7.3.6. The *Anti-Discrimination Act* should expressly cover acts which describe people’s sexual orientation and gender identity as faults or dysfunctions and imply that such attributes can and should be ‘cured’ (i.e. changed, suppressed, or eradicated). This may be achieved by adding a sub-section to s 19 of the Act specifically stipulating that indirect conversion practices fall within the scope of the provision.
- 7.3.7. Section 19 of the *Anti-Discrimination Act* should be amended to include a sub-section clarifying that a public act constitutes incitement of hatred towards, serious contempt for, or severe ridicule of, a person or a group of persons on the ground of sexual orientation and gender identity (and any other attributes the Parliament considers appropriate other than 19(d)<sup>445</sup>) if it:
- Characterises the protected attribute as the product of a fault or disorder; and
  - States or implies that the protected attribute can be changed, suppressed or eradicated; and
  - States or implies that the person or group of persons should change, suppress or eradicate the attribute.
- 7.3.8. An amendment to s 19 should explicitly exclude:
- Assessments and treatments authorised under Tasmanian Law, including the *Mental Health Act*, *Health Complaints Act* and *Tasmanian Charter of Health Rights*.<sup>446</sup>
  - Publications about protected attributes issued or authorised by:
    - The Anti-Discrimination Commissioner;
    - A Chief Psychiatrist appointed under the *Mental Health Act*;
    - The Director of Public Health appointed under the *Public Health Act*;
    - The Tasmanian Minister of Health;
    - The Secretary of the Tasmanian Department of Health; or

<sup>444</sup> See *Anti-Discrimination Act 1998* (Tas) s 89.

<sup>445</sup> The Institute would not recommend extending the clarifying provision to 19(d) ‘religious belief or affiliation or religious activity’ to avoid any potential for the provision unintentionally capturing proselytization.

<sup>446</sup> Notably these would rarely, if ever, be ‘public acts’ for the purposes of s 19 as they are ordinarily confidential, private and individual consultations.

- An officer, department or minister of the Commonwealth.
- 7.3.9. The Institute recommends altering the title of s 19 (which presently only refers to ‘Inciting *hatred*’) to ‘Prohibition of incitement and conversion practices’. This broader title would be consistent with s 17 (‘Prohibition of certain conduct *and sexual harassment*’) and make the Act’s application to conversion practices clearer to the public and complainants.

### **Existing exceptions are appropriate**

- 7.3.10. The Institute recommends that the current exceptions under s 55, which provides that ss 17(1) and 19 do not apply if a person’s conduct is (among other things) a public act done in good faith for academic, artistic, scientific or research purposes or any purpose in the public interest, remain as is and apply to this extension of s 19. That is because s 55 provides a well-known and appropriate balancing mechanism that ensure that anti-discrimination law does not impermissibly burden general freedom of expression.

**Recommendation 10. Indirect conversion practices to be a form of incitement, contempt or ridicule**

Section 19 of the *Anti-Discrimination Act 1998* (Tas) should be amended to clarify that a public act promoting conversion practices amounts to incitement of hatred towards, serious contempt for or severe ridicule of another person or group of persons on the grounds of sexual orientation and/or gender identity.

### **Anti-Discrimination Commissioner should be able to collaborate with other bodies**

- 7.3.11. The Anti-Discrimination Commissioner as the head of Equal Opportunity Tasmania has a wide range of powers to inquire into discriminatory conduct and refer matters to the Anti-Discrimination Tribunal to determine whether those acts breach Tasmanian anti-discrimination law. The Institute considers that Equal Opportunity Tasmania is the most appropriate Tasmanian statutory body to inquire into and make determinations about indirect conversion practices. As noted, it also has jurisdiction over a range of discriminatory or prohibited acts which may also amount to direct conversion practices. Indeed, that would include discriminatory conduct by both health professionals and non-health professionals.
- 7.3.12. To avoid overlapping and problems of duelling jurisdictions, and to ensure complainants do not have to unnecessarily restart their complaint in a different jurisdiction than the one it was commenced in, the Institute recommends statutory authorities be empowered to coordinate and where necessary cooperate in their investigations.

- 7.3.13. The Anti-Discrimination Commissioner, Health Complaints Commissioner and, where appropriate other bodies such as the Chief Civil Psychiatrist and police should be permitted — with the consent of complainants — to refer matters to each other where necessary, and for each to accept those referrals at their discretion. This will serve to reduce the regulatory burden on health authorities and retain the jurisdictional competence and expertise of Equal Opportunity Tasmania to regulate discriminatory conduct in Tasmania more generally. It will also ensure that complainants do not ‘fall between the cracks’ of different regimes, or experience distress from having to make multiple applications in different forms and/or to repeatedly tell their stories to different public authorities.
- 7.3.14. Following further discussions with Equal Opportunity Tasmania on inter-commission/office cooperation, the Commission emphasised that any sharing of investigative responsibilities should be framed with the following considerations in mind:
- That a referral, cooperation or involvement of another agency regarding a complaint only takes place with the consent of the original complainant, regardless of which agency the complainant first approached.
  - That referrals be appropriate where a matter is outside Equal Opportunity Tasmania’s jurisdiction or areas of expertise; for example a complaint relating to a health practitioner that would be more appropriately characterised as a health complaint and thus investigated by the Chief Civil Psychiatrist or the Health Complaints Commission, either initially or in full.
  - That the power to refer or involve another agency be discretionary, in that the receiving agency will retain the discretion to reject the request for referral.

**Recommendation 11. Anti-Discrimination Commissioner should be empowered to cooperate and coordinate with other bodies**

Tasmanian anti-discrimination law should be reformed to provide the Anti-Discrimination Commissioner the discretionary power to cooperate and coordinate with other state offices in investigations into alleged SOGI conversion practices.

- 7.3.15. The Institute recommends inserting a mirror provision into the *Health Complaints Act* to allow the Health Complaints Commissioner to cooperate and coordinate with the Anti-Discrimination Commissioner and any other relevant state offices.

**Limitation period extension clarifications**

- 7.3.16. At present the *Anti-Discrimination Act* contains a limitation period of twelve months between the commission of a discriminatory act against a person, and that person lodging the complaint at Equal Opportunity Tasmania.<sup>447</sup> The Institute notes that serious distress, humiliation or insult may not manifest for some time after the act constituting a SOGI conversion practice itself first occurs and very often more than twelve months. That is partly because conversion practices often take place over several years and the mental harm cognitive distress and trauma only becomes apparent after a prolonged period of unsuccessful submission to the practices [see 7.2.15].
- 7.3.17. The TLRI considered recommending the extension of the limitation period in s 63 of the *Anti-Discrimination Act*. However, during continuing consultations Equal Opportunity Tasmania highlighted that such a proposal would put Tasmanian anti-discrimination law out-of-step with other Australian regimes. It submitted that there were important reasons around the availability and recall of persons involved in potentially discriminatory behaviour that would make investigations with such lengthy time gaps exceedingly difficult.
- 7.3.18. The Anti-Discrimination Commissioner has the discretionary power to lift the ordinary time bar in appropriate circumstances. Section 63(2) provides that the Commissioner may accept a complaint made after the twelve-month period has expired ‘if satisfied that it is reasonable to do so’. This provision ‘ameliorates the impact of the limitation period by empowering the Commissioner to relax the [limitation period] ... subject to the Commissioner determining that the circumstances explaining the delay, make it reasonable to do so’.<sup>448</sup>
- 7.3.19. The TLRI recommends that the series of factors that currently guide the Commissioner’s decision be made clear in legislation. That may include the consideration of whether:
- The offence, insult or humiliation caused by the conduct may not have been apparent at the time of the conduct.
  - The extension affords procedural fairness to all parties; and
  - The extension does not cause undue hardship to a party.
- 7.3.20. These express considerations would also make it clear to potential complainants that a complaint relating to conduct outside of the ordinary twelve-month limitation period will not necessarily be rejected.

**Recommendation 12. Commissioner’s power to extend limitation period should be clarified.**

<sup>447</sup> *Anti-Discrimination Act 1998* (Tas) s 63.

<sup>448</sup> *Bullard v Anti-Discrimination Tribunal* [2020] TASSC 15 (19 May 2020) [26] (Geason J).

Section 63(2) of the Anti-Discrimination Act should be clarified to state considerations that may be relevant to the Commissioner's decision to accept a complaint beyond the 12-month limitation period where the harm from a conversion practice is manifested beyond that 12-month period.

# Civil liability reform

## 8.1. Tasmanian civil law

- 8.1.1. Existing Tasmanian civil law already proscribes and provides remedies for mental and physical harm. These provisions would likely cover mental harm caused by exposure to SOGI conversion practices. To the TLRI's knowledge, no civil claim has been adjudicated in Tasmania alleging harm from SOGI conversion practices. As noted in 5.1.3, it is possible that claims have been brought and either withdrawn or settled, and that those settlements are subject to confidentiality for the parties and lawyers involved.
- 8.1.2. TLRI received one submission that possibly suggested that a claim relating to conversion practices in Tasmania had been settled.<sup>449</sup> It is also possible that no claims have been brought because of the state of the law and its uncertainties; for example, because of the cost of bringing a claim, the uncertainty around whether the law on civil wrongs would extend to conversion practices, difficulties of causation requirements, and/or issues of evidence and proof.
- 8.1.3. No respondent to this Inquiry indicated whether they had contemplated litigation against the person(s) or organisation(s) that subjected them to conversion practices.
- 8.1.4. A civil wrong is generally an act that causes harm to another person and warrants some form of compensation. Like criminal offences, civil wrongs can be laid out in statutes. Whereas criminal penalties seek to 'punish' defendants, civil penalties aim to remedy harm to the claimant. The remedy ordered by the court aims to compensate the claimant for harm suffered. This generally means attempting to put them in the position they would have been in, to the extent it is possible to do so, had the defendant's conduct never occurred. Most often this involves ordering the defendant to pay the claimant a sum of money that represents or compensates the harm done to the claimant and the costs linked to that harm (for example, medical bills, lost income, pain and discomfort).

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<sup>449</sup> As noted at n 305, one submission made reference to a possible legal process related to conversion practices in Tasmania. Submission 123 stated '[redacted] actually won a case against [redacted — Tasmanian council] for engaging [redacted] and thereby [sic] this practice'. This seems to be a reference to a conciliation or other tribunal process related to conversion practices, but no further details were provided or could be found in public reports.

- 8.1.5. Reform need not necessarily involve creating a new civil wrong. It may involve expanding or clarifying an existing civil wrong. For instance, the *Civil Liability Act 2002* (Tas) has been amended to clarify the duty of care of good Samaritans, food donors, volunteers, community organisations or accommodation providers.<sup>450</sup> In some cases, the amendments limit liability, in others they clarify and expand on the responsibility of these bodies towards others.
- 8.1.6. This type of reform occurred most recently in respect of child sex abuse with Parliament adding provisions to the *Civil Liability Act 2002* (Tas) to clarify that organisations that have responsibility for children are negligent if they fail to exercise a duty of care to prevent child abuse while that child is in their care.<sup>451</sup> The amendments make the duty of care between the organisation and children clearer and remove barriers to proving responsibility for child abuse for people abused while in the care of an organisation. The amendments also clarify that child abuse may occur in different ways and result in both physical and mental harm, and that individuals associated with an organisation who have failed to exercise a duty of care to prevent the abuse may also be found personally liable.

## 8.2. Tasmanian civil liability options

- 8.2.1. Statute<sup>452</sup> and common law on tort/civil liability may currently provide avenues for redress for harms caused by SOGI conversion practices. In particular, those subjected to SOGI conversion practices may have actions against conversion practitioners in negligence, nuisance or breach of duty.<sup>453</sup> However, there are a range of practical and legal barriers for complainants. In particular, civil actions are time-consuming, expensive and stressful for complainants. The experience of giving evidence needed to establish harm, duty and causation may also be retraumatising to survivors. These actions would need to overcome a range of evidential, procedural and practical hurdles. Those issues are compounded because it is not clear whether the law does or does not apply to the conduct.
- 8.2.2. A first issue is the nature of the harm. The *Civil Liability Act* has a range of provisions that limit both the duty of care and the types of compensation available for ‘mental harm’.<sup>454</sup> If SOGI conversion practices caused only mental harm to a particular claimant, then that would need to include a recognised psychiatric illness caused by the practices.<sup>455</sup> It may take many

<sup>450</sup> See, e.g., *Civil Liability Act 2002* (Tas) pts 8A, 8B, 10, 10A.

<sup>451</sup> *Justice Legislation Amendment (Organisational Liability for Child Abuse) Act 2019* (Tas).

<sup>452</sup> Namely, the *Civil Liability Act 2002* (Tas).

<sup>453</sup> *Civil Liability Act 2002* (Tas) pt 6.

<sup>454</sup> *Civil Liability Act 2002* (Tas) pt 8.

<sup>455</sup> *Civil Liability Act 2002* (Tas) s 33: ‘There is no liability to pay damages for pure mental harm resulting from breach of duty unless the harm consists of a recognised psychiatric illness.’

years for those conditions to appear, raising potential issues under the Tasmanian *Limitation Act*.<sup>456</sup> Furthermore, pure mental harm claims involve a higher duty of care requirement that might not include some relationships like counselling or pastoral care, and might only apply to medical practitioners providing SOGI conversion practices.<sup>457</sup>

- 8.2.3. Another evidential barrier is the requirement for causation. Causation is the requirement that a causal link between the defendant's conduct and the harm suffered by the plaintiff be proved.<sup>458</sup> This might be assessed by the application of a 'but for' test: that, but for the defendant's conduct, the plaintiff would not have suffered the harm. For some psychiatric conditions, it may be difficult to show that exposure to SOGI conversion practices was indeed the factor 'but for' which the harm would not have been suffered. That is particularly difficult if it has taken several years for the condition to emerge. Wider 'common sense connection' tests might not help overcome this problem.<sup>459</sup>
- 8.2.4. Overall, the TLRI does not believe that Tasmanian civil law currently provides a strong legal avenue for redress for harms from SOGI conversion practices.

### 8.3. Consultation responses on civil wrongs

- 8.3.1. Question 6 asked respondents 'Should some or all forms of SOGI conversion practices be made civil wrongs in Tasmania? If so, what sort of practices should people be liable for and how should those subject to such practices be compensated?'
- 8.3.2. Most respondents did not answer this question, with only 68 submissions providing a relevant answer.<sup>460</sup> Twenty-two respondents opposed amending the law on civil wrongs.<sup>461</sup> Thirty-seven respondents supported amending the law on civil wrongs to cover SOGI conversion practices,<sup>462</sup> with a suggested mixture of civil and criminal penalties.<sup>463</sup>

<sup>456</sup> *Limitation Act 1974* (Tas) s 5A stipulates that damages claimed by the plaintiff for the negligence, nuisance or breach of duty where the damages claimed consist of, or include, damages in respect of personal injuries to any person, must not be brought after the expiration of 3 years commencing on the date of discoverability. This is unless the damages arose from the serious physical or mental abuse of the person when they were a child (s 5B).

<sup>457</sup> *Civil Liability Act 2002* s 34: in mental harm claims, the duty to take care only exists if 'a reasonable person in the position of the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care were not taken'.

<sup>458</sup> *Strong v Woolworths Ltd (trading as Big W)* (2012) 246 CLR 182.

<sup>459</sup> *March v E & MH Stramare* (1991) 171 CLR 506.

<sup>460</sup> Remaining submissions stated either stated 'uncertain/don't know' or misunderstood the question.

<sup>461</sup> Submissions 2, 8, 31\*, 34\*, 37, 41, 42, 65, 67, 71, 73, 76\*, 77\*, 78\*, 86, 89, 99, 116, 161\*, 177, 179\*, 180\*.

<sup>462</sup> Submissions 25, 49, 58, 79, 80, 93, 94, 111\*, 113, 114, 115, 118, 120, 121, 122, 124, 127, 130\*, 131, 134\*, 138\*, 150, 153\*, 154C, 156, 158C, 159\*, 162, 163C, 164\*, 165, 168, 169, 170, 173\*, 175, 182C.

<sup>463</sup> See, eg, Submissions 80, 114, 115, 117, 118.

- 8.3.3. Submissions that advocated for SOGI conversion practices to be made civil wrongs gave varied responses, with most suggesting that a combination of civil and criminal penalties should be available to victims, and that the severity of civil penalties should depend on the gravity of the actions and harm suffered.<sup>464</sup> Some submissions appeared to misunderstand the civil wrongs options, mostly in equating civil wrongs with other legislative schemes like the *Anti-Discrimination Act*.
- 8.3.4. The most common specific suggestions for civil claims were that they should cover or include:
- Physical harms arising from the SOGI conversion practices,
  - Mental harms that arose as a result of the physical harm (consequential harm),
  - Future loss of earning capacity as a result of physical or mental harm,
  - Pure mental harms from non-physical SOGI conversion practices,
  - Compensatory damages for loss economic losses suffered to a plaintiff,
  - Compensatory damages for non-economic losses such as pain and suffering,
  - Aggravated/exemplary damages for serious/repeated conduct,
  - Orders (e.g. injunctions) to stop continuing SOGI conversion practices by the defendant,
  - Orders to destroy, rectify or take down materials relating to SOGI conversion practices controlled by the defendant,
  - Orders to publicly and/or privately apologise to the plaintiff.
- 8.3.5. Many respondents indicated that all these options should be part of reforming the civil law,<sup>465</sup> while some respondents in favour of reform included only one or a few of these options.<sup>466</sup>
- 8.3.6. One important disagreement among those who supported a civil wrongs approach to SOGI conversion practices was over the time limits within which a person could make a claim for compensation. One respondent stated that, as with the *Anti-Discrimination Act*'s 12-month time bar, current legislation on civil wrongs does not provide victims with enough time to claim compensation: identifying the conduct and harm that are the grounds for the claim may take several years.<sup>467</sup> A number of submissions stated that a limit of bringing a claim within three years after conversion practices last occurred was appropriate for 'consenting' adults.<sup>468</sup>

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<sup>464</sup> Submissions 80, 118, 169.

<sup>465</sup> Submissions 91, 127, 130\*, 157\*, 158, 168.

<sup>466</sup> Submissions 129\*, 131, 134\*, 138\*, 148\*, 150, 153\*, 156, 158C, 159\*, 162, 163C, 164\*, 165, 169, 173\*, 182C. Note that some responses mistakenly read 'civil wrongs' as meaning statutory investigations and the time limits around them (eg, under the *Anti-Discrimination Act*). The general concerns and points nonetheless apply to the question of the statute of limitations, which for the *Civil Liability Act* is that a claim must generally be brought within six years.

<sup>467</sup> Submission 117.

<sup>468</sup> Submissions 58, 138\*, 154C, 159\*, 165.

- 8.3.7. Given people who have been exposed to conversion practices may not be aware for some time after the fact, some respondents were in favour of extending the limitation period for a civil claim further, to go beyond three years, and up to 12 years.<sup>469</sup> Most respondents in favour of reform stated there should be no time period limitation within which a claim must be brought, particularly for victims who are children or were children at the time they were subjected to conversion practices.<sup>470</sup> These respondents argued that providing an ‘indefinite’ time for claims was necessary to allow survivors of conversion practices the time to connect the mental harm they are experiencing with the conversion practice that they had been subjected to. This is especially the case if they had ‘consented’, were coerced to participate, or were subjected to false information that led them to participate.<sup>471</sup>
- 8.3.8. One respondent suggested that the time limit on all claims should be ‘indefinite’ because enforcing a time limit suggests there is a time limit on trauma, which grossly disempowers victims.<sup>472</sup> Another strong example of this sentiment was one respondent who stated claims should be indefinite due to their personal experience: ‘a person who is brainwashed and come out it could take years for the penny to drop to realize what has been done to them and wanting an apology. In my situation it took 10 years from leaving to start to realize what had been done to me was wrong’.<sup>473</sup>
- 8.3.9. Some respondents interpreted the ‘civil wrongs’ question as primarily about investigations by government bodies who might be empowered to issue civil penalties like fines. These submissions advocated for government bodies investigating SOGI conversion practices to either impose civil penalties or decide to charge and prosecute more serious offences.<sup>474</sup> Some submissions suggested this could take the form of a response scheme similar to the Victorian legislation, which empowers the Victorian Equal Opportunity and Human Rights Commission to conduct investigations with civil orders or criminal penalties.<sup>475</sup> For example, one submission suggested that where SOGI conversion practices are serious or systemic, they should be subject to a civil investigation process.<sup>476</sup> The most important reason for these respondents was the ability for survivors to receive financial compensation without experiencing the numerous

<sup>469</sup> Submissions 79, 130\*, 134\*, 140\*, 162.

<sup>470</sup> Submissions 58, 130\*, 127, 129, 131, 134\*, 138\*, 148\*, 150, 153\*, 158C, 159\*, 162, 163C, 164\*, 165, 168, 169, 173\*, 182C.

<sup>471</sup> Submission 173\*.

<sup>472</sup> Submission 177.

<sup>473</sup> Submission 165.

<sup>474</sup> Submission 122.

<sup>475</sup> Submissions 91, 93, 120, 122. See *Change or Suppression (Conversion Practices Prohibition Act 2021 (Vic)* pt 3 div 3 (‘Investigations’).

<sup>476</sup> Submission 94.

barriers and obstacles associated with criminal trials.<sup>477</sup> Linked to this, many respondents who supported a civil wrongs approach emphasised that they must be accompanied by a comprehensive redress scheme, funded by government, with fines for perpetrators.<sup>478</sup>

- 8.3.10. Finally, some submissions supported introducing a scheme of organisational liability for conversion practices similar to that recently enacted to deal with organisational liability for child abuse.<sup>479</sup>
- 8.3.11. Tasmania Police pointed out that recent amendments around the liability of organisations for child abuse might be appropriate to respond to organisations that promote, provide or tolerate SOGI conversion practices.<sup>480</sup>
- 8.3.12. The petition signed by 377 people supported a scheme that would treat institutions that fail to prevent SOGI conversion practices from taking place in a similar manner to those accountable for ‘sexual abuse of people in [the institution’s] care’.
- 8.3.13. Most respondents who opposed reforming the law on civil wrongs to cover SOGI conversion practices did so to reiterate their opposition to any law reform at all.<sup>481</sup>
- 8.3.14. Some respondents who did support law reform generally specifically opposed using a civil wrongs approach at all as part of that reform, mostly because using the civil law was seen as ‘diluting’ the importance of banning or criminalising SOGI conversion practices.<sup>482</sup> Most of these respondents stated that fines and civil penalties were not appropriate because they focus on preventing or compensating injury and harm, which would not be an effective way of addressing harm done to current survivors, and would not deter people from engaging in SOGI conversion practices in the future.<sup>483</sup> Other submissions opposed extending the law on civil wrongs because of procedural concerns, namely the significant challenges associated with pursuing compensation claims, the distress and further harm that can be caused by the process itself (and in particular the length of litigation), and the significant resource burden placed on survivors seeking compensation.<sup>484</sup> Finally, some of these respondents stated that the burden of proof of harm for survivors of conversion practices was difficult to meet in most cases,

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<sup>477</sup> Submissions 79, 93, 124C, 177.

<sup>478</sup> Submissions 80, 113.

<sup>479</sup> Submissions 177, 180.

<sup>480</sup> Submission 25 at 2.

<sup>481</sup> Submissions 2, 8, 31\*, 34, 41, 65, 76\*, 78\*.

<sup>482</sup> Submissions 42, 89.

<sup>483</sup> Submission 37.

<sup>484</sup> Submissions 42, 71, 79, 86, 177, 179.

regardless of whether they were a civil law balance of probabilities or a criminal beyond reasonable doubt standard.<sup>485</sup>

## 8.4. Reforming the *Civil Liability Act*

- 8.4.1. The Institute recognises that there may be barriers to justice in existing civil law in its current potential application to conversion practices. In particular, people who are subjected to conversion practices may do so ‘voluntarily’ at the time, with harm only manifesting much later when it becomes clear that such practices do not work. Furthermore, people conducting conversion practices may genuinely believe that they are acting in the best interests of the subject to ‘heal’ or improve their physical or mental state.
- 8.4.2. SOGI conversion practices against children that manifest as harm later in life raise similar issues to other historical child abuse, and produce evidential barriers to justice, especially in respect of vicarious or organisational responsibility. Civil claims can also be expensive and burdensome to litigate. Uncertainty around the application of the law to this kind of harm and evidentiary barriers mean that civil wrongs may go unremedied. On the other hand, this uncertainty may also result in weak or groundless actions being pursued and sustained against defendants for longer than is necessary given the lack of clarity about whether the law applies to conversion practices.
- 8.4.3. Reform should clarify the law for the benefit of plaintiffs and defendants, and aim to clarify, lower or remove those barriers to access to justice. That reform should complement the primary statutory reforms of Tasmanian health and anti-discrimination law to provide mechanisms for compensation for conversion practices which a person knew would cause physical or mental harm to a person, or was reckless about the risks of that harm.
- 8.4.4. Civil penalties and compensation orders are remedial in character. While compensation orders can be made by the Equal Opportunity Tribunal,<sup>486</sup> neither an order under the *Mental Health Act* or *Health Complaints Act* nor a criminal prosecution would result in any financial compensation to the complainant. The TLRI recognises, nonetheless, that evidentiary and financial barriers may make civil litigation impossible for many potential SOGI conversion practice claimants who have suffered harm.
- 8.4.5. The TLRI recommends that the *Civil Liability Act 2002* (Tas) be reformed to clarify that direct conversion practices are a civil wrong.

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<sup>485</sup> Submissions 79, 161\*, 118, 177.

<sup>486</sup> *Anti-Discrimination Act 1998* (Tas) s 89(1)(d).

- 8.4.6. One part of that clarification is for the Act to contain a clear definition of conversion practices in s 3 (applicable to multiple parts of the Act). The Institute recommends that, for the purposes of Tasmanian civil law, the following definition is appropriate to the *Civil Liability Act*:

Sexual orientation and gender identity (SOGI) conversion practice means a course of conduct that:

- i) Purports to diagnose, assess or treat the plaintiff's sexual orientation or gender identity in a manner which is inconsistent with the *Mental Health Act*; or
- ii) Purports to attribute mental health symptoms to the plaintiff's sexual orientation or gender identity in a manner which is inconsistent with the *Mental Health Act*; or
- iii) Aims to change, suppress or eradicate the sexual orientation or gender identity of the plaintiff; or
- iv) Asserts to the plaintiff or others that sexual orientation or gender identity are the result of a fault or dysfunction and can and should be changed, suppressed or eradicated.

- 8.4.7. The definition should clarify that genuine healthcare practices do not fall within this meaning, namely that a person who is a health professional who is acting in good faith and in accordance with Tasmanian health law is excluded from the definition.

**Recommendation 13. Civil liability law should be clarified**

The *Civil Liability Act* should contain a new provision clearly setting out the elements of SOGI conversion practices under tort law.

This provision should clarify that a person acting in good faith and in accordance with Tasmanian health law is not captured by this definition.

- 8.4.8. Based on the above definition, s 34 of the *Civil Liability Act* should be amended to clarify that a person in the position of the defendant is taken to have foreseen that a person of normal fortitude might suffer a recognised psychiatric illness if they subjected that person to a sexual orientation or gender identity conversion practice following the date of the introduction of that provision.
- 8.4.9. The TLRI recommends that the liability of organisations for child abuse provisions in the current *Civil Liability Act* be extended to clarify that organisations that engage in SOGI conversion practices are a form of child abuse. Section 49H(5) currently specifies that

child abuse, in relation to a child, means

- (a) sexual abuse, or physical abuse, of the child; and

- (b) any psychological abuse of the child that arises from the sexual abuse or physical abuse,  
but does not include an act that is lawful at the time which it occurs.
- 8.4.10. A provision should be added to s 49H(5) to clarify that a SOGI conversion practice, as defined in the *Civil Liability Act*, when performed on a child, is a form of child abuse, following the date of the introduction of that provision.
- 8.4.11. To ensure the addition is subject to the same limitation period as other forms of child abuse, s 5B of the *Limitation Act* should be amended to specify that an action for damages for personal injury to a person arising from or related to the conversion practices conducted on a person when the person was a minor can be brought at any time. The definition of child abuse in s 5C of the *Limitation Act* should be amended to mirror the new definition in 49(H) of the *Civil Liability Act* — namely to include conversion practices performed on a child.
- 8.4.12. One important consideration for civil liability is a transition period. The law should not operate retrospectively, and only apply to harms that result from conduct that takes place 24 months after the reform of Tasmanian law. That is because time periods are required to engage, understand and implement necessary changes to comply with new laws. This would only apply to the new provisions: a claimant could still bring a general tort action under the existing law for a SOGI conversion practice based on general principles of civil liability.

**Recommendation 14. The *Civil Liability Act* should be amended to include SOGI conversion practices within institutional child abuse provisions**

The *Civil Liability Act* should be amended to include SOGI conversion practices as a form of child abuse for which organisations responsible for the care of a child are vicariously liable if the organisation did not take reasonable precautions to prevent an individual associated with the organisation perpetrating conversion practices on a child. The provision should become operative 24 months after the reform of Tasmanian law.

# Criminal law reform

## 9.1. Tasmanian criminal law

- 9.1.1. Criminal laws are generally reserved for serious offences. They prohibit particular conduct and provide for sanctions such as financial penalties (fines) and/or imprisonment.
- 9.1.2. Current Tasmanian criminal laws on assault,<sup>487</sup> wounding or causing grievous bodily harm<sup>488</sup> would likely apply to physical forms of SOGI conversion practices like aversion therapy. Criminal prohibitions on ill treatment of children may also apply if the subject is under 14.<sup>489</sup> Physical forms of direct conversion practices are reportedly rare. Save for reports of exorcisms, which may have involved physical contact or harm [see 3.4.5, 3.4.7, and 4.5.16], no respondents to the consultation reported themselves or another person being subjected to physical SOGI conversion practices in the past decade. Some respondents noted accounts of physically abusive SOGI conversion practices taking place in the 1960s and 1970s.
- 9.1.3. SOGI conversion practices might constitute a statutory offence of ‘stalking and bullying’, which criminalises a prolonged course of conduct which causes physical or mental harm.<sup>490</sup> This includes a wide range of repeated behaviours, such as subjecting another person to extreme humiliation, or causing them apprehension, fear or to self-harm. The offences expressly mention conduct such as placing someone under surveillance, sending offensive material, making threats or abuse, and causing fear and apprehension.<sup>491</sup> Such conduct may be part of some forms of SOGI conversion practices. A person is deemed to have intended to stalk or bully another person so long as they knew or ought to have known that pursuing a course of conduct would have resulted in the harms described in the provision.<sup>492</sup>

## Criminalisation in Other Australian States

- 9.1.4. Criminalisation has been one part of legislative responses in other States.

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<sup>487</sup> *Police Offences Act 1935* (Tas) s 35.

<sup>488</sup> *Criminal Code Act 1924* (Tas) sch 1 (‘*Criminal Code*’) s 172 (wounding or causing grievous bodily harm).

<sup>489</sup> *Criminal Code* (n 488) s 178 (ill-treatment of children under 14 years of age).

<sup>490</sup> *Criminal Code* (n 488) s 192.

<sup>491</sup> *Criminal Code* (n 488) s 192(b), (ea), (f), (j).

<sup>492</sup> *Criminal Code* (n 488) s 192(3).

- 9.1.5. Queensland made conducting SOGI conversion practices a misdemeanour criminal offence punishable by up to 12 months in prison or a \$13,345 fine or, if the subject is a vulnerable person or child, up to 18 months in prison or a \$20,000 fine.<sup>493</sup> Queensland's law only applies to healthcare practitioners.
- 9.1.6. The ACT's criminal offence only applies if the subject is a child or a person with impaired decision-making abilities, but it applies to all people and not just health practitioners. The penalty is up to 12-months imprisonment or a fine of \$24,000.<sup>494</sup>
- 9.1.7. Victoria's criminal offence applies to all people and is not limited to instances where the subject is a child or person with impaired-decision making abilities. Sections 10 and 11 make it an offence to engage in 'one or more' change or suppression practices that cause (serious) injury. These offences require that a person 'intentionally engages in a change or suppression practice directed towards another person' that causes the other person either a 'serious injury'<sup>495</sup> or an 'injury',<sup>496</sup> and the person is 'negligent as to whether engaging' in the practice will cause a (serious) injury to the other person. The 'serious injury' offence carries a maximum penalty of 10 years imprisonment and/or a maximum \$198,264 fine. The 'injury' offence carries a maximum penalty of 5 years imprisonment and/or a maximum \$99,132 fine. If the offender is a body corporate, it can be fined a maximum of \$991,320 for the 'serious injury' offence, or \$495,660 for the 'injury' offence.<sup>497</sup> Section 12 makes it an offence for a person to take another person from Victoria with the intention that a change or suppression practice directed at the other person will be engaged in outside Victoria, that does occur, and it causes an injury to the other person, and the person is negligent as to whether the practice will cause injury to the other person. Section 13 makes it an offence to advertise a change or suppression practice. Section 14 makes it an offence to refuse to produce documents requested by the Victorian Equal Opportunity and Human Rights Commission for the purposes of investigating a s 13 offence.
- 9.1.8. Finally, s 15 clarifies the additional requirements for corporate criminal responsibility mentioned in the 'serious injury' and 'injury' offence provisions. The relevant conduct must be engaged in by an associate of the body corporate; the knowledge requirements must be knowledge of an associate of the body corporate; and the intention requirement must be of either the board of directors or an officer of the body corporate, or of an associate of the body corporate provided that 'a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the formation of that intention' (s 15(1)(c)). Section 15(2)

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<sup>493</sup> *Public Health Act 2005* (Qld) s 213H.

<sup>494</sup> *Sexuality and Gender Identity Conversion Practices Act 2020* (ACT) s 8.

<sup>495</sup> *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) s 10.

<sup>496</sup> *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) s 11.

<sup>497</sup> *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) ss 10 and 11.

clarifies that if an officer engages in conduct that would be an offence under this part, the body corporate may be prosecuted and found guilty of having committed that offence, even if the officer has not been personally found guilty of that offence.

## 9.2. Consultation responses on criminal law

- 9.2.1. Question 5 asked ‘Should some or all forms of SOGI conversion practices be criminalised in Tasmania? If so, which, if any, should be dealt with as serious (indictable) crimes and which, if any, should be dealt with as less serious (summary) offences?’.
- 9.2.2. Fifty submissions and the petition of 377 signatories expressed strong support for the criminalisation of SOGI conversion practices in Tasmania.<sup>498</sup> Respondents in favour of criminalisation argued that statutory and civil offences are inadequate and/or incapable of effectively reducing the harms caused by conversion practices.<sup>499</sup> Overall, there was considerable support for SOGI conversion practices to be criminalised, with some specific practices being made summary or indictable offences.
- 9.2.3. Respondents generally wanted criminal sanctions not to fixate solely on the actions of individual SOGI conversion practitioners but also extend to their affiliated members, supporters, groups, collectives, or organisations.<sup>500</sup> Many emphasised that this was due to the harm that conversion beliefs and practices have caused others<sup>501</sup> and/or because they are morally wrong.<sup>502</sup> Some respondents asserted that all forms of conversion practices should be treated equally before the law and criminalised severely.<sup>503</sup> These respondents tended to justify this on the basis that they had been personally harmed by SOGI conversion practices, or knew or had experienced someone else endure significant harm due to SOGI conversion practices.<sup>504</sup>
- 9.2.4. Other submissions, including the petition of 377 signatories, stated that the more serious form of an indictable offence should be legislated and used to prosecute people who administer or perpetuate conversion beliefs in formal, clinical, and informational settings on the basis of the serious, sometimes life-threatening harm these practices can cause.<sup>505</sup> These respondents

<sup>498</sup> Submissions 25, 37, 42, 58, 66, 79, 80, 82, 86, 89, 91, 93, 94, 104, 111\*, 113, 114, 115, 117, 118, 120, 121, 124, 127, 129\*, 130\*, 131, 138\*, 148\*, 150, 153\*, 154C, 156, 157\*, 158C, 159\*, 161\*, 162, 163C, 164\*, 165, 167, 168, 169, 170, 173\*, 175, 177, 179\*, 180\*, 182C.

<sup>499</sup> See, eg, Submission 79.

<sup>500</sup> Submissions 37, 42, 93, 113, 114, 148\*, 180\*.

<sup>501</sup> Submissions 37, 42, 66, 79, 117, 118, 121, 124, 129, 153\*, 161\*, 168, 169, 175, 177, 179\*.

<sup>502</sup> Submission 131.

<sup>503</sup> Submissions 58, 79, 124, 129, 130\*, 175.

<sup>504</sup> Submissions 89, 121.

<sup>505</sup> Submissions 85, 94, 124C.

generally concluded that maximum penalties would be appropriate where the victim is under the age of 18 or has decision-making impairments.<sup>506</sup>

- 9.2.5. A common argument was that making conversion practices criminal offences would act as a deterrent by simultaneously announcing the Tasmanian Government's and Tasmanian society's opposition to them, and also reaffirming the Tasmanian Government's support for LGBTQA+ people in the community.<sup>507</sup>
- 9.2.6. Many submissions that supported the criminalisation of SOGI conversion practices drew from a range of current Australian legislation to inform their perspectives. Some requested law reform follow Queensland and Victorian legislation, particularly around the text of provisions, and the circumstances, penalties, and sanctions provided in those statutes.
- 9.2.7. Collating from the submissions,<sup>508</sup> respondents suggested the following actions should be considered criminal, either as one individual or a group of individuals:
- Engaging in SOGI conversion practices, whether forced or coercive or not, that cause injury, or serious injury,
  - Engaging in activities that are SOGI conversion practices whether paid or unpaid,
  - Engaging in SOGI conversion practices in formal or informal settings,
  - Referring a person (formally or informally) to an individual or service which administers SOGI conversion practices,
  - Removing a person from Tasmania for the purpose of SOGI conversion practices, and
  - Advertising SOGI conversion practices.
- 9.2.8. Some respondents emphasised that there was a need to penalise conversion practices in a wide range of formal and informal settings, such as religious and health settings, where services of counselling, psychology practices or psychotherapy are offered.<sup>509</sup> Others suggested that criminal offence provisions should apply to health professionals,<sup>510</sup> or persons in positions of authority.<sup>511</sup>
- 9.2.9. As these examples demonstrate, the responses were broad and diverse, with some respondents taking a very formal approach that referenced current laws and *Criminal Code* provisions in detail, while others expressed their support for criminalisation in general terms, without

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<sup>506</sup> Submission 124C.

<sup>507</sup> Submissions 175, 179\*.

<sup>508</sup> Submissions 42, 37, 42, 58, 79, 85, 91, 113, 118, 120, 150, 173\*, 179\*, 167, 169, 186\*.

<sup>509</sup> Submissions 37, 85.

<sup>510</sup> Submission 25, 90, 130\*.

<sup>511</sup> Submission 167.

explicitly stating what should or should not be an indictable or a summary offence, or what criminal penalties would be appropriate.<sup>512</sup>

- 9.2.10. Several peak medical bodies made submissions on criminalisation and healthcare providers.
- 9.2.11. The **Australian Psychological Society** endorsed a comprehensive ban, similar to that in the ACT or Victoria, and rejected the Queensland approach of only regulating healthcare providers, but also encouraged a good ‘Code of Ethics’, to ensure that practices which might otherwise seem like SOGI conversion practices (especially around transgender health) are supported by a sound evidence base, and ‘boundaries in legislation’ would avoid risks of regulation or criminalisation of genuine care.<sup>513</sup>
- 9.2.12. The **Australian Professional Association for Trans Health** endorsed both criminal and civil penalties.<sup>514</sup>
- 9.2.13. The **Australian Medical Association Tasmania** raised a number of concerns about criminalisation in general, and the Victorian approach specifically. AMA Tasmania reported concerns by some of its members that the Victorian legislation went ‘too far ... the perception [of AMA Tasmanian members] being that it forbids anyone from ever saying anything other than agreeing with the person’s statement on their gender identity’.<sup>515</sup> It noted the concerns of the psychiatric and psychological community in Victoria that the new law may constrain legitimate psychiatry and psychotherapy practice to treat gender dysphoria which might lead to psychiatrists and psychologists declining to do so at all.<sup>516</sup> AMA Tasmania stated that its members ‘want to ensure that doctors are not left open to criminal prosecution for asking what they consider to be necessary questions to understand their patients’ needs and desires’.<sup>517</sup> AMA Tasmania stated that criminal sanctions should never apply to healthcare professionals ‘acting in good faith and in accordance with reasonable standards of diagnostic assessment, clinical counselling and patient management’.<sup>518</sup>

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<sup>512</sup> Submissions 82, 157\*, 158C, 159\*, 163C, 165, 170.

<sup>513</sup> Submission 18 at 3 and 4.

<sup>514</sup> Submission 114.

<sup>515</sup> Submission 90 at 2.

<sup>516</sup> Submission 90 at 2.

<sup>517</sup> Submission 90 at 2.

<sup>518</sup> Submission 90 at 2.

## Opposition to criminalisation

- 9.2.14. Respondents who opposed any legislative change also rejected the criminalisation of SOGI conversion practices. Only 18 respondents of the 90 who opposed law reform at all made submissions on the question of criminalisation specifically. These responses tended to reiterate that there was insufficient evidence that SOGI conversion practices are occurring in Tasmania,<sup>519</sup> that criminalisation would impinge on religious freedom or parental rights,<sup>520</sup> and that criminalisation would lead to prosecution of people who did not support current treatment pathways for gender affirmation.<sup>521</sup> Some opponents of criminalisation argued that, if conversion practices are occurring in Tasmania, then the existing criminal law sufficiently covers them.<sup>522</sup> This view perhaps reflects the definitional point made by some opponents of law reform that conversion practices should only be defined as physically abusive acts [see 2.7.5].
- 9.2.15. Tasmania Police acknowledged issues around uncertainty of the law relating to conversion practices, agreed with the TLRI's concerns about including 'ideology' in a criminal offence, and stated that they 'support the strength' of existing criminal laws to address SOGI conversion practices that take place outside of the health and medical fields:

Tasmania Police acknowledges the observations of the Issues Paper at 3.2.1–3.2.3 on the criminal law in Tasmania and also recognises the legitimate concerns regarding the uncertainty of the law. We note that the current trends in other Australian jurisdictions limit the scope of the criminal law in relation to SOGI conversion practices to health and medical practitioners.

It should be noted that offences that require ideological motivations are likely to complicate the process of police investigation and prosecution for activities that otherwise constitute unlawful behaviour. The TLRI is correct, in the view of Tasmania Police, to assert that law enforcement agencies do not have the capacity or expertise to investigate or prosecute matters that require establishment of an ideological basis for an act (1.2.14).

The TLRI has noted that SOGI conversion practices might constitute statutory offences such as stalking, bullying, assault and other applications of force (3.2.3). In the context of the legislation in Queensland and the ACT and the complications of investigating and prosecuting ideologically motivated offending, Tasmania Police supports the strength of

<sup>519</sup> Submissions 44, 116.

<sup>520</sup> Submissions 31\*, 71, 178\*.

<sup>521</sup> Submissions 8, 51, 52, 72, 73.

<sup>522</sup> Submissions 2, 8, 31\*, 34, 41, 49, 50, 52, 73, 76\*, 78\*, 77, 78, 81, 90, 99, 101, 109, 116, 125, 140.

existing criminal laws to address SOGI conversion practices that take place outside of the health and medical fields.<sup>523</sup>

### 9.3. Reforming Tasmanian criminal law

- 9.3.1. The TLRI is generally sceptical of the criminal law and incarceration as a useful tool for preventing harm or guiding social behaviour.
- 9.3.2. The *Criminal Code* should be used as an option of last resort for serious, egregious or repeated forms of SOGI conversion practices that manifest as serious physical or mental harm (or a person is reckless about them manifesting that harm), proven beyond reasonable doubt. Criminal sanctions should contain express provisions exempting medical professionals where the conduct is a medical practice undertaken in good faith, in compliance with relevant medical standards and authorised by law.
- 9.3.3. SOGI conversion practices need not be physical to cause severe and lasting mental harm, such as depression, anxiety, suicidal ideation, and indeed suicide itself. These harms often do not manifest until years, or even decades after initial exposure to the SOGI conversion practice. The severity of that outcome makes a last resort criminal offence important for signalling the danger of these practices, even (or especially) where a SOGI conversion practitioner believes they are helping another person.
- 9.3.4. The probability of a successful criminal prosecution, however, under an offence like that recently passed in Victoria, seems low. While multiple clinical and scientific studies provide strong evidence for correlations between exposure to conversion practices and higher risks of serious harm for large cohorts of study subjects [see Chapter 4], proving beyond a reasonable doubt that exposure to SOGI conversion practices caused a later harm to a person is a high and difficult burden. Moreover, carceral approaches to social problems, particularly involving minority communities, are rarely successful.
- 9.3.5. The scope and application of criminal offences can also have a chilling effect on legitimate conduct. In the Institute's view the perceived harshness of the Victorian legislation — despite the high thresholds and range of exceptions for legitimate medical practices — has resulted in a degree of concern amongst parts of the medical community who work with gender diverse people [see 9.2.10–9.2.13]. Given the need for caring, open and supportive care of people who

<sup>523</sup> Submission 25 at 1–2. Note the bracket numbers are references to paragraphs in *TLRI SOGI Conversion Practices Issues Paper* (n 7).

experience health complications relating to gender dysphoria/incongruence, that is concerning and should be avoided.

- 9.3.6. Similarly a range of respondents to this Inquiry expressed fears that the introduction of a criminal offence similar to Victoria’s would lead to parents or guardians being prosecuted and jailed for up to ten years for talking to their children about sexuality or gender identity issues. The Institute does not consider such conduct would, on any reasonable reading of the Victorian legislation, fall within the definition of a conversion practice, or result in a criminal prosecution. Any educational or community campaigns associated with law reform must work to dispel these sorts of fears [see Chapter 10].
- 9.3.7. Based on these observations the Institute recommends only using criminal law as a capstone provision to respond to conduct which results in clearly foreseeable and serious harm that is not suitably dealt with under health or anti-discrimination law. The Institute agrees with Tasmania Police that criminal provisions should only be addressed to seriously harmful conduct and not to the ideology or beliefs which drive that conduct. However, the Institute does not share the view that existing offences are appropriate to the specific form of conduct that direct conversion practices involve.
- 9.3.8. Whilst there are certainly overlaps between stalking, bullying, assault, and conversion practices, there are also clear distinctions in form and function specific to each. Unlike the former offences, conversion practices
- involve a degree of voluntariness by the victim at the time of offence,
  - are likely to be perpetrated by a person who is intimately trusted by the victim, and
  - involve conduct that aims to bring about a change to the fundamental attributes of a person.
- The inclusion of an offence in the *Criminal Code* tailored to those specific elements will serve as a declaratory statement that knowingly undertaking a practice that can lead to serious harm and potentially suicide is not permitted by Tasmanian law.
- 9.3.9. Noting the differences in conversion practices to existing crimes, the crime of stalking and bullying under s 192 provides an appropriate template for a mechanism to address an intentional course of conduct which leads to ‘physical or mental harm, including self-harm, or extreme humiliation’. However, unlike s 192 the mental element should be concerned with knowing or being reckless about the conduct causing harm — rather than intending to cause harm through the commission of the conduct.<sup>524</sup>

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<sup>524</sup> *Criminal Code* (Tas) s 192; *Police v Nunn* [2021] TASM 3.

- 9.3.10. The Institute is especially concerned to avoid any criminal provision causing a chilling effect on legitimate health practices relating to sexual orientation and gender identity. As discussed, all jurisdictions provide exceptions or defences for health professionals to offences proscribing conversion practices.
- 9.3.11. In some jurisdictions this has taken the form of an exception for services which are, in the provider's 'reasonable professional judgment', necessary for the health service or compliance with professional obligations. For the reasons stated above [see 6.4.19 and Appendix A] the Institute considers that 'reasonable professional judgement' may import too much subjectivity and uncertainty into the assessment of what is legitimate or not. The phrase is not consistent with healthcare regulation. It places a burden on healthcare professionals to make decisions based on their own opinion rather than with explicit reference to appropriate professional codes or standard. It imposes this subjective obligation under the force of law. Introducing a different standard may add to confusion among healthcare professionals already concerned about whether their clinical practice would be in line with reformed laws around SOGI conversion practices [see Appendix A at 187].
- 9.3.12. The Institute prefers that the exception be framed by reference to good faith compliance with (reformed) Tasmanian health law, and in particular the provisions of the *Mental Health Act*. The reforms recommended here allow the health profession to set the appropriate clinical standards for the care and treatment of people who are experiencing health symptoms relating to sexual orientation or gender identity. So long as a health professional is acting in good faith and compliance with the standards declared under that Act they will not be liable for any criminal offence.
- 9.3.13. The TLRI agrees with the approach in other States to assistance, acceptance and support exceptions.<sup>525</sup> These are useful indicators that general counselling to assist, accept and support people in relation to their sexual orientation and gender identity are not SOGI conversion practices: they do not seek to change or suppress or eradicate a person's sexual orientation or gender identity but merely provide support for that person.
- 9.3.14. For the purposes of Tasmanian criminal law, the following definition of SOGI conversion practices and offence provision is appropriate:

Conversion practice means a course of conduct that attempts to change, suppress or eradicate the sexual orientation or gender identity of another person.

(1) Any person who –

<sup>525</sup> See, eg, *Change or Suppression (Conversion) Prohibition Act 2021* (Vic) s 5(2) in Appendix D.3.

- (i) intentionally conducts a conversion practice on another person,
- (ii) knowing or being reckless about whether that course of conduct would cause the other person serious physical or mental harm,
- (iii) and through that course of conduct causes serious physical or mental harm, including self-harm, or extreme humiliation or to be apprehensive or fearful –

is guilty of a crime.

Charge: Conducting an illegal conversion practice.

(2) A person who commits the offence of conducting an illegal conversion practice and –

- (i) at any time during the conversion practice the other person was under the age of 18 years

is guilty of a crime.

Charge: Conducting an illegal conversion practice on a child.

(3) For the purposes of subsection (1) –

- (a) a person pursues a course of conduct if the conduct is sustained or the conduct occurs on more than one occasion; and
- (b) if the conduct occurs on more than one occasion, it is immaterial whether the actions that make up the conduct on one of those occasions are the same as, or different from, the actions that make up the conduct on another of those occasions.

(3) A reference in this section to mental harm includes a reference to suicidal thoughts.

(4) Subsection (1) does not apply to a person if

- (a) the person is a health professional who is acting in good faith in compliance with the *Mental Health Act 2013* (Tas);
- (b) the person is, or reasonably believes they are, expressly authorised to undertake the conduct by another Act; or
- (c) the conduct amounts to no more than:
  - (i) an expression of an opinion, idea or belief, or
  - (ii) acceptance, support, or understanding of the other person; or
  - (iii) assisting the other person to undertake a gender transition, or
  - (iv) the facilitation of the person's mental or emotional resilience, coping skills, or identity exploration and development; or
  - (v) the facilitation of social care or support for the person.

(5) The person on whom the conversion practice was performed is not an accessory to a conversion practice and does not aid and abet the person who conducted a conversion practice.

(6) It is not a defence to a charge under this section that the person on whom the conversion practice was performed consented to the course of conduct.

(7) A prosecution under this section must not be commenced without the consent of the Director of Public Prosecutions.

- 9.3.15. A provision should be added to s 178B of the *Criminal Code* to proscribe the removal of a child from Tasmania for the purposes of performing a conversion practice on that child. In either case the relevant wording of s 178B should be replicated.
- 9.3.16. The new provision of ‘Conducting an illegal conversion practice on a child’ should be included as an abuse offence under s 105A(1) of the *Criminal Code*, so as to proscribe the failure to report such an illegal practice being conducted on a child.
- 9.3.17. The new provisions of ‘Conducting an illegal conversion practice’ and ‘Conducting an illegal conversion practice on a child’ should be included under the referenced provisions in s 192A(1) of the *Criminal Code*, so as to provide those offences with extra-territorial effect. Alternatively a sub-section should be added to the provision itself specifying that the conduct of the conversion practice may occur within or outside of Tasmania provided that the conduct has a connection with Tasmania.

**Recommendation 15. Offence for serious physical or mental harm**

A specific offence should be included in the *Criminal Code Act 1924* (Tas) to proscribe SOGI conversion practices that cause (or a person was reckless about causing) serious physical or mental harm.

This provision should clarify that a person acting in good faith and in accordance with Tasmanian health law is not captured by this offence.

# Complementary measures

## 10.1. Individual, social and systemic harm reduction requires more than law reform

- 10.1.1. The Institute considers that the object of individual, social and systemic harm reduction will be best achieved through a holistic approach that goes beyond law reform to include appropriate public education, policy and service support. This is especially the case where practices are ‘hidden’, conducted within close-knit communities, or where social stigma or other risks may dissuade or prevent a vulnerable member of that community from raising a complaint.
- 10.1.2. People are less likely to turn to the law to resolve their complaints if they are unaware of the appropriate mechanisms to do. The existence of support services to help a person through the complaint process, explain the law and procedure, and assist them in dealing with the social consequences is also important to facilitate redress in a manner that does not compound trauma and distress. While these considerations are beyond the scope of a law reform inquiry *per se*, they are necessarily related to the success of any law in achieving its aims of protecting individuals and achieving public policy objectives.
- 10.1.3. It is also important to remember that SOGI conversion practices occur on the margins of society and within minority groups, namely religious denominations and the LGBTQA+ community. Given that is the case it may be appropriate to encourage self-reform that complements the belief systems of those groups; for instance, by developing codes of practice, or self-regulation frameworks which is in keeping with core tenets of faith or opinion. The law will be most effective where there is fidelity, trust and support by those who are affected by it.

## 10.2. Consultation views on complementary measures

- 10.2.1. Question 8 of the Issues Paper to this Inquiry asked ‘Are there any other models or approaches that are preferable to, or should complement, changing the law?’.

- 10.2.2. Respondents who supported law reform to address SOGI conversion practices also largely agreed that law reform must be complemented by measures to support survivors, educate the community, and target the drivers of harm.<sup>526</sup>
- 10.2.3. The submissions expressed a range of views and suggestions on schemes and support models that might accompany law reform. One suggestion was to take an entirely non-legal approach to conversion practices, instead providing public, online education.<sup>527</sup> Most respondents, however, advocated for support programs to complement and strengthen changes in the law.<sup>528</sup> For example, the Australian Professional Association for Trans Health urged that law reform be accompanied by, but most certainly not replaced by, initiatives to ensure adequate education and training for professionals and the organisations in which they work; amendments, where necessary, to codes of conduct and membership practices for professional bodies; and properly implemented comprehensive sexuality education in schools.<sup>529</sup>
- 10.2.4. Common examples of complementary supports to law reform included:
- Industry/stakeholder code(s) of practice,
  - Dedicated telephone/online support hotlines,
  - Anonymous complaint mechanisms,
  - Community education,
  - Specialist education for organisations, leaders, and healthcare practitioners,
  - SOGI conversion practice survivor support/counselling,
  - Redress schemes.<sup>530</sup>
- 10.2.5. Many submissions that advocated for policy and social service reform emphasised that reforms need to be survivor-led and informed.<sup>531</sup> One suggestion was to appoint an independent public officer to investigate evidence of conversion practices, instead of relying on existing commissions and officers.<sup>532</sup> Others suggested this investigative function should be comprised of an expert panel of at least 50 per cent survivors of SOGI conversion practices to undertake these functions. It was submitted that such a constitution was necessary to ensure proper

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<sup>526</sup> Submission 120.

<sup>527</sup> Submission 68\*.

<sup>528</sup> Submission 79.

<sup>529</sup> Submission 114 at 3.

<sup>530</sup> Submissions 58, 85, 111\*, 115, 129, 130, 131, 133\*, 134, 138, 141, 140\*, 142, 144, 146C, 148, 150, 152, 153, 154, 156, 157, 158, 159, 161, 162, 164, 165, 166, 167, 168, 169, 170, 173, 175, 176, 177, 178\*, 179, 180.

<sup>531</sup> Submissions 86, 111\*, 120, 126C, 180\*.

<sup>532</sup> Submissions 86, 91.

consideration of the harms caused by conversion practices and the appropriate remedies for individuals affected by them.<sup>533</sup>

- 10.2.6. A redress scheme for survivors of SOGI conversion practices was the most common complementary reform suggestion. Many respondents stated that this should be survivor-focused, trauma-informed and guided by the SOGICE Survivor Statement.<sup>534</sup> The need for the scheme to be reflexive and responsive to the wide range of immediate and long-term harms was highlighted by some respondents.<sup>535</sup> It was emphasised that survivors require consistent and diverse support services due to recovery taking years and involving multiple forms of assistance, such as general practice doctors, individual sessions with psychologists and psychiatrists, and group support sessions, among other things, to help heal from complex trauma.<sup>536</sup>
- 10.2.7. One commonly suggested requirement for a redress scheme was funding for support groups where survivors are surrounded by affirming friends and peers. This was because support groups equipped survivors with the resources to help them develop new understandings of themselves and the relationship between their faith, gender identity and sexuality.<sup>537</sup> Respondents stated that, at a minimum, a redress scheme should prioritise the diverse lived experiences of LGBTQA+ people in Tasmania who have survived SOGI conversion practices, understand their needs, and provide respect and dignity to them by ensuring access to the medical and legal assistance they need to heal from their trauma and access justice.<sup>538</sup>
- 10.2.8. Most respondents to Question 8 stated that law reform would be best accompanied and made effective by community education programs.<sup>539</sup> Education efforts were seen as vital to countering the false beliefs that drive conversion practices.<sup>540</sup> This is especially important because some conversion practice survivors still want to remain part of a faith community and maintain strong relationships within that community.<sup>541</sup>
- 10.2.9. Some respondents emphasised that education must be appropriately tailored to the diversity of the LGBTQA+ community. For example, cisgender lesbians may experience a different type of

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<sup>533</sup> Submission 8.

<sup>534</sup> Submissions 8, 92, 115.

<sup>535</sup> Submissions 38, 80, 85.

<sup>536</sup> Submissions 92, 94, 124C, 126C, 177.

<sup>537</sup> Submissions 38, 126.

<sup>538</sup> Submission 115.

<sup>539</sup> Submissions 37, 42, 58, 68\*, 91, 93, 94, 105\*, 113, 115, 121, 180\*.

<sup>540</sup> Submission 124.

<sup>541</sup> Submission 126.

SOGI conversion practice and harm than transgender or gender diverse people, and the education surrounding SOGI conversion practices needs to reflect this.<sup>542</sup>

- 10.2.10. Several respondents also stated that public health campaigns and community education and awareness programs should be implemented alongside law reform. It was submitted that these campaigns and programs should explain what conversion practices are, their risks, and how any new laws and complementary services operate.<sup>543</sup> The Australian Psychological Society endorsed a ‘good evidence-based peer support model’ to complement law reform and minimise harm, namely by targeting psychologists and associated workers to ensure good clinical governance.<sup>544</sup>
- 10.2.11. Some respondents expressed a concern that, without widespread community education there may be misinformation, non-compliance or deliberate resistance to law reforms. The concern was that without sufficient public education, changes to the law would be ineffective or liable to being wound back or repealed entirely in the future.<sup>545</sup> Other respondents specifically noted that any implications for sex and gender education in schools<sup>546</sup> and codes of conduct for professionals and their organisations on what are and are not SOGI conversion practices<sup>547</sup> would be useful to facilitate intergenerational change.<sup>548</sup>
- 10.2.12. Overall, submissions that addressed Question 8 expressed the need for the state to ground its responses in a human rights compliant, restorative, and deliberative approach.<sup>549</sup>

### 10.3. Supporting law reform

- 10.3.1. Given that SOGI conversion practices are driven by underlying beliefs that are not supported by mainstream scientists, medical professionals, or health experts, education will be key to reducing social harms from such practices. While the law itself can play an educative role, and public discussions around law reform milestones like the introduction of a Bill or its passage can be important points for public education, there are other important, direct and effective ways of engaging the healthcare, LGBTQA+ and religious communities and the general public on these issues that may likely need to continue well after any reform is implemented.

<sup>542</sup> Submission 126.

<sup>543</sup> Submission 37, 68\*, 93, 94, 113, 115.

<sup>544</sup> Submission 18 at 3.

<sup>545</sup> Submissions 42, 58.

<sup>546</sup> Submissions 2, 104.

<sup>547</sup> Submissions 65, 114.

<sup>548</sup> Submission 115.

<sup>549</sup> Submissions 71, 85, 91, 115.

- 10.3.2. The TLRI also believes it is essential to remember that many conversion practice survivors remain connected to their faith. A strong theme in the accounts of survivors was the fear of losing their connection to religious community support and care [see 4.5]. Faith can play an important and integral role in the wellbeing and healing process for many people, regardless of their sexual orientation or gender identity. Repairing and responding to harm does not require disconnecting people from their faith or dismantling religious communities. Engagement, involvement and respect for faith communities in the reform process is key to ensuring all rights and responsibilities are progressively improved into the future.
- 10.3.3. The TLRI acknowledges that bare law reform is unlikely to succeed in addressing SOGI conversion practices as a societal and systemic practice that is harmful and should cease to occur. Carceral responses are unlikely to be as successful as community support, education and redress achieving sustainable and meaningful social and systemic change. The TLRI therefore urges a broader reform agenda and the commitment of adequate resources to the process of redressing, responding to and reducing the perpetuation of injustice against LGBTQA+ people.

**Recommendation 16. Appropriate funding, education and support is needed**

Adequate funding should be provided to community legal centres and medical, LGBTQA+ and religious organisations for education and support campaigns to inform their communities about changes in the law, what is and is not acceptable, and what avenues of redress may be possible for those who have been subjected to SOGI conversion practices.

Part IV

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**APPENDICES**

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## Appendix A

# ‘Reasonable Professional Judgement’ and Assistance, Acceptance, Support Exemptions

## A.1. Background

- A.1.1. Several medical bodies made submissions to this Inquiry that noted concerns about medical exemptions in the definition of conversion practices and/or exempting legitimate healthcare practices from any criminal offence provisions. Some of those concerns related to the ways that other States had dealt with medical exemptions in their recent legislative changes in response to conversion practices. This Appendix examines the exceptions for professional healthcare services in other law reforms relating to conversion practices in Queensland, the ACT and Victoria.
- A.1.2. The TLRI has analysed these laws. They ensure that healthcare practices like assessments, treatments, consultations and giving general medical advice, where engaged in by a health practitioner and in accordance with the professional and legal standards of that profession and that assessment/treatment, will not fall within the definition of ‘conversion practices’ for the purposes of those laws. Consequently, any criminal offence provisions will not apply to those healthcare practices. These State reforms use a standard that the healthcare is within ‘the provider’s reasonable professional judgement’ and is part of a clinically appropriate assessment, diagnosis, treatment or clinically appropriate support, or to facilitate the provision of healthcare for a person in a safe and appropriate manner, or is otherwise necessary to comply with the provider’s legal and professional obligations.
- A.1.3. A ‘reasonable professional judgement’ standard suggests that the question of whether a health service is a SOGI conversion practice will ultimately depend on expert evidence from other practitioners. What is clinically appropriate will change with the science and general professional consensus of these bodies. Consequently, this is an important carve-out for health practitioners that means a conversion practice offence could only apply to them if their practice falls outside the standard of a reasonable professional judgement.
- A.1.4. The TLRI has formed the view, however, that the ‘reasonable professional judgement’ standard is new or newly applied from other professional duty tests. It is not a phrase that is used in other healthcare regulation under statutory or common law. The Institute agrees that a clear

exemption for genuine healthcare is essential, and recommends an exemption that is appropriate to Tasmanian health law.

## Queensland

- A.1.5. Queensland's Act only applies to healthcare professionals. Section 213F(2) exempts certain treatments from the definition:

Conversion therapy does not include a practice by a health service provider that, in the provider's reasonable professional judgement—

- (a) is part of the clinically appropriate assessment, diagnosis or treatment of a person, or clinically appropriate support for a person; or
- (b) enables or facilitates the provision of a health service for a person in a manner that is safe and appropriate; or
- (c) is necessary to comply with the provider's legal or professional obligations.

Section 213F(3) then provides several examples of the practices that may fall within s 213F(2):

Without limiting subsection (2), the following are examples of the types of practices to which that subsection may apply—

- (a) assisting a person who is undergoing a gender transition;
- (b) assisting a person who is considering undergoing a gender transition;
- (c) assisting a person to express the person's gender identity;
- (d) providing acceptance, support or understanding of a person;
- (e) facilitating a person's coping skills, development or identity exploration, or facilitating social support for the person.

Examples of the types of practices—

- exploring psychosocial factors with a person or probing a person's experience of sexual orientation or gender identity
- providing a speech pathology or gender transition service for a trans-gender or gender-diverse person wishing to alter the person's voice and communication to better align with the person's gender identity
- advising a person about the potential side effects of sex-hormonal drugs or the risks of having, or not having, surgical procedures.

## Australian Capital Territory

- A.1.6. Australian Capital Territory legislation contains a similar exemption for healthcare professionals, inserted into the definition of SOGI conversion practices in s 7:

- (2) However, sexuality or gender identity conversion practice does not include a practice the purpose of which is to—
- (a) assist a person who is undergoing a gender transition; or
  - (b) assist a person who is considering undergoing a gender transition; or
  - (c) assist a person to express their gender identity; or
  - (d) provide acceptance, support or understanding of a person; or
  - (e) facilitate a person’s coping skills, social support or identity exploration and development.

Examples—s (2)

diagnosis and assessment of a person with gender dysphoria or gender non-conforming behaviour or identity

support for a person with social adjustments related to gender dysphoria

gender-affirming hormone treatment

other gender transition services, for example, speech pathology services for a transgender or gender-diverse person who wishes to alter their voice and communication to better align with their gender identity ...

- (3) Also, sexuality or gender identity conversion practice does not include a practice by a health service provider that, in the provider’s reasonable professional judgment, is necessary to—
- (a) provide a health service in a manner that is safe and appropriate; or
  - (b) comply with the provider’s legal or professional obligations.

A.1.7. The ACT legislation is somewhat wider than the Queensland provision, in that it applies to ‘practices’ generally, rather than specifically ‘a practice by a health service professional’ that in their ‘reasonable professional judgement’ falls into one of the categories. That is because the ACT legislation applies generally, not just to healthcare practitioners, which is the case in the Queensland approach.

## Victoria

A.1.8. The Victorian Act also excludes professional healthcare from the definition of ‘conversion practices’. Sections 5(2) provides:

For the purposes of subsection (1), a practice or conduct is not a change or suppression practice if it—

- (a) is supportive of or affirms a person’s gender identity or sexual orientation including, but not limited to, a practice or conduct for the purposes of—

- (i) assisting a person who is undergoing a gender transition; or
  - (ii) assisting a person who is considering undergoing a gender transition; or
  - (iii) assisting a person to express their gender identity; or
  - (iv) providing acceptance, support or understanding of a person; or
  - (v) facilitating a person’s coping skills, social support or identity exploration and development; or
- (b) is a practice or conduct of a health service provider that is, in the health service provider’s reasonable professional judgement, necessary—
- (i) to provide a health service; or
  - (ii) to comply with the legal or professional obligations of the health service provider.

A.1.9. Section 5(3), however, clarifies practices that may indeed be covered by the definition in s 5(1):

- For the purposes of subsection (1), a practice includes, but is not limited to the following—
- (a) providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy;
  - (b) carrying out a religious practice, including but not limited to, a prayer based practice, a deliverance practice or an exorcism;
  - (c) giving a person a referral for the purposes of a change or suppression practice being directed towards the person.

A.1.10. The Victorian legislation thus does explicitly state that psychiatry or psychotherapy consultations, treatments and therapies, or other similar treatments and therapies, can be conversion practices for the purposes of s 5(1). The TLRI’s understanding is that s 5(2)(b) would then exempt consultations, treatments and therapies that fall within the reasonable professional judgement of the care provider, or were required to comply with their legal or professional obligations.

## **A.2. Evaluation of ‘reasonable professional judgement’ exemptions**

A.2.1. The TLRI notes that the phrase ‘reasonable professional judgement’ does not appear in the *Health Practitioner Regulation National Law*,<sup>550</sup> nor in any other Tasmanian laws. Instead, the National Law focuses its board investigations on professional misconduct and unprofessional conduct.

<sup>550</sup> *Health Practitioner Regulation National Law Act 2009* (Qld). Note the National Law was enacted as a schedule to this Queensland Act, which the other States and Territories have incorporated into their State and Territory laws. In Tasmania, this occurred through the *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas), specifically s 4.

- A.2.2. ‘Professional misconduct’ is defined as including ‘unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience’.<sup>551</sup>
- A.2.3. Under the National Law ‘unprofessional conduct, of a registered health practitioner’ is defined as ‘professional conduct that is of a lesser standard than that which might reasonably be expected of the health practitioner by the public or the practitioner’s professional peers’, with a range of examples, including contravening the National Health Law, a conviction for an offence under another Act, and ‘providing a person with health services of a kind that are excessive, unnecessary, or otherwise not reasonably required for the person’s well-being’.<sup>552</sup> The phrase ‘reasonable belief’ is used as part of the elements for health practitioners to notify the National Board of ‘notifiable conduct’,<sup>553</sup> which in turn relates to, among other things, ‘placing the public at risk of harm by practising the profession in a way that constitutes a significant departure from accepted professional standards’.<sup>554</sup>
- A.2.4. Tasmanian law on professional negligence does not use the phrase ‘reasonable professional judgement’, though the standard of care required is perhaps similar to what might be expected from that phrase. Section 22(1) of the *Civil Liability Act 2002* (Tas) provides that a professional ‘does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice’.
- A.2.5. Where a court considers the opinion ‘irrational’, peer professional opinion cannot be relied upon for the purposes of assessing the standard of care under s 22.<sup>555</sup> A plurality of peer professional opinions about a matter does not prevent any one, or more, or all of those opinions being relied upon for the purposes of sub-s (1).<sup>556</sup> Peer professional opinion need not be universally accepted to be considered ‘widely accepted’.<sup>557</sup> Finally, s 22 does not apply to ‘liability arising in connection with the giving (or the failure to give) a warning, advice or other information in relation to a risk of harm associated with the provisions by a professional of a professional service to a person’.<sup>558</sup> Tasmania’s *Civil Liability Act* is largely consistent with other State-level approaches to professional negligence under tort law.

<sup>551</sup> *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) s 5.

<sup>552</sup> *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) s 5(a), 5(c), 5(d), respectively.

<sup>553</sup> *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) s 141.

<sup>554</sup> *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) s 140(d).

<sup>555</sup> *Civil Liability Act 2002* (Tas) s 22(2).

<sup>556</sup> *Civil Liability Act 2002* (Tas) s 22(3).

<sup>557</sup> *Civil Liability Act 2002* (Tas) s 22(4).

<sup>558</sup> *Civil Liability Act 2002* (Tas) s 22(5).

- 10.3.4. The phrase ‘reasonable professional judgement’ does, however, appear in case law in connection with professional standards for accountants, legal practitioners, town planners, and social services job capacity assessors, among other professions.<sup>559</sup> In the *Public Health Act 2005* (Qld), the phrase ‘reasonable professional judgement’ is used only in the sections covering ‘conversion therapies’.
- 10.3.5. Consequently, it appears that ‘reasonable professional judgement’ would seem to be a new (or newly applied) standard for assessing medical practice that applies only to the new SOGI conversion practices definitions and offences.
- 10.3.6. The TLRI reads the ‘reasonable professional judgement’ exemption as meaning that, for example, whether a practising psychiatrist who treated a person for gender dysphoria/incongruence would be engaging in a conversion practice depends upon whether the psychiatrist believed their treatment complied with the standard of a ‘reasonable professional judgement’ and was needed to provide a health service or comply with other legal or professional obligations. As this is not a standard used in current healthcare regulation, it is not clear how it might be applied in the healthcare context. Presumably a court would look to expert evidence to establish whether the treatment falls within the scope of ‘reasonable professional judgement’, which may not be as high a standard as the ‘significant departure’ standard under the National Health Law. It may also import a subjective element into the examination, namely that the healthcare practitioner must show they held a genuine belief that they were acting in accordance with a ‘reasonable professional judgement’.
- 10.3.7. Given the uncertainty in this phrasing and its application, and the need for healthcare practitioners to have clear and consistent standards for professional regulation, the TLRI recommends that the exemption for genuine healthcare services not use the language of ‘reasonable professional judgment’. There is no obvious reason why healthcare practices that might border on being considered SOGI conversion practices should be subject to a different standard or mechanism of professional oversight and regulation than other treatments. Introducing a different standard may add to confusion among healthcare professionals already concerned about whether their clinical practice would be in line with reformed laws around SOGI conversion practices. That said, a clear medical exemption is important and necessary. The TLRI proposes an alternative means of excluding genuine healthcare services in the *Mental Health Act* that is appropriate to existing Tasmanian law and professional regulation.

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<sup>559</sup> See, eg, *Forrest v Commissioner of Taxation* (2010) 78 ATR 417; *Victorian Legal Services Commissioner v McDonald* (2019) 57 VR 186; *Wattleup Road Development Company Pty Ltd v Western Australian Planning Commission* [2014] WASAT 159; *Department of Social Security v Smalldon* [2015] AATA 710.

- 10.3.8. Finally, the TLRI agrees with the approach in other States to assistance, acceptance and support exceptions. These are useful indicators that general counselling to assist, accept and support people in relation to their sexual orientation and gender identity are not SOGI conversion practices: they do not seek to change or suppress or eradicate a person's sexual orientation or gender identity but merely provide support for that person.

## Appendix B

# Diagnosis and treatment of mental health conditions relating to SOGI in Australia

## B.1. Accepted classification systems for mental disorders in Australia

- B.1.1. In Australia, the Diagnostic and Statistic Manual of Mental Disorders (DSM-5) is now the primary system for classifying mental disorders in Australia. The International Statistical Classification of Diseases and Related Health Problems (ICD) is also used as a diagnostic tool where the latter provides greater clarity or a more contemporary diagnostic tool relevant to a condition under investigation.<sup>560</sup> While the ICD-11 is the most recent version, the version currently used in Australia and Tasmania is the ICD-10AM.<sup>561</sup>
- B.1.2. Both the DSM-5 and ICD are concerned with describing symptoms — notably labels for clusters of behaviour health symptoms — of a condition. Neither system generally purports to describe the aetiology of the disorders it identifies.

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<sup>560</sup> Rhys Price-Robertson, 'Diagnosis in Child Mental Health: Exploring the Benefits, Risks and Alternatives' (Australian Institute of Family Studies, Child Family Community Australia Paper No 48, July 2018) 2 <<https://aifs.gov.au/cfca/publications/diagnosis-child-mental-health>>.

<sup>561</sup> See Department of Health, Tasmanian Government, 'Tasmanian Health Service 2020–21 Service Plan' (30 June 2020) at 6 <[https://www.dhhs.tas.gov.au/\\_\\_data/assets/pdf\\_file/0017/410048/115616\\_-\\_Service\\_Plan\\_-\\_Full\\_Version\\_-\\_signed.pdf](https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0017/410048/115616_-_Service_Plan_-_Full_Version_-_signed.pdf)>.

## **SOGI not disorders in either system**

- B.1.3. Sexual orientations, such as homosexuality and bisexuality, are not included in the DSM-5 or ICD as a mental health condition or disorder. TLRI understands that LGBTQA+ people, including homosexual and bisexual people, continue to experience mental health conditions at a higher level than the general population. In consultations with peak health bodies the Institute was informed that this is often a consequence of social stigma and continuing discrimination which may cause distress, anxiety and other mental health disorders. Notably, no professional body in Australia considers homosexuality, bisexuality or other forms of sexual orientation themselves to be a mental health disorder.

## **Gender identity is a diagnostic criteria in both systems**

- B.1.4. Both the DSM-5 and the ICD do include ‘gender dysphoria’ (DSM-5 and ICD-10AM) or ‘gender incongruence’ (ICD-11) as disorders. However, these are not aetiological descriptions, but rather are concerned with the feelings (such as ‘distress’) stemming from the incongruence between birth (natal) sex and gender identity. The DSM-5 defines gender dysphoria as:

*the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical intervention by means of hormones and/or surgery are not available (emphasis added)*

- B.1.5. For the ‘distress’ to amount to a diagnosis of gender dysphoria it must have:

- Been present for at least six months;
- Be clinically significant; or
- Impair social, occupational, or other important areas of functioning.

- B.1.6. DSM-5 Part A sets out six manifestations of marked incongruence, two of which must be present for at least six months. Part B requires the incongruence to be associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

- B.1.7. The ICD-11 recently reclassified ‘gender dysphoria’ as ‘gender incongruence’:

*Gender incongruence is characterised by a marked and persistent incongruence between an individual’s experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group.<sup>562</sup>*

<sup>562</sup> (emphasis added). The ICD-11 also contains adolescent and childhood versions, HA60 and HA61 namely:

B.1.8. The ICD identifies the following diagnostic characteristics of gender dysphoria/incongruence in post-pubescent adolescents and adulthood;

- A marked and persistent incongruence between an individual's experienced gender and the assigned sex,
- A desire to 'transition', in order to live and be accepted as a person of the experienced gender, and
- A desire to make the individual's body align, as much as desired and to the extent possible, with the experienced gender.

The diagnosis cannot be assigned prior the onset of puberty.

B.1.9. ICD-11 also moved 'gender incongruence' from the 'mental and behavioural disorders' chapter to a new chapter entitled 'conditions related to sexual health'.

## B.2. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis

B.2.1. Essentially, neither diagnostic manual describes a person's gender orientation ('experienced gender') as a medical dysfunction. There is no evidence that the distress arising from gender dysphoria/incongruence has any simple biological cause or biomarker.<sup>563</sup> Indeed, submissions to the Inquiry which argued that persons with a gender identity different to their assigned sex were

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**Gender Incongruence of Adolescence and Adulthood** is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

**Gender Incongruence of Childhood** is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

The TLRI notes that ICD-11 revised the ICD-10 definition of gender identity disorders (F64), which read: A disorder characterized by a strong and persistent cross-gender identification (such as stating a desire to be the other sex or frequently passing as the other sex) coupled with persistent discomfort with his or her sex (manifested in adults, for example, as a preoccupation with altering primary and secondary sex characteristics through hormonal manipulation or surgery).

The TLRI notes the ICD-10 includes a specific childhood sub-category for gender identity disorders (F64.2).

<sup>563</sup> Brett J Deacon, 'The Biomedical Model of Mental Disorder: A Critical Analysis of Its Validity, Utility, and Effects on Psychotherapy Research' (2013) 33 *Clinical Psychology Review* 846; Allen J Frances and Thomas Widiger, 'Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for the DSM-5 Future' (2012) 8 *Annual Review of Clinical Psychology* 109.

medically disordered or dysfunctional were entirely made by persons or entities which were not peak health bodies, or clinically trained health professionals.

- B.2.2. International protocols for the care of trans and gender diverse children experiencing gender dysphoria have been established by the World Professional Association for Transgender Health *Standards of Care* (7<sup>th</sup> ed, 2011) and the Endocrine Society *Treatment Guidelines* (2009), which have been used to inform Australia specific standards, being the basis of treatment protocols internationally, including throughout Australia.<sup>564</sup> These international protocols are implemented in domestic standards within the *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* ('the Australian Standards').<sup>565</sup> Those standards recommend a coordinated, multidisciplinary approach including clinicians with experience in the disciplines of child and adolescent psychiatry, paediatrics, adolescent medicine, paediatric endocrinology, clinical psychology, gynaecology, andrology, fertility services, speech therapy, general practice and nursing.<sup>566</sup>
- B.2.3. The Australian Standards set out a treatment pathway which seeks to reduce the distress of gender dysphoria through different forms of clinical intervention. Importantly, the standards require a 'gender affirming' approach to clinical intervention.<sup>567</sup> The Family Court has accepted the Australian Standards as the appropriate professional standards for the care of trans and gender diverse people in Australia.<sup>568</sup>
- B.2.4. Guided by medical and scientific experts, and the current state of Australian law, the TLRI accepts that the Australian Standards are the appropriate standard of care for persons experiencing gender dysphoria/incongruence in Australia. The TLRI accepts that the present standard of care in Australia is gender affirming.

<sup>564</sup> World Professional Association for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (7<sup>th</sup> ed, 2011) <[https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7\\_English.pdf](https://www.wpath.org/media/cms/Documents/SOC%20v7/SOC%20V7_English.pdf)>. The most recent version of the Endocrine Society guidelines is Endocrine Society, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline* (1 September 2017) <<https://www.endocrine.org/clinical-practice-guidelines/gender-dysphoria-gender-incongruence>>, published as Wylie C Hembree et al, 'Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline' (2017) 102 *Journal of Clinical Endocrinology and Metabolism* 3869.

<sup>565</sup> Michelle Telfer et al, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents Version 1.3* (Royal Children's Hospital, Melbourne, 2020) <<https://www.rch.org.au/uploadedFiles/Main/Content/adolescent-medicine/australian-standards-of-care-and-treatment-guidelines-for-trans-and-gender-diverse-children-and-adolescents.pdf>>.

<sup>566</sup> *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* (n 565) 11.

<sup>567</sup> Stage 1 treatment as 'puberty suppression' which typically relieves distress for trans adolescents by halting progression of physical changes such as breast growth in trans males and voice deepening in trans females. Stage 2 treatment as gender affirming hormone treatment. Stage 3 treatment.

<sup>568</sup> *Re: Imogen [No 6]* [2020] FamCA 761.

## Appendix C

# Community Consultation Responses to the Issues Paper

- C.1.1. This Appendix collates and describes responses to the specific questions asked in the Issues Paper that formed the basis for the community consultation phase of the Inquiry. It does not detail each and every point made in relation to each question by every respondent, but collects and summarises them under various themes, with illustrative quotes. It sets out the views of respondents who supported and opposed law reform. It collects some material from written submissions that occasionally did not respond directly to the questions asked, but which contained material relevant to those questions. Some of this material is used above in the Final Report, and parts of this Appendix and the Report will overlap closely. The Final Report, however, uses respondent points as part of an analysis and discussion of options for law reform. This Appendix is intended to simply describe what respondents submitted to the Inquiry. The questions are printed verbatim, and references to paragraphs and pages are to the Issues Paper, not this Final Report.

## C.2. Question 1: Definitions

### **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’?**

- c.2.1. Respondent submissions demonstrated the importance of defining SOGI conversion practices for this Inquiry. These submissions also showed the inherent complexities in defining conversion practices. Respondents disagreed in a range of ways about the definition, its meaning, what conduct it might or might not apply to, and the justification for its scope and reach. Perhaps the most important of these difficulties was how the term ‘conversion practices’ might change in different social, religious or medical contexts. Throughout the submissions, respondents drew from historical events, popular culture, and medical settings to define what they believed to be a ‘conversion practice’ and how this should be defined in legislation. Many respondents, particularly those opposed to law reform, interpreted the TLRI’s working definition as a proposed or draft legislative definition. The working definition was explicitly not presented as a proposed legal definition, but a general definition for the purposes of community consultation.
- c.2.2. Thirty-eight respondents and the petition of 377 signatories generally agreed with the broad definition offered in the Issues Paper.<sup>569</sup> Some of these submissions supported the need for a ‘broad’ definition, and suggested emphasising the social and institutional contexts in which conversion practices take place, such as medical and religious environments, drawing from the *SOGICE Survivor Statement* for guidance.<sup>570</sup> Some respondents requested a narrow definition of what conversion practices were, with a strong focus on physical acts, the separation of ‘sex’ and ‘gender’ and the explicit exclusion of religious activities. For these respondents, the aim of this narrower definition was to achieve clarity surrounding potentially lawful or unlawful behaviour, stating that a ‘one size fits all approach’ would not be appropriate in all circumstances and situations.<sup>571</sup>
- c.2.3. What follows discusses both general affirmative/negative positions through a range of themes that many respondents mentioned in their comments:
- The importance of ‘conversion ideology’ for a definition
  - Whether ‘statements’, ‘acts’, ‘conduct’ or ‘practices’ is the right terminology;

<sup>569</sup> Submissions 37, 89, 90, 104, 120, 122, 123, 127, 128, 129, 130, 131, 133, 134, 138, 143, 148, 150, 151, 152, 155, 156, 158, 159, 161, 162, 163, 164, 165, 167, 170, 173, 175, 177, 179, 180, 180, 182, 182.

<sup>570</sup> Submissions 37, 80, 94, 95, 111\*, 113, 114, 169, 175, 177, 179\*.

<sup>571</sup> See, eg, Submission 27.

- The ‘formality’ or ‘informality’ of the setting in which the practice takes place;
- Whether religious settings ought to be excluded;
- Whether medical settings ought to be excluded; and
- Whether a distinction should be made between ‘sexual orientation conversion practices’ and ‘gender identity conversion practices’ (that is, that the working definition conflates two distinct activities, and that sexual orientation conversion practices are impermissible, but gender identity conversion practices may be permissible).

## Conversion ideology

- c.2.4. Several respondents pointed to a diverse range of methods in which conversion practices were/are conducted on the basis of adhering to underlying ‘conversion ideology’.<sup>572</sup> For example, any practice, activity, or treatment (in any setting) that seeks, or is used, to target an individual’s sexual or gendered identity, where that change is deemed necessary due to the instigator’s belief in or adherence to conversion ideology.<sup>573</sup> This included the creation and distribution of misleading and pseudoscientific documents and the promotion, advertising or running of counselling or educational courses, training, retreats, camps, or any form of education, formal or informal, that claims to assist or be able to change someone’s sexual orientation or gender identity.<sup>574</sup>
- c.2.5. Other methods of practices noted by respondents included recommendations and referrals from practitioners for third party conversion ‘therapies’ or removal of children from a jurisdiction for the purpose of conversion practices.<sup>575</sup> The broadening of the definition to include these topics is reflected in the comments of one respondent who stated:

conversion practices can not be isolated from conversion ideology. Any policy, regulatory, legislative, public health, or survivor support responses that separate the two will not adequately address the conversion movement.<sup>576</sup>

## Statements and practices

- c.2.6. Some respondents were supportive of the language of ‘statements’ and ‘practices’ in the definition of a ‘conversion practice’.
- c.2.7. Some submissions focused on the intertwined nature of ‘statements’ and ‘practices’ as important in clarifying what is or is not a conversion practice. For example, the term ‘practices’

<sup>572</sup> Submissions 93, 111\*, 124.

<sup>573</sup> Submission 124.

<sup>574</sup> Submissions 85, 138, 10, 141\*, 155.

<sup>575</sup> Submissions 10, 94, 125, 118, 173\*.

<sup>576</sup> Submission 111\*.

should be used so as to deliberately avoid confusing ‘practices’ with ‘therapy’ and implying that conversion practices have some scientific or medical endorsement, or relate to a genuine dysfunction or disease. As explained by one respondent:

Therapy is a word associated with processes and practices which treat or cure a disorder or a disease. Having a diverse sexuality or gender is not a disorder or a disease. Such confusion would be unhelpful in legislation framed to deter harmful practices.<sup>577</sup>

- C.2.8. This is relevant as some submissions that supported conversion practices stated that these services were not conversion, but a ‘type’ of therapy (‘talk therapy’, which is a term for a genuine form of psychological practice, or ‘reparative therapy’) which assist people with ‘unwanted sexual attractions’.<sup>578</sup>
- C.2.9. Some respondents who supported the inclusion of ‘statements’ believed this would help ensure the definition would include any suggestive, inducement or advertisement for SOGI conversion practices.<sup>579</sup> Some respondents made suggestions that ‘statements’ should be qualified by a term like ‘ongoing’, ‘sustained’ or ‘continuing’.<sup>580</sup> This was demonstrated by a number of submissions that explained how the repetition of discriminatory statements and messages about SOGI produced shame, fear and concern about the ‘causes’ or the ‘nature’ of their gender or sexual identity.<sup>581</sup>
- C.2.10. Other respondents were deeply opposed to the term ‘statements’ at all due to concerns over freedom of expression, and viewed as potentially infringing on religious freedom and self-expression, where some feared simply talking about religious beliefs were considered conversion practices,<sup>582</sup> and/or because the term ‘statements’ was considered too broad and needed further refining on what a ‘good’ or ‘bad’ ‘statement’ was, either by content or intent, and in what context.<sup>583</sup>

## Informal/religious contexts

- C.2.11. Several submissions mentioned ‘formal’ and ‘informal’ contexts in which conversion practices might take place, most often to argue that any definition must cover both.<sup>584</sup> The meanings or suggestions from the language of ‘formal’ and ‘informal’ were sometimes unclear. In general it

<sup>577</sup> Submission 37.

<sup>578</sup> Submission 7.

<sup>579</sup> Submissions 80, 124.

<sup>580</sup> Submission 80.

<sup>581</sup> Submissions 1C, 42, 72, 85, 92, 113, 121, 163\*, 165.

<sup>582</sup> Submissions 33\*, 43\*, 57, 97, 147C.

<sup>583</sup> Submissions 43\*, 44, 65, 68\*, 86, 90, 97, 104, 109C, 116, 144C.

<sup>584</sup> Submissions 10, 42, 79, 93, 94, 168, 169, 179\*.

seemed that by ‘formal’ most respondents meant conversion practices labelled and presented to participants as such. The distinction between ‘formal’ and ‘informal’ contexts was used by a number of respondents to capture medical, psychological and counselling environments as well as ‘informal’ religious settings.<sup>585</sup> For these respondents, the aim of including a range of contexts was to capture any ‘treatment’, or activity in any setting, which aims to, seeks, or is used to further conversion ideology.<sup>586</sup> Respondents also used formal/informal to indicate the context or setting, where or formal settings like an appointment with a doctor whose treatments amounted to conversion practices, or a formal religious activity like a sermon. Informal contexts meant activities that amounted to conversion practices but were not labelled as such; for example, a regular small-group meeting of congregants that is labelled a ‘prayer group’ or simply a meeting, but on one or more occasions involves conduct that amounts to conversion practices.

- C.2.12. Some submissions which focused on the importance of informal and formal contexts emphasised that a conversion practice could appear as unintentionally coercive within religious settings. These submissions emphasised that regardless of whether the practice is offered with genuine belief that it is in the best interests of the subject, who may be said to be ‘confused’ about their gender or sexual identity, ‘assisting’ them could cause unintentional harm and consequences, particularly if the individual does not have any medical training or qualifications.<sup>587</sup> For example, one submission explicitly encouraged a broad definition to capture practices within informal religious settings, which included ‘counselling, prayer, scripture reading, fasting, retreats and “spiritual healing”’.<sup>588</sup>
- C.2.13. Some respondents explained their views on definitions with reference to examples of when they themselves, or someone they know, had been a member of a religious group, which had then prayed on their behalf to free them from their ‘sexual disfunction’, or were told to pray to suppress their sexual desires, or undergo some form of spiritual counselling to ‘change’ their sexuality.<sup>589</sup> Other examples were extensive group prayer sessions and, in extreme cases, exorcisms with the aim of ‘punishing’ or ‘freeing’ the afflicted from their sexuality or gender identity.<sup>590</sup> One respondent expressed support for the definition to explicitly include conversion practices within religious settings (both formal and informal) because most survivor stories

<sup>585</sup> Submissions 10, 42, 80, 85, 79, 111\*, 121, 124, 179\*.

<sup>586</sup> Submissions 93, 80, 111, 110\*, 124\*.

<sup>587</sup> Submissions 54\*, 59, 100\*.

<sup>588</sup> Submission 144.

<sup>589</sup> Submissions 42, 105\*, 120, 123, 126C, 129\*, 113.

<sup>590</sup> Submissions 85, 105, 165, 173\*.

related to religious settings, and thus that is how and where most of these practices and associated harms originate and occur.<sup>591</sup>

- C.2.14. Some respondents emphasised that any encouragement to live ‘sexually pure’ or ‘happy heterosexual lives’ through celibacy or abstinence when an individual is same-sex attracted should be considered a conversion practice because it ultimately aims to suppress and change their sexuality.<sup>592</sup>
- C.2.15. According to one of these respondents, this is because not only does suppression cause harm, but coercive celibacy also supports the narrative that ‘change’ is possible, in that a person can be ‘cured’ from ‘unwanted same sex attraction’ by refusing to act on those desires.<sup>593</sup> Similarly, for other respondents any settings where non-binary people are counselled in a way that promotes a binary identification as male or female should be considered a form of suppression.<sup>594</sup> These respondents argued that this is because conversion practices are not limited to efforts to ‘change’ someone’s sexuality or gender identity but to ‘suppress’ their identity as well, and an insistence on gender binaries suppresses the ability of non-binary people to express their gender identity, and to neglect this distinct difference within this context would fail to address these practices adequately.<sup>595</sup>
- C.2.16. Some respondents who mentioned formal/informal settings emphasised that the importance of capturing informal contexts such as religious settings would help to shed light on otherwise private and discreet forms of SOGI conversion practices. As one respondent stated, their church was quietly disapproving of their sexuality and anyone who was not cisgender.<sup>596</sup> Any references to SOGI conversion practices were almost always at a personal level between religious leaders during confession or other forms of private counselling, advice or pastoral care.<sup>597</sup> Referrals to these sessions were encouraged but ‘low key’, and some individuals were not aware that their own church were promoting SOGI ‘courses’.<sup>598</sup> Another respondent reported that the consequences of these practices in spiritual and religious settings is twofold for the individual subjected to these practices:
- They perpetuate the harmful narrative that a person is defective and unacceptable in the eyes of their god and community;

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<sup>591</sup> Submission 79.

<sup>592</sup> Submissions 37, 42, 85, 119, 168, 169.

<sup>593</sup> Submission 119.

<sup>594</sup> Submissions 124, 167.

<sup>595</sup> Submissions 37, 167.

<sup>596</sup> Submission 153\*.

<sup>597</sup> Submission 153\*.

<sup>598</sup> Submission 153\*.

- These practices can alienate people from their faith and their faith communities, causing further trauma and psychological distress.<sup>599</sup>

C.2.17. A number of submissions explicitly requested the inclusion of informal and unregulated counselling services to capture different types of conversion practices.<sup>600</sup> Respondents mentioned other examples of SOGI conversion practices beyond individual or small group counselling or prayer sessions, including external religious support groups (ie, beyond a single church, eg via online communication), conferences, rallies, online coursework, and online mentorship programs,<sup>601</sup> all of which specifically aim to change or work towards more ‘acceptable’ sexual/gendered behaviours.<sup>602</sup> One respondent, who is a researcher on conversion practices, emphasised that within religious settings, individuals can be taught that being LGBTQA+ is not compatible with membership of their religious community. The respondent argued that this leads to internalisation and acceptance of these messages, where:

individuals may voluntarily engage in change and suppression efforts in order to sustain religious membership and maintain relationships with faith, family, and community.<sup>603</sup>

C.2.18. Some respondents who expressed support for conversion practices used religious language in their explanations of them. An anonymous submission supportive of conversion practices stated that they are being conducted through informal faith-based groups, retreats and camps:

[C]ounselling, support groups, prayer, insightful retreats and camps and peer support has tremendously helped, and is helping, very many of my fellow Australians to take charge of their lives and to live in accordance with their values and beliefs, all for the overall betterment of Australia as a nation.<sup>604</sup>

C.2.19. Some submissions drew explicit links between religious and medical practitioners, suggesting that counselling by non-medically trained people were equivalent to the work done by professional mental health practitioners. For example, one respondent stated that having a broad definition of a ‘conversion practice’ would: ‘severely restrict the capacity for health professionals, parents, teachers and other community members to provide comprehensive care of a child or young person with gender dysphoria’.<sup>605</sup> Another anonymous submission made a similar point that emphasised spirituality as a form of care: ‘gentle person-centred counselling and support is what is needed for gender-confused persons, especially for those actively

<sup>599</sup> Submission 42.

<sup>600</sup> Submissions 10, 41, 80, 82, 114, 122, 124, 138\*, 156, 167.

<sup>601</sup> Submissions 37, 42, 111, 105\*, 121, 165.

<sup>602</sup> Submission 42.

<sup>603</sup> Submission 92.

<sup>604</sup> Submission 110\*.

<sup>605</sup> Submission 55\*.

seeking counsel, or even prayer'.<sup>606</sup> One religious leader stated that as a preacher they are 'like a medical doctor who explains the disease so the patient can understand the need for treatment and be persuaded to take it'.<sup>607</sup> The suggestion that faith-based teaching or pastoral care was synonymous with the practice of psychologist and medical practitioners was further evident in another submission:

Intentionally or not, [the TLRI definition] captures helpful counselling and psychological support for children, teens and adults struggling with gender dysphoria. It also captures spiritual counselling around sexual ethics and identity. Any proposal to ban conversion therapy must clarify that these practices are not conversion therapy, nor is religious instruction promoting healthy sexuality in line with biblical teaching. Any ban on conversion therapy must not lump the helpful with the harmful. Conversion therapy bans also condemn efforts to help someone manage unwanted sexual desires or urges. For example, a person may prefer to diminish feelings of same-sex attraction and enhance feelings of opposite-sex attraction to have a traditional family, for reasons of religion or conscience, or for other legitimate personal reasons that the state should respect.<sup>608</sup>

- c.2.20. In contrast to the above, a few submissions explicitly requested that some practices or activities which were held in religious settings be excluded from the definition. This is due to the concern that religious communities hold ethical and spiritual concerns about this issue, or have a general freedom to set and enforce religious prescriptions about sexual morality, sexual behaviour, and the requirements of gender identity, such as gender roles or an insistence on the male–female gender binary.<sup>609</sup>
- c.2.21. These respondents emphasised that 'acts' or 'activities' such as sermons, spiritual teachings, scripture, study groups, pastoral care, faith counselling and Confession should be exempt from being defined as a conversion practice.<sup>610</sup> One respondent stated that prayer ministries aimed at 'curing' specific individuals of their gender or sexual diversity should be included in the definition, but that sermons to congregations that urged them against homosexuality should not be, even if they are potentially damaging in a general sense. It was argued that the latter is not a SOGI conversion practice because it is a general statement, rather than one targeted at a specific individual.<sup>611</sup> Similarly, another respondent stated that it would be unfair to include the simple act of praying for someone to be placed in the same legal category as physical torture.<sup>612</sup>

<sup>606</sup> Submission 100\*.

<sup>607</sup> Submission 3.

<sup>608</sup> Submission 20.

<sup>609</sup> Submission 41.

<sup>610</sup> Submissions 30, 44, 71, 68\*, 141\*.

<sup>611</sup> Submission 42.

<sup>612</sup> Submission 41.

These concerns were also reflected in respondent suggestions to exclude ‘statements’ from a definition of conversion practices, and limit them to only coercive and physical acts like aversion therapy.

## Formal/medical contexts

C.2.22. TLRI received several submissions from respondents in a range of health professions, both as individual practitioners and from peak or representative bodies. These submissions suggested a broad definition of conversion practices was essential, but that it should be carefully defined around clinical contexts.<sup>613</sup>

C.2.23. Respondents with medical qualifications and peak medical bodies generally submitted that legislation which aims to criminalise certain conduct must be framed in a way that does not impede on legitimate forms of psychiatric or medical care, practised by appropriately qualified and regulated health practitioners, and informed by the scientific and clinical standards as reviewed and announced in the guidance of professional and regulatory bodies. A clear distinction between legitimate psychiatric treatment and conversion practices was especially important for practitioners who deal with patients that may want to discuss a diagnosis, treatment or counselling for gender dysphoria/incongruence. One respondent stated:

It is important that individuals questioning their gender or considering treatment can be appropriately counselled and supported using an evidence-based approach with reference to accepted professional standards.<sup>614</sup>

C.2.24. This was further emphasised by another respondent who stated that conversion practices should not include:

any practice or treatment that provides assistance to an individual undergoing a gender transition, or provides acceptance, support and understanding of an individual, or facilitates an individual’s coping, social support and identity exploration and development, — including sexual orientation-neutral interventions as long as such practices or treatments do not seek to change an individual’s sexual orientation or gender identity.<sup>615</sup>

C.2.25. Community groups also made submissions on health practices that emphasised the need for legitimate healthcare to be excluded from any definition. Working It Out stated that health practices which are in line with current therapeutic guidelines, particularly in relation to the Australian Standards of Care and Treatment Guidelines for transgender and gender diverse

<sup>613</sup> Submissions 41, 42, 79, 120, 121.

<sup>614</sup> Submission 5.

<sup>615</sup> Submission 38.

adults and children, or any relation to gender affirmation should not fall within the definition of SOGI conversion practices.<sup>616</sup>

### *Peak Medical Bodies*

- C.2.26. Several submissions from peak medical bodies gave direct feedback on the TLRI working definition.
- C.2.27. The Australian Psychological Society generally agreed with the TLRI definition, but noted that ‘dysfunction’ in connection with conversion ideologies may not be appropriate in all cases. The APS posited that a conversion practitioner may not go so far as to say an experienced sexual orientation or gender identity is broken, but simply that a person would be ‘happier’ if they became heterosexual and/or cisgender.<sup>617</sup> The Society also queried whether the use of ‘practices’ implicitly focuses on purposive acts, which leaves online, media or family discussions, eg of the ‘dysfunctionality’ of transgender people, outside of ‘conversion practices’.<sup>618</sup>
- C.2.28. The Australian Medical Association Tasmania reported that its members largely agreed with the definition, with the caveat that ‘like any definition, it will be how the words within it are interpreted and thus the line drawn on what constitutes conversion therapy and how the intent that sits behind an act or statement can be proved, that will be important’.<sup>619</sup> AMA Tasmania also emphasised the need to have a clear exemption for doctors from any criminal offence provisions:
- AMA Tasmania members want to ensure that doctors are not left open to criminal prosecution for asking what they consider to be necessary questions to understand their patients’ needs and desires. Healthcare professionals acting in good faith and in accordance with reasonable standards of diagnostic assessment, clinical counselling and patient management must never be exposed to criminal sanction for competently doing their job.<sup>620</sup>
- C.2.29. The Tasmanian Chief Civil Psychiatrist, suggested expanding ‘acts or statements’ to be ‘more prescriptive of the acts, statements or types of SOGI conversion practices’.<sup>621</sup>

## **Separating sexual orientation and gender identity**

- C.2.30. Approximately 20 respondents requested that any reference to gender identity be removed from the definition of conversion practices entirely, and that any definition should only cover ‘sexual

<sup>616</sup> Submission 42.

<sup>617</sup> Submission 18 at 2.

<sup>618</sup> Submission 18 at 3.

<sup>619</sup> Submission 90 at 1.

<sup>620</sup> Submission 90 at 3.

<sup>621</sup> Submission 104 at 2.

orientation conversion practices'. Several respondents expressed strong views that including 'gender identity' and 'sexual identity' within the definition of conversion practices was a conflation of two otherwise entirely separate issues.<sup>622</sup> Some respondents justified this by stating that 'assisting a person with gender dysphoria to come to terms with their natal sex'<sup>623</sup> is and should remain lawful. Others emphasised that sex was a 'biological reality' or 'biological fact', whereas gender was purely 'ideological'.<sup>624</sup>

- C.2.31. Some of these respondents suggested that if a definition of SOGI conversion practices did still include 'gender identity', it should be framed as narrowly as possible, so that any ban does not reduce the number of 'treatment pathways' or operate to outlaw any medical practices besides gender affirmation.<sup>625</sup> Sixteen respondents stated that the definition should only apply to an individual's sexual orientation.<sup>626</sup> Some participants specifically defined 'sexual orientation' to mean 'gay'<sup>627</sup> or 'homosexual'<sup>628</sup> with minimal or no reference to lesbian, bisexual, or other types of sexual identities.
- C.2.32. A number of submissions that focused only on sexual orientation framed conversion practices in a similar way, through the emphasis on 'changing', 'reverting' or 'revising' sexuality, but did not consider whether or how this might extend to suppression efforts.<sup>629</sup>
- C.2.33. Other experts who are not healthcare practitioners themselves expressed concerns about the inclusion of 'gender identity conversion practices', arguing that these were legitimate treatments: 'treatment programs responding to those with gender identity concerns' should not be conflated with 'sexual orientation conversion practices'.<sup>630</sup>
- C.2.34. The remaining submissions besides these did not raise 'gender identity' as an issue, or something that needed to be dealt with separately from sexual orientation. One respondent stated that it was critical that any legislation which aimed to address conversion practices must include any intention to change or suppress gender identity.<sup>631</sup> For some respondents, sexual orientation and gender identity were both central to their experiences of conversion practices, in

<sup>622</sup> Submissions 8, 19, 27, 36\*, 29C, 43\*, 47, 50, 51, 52, 66, 71, 72, 73, 74, 75\*, 77\*, 107, 140\*, 166\*, 174.

<sup>623</sup> Submissions 51, 52, 67, 139\*.

<sup>624</sup> Submissions 12, 47, 52, 57, 66, 75\*, 76\*, 139\*, 174.

<sup>625</sup> Submissions 27, 29C, 55C, 66, 67.

<sup>626</sup> Submissions 7, 8, 27, 28, 34, 42, 51, 52, 66, 72, 77, 82, 136\*, 141, 142, 154.

<sup>627</sup> Submissions 136\*, 34, 105\*.

<sup>628</sup> Submissions 51, 52, 141\*.

<sup>629</sup> Submissions 7, 21, 27, 28\*, 34, 51, 52, 82, 93, 141\*, 142\*.

<sup>630</sup> Submission 21.

<sup>631</sup> Submission 37.

that they had been subjected to conversion practices targeting both of these aspects of their identity.<sup>632</sup>

### Physical actions only

C.2.35. Thirty respondents expressed the view that ‘conversion practices’ be narrowly defined to include only physical actions that aimed to change, suppress or eradicate sexual orientation or gender identity. Examples given were chemical castration, electric shock, forcible medication and aversion ‘therapies’.<sup>633</sup> For example, one respondent stated that it ‘should be narrowly limited to extreme acts that would normally be described as torture — such as non-consensual electroshock or aversion therapy’.<sup>634</sup> The common theme within these responses was the emphasis on harm. Acts which caused psychological or physical pain, shame, or confusion were considered ‘physically abusive’, ‘abhorrent’ and ‘wrong’.<sup>635</sup> Whilst a small number of respondents stated they believed these practices have not occurred in Australia for decades,<sup>636</sup> overall, these respondents were supportive of a definition that covered only the most extreme forms of conversion practices because they are not part of a caring society.<sup>637</sup>

<sup>632</sup> Submissions 1C, 110\*, 121, 126C, 129\*, 148\*, 159\*, 167\*, 168\*.

<sup>633</sup> Submissions 3, 7, 19, 20, 21, 27, 28\*, 41, 43\*, 45\*, 48, 52, 60\*, 61, 63\*, 64\*, 65, 68\*, 72, 76\*, 82, 88C, 95\*, 99, 100\*, 109C, 116, 125, 141\*, 148\*.

<sup>634</sup> Submission 3.

<sup>635</sup> Submissions 3, 7, 19, 20, 27, 45\*, 48, 65, 88C, 82, 60\*, 61, 63\*, 64, 65, 95\*, 99, 100\*, 116, 148\*.

<sup>636</sup> Submissions 63\*, 64\*, 88C, 99, 100\*.

<sup>637</sup> Submission 48.

### C.3. Question 2: Consent

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

C.3.1. Most respondents provided a broad explanation for who should or should not be able consent to SOGI conversion practices and under what conditions, drawing from literature, personal anecdotes, and religious sentiments. Many respondents held strong beliefs on issues of consent when involving minors. Some respondents believed consent to conversion practises were largely contextual with most submissions focusing on gender in isolation, with some disagreeing with treatment pathways for gender affirmation.<sup>638</sup> For example, a mixture of respondents stated ‘No’ or ‘Yes’ to consent to conversion practices and then further elaborated that children should be able to explore ‘alternatives’ to gender affirmation.<sup>639</sup> These responses put forward a often very different range of views and arguments, however they all shared similar views to the example provided here by one respondent:

if it is deemed appropriate for a child seeking gender- re-assignment surgery/medical treatment to receive such treatment, they should also be offered the opportunity to explore the alternative option of becoming more comfortable with their natal gender (which may be defined as SOGI conversion practice). This is only fair and reasonable, and aligns with the widely-celebrated principles of free choice and informed consent.<sup>640</sup>

C.3.2. A small number stated that consent depends on the person, age or circumstances in which individuals might consent to SOGI conversion practices, with most not elaborating on what exactly these conditions, circumstances or practices should be.<sup>641</sup> General themes surrounding consent can be summarised by these key points:

- Yes, consent can be freely given.
- Yes, but only informed consent.
- No, consent cannot be given under any circumstances.

<sup>638</sup> Some respondents considered gender affirmation treatments, or indeed any social recognition or physical alterations that diverge from the gender a person was assigned at birth, to be a conversion practice. These respondents then discussed consent mostly in reference to those treatments. The TLRI accepts that gender affirmation is the current standard of care, that the assessment and treatment of gender dysphoria/incongruence by qualified and licensed healthcare professionals acting in accordance with their professional, ethical and legal duties are not conversion practices, and notes that no peak medical bodies consider such assessments or treatments to be conversion practices: see Appendix B.

<sup>639</sup> Submissions 2, 8, 13\*, 20, 27, 29C, 31\*, 39, 43\*, 44, 47, 50, 51, 52, 55C, 57, 60\*, 66, 67, 68\*, 71, 75\*, 77\*, 81, 97, 100\*, 106, 136\*, 141\*.

<sup>640</sup> Submission 141\*.

<sup>641</sup> Submissions 138\*, 140\*, 149C, 151, 158C, 181C.

## Yes, consent can be freely given

- C.3.3. Thirty-nine respondents suggested that SOGI conversion practices should be accessible by consent for those who wish to seek them.<sup>642</sup> For these respondents, denying individuals the option would be denying free will and personal choice. For example:

If an adult feels distress over their sexual orientation and seeks to try an evidence-based therapeutic approach to address this (ie CBT [cognitive behavioural therapy]/reframing) then that is their prerogative and this should be made available to them without having practitioners be too afraid to practice this modality under threat of deregistration or legal punishment.<sup>643</sup>

- C.3.4. For some respondents, law reform would deny consenting adults their freedom of agency and was viewed as a fundamental breach of civil liberties.<sup>644</sup> For example:

[the current definition] specifically precludes any person, even a competent adult, from consenting to such a practice. A provision in these terms clearly disregards the basic human right to self-determination. No matter how odious the parliament considers conversion practices to be, banning competent adults from making a choice to partake of them demonstrates an unequivocal attempt to regulate civil liberties beyond the bounds of what should be considered acceptable.<sup>645</sup>

- C.3.5. For some, consenting to conversion practices included the ability for parents to make decisions on their child's behalf.<sup>646</sup> In general, those who believed conversion practices should be available for those who are able to consent did not provide explicit conditions for where this would not be applicable, such as age or intellectual impairment.

## Yes, but only informed consent

- C.3.6. Respondents who stated SOGI conversion practices should be available for those who request them largely believed it should only be on the grounds of informed consent. A small number of submissions emphasised that individuals should be able to consent only after being presented with sufficient education on SOGI conversion practices, including expected harms and outcomes or the 'potential benefits and negative side effects' of them.<sup>647</sup> One respondent

<sup>642</sup> Submissions 2, 8, 12, 20, 28\*, 33\*, 34, 41, 65, 69\*, 76\*, 81, 82, 95\*, 96C, 99, 100\*, 106, 109C, 114, 116, 118, 125, 133\*, 139\*, 141\*, 142\*, 143\*, 144C, 146C, 147C, 154\*, 160\*, 163\*, 166\*, 171\*, 176\*, 178\*, 183\*.

<sup>643</sup> Submission 136\*.

<sup>644</sup> Submissions 73, 152\*, 172\*.

<sup>645</sup> Submission 73.

<sup>646</sup> Submissions 8, 27, 34, 68\*, 69\*, 95\*, 116.

<sup>647</sup> Submissions 114, 118, 125, 130\*, 178\*.

mentioned that this decision should be made without pressure or coercion.<sup>648</sup> For some of these respondents, in the case of religious practice, it was submitted that adults should be able to consent but not children or teenagers:

Physical conversion practices for people with same sex attraction have already been outlawed so the only ones left for consideration would be those of a psychological nature including abstinence. Since many faith based organisations now accept same sex attraction and understand it is not something that can be changed I believe adults should be able to decide how and in which way they would like to meet the principles of their faith. Children and teens are a different matter they cannot consent to any form of coercion or principles to change their sexual orientation.<sup>649</sup>

Another submission stated the law should specifically protect children and any person who has a mental illness, cognitive impairment, or intellectual disability from these practices because of the inherent difficulties in gaining informed consent.<sup>650</sup>

- c.3.7. Tasmania Police noted that s 2A of the *Criminal Code* provides for an extensive definition of consent in relation to unlawful criminal acts, and submitted that that model adequately provides for the circumstances where a person may be able to consent to what would otherwise be an unlawful act.<sup>651</sup> Section 2A defines consent as ‘free agreement’ and indicates that ‘free agreement’ is not possible by non-communication of consent or where the submission is due to force, threat, unlawful detention, fraud, reasonable mistake as to the nature or purpose of the act or the identity of the accused, unconsciousness or intoxication, or where a person is ‘overborne by the nature or position of another person’ or unable to understand the nature of the act. Section 2A(3) provides that where a crime results in grievous bodily harm, lack of consent is presumed.

### **No, consent cannot be given under any circumstances**

- c.3.8. Thirty-seven submissions and the petition of 377 signatories stated that no-one should be able to consent to conversion practices regardless of age or circumstances.<sup>652</sup> Whilst some did not elaborate on their response further, many of those respondents that did expressed strong views on why individuals cannot consent or should not be taken to have consented to these practices.

<sup>648</sup> Submission 148\*.

<sup>649</sup> Submission 166\*.

<sup>650</sup> Submission 118.

<sup>651</sup> Submission 25 at 2.

<sup>652</sup> Submissions 58, 79, 80, 86, 89, 90, 91, 93, 104, 110\*, 113, 115, 117, 121, 122, 142, 127, 128, 129\*, 131, 135\*, 137\*, 150, 155, 157\*, 162, 165, 167, 168, 169, 170, 173\*, 175, 177, 179\*, 180\*, 182\*.

- C.3.9. Peak medical bodies and statutory medical officers stated that consent to conversion practices was not possible.<sup>653</sup> For example, the Australian Psychological Society stated:

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.<sup>654</sup>

The Chief Civil Psychiatrist stated that conversion practices could not be consented to by any person, regardless of decision-making capacity, because they are ‘unethical, not based on medical evidence, and can cause significant long-term harm’.<sup>655</sup>

- C.3.10. Most submissions that expressed similar views to the above example emphasised that SOGI conversion practices, by their nature, denied any individual the possibility of providing informed consent because they are inherently coercive and built on falsehoods and misinformation. One respondent pointed to the repetitive nature of conversion ideology and its broad-reaching harm:

people who have been indoctrinated with this abusive ideology, whether in familial, educational, health and/or religious settings, and therefore experience severe shame about who they are, are not in a position to provide genuine consent to what is simply further abuse.<sup>656</sup>

Coercion was expressed as the repetitive, ingrained attitudes which are targeted at individuals from a young age, where ‘conversion’ then becomes the only available option for the individual to find freedom within themselves or to participate in their religious faith or community.<sup>657</sup> This is illustrated by one respondent’s experience:

I was doused in conversion ideology since I was a small child. This meant that by the time I was 11 or 12 and starting to realise that I might be gay, I already believed that I was broken, sick, perverted, demon-possessed. Because I believed this, when I finally ‘came out’ to my pastor at 16, I needed no convincing that I needed to be ‘healed’ and I had already started seeking out conversion practices.<sup>658</sup>

- C.3.11. When addressing the topic of consent specifically, some respondents drew on misinformation as going hand-in-hand with coercion. This was because ‘informed consent cannot truly be

<sup>653</sup> Submissions 18, 37, 90, 104.

<sup>654</sup> Submission 18 at 3.

<sup>655</sup> Submission 104 at 2.

<sup>656</sup> Submission 79.

<sup>657</sup> Submissions 37, 85, 94, 134\*, 165, 167, 173\*.

<sup>658</sup> Submission 110\*.

gained when the information is false'.<sup>659</sup> Some respondents stated that because conversion practices were based in misinformation rather than evidence, consent can never be 'informed' because the subject cannot be provided with accurate resources or evidence that these practices work.<sup>660</sup> For example, one respondent wrote:

Given there is no evidence that conversion practices work or are beneficial, and that we know people are often coerced into agreeing to partake in these practices, including by being provided with false and misleading information about the benefits and success, consent of any kind should not be considered an option. A parallel may be drawn from consumer protection whereby consent given on the basis of false information is not genuine consent.<sup>661</sup>

C.3.12. Respondents who stated that it was impossible to consent to conversion practices largely applied this to both children and adults, and to contexts of either forced or 'purportedly consensual' involvement.<sup>662</sup> In discussing consent, some respondents made specific reference to the removal of children from their jurisdictions for the purposes of conversion practices, which they suggested was an act of parental coercion and should be unlawful.<sup>663</sup> Similarly, another respondent stated that acting 'in the best interest of the child' was flawed and should not be available to be used as a defence or mitigating factor for conversion practices for those under the age of 18.<sup>664</sup> One submission suggested that parents whose children have been subject to conversion practices should be able to take legal action against the perpetrators on behalf of the affected child.<sup>665</sup> Lastly, on the topic of consent more broadly, the Anti-Discrimination Commissioner raised a concern that it would be legally problematic if a person were able to consent to conversion practices which would then undermine any possible legal avenue where that person could seek a remedy after experiencing harm such as making a claim under the *Anti-Discrimination Act*.<sup>666</sup>

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<sup>659</sup> Submission 89.

<sup>660</sup> Submissions 37, 79, 80, 91, 93, 113, 121, 122, 124, 129\*, 159\*, 161\*, 164\*, 165, 167, 168, 169, 175, 177, 179\*, 182C.

<sup>661</sup> Submission 42.

<sup>662</sup> Submissions 80, 93, 115, 124, 150, 173\*.

<sup>663</sup> Submission 85.

<sup>664</sup> Submissions 115, 120.

<sup>665</sup> Submission 124.

<sup>666</sup> Submission 117.

## C.4. Question 3: SOGI Conversion Practices in Tasmania

**Have you been involved in or offered, or are you aware of, any forms of SOGI conversion practices in Tasmania? If so, what were the effects on you, or the person exposed to them?**

- c.4.1. Responses to this question provided strong evidence for the existence of a wide range of conversion practices in Tasmania, both in the past and ongoing today.
- c.4.2. Forty-six submissions reported people being offered or undergoing conversion practices in Tasmania.<sup>667</sup> Nineteen submissions reported harmful effects.<sup>668</sup> Some of these reports related to the respondent themselves, others provided accounts of experiences and/or harms, and some respondents submitted multiple accounts. Some individuals and organisations stated or implied they offered conversion practices. These reports ranged from:
- Expressions of knowledge from members of the community in general terms and without specific details, such as ticking the box on the survey instrument ‘I am aware of forms of SOGI conversion practices which are currently being offered or delivered in Tasmania’<sup>669</sup>
  - Health practitioners reporting that clients have disclosed encounters with SOGI conversion practices in Tasmania. For example, one practitioner stated: ‘Many of our clients are members of the LGBTIQ community and have a diverse sexual orientation or gender identity and have experienced conversion practices at some point in their lives’.<sup>670</sup>
  - Detailed stories from friends, family, or professional clients were submitted, or stories with specific details, for example: ‘I am aware of a church group that used to run weekend camps for girls who were questioning their sexuality, as way of encouraging them to work through this “phase”’.<sup>671</sup>

### **People and organisations that stated or implied they fell under the working definition**

<sup>667</sup> Submissions 1C, 3, 30, 37, 38, 42, 58, 60\*, 85, 89, 91, 92, 93, 94, 102\*, 105\*, 110\*, 111\*, 113, 119, 120, 121, 123, 126C, 130\*, 131, 132, 136\*, 141\*, 147C, 148\*, 151, 153\*, 154\*, 155, 157\*, 163\*, 164\*, 165, 169, 173\*, 175, 177, 180\*, 181.

<sup>668</sup> Submissions 1C, 85, 89, 91, 93, 102\*, 105\*, 110\*, 111\*, 119, 121, 126C, 130\*, 148\*, 155, 163\*, 165, 173\*, 180\*.

<sup>669</sup> Submissions 128, 131, 151, 157\*, 164\*, 181\*.

<sup>670</sup> Submission 89.

<sup>671</sup> Submission 136\*.

C.4.3. Several submissions from religious people and groups stated or implied that they encourage, participate in, or offer SOGI conversion practices within Tasmania.<sup>672</sup> A number of submissions expressed that under the working definition in the Issues Paper, they would be criminalised for their actions, or that they simply would not change their practices due to personal views or religiosity.<sup>673</sup>

C.4.4. Some respondents accepted that the TLRI's working definition would capture their present or future activities. None of these people were health professionals. For instance, one respondent, who works in compliance and public policy stated:

I am personally invested in this proposal to the extent that the more extreme suggestions, if adopted, would likely see me in prison.<sup>674</sup>

C.4.5. Some submissions by religious leaders and/or organisations stated they engaged in SOGI conversion practices. The Reverend of the Free Reformed Church of Launceston wrote:

... our church preaches and teaches what the Bible says, including what it says about sexual orientation and gender identity. We do this out of our ultimate commitment to God, our love for him, and out of love for the people around us. We counsel accordingly. We pray publicly and privately accordingly. According to the working definition the Issues Paper provides, we **are** involved in SOGI conversion practices. We make no apologies for that. Moreover, as stated above, this is non-negotiable for our church since we believe what the Bible says. For us to do otherwise would be unloving and disingenuous.<sup>675</sup>

The Reverend indicated that both their church and several others operated schools that taught 'what the Bible teaches about SOGI':

While it is not operated or governed by our church, members of our church community operate a Christian school in Launceston. This Christian school is also unreservedly committed to what the Bible teaches about SOGI. The children who attend this school are taught accordingly, because their parents want their children to be taught in a way which corresponds with their Christian faith. In fact, the parents have all made public vows to this effect — this is taken very seriously in our community. There are several similar Christian schools throughout Tasmania.<sup>676</sup>

<sup>672</sup> Submissions 3, 106, 34.

<sup>673</sup> Submissions 3, 16, 20, 22\*, 23\*, 27, 31\*, 34, 41, 44, 53, 54\*, 62, 65, 69\*, 71, 83C, 99, 101\*, 106, 109C, 125, 145\*, 178\*.

<sup>674</sup> Submission 34 at 1.

<sup>675</sup> Submission 3 at 3 (bolded emphasis in original).

<sup>676</sup> Submission 3 at 4–5.

The Reverend stated ‘I also respectfully provide this submission to alert you to the fact that Christian churches like ours will not change our practices.’<sup>677</sup>

- c.4.6. Religious educational providers stated they did not engage in ‘coercive’ or ‘forcible’ SOGI conversion practices, but expressed concern that their educational programs, including counselling and pastoral care of students around sexuality and gender identity questions, might be covered by the TLRI’s proposed definition of SOGI conversion practices.
- c.4.7. The Australian Association of Christian Schools, affiliated with ten Tasmanian schools, provided statements around their educational practices around sexuality and gender identity. The Association stated that they did not engage in or support any ‘attempt to forcibly change, suppress or eradicate’ sexuality or gender identity, and emphasised that they taught a Christian worldview around those topics in their curriculum and educational objectives:

... our schools do not attempt to forcibly change, suppress or eradicate the sexual orientation or gender identity of any child, nor do we support this practice. We do promote a Biblical worldview on these topics consistent with the religious teachings of the Christian faith. Our schools believe that God designed two biological genders, male and female, and that families are formed through marriage which is a commitment between one man and one woman, to the exclusion of all others for life and is the rightful place for sexual activity and procreation. AACCS agrees that education of the whole child is not complete unless it includes spiritual and moral development ... Our schools take seriously their responsibility to nurture children’s moral and spiritual development in accordance with the values and beliefs of the Christian faith. We partner with families in teaching children that the world and everything in it belong to God. Christian schools weave this understanding all through their curriculum and in their everyday practices ...<sup>678</sup>

- c.4.8. The Association also stated it did not believe that ‘coercive’ SOGI conversion practices were taking place in Tasmania. In its response to Question 3, it wrote:

For our schools, as they journey alongside emerging adults establishing their identity and developing personhood, the freedom to have conversations about a wide range of topics and ideas is essential. Any new law which mandates a teacher’s or counsellor’s response to a particular student’s concerns about their sexuality or gender under the guise of banning ‘conversion practices’ is unjustified and potentially harmful. Generations of young people have sought the advice of teachers and other staff in matters far beyond the subject matter of a classroom. Staff do not attempt to force their beliefs and values upon any student in relation to these deeply personal matters which go to the heart of someone’s identity and

<sup>677</sup> Submission 3 at 1.

<sup>678</sup> Submission 44 at 2.

faith. We do, however, seek to lovingly support young people as they explore questions about their identity in the context of their faith in Christ on a broad range of topics including gender, sexuality and personal relationships.<sup>679</sup>

## Reports of conversion practices conducted by non-medical practitioners

- C.4.9. Many submissions provided experiences of SOGI conversion practices in Tasmania, primarily undertaken by non-medical practitioners. These were generally conducted by people with positions of power or influence, such as religious leaders, educators or other community leaders who had responsibility for the care of young people. One strong theme in submissions reporting experiences with SOGI conversion practices in Tasmania was the prevalence of various community members holding themselves out as having the knowledge and skills to ‘care’ for those exploring or confused about their sexuality and gender identity, but not holding any medical or health practice qualifications that might be relevant to such activities.<sup>680</sup>
- C.4.10. Submissions from survivors and their friends and relatives confirmed the connection or overlap drawn between spiritual guidance and pseudo-health practice in the discussions on the definition of conversion practices. Some submissions reported confiding in loved ones, friends, professionals, or religious leaders which led to significant pressure from those people to undergo some form of ‘treatment’ or ‘therapy’ to ‘fix’ or ‘correct’ those identities or orientations, instead of being affirmed or supported by these trusted people.<sup>681</sup> For example, one anonymous submission stated:

I have been offered (but not accepted) forms of SOGI conversion practices in Tasmania ... An evangelical priest who considered my exorcism would lead to my ‘saving’ and conversion, leading me to be ‘a happily married man with children.’ It happened at the [redacted Hobart church]. I had been in a car accident and had injured my neck. Noting my brace, the priest said that my ‘sexuality’ is the cause of sin and he could take the sin from me restoring me to full health. I was stressed as at this stage I was still struggling to come to terms with who I was, let alone be a practicing gay man. I am not aware I had actually ‘come out’ to anyone. It left me feeling exposed, frightened and probably led to another few years of being closeted and depressed.<sup>682</sup>

<sup>679</sup> Submission 44 at 5.

<sup>680</sup> Submissions 2, 3, 9, 14, 16, 17, 24\*, 26\*, 28\*, 32, 36, 37, 38, 39, 43\*, 44, 45\*, 48, 53, 55C, 57, 63\*, 64\*, 65, 67, 68\*, 70\*, 72, 83C, 88C, 96C, 100\*, 108, 109, 112\*, 124, 125, 138\*, 141, 146C.

<sup>681</sup> Submissions 126C, 155, 163\*, 165.

<sup>682</sup> Submission 173\*.

- C.4.11. Conferences, prayer groups and counselling were the most common SOGI conversion practice activities for those exposed to SOGI conversion practices within faith-based communities.<sup>683</sup> Transforming Tasmania provided several anonymised accounts of the experiences of people with SOGI conversion practices in Tasmania, both in religious and medical settings. Two cases related to transgender people in religious settings. The first, ‘Ben’, a 25-year-old trans man, experienced exclusion from his religious community during school, presumably approximately seven to ten years ago. His faith community encouraged the suppression of his gender identity by a demand to remain ‘abstinent’ from expressing that identity, or face exclusion from the faith community:

My faith is a huge part of who I am. It’s the foundation of me. Back when I was at [education provider], I wanted to join a social group for my faith, and since service to others and the community is a core value of my faith, I wanted to be an active part of that group. For a while, it was great—I was part of the group’s music crew and volunteered at events, and it seemed to be a really warm, loving community dynamic.

And then they found out I was trans.

Suddenly I got booted out of the music crew and got banned from volunteering. I was told by the group’s leadership that I could still be a member, but only if I ‘abstained’ from being who I am and didn’t ever mention it again. They prayed for me to be ‘healed’.

The sense of whiplash was incredible. Being cut off from my faith community so suddenly, it was like I couldn’t breathe. They said I could rejoin the music crew, on the condition that I denounced my identity publicly and went to regular ‘healing’ prayer sessions. For a while I tried to continue attending the group’s events, pretending I was a good little cis-het girl just to be there, but I couldn’t keep it up. Everyone had suddenly become so cold, and knowing that my acceptance in that community was contingent on me lying about who I am — that damage was done. I couldn’t be at home there any more, and I couldn’t trust any of those people. It hurt so bad, like my family had died but was somehow still standing around making small talk with each other.

It totally destroyed my self worth, I hated myself. I started drinking myself into oblivion every night, sleeping with strangers compulsively and putting myself in unsafe situations. I thought I deserved to suffer, and I was going to hell anyway, so I might as well get there a bit quicker.

I guess I’m one of the lucky ones, in that it didn’t end up actually stopping me transitioning, and I made it to a better place eventually. But I lost so much.

<sup>683</sup> Submissions 85, 93, 105\*, 110\*.

Honestly, I still don't trust any faith groups. I haven't been able to be part of any since. I don't know how to find a church community where I'll be able to feel safe, and not like they might suddenly turn on me. My faith is still the core of my identity, but trying to find other people to share that with is too much for me most of the time.

- C.4.12. The second, 'Chloe', a 28-year-old trans woman, confided in a trusted pastor that she was trans, and received pastoral counselling and focused bible study to 'fix' her:

When I was 17, my family kicked me out—we'd never had good relationships. I was on my own, depressed, anxious, living in totally gross conditions, couldn't afford to eat properly. What kept me going was the support of my pastor and my girlfriend at the time. My pastor made so much time for me — he always checked in, counselled me about so many things, listened to me, helped me out with food and care packages. Our church—my girlfriend and I went to the same one—became my real home.

I'd secretly known I was trans for a long time, but I was too scared to do anything about it. I grew up hearing all the terrible things that get said about gay folks in churches, and I'd lain awake at night for years trying to work out if God had a place for me, if I could ever really be forgiven or if my sin was too great for God to love me.

When I — utterly terrified — finally told my pastor I was trans and asked him if there was any hope for me, his tone didn't really change. He'd always been worried for me, and he stayed as gentle and kind as he'd always been. But gently, kindly, he told me that queerness was a kind of spiritual brokenness, and I needed to be healed—and it was part of his calling to help me find my way back to 'what God intended' for me.

To have the main authority and parental figure in my life tell me that who I was was fundamentally wrong, and corrupted by the Devil? Saying out loud all the things my anxiety and depression had been saying inside my head? I can't explain what that felt like. Multiple times a week, we would have one on one 'bible studies' that were all about convincing me to change my sinful heart and let God heal me. The other emotional and material help my pastor had been giving me all stopped.

My girlfriend got taken in for compulsory 'faith counselling', too. They told her she had to break up with me, that she wasn't the right person to guide me back to righteousness, and that if she wanted to stay at that church she wasn't allowed to talk to me or sit with me during services any more. She needed the church community, so she stopped talking to me. I don't blame her.

A month into my 'rehabilitation' I tried to kill myself. I left the church after that.

I actually tried to kill myself a few times over the next few years. I guess I was pretty bad at it.

I'd like to say I'm all better these days, but I'm not. I'm still totally fucked up. I can't hold

down a relationship. My faith is a source of constant pain. I'm scared of Christians, but I am a Christian still, so I can't practice my own faith. I feel safest around other queer people who hate Christianity because of how it's treated them, but then, I end up feeling like they hate that part of me and I have to keep that secret. I can't be my whole self anywhere. Deep down I think I still believe I deserve to suffer.

I don't know if things will ever get better for me. But any laws that could stop that happening to someone else are a good thing as far as I'm concerned.<sup>684</sup>

- C.4.13. One respondent noted how his voluntary participation in conversion practices occurred over a number of years in different ways, such as online conferences, private 'counselling', group prayer and training retreats which were costly emotionally and financially:

I even participated in a 10-week course with [a conversion practitioner] via Skype sessions when I was living in Launceston. In 2012 and 2013, [an] international 'ex-gay' leader [name redacted] visited [Tasmanian town — redacted] for conferences ... [The Speaker used] terms like 'sexual brokenness'. Regardless, these conferences were run as conversion gatherings, focussing heavily on all aspects of conversion practices and ideology outlined in the TLRI issues paper. Between 2009 to 2013, I was introduced to, and met with, members of [struck] three times for the purpose of prayer ministry. I was desperate for healing and wholeness, and drove from Launceston to a house in South Hobart ... where I underwent nine hours of prayer ministry, including an exorcism, in the hope of healing from my same sex attraction. Two years later, I again met for prayer ministry that lasted five hours at a church in [struck — Launceston suburb] with members of this group, and finally in 2013, I drove up to [struck — reference to rural town] to have 2.5 hours of prayer ministry, all in the hope of finding healing. Each time I was urged by the leadership in this group to attend training weekends that were very costly, and I didn't have the money, and when I reached out a fourth time for prayer, it was suggested I do the weekend training retreat, where I could also receive prayer, but my delay to find the finances meant I missed out as they were 'booked out', and I never contacted them again. In 2013–2014, I would drive from Launceston to [Hobart suburb] to see a Christian counsellor [who] used prayer ministry and talk therapy to try to deal with the issues in my life, including the 'underlying issues' behind my same-sex attraction. This was, obviously, not successful.<sup>685</sup>

- C.4.14. Other submissions noted the prevalence of camps and retreats that espoused conversion ideology

<sup>684</sup> Submission 121.

<sup>685</sup> Submission 105\*.

I had been exposed to LGBTQA+ conversion ideology (see SOGICE Survivor Statement) from a very young age. The messages about ‘gay people’ that I received over many years convinced me that LGBT+ people were perverted and suffered from a broken form of sexuality. These messages were present in my home life, my (Christian) school-life and my church life. By the time I was in junior high school, I strongly believed that I was ‘broken’ and possibly demon-possessed, which was terrifying[,] ‘came out’ to my pastor at 16, who told me that he knew people who had been ‘healed’ of homosexuality and that he would introduce me to them. I already believed I needed to be healed, so I was more than willing to go along with anything that I thought may ‘fix’ me. Whilst I waited for these meetings, I went to an informal Christian counselling session through a church, which involved discussing my sexual orientation and my desire for healing, as well as past trauma and relational issues to determine possible influencing factors in my sexuality ... In the Summer of 2003, when I was 17, my parents took our family to an isolated village in Tasmania to complete a week-long Christian ‘course’ (not an ex-gay course). I was not happy to be there, as I had been trying to accept my sexuality for roughly four months and felt that I would be discriminated against in such a community. The leaders of the organisation that ran the course (and the village) heard that I was gay and I was approached by one of them. They told me that they would allow me to participate in the course but that I would have to keep my sexuality a secret. I hazily recall them telling me that the view of the organisation was that homosexuality was a sin and that it was not God’s plan for my life. I was given the choice to join in and comply or to hang around the village on my own for the week whilst everyone else in the village participated in the course (it was nowhere near a town and I had no transport). I decided to join in ... The next year, I moved to Tasmania to live in the same Christian community and study a Certificate 4 in Youth and Community Work (Christian), which was seen by the organisation as an extension of the short course my family and I had 18 months earlier. I wish to make clear that neither course was an ‘ex-gay course’. I lived in Tasmania for six months. During that time, I was informally exposed to what SOGICE Survivors refer to as ‘conversion ideology’ — claims about the nature of LGBTQA+ people or identities (including sexual brokenness, dysfunction or sickness etc), or about the ‘cause’ of LGBTQA+ identities (including past trauma, abuse, sin, etc). was not well — I suffered crippling anxiety and obsessive religiosity. I believed that my life couldn’t truly begin until my homosexuality was gone. [These] were self-directed efforts that were a result of years of exposure to conversion ideology and the subsequent inner belief that I was broken, sick, perverted, dysfunctional and that I needed to seek healing for that. I became aware of other ‘ex-gays’ in Tasmania who had also been exposed to the same ideology. Some were married

or in heterosexual partnerships and were not open to discussing it. This indicated to me that the ‘ex-gay’ movement was absolutely present in Tasmania.<sup>686</sup>

- c.4.15. One Tasmanian clinical psychologist stated that some of their clients encountered SOGI conversion practices within religious educational institutions:

I have also assisted young people who have been advised by members of the Catholic education system that they require counselling within the church to ‘address their confusion’. Language is a subtle form of conversion that needs to be addressed within our medical and education system.<sup>687</sup>

- c.4.16. Finally, other submissions suggested the long history of these practices in Tasmania. A prominent Tasmanian LGBTQA+ activist gave his account of the history of SOGI conversion practices, both through his own experience and the stories of others:

As I came out in the late 1980s, I quickly became aware of aversion practices based on behaviouralist ideas about operant conditioning. Older gay men passed down stories of aversion practices, including electric shock treatment, inflicted on them in the 1960s and 1970s. I also became aware of the subsequent generation of change and suppression efforts - ex-gay groups like Exodus International - which relied less on behaviouralism and more on pseudo-psychoanalysis and Bible study ... A person with whom I had a pre-existing relationship sought to persuade me to undergo conversion practices through their church. They provided personal testimonies of other people we knew who were now ‘ex-gay’. I am fortunate that I firmly believed my sexual and romantic orientation was natural, fixed and unchanged-able so the approach did not cause me any inner conflict or distress. But I can imagine how difficult it would be for people who are unsure why they are same-sex attracted, feel shame about it, and are approached by people in authority they respect or rely on. ... ‘For a Caring Tasmania’ was established in Launceston, based chiefly in the Baptist Church ... In the early 1990s it hosted more subdued rallies against decriminalisation. It also hosted a conversion conference in the northern suburbs of Launceston where high-profile American ‘ex-gays’ spoke about their ‘escape from the homosexual lifestyle’.

...

My chief contact with conversion practices is now through those Tasmanian survivors who have contacted me and provided me with details of their experiences. There are several notable patterns within this personal testimony: Overwhelmingly survivors are under 30, have been part of evangelical Protestant, or traditionalist Catholic or Orthodox

<sup>686</sup> Submission 111\*.

<sup>687</sup> Submission 159\*.

congregations, and have worshipped in an environment saturated with conversion ideology and with antagonism to LGBTIQ+ equality.<sup>688</sup>

- C.4.17. Other community organisations, such as Relationships Australia Tasmania, stated that their clients had reported experiences of SOGI conversion practices in informal religious settings that aimed at developing core beliefs that their sexuality was ‘evil or defective’.<sup>689</sup>
- C.4.18. Another anonymous respondent submitted an anonymous account of a person who stated ‘I spend time regularly in Tasmania. If I cannot find the ongoing help and support I need there as a result of changes in law relating to therapy then I, like others, will have to cease doing work and visiting there’,<sup>690</sup> suggesting that that person is involved in conversion practices when they visit Tasmania.

### Conversion among Tasmanian healthcare practitioners

- C.4.19. Some submissions reported SOGI conversion practices by medical professionals in Tasmania. These included psychiatrists, psychologists and hospital staff subjecting clients/patients to undertake medical intervention, hospitalisation, or misdiagnosis for the aim to suppress or change their sexual orientation or gender identity.<sup>691</sup> These experiences have occurred to people across varying ages and stages of their lives. Some of these practices occurred several decades ago. For example, one respondent reported a historical experience of SOGI conversion practices from more than three decades ago:

At the age of 16 I had a huge crush on a girl at school. I was sent for hypnotherapy to ‘support me through my confusing time’ ... I had 8 sessions. She had said that gay people are harmful to children and it is part of their gay agenda to recruit young people to their way of life.<sup>692</sup>

- C.4.20. A relatively recent experience of a psychologist offering conversion to a client for their sexuality and gender was provided by a respondent:

My last psychologist told me that being agender and asexual was ‘fundamentally wrong’ and suggested that I start treatment for it, despite never telling me what that ‘treatment’ involved. I was made to feel like my identity and sense of self was something unusual or perverse... [they] told me that I should start treatment to ‘fix’ my sexuality and gender

<sup>688</sup> Submission 113.

<sup>689</sup> Submission 85.

<sup>690</sup> Submission 110\*.

<sup>691</sup> Submissions 180\*, 126C, 159\*, 161\*, 163\*.

<sup>692</sup> Submission 130\*.

identity. I refused but felt very pressured in the next 4 sessions that we had. It was because of this that I stopped seeing her and have moved to another doctor[']s care.<sup>693</sup>

- c.4.21. Another submission reported that a psychologist had offered cognitive behavioural therapy to ‘treat’ their report of being transgender, which led to them stopping treatment for mental health issues and being reluctant to seek treatment in the future:

I have been offered (but not accepted) forms of SOGI conversion practices in Tasmania ... I was seeing a local psychologist for mental health stuff and came out to them as trans. The psychologist then offered me CBT [cognitive behavioural therapy] to ‘make it go away’. I declined and changed psychologists. That hurt a lot and made me feel unsafe. It stopped me accessing any mental health care for a while, because I was afraid the next psychologist would try to ‘cure’ me as well.<sup>694</sup>

- c.4.22. Transforming Tasmania’s anonymised accounts of the experiences of people with SOGI conversion practices in Tasmania, included ‘Rae’, whose psychiatrist also offered cognitive behavioural therapy to ‘treat’ her nonbinary status

Shortly after I came out to myself as nonbinary, and started coming out to the world, I was dealing with a lot of depression-not from my identity, but from unrelated health and disability issues. I saw a psychiatrist to try and get some help.

After we did introductions in the first session, the psychiatrist immediately started in on me. ‘You’re not transgender. Nonbinary isn’t a real thing; that’s just a mental illness. You’re damaged, and what you need is therapy and then you’ll realise you’re just a girl who’s attention-seeking because you need to feel special.’

The psychiatrist put me on a course of CBT [cognitive behavioural therapy] to try and ‘train’ me back towards being cis and straight. When it didn’t seem to be working, he told me I was deliberately deluding myself and that I wasn’t trying hard enough, that I didn’t want to ‘get better’. At the time, I was devastated by it all, but the full damage of it didn’t really become clear to me until years later. I’m still unpicking it. I had never before, and have never since, been so systematically undermined and invalidated and traumatised by someone who was meant to be helping me. When I told my dad about what had happened — a man of fierce and fearless Christian faith — he cried, because of how they’d hurt me. The next couple of years after that were a hellish storm of suicidality.

Although religion was never mentioned, I definitely got the sense that he was operating from a religiously conservative moral framework. I bounced between protestant denominations until I was fifteen, and I remember what it felt like. When I told people I

<sup>693</sup> Submission 163\*.

<sup>694</sup> Submission 180\*.

knew about what the psychiatrist had done and said, everyone said, ‘Surely they can’t do that. That’s so wrong.’ But what could I do? As far as I knew at the time, the psychiatrist was within his rights to say and do that. I know now that he wasn’t, but even then, all I could have done would be to make a complaint to the regulatory body. At which point it’s his word against mine, on a very poorly defined issue... and here I am, someone whose mental illness is defined entirely by the way he, the respected medical professional, describes it. That sort of power dynamic is basically insurmountable.

I didn’t go back to a psychiatrist for years after that, even though I needed to. Eventually I was forced to, after a couple of instances of becoming so suicidal I had to go to the ER [emergency room]. By that point, I’d finally just managed to start HRT [hormone replacement therapy], but was having a lot of trouble coming to terms with it because part of me still believed what that first psychiatrist had tried to train me to—that my transness wasn’t real, that I was just wrong and broken and attention-seeking.

The new psychiatrist I was referred to told me she wouldn’t review my medications or treat me unless I stopped taking my HRT. At least that time it made me so angry I walked out and decided I was going to live, if only out of spite to prove her wrong. She made it clear that my stopping being trans was more important than making sure I was going to survive.

I really believe that if there had been legislation explicitly banning conversion practices, with real and meaningful penalties, it wouldn’t have happened to me like it did—or if it still had, I would have had far more of a chance to do something about it.

I know who I am now. Frankly I’m shocked I made it this far, though. And I’m so scared of psychiatrists that I can’t engage with them properly, which has caused me a lot of problems trying to deal with my other health issues. Hopefully that bit won’t kill me in the long run.<sup>695</sup>

- C.4.23. Some submissions presented accounts of SOGI conversion practices appearing in more subtle, suggestive ways.<sup>696</sup> For example, the clinical psychologist noted above stated that some of their clients have experienced both overt and subtle forms of SOGI conversion practices in medical settings in Tasmania:

I have also supported young people who have been advised by general practitioners that their questions relating to their gender are ‘ridiculous’ and to ‘stop just trying to be part of a trend’. These comments are extremely concerning as they have resulted in an increase in suicidal ideation for the young person and a reluctance to access medical care when needed.<sup>697</sup>

<sup>695</sup> Submission 121.

<sup>696</sup> Submissions 122, 126C, 159\*, 163\*, 173\*, 111\*, 121.

<sup>697</sup> Submission 159\*.

## Survivor experiences

C.4.24. As noted in the accounts above, respondents who had been exposed to conversion practices reported a range of harms.

10.3.9. These negative effects included community-related harms, such as:

- a loss of trust in religious leaders and other congregants;<sup>698</sup>
- a loss of emotional and/or material support from a religious community;<sup>699</sup>
- threatened, feared or actual exclusion from a religious community;<sup>700</sup>
- an inability to feel comfortable or accepted in a religious community;<sup>701</sup>
- problems with/distancing self from families, (religious) communities or intimate relationships;<sup>702</sup>
- a loss of trust in medical practitioners and/or feeling reluctant to seek medical advice for fear of further exposure;<sup>703</sup>

10.3.10. Negative effects also included individual harms, including some extremely serious physical and mental health effects:

- a loss of self-worth or low self-esteem;<sup>704</sup>
- self-hatred;<sup>705</sup>
- alcohol and drug abuse;<sup>706</sup>
- risky sexual behaviour;<sup>707</sup>
- depression;<sup>708</sup>
- anxiety;<sup>709</sup>
- emotional distress, trauma, harm or hurt;<sup>710</sup>
- feeling unsafe,<sup>711</sup> invalidated, traumatised or undermined;<sup>712</sup>

<sup>698</sup> Submissions 42 at 4, 121 ‘Ben’.

<sup>699</sup> Submission 121 ‘Chloe’.

<sup>700</sup> Submissions 85 at 9, 93 at 10, 121 ‘Ben’.

<sup>701</sup> Submission 121 ‘Ben’.

<sup>702</sup> Submissions 37 at 6, 42 at 4, 85 at 9, 148\*, 167, 168, 179\*.

<sup>703</sup> Submissions 1C, 92 at 21, 180\*, 1C.

<sup>704</sup> Submissions 42 at 4, 121 ‘Ben’, 169, 179\*.

<sup>705</sup> Submissions 42 at 4, 121 ‘Ben’, 177.

<sup>706</sup> Submission 121 ‘Ben’.

<sup>707</sup> Submissions 85 at 9, 121 ‘Ben’.

<sup>708</sup> Submissions 42 at 4, 85 at 7, 121 ‘Chloe’, 169, 179\*.

<sup>709</sup> Submissions 42 at 4, 85 at 7, 111\*, 121 ‘Chloe’, 169, 179\*.

<sup>710</sup> Submissions 1C, 85 at 7, 92, 119, 120, 121, 126C, 129\*, 168, 169, 179\*, 180\*.

<sup>711</sup> Submission 180\*.

<sup>712</sup> Submissions 85 at 9, 121 ‘Rae’, 1\*.

- exacerbation or compounding of pre-SOGI conversion practice mental health issues;<sup>713</sup>
- suicidal ideation;<sup>714</sup> and/or
- suicide attempts, and suicides by friends or loved ones.<sup>715</sup>

C.4.25. A first strong theme was feeling lost, betrayed or scared because of a loss of faith in religious or medical authorities. Some respondents who had encountered SOGI conversion practices from medical practitioners suggested they were reluctant to seek return to treatment for other mental health problems. Those who were exposed to conversion practices in faith-based communities reported fears or threats of being excommunicated from their church and cut-off from people they love for because of their sexual orientation or gender identity. Respondents gave examples of being persuaded to suppress their sexual orientation or gender identity if they wanted to remain connected to their faith-based community and relationships. One respondent who was raised Mormon, expressed these difficulties:

Very repressed about any sexuality. Lots of pressure to get married and start a family. There was a need to confess any sexual sins (including thoughts) in order to be able to be considered worthy before God ... I am aware that religious groups offer to run prayer groups and guided support to people whether or not they want to change. The opportunity to participate in a strong, welcoming, loving religious community is very appealing but to be a part of that, you have to renounce LGBTIQA behaviours, including thoughts.<sup>716</sup>

C.4.26. Submissions from friends and relatives of survivors also made comments on harm. One submission expressed sadness when discussing how they assisted a young man who attempted suicide due to the harm caused by conversion practices, suggesting that while parents and those in faith communities often want to ‘support’ others, this can come at a great cost to those people, in particular a loss of trust and faith and connection to their faith communities:

[they used] religious and superstitious practices (ie ‘witchcraft’) to have their son ‘cured.’ This included an exorcism. The damage that the young man received at the hand of this was considerable. His faith journey and fundamental beliefs were destroyed.<sup>717</sup>

C.4.27. Conversion practices were presented as services that could ‘heal’ an individual of a perceived brokenness or deficiency, which positioned the individual as central to its effectiveness, and when those practices were ‘unsuccessful’, this was the fault of the individual. This aligns with the clinical reports on feelings of worthlessness and hopelessness from the non-efficacy of

<sup>713</sup> Submissions 1C, 121 ‘Rae’, 168.

<sup>714</sup> Submissions 92, 121 ‘Chloe’ and ‘Rae’, 177, 179\*.

<sup>715</sup> Submissions 93 at 17, 121 ‘Chloe’, 123, 126C, 129\*, 159\*.

<sup>716</sup> Submission 148\*.

<sup>717</sup> Submission 173\*.

SOGI conversion practices, leading these respondents to blame themselves. This was most salient in the common occurrence of prayer ministry, deliverance, and exorcisms.<sup>718</sup> For example:

I was involved from the age of 16–36 with churches in the Launceston area ... through many years I went through many different types of conversion therapy from counselling, prayer groups. Exorcism through prayer by strong Pentecostal believers that i had demons and the only way that I can rid myself was to have them prayed out. That would involve multiple sessions hours on end, with shouting, shaking and making the ‘demons’ manifest, call them by their names and try to rip them out of my being. None of this of course worked and i was blamed and told that it was my fault that you were not delivered of the demons. ... Over the years i was subjected to different forms of spiritual abuse, from counselling in many different forms, lectures, ostracized to full on: ‘having demons’ expelled from my body in which ever form that the particular movement believed in. This would occur over may sessions, i only did it to want to do the right thing. When it did not work i was pushed aside, ostracized and told i was going to burn in hell unless i stop living this ‘lifestyle. It’s been 14 years since i attend a church. I am now 50 it has scarred me emotionally suffer anxiety and depression which i can trace back to these practices, when i was in the midst of it and played the game and spoke the mantra i knew no different i had been brainwashed and it still affects me in ways today in my daily life.<sup>719</sup>

C.4.28. Tasmanian community and counselling services provided reports of negative harm from SOGI conversion practices on their clients. Some submissions went into considerable detail, whereas other submissions simply stated that their practice has ‘consulted extensively with survivors of conversion practices’.<sup>720</sup> For example, Relationships Australia Tasmania stated:

SOGI conversion practices not only do not achieve their stated aims. but are harmful. with survivors experiencing severe anxiety, depression, guilt. and shame. ... As a counselling service, RA Tas has seen the impact of SOGI conversion practices on staff and clients. [including] long-lasting depression, anxiety and trauma, guilt and shame about their sexuality or gender identity , dissociating or suppressing their identity and sexuality (which may result in a belief that they are cured, but in a belief that they are cured, but ultimately has the same traumatic impact as any other form of dissociation), and a resulting impact on the ability to seek, build and sustain healthy interpersonal relationships. Additional

<sup>718</sup> Submissions 85, 93, 165, 173\*.

<sup>719</sup> Submission 165.

<sup>720</sup> Submission 91.

observations in other contexts include outcomes of individuals undergoing conversion therapy engaging in compulsive and unsafe sex as a response to trauma symptoms.<sup>721</sup>

c.4.29. Conversely, a small number of submissions reported positive results from SOGI conversion practices, stating that they worked or have been successful for them. For example, one submission by an anonymous person outside of Tasmania who operates a conversion practices website submitted a series of ‘success stories’:

- ‘I learnt to look more deeply into my history and to own the dysfunction, trauma and brokenness for what it really was, and to permit myself to gently enter onto a pathway of healing, conversion and restoration. The Christian Churches were the only ones that would support me ...’
- ‘My heart is miraculously changing thanks to ongoing therapy and prayer. I am being fine-tuned into the man that I now see I was created to be. I am now reaping the benefits of pursuing purity and being affirmed by God ... In place of wearing makeup and doing drag, I now embrace my true identity as a man ... Where I was highly promiscuous and sexually depraved, I now pursue chastity and others’ dignity’<sup>722</sup>

c.4.30. Respondents who supported conversion practices also mentioned the methods of prayer, ‘talk therapy’, ‘reparative therapy’ and counselling to ‘fix’ or ‘heal’ sexual brokenness and perversion to ‘embrace’ heterosexuality and cisgender identity through the suppression of sexual urges that were reported by respondents who had negative experiences with SOGI conversion practices.<sup>723</sup>

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<sup>721</sup> Submission 85.

<sup>722</sup> Submission 110\*.

<sup>723</sup> Submissions 7, 27, 34, 44, 53, 69\*, 71, 83C, 99, 109C, 110\*, 102\*.

## C.5. Question 4: Is Law Reform Necessary?

**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)?**

### Support for law reform

- C.5.1. Comprehensive law reform was supported by 61<sup>724</sup> submissions and 377 petition signatures.
- C.5.2. Respondents in favour of law reform advocated for either a stand-alone law that targets SOGI conversion practises specifically, or a combination of new legislation and amendments to existing statutes to capture a broad spectrum of conversion practices.
- C.5.3. Some responses stated that any legislation that aims to respond to SOGI conversion practices must take a human-rights approach<sup>725</sup> and/or be accompanied by strategies outlined in the SOGICE Survivor Statement.<sup>726</sup> This was because survivor experiences were crucial in understanding the nature of conversion practice methodologies and focusing on those experiences would ensure that legislation is appropriately constructed to address SOGI conversion practices as experienced by survivors.<sup>727</sup>
- C.5.4. Other submissions suggested that law reform should be focused on harm and severity and be adjusted accordingly.<sup>728</sup> A small number stated amending existing laws alone was appropriate.<sup>729</sup> Ten respondents advocated for a hybrid approach.<sup>730</sup> A further 10 urged comprehensive law reform.<sup>731</sup>
- C.5.5. The most common suggestion was a standalone form of legislation, with 19 submissions specifically stating this was the best cause of action.<sup>732</sup> Respondents who were supportive of law reform by a standalone statute believed that these practices were deeply harmful and that current legislative frameworks were inadequate for preventing these practices from occurring.

<sup>724</sup> Submissions 4, 5, 10, 18, 37, 38, 40\*, 42, 58, 67, 79, 80, 82, 85, 86, 89, 90, 91, 93, 94, 104, 105\*, 111\*, 113, 115, 117, 118, 119, 120, 121, 122, 124C, 127, 129\*, 130\*, 131, 134\*, 135\*, 138\*, 150, 153\*, 154\*, 156, 157\*, 158C, 159\*, 161\*, 162, 163\*, 164\*, 165, 167, 168, 169, 170, 173\*, 175, 177, 179\*, 180\*, 182\*.

<sup>725</sup> Submissions 121, 177, 4, 5, 80, 91, 104.

<sup>726</sup> Submissions 91, 93, 111\*, 167.

<sup>727</sup> Submission 42.

<sup>728</sup> Submission 119.

<sup>729</sup> Submissions 130\*, 168, 169.

<sup>730</sup> Submissions 82, 91, 124C, 129\*, 130\*, 153\*, 154, 157\*, 163, 182.

<sup>731</sup> Submissions 10, 37, 38, 42, 89, 104, 118, 120, 150, 179\*.

<sup>732</sup> Submissions 93, 94, 111, 115, 117, 121, 122, 127, 131, 159\*, 162, 164\*, 165, 167, 170, 173\*, 175, 177, 180\*.

## Current laws are inadequate

- C.5.6. A key drive for those advocating legislative change was due to current legislation being insufficient in scope to suspend, criminalise or dismantle conversion practices.<sup>733</sup> For example, a representative from Women’s Health Tasmania stated:

Tasmanian law is currently inadequate to deal with the issue of SOGI conversion practices. Our discussions with survivors of SOGI conversion practices about this experience and a review of survivor testimonies reinforces for WHT the veracity of the Institute’s conclusion that current law is not appropriately directed and tailored to the nature and scope of SOGI conversion practices. We therefore support comprehensive reform.<sup>734</sup>

- C.5.7. Other submissions expressed dissatisfaction with current legislation because there were no clearly defined protections in place for LGBTQA+ people from these practices and the government should take responsibility to address this.<sup>735</sup> One respondent stated that they did not believe there is any existing legislation that could address conversion practices.<sup>736</sup> More generally respondents explained why current legislation is ineffective and how it could be improved in their responses to Questions 5–8.

## SOGI conversion practices are harmful and morally wrong

- C.5.8. Those who were supportive of comprehensive law reform frequently drew from their personal or religious codes of ethics to frame SOGI conversion practices as harmful or morally wrong.<sup>737</sup> Among these were religious leaders and practitioners who supported law reform.<sup>738</sup> These responses included the voices from members of the public whose perspective represented broad community attitudes towards these practices. For example, medical practitioners and religious leaders who advocated for law reform shared similar views that conversion practices are inherently harmful. A respondent who identified as Presbyterian, stated:

Restricting or banning practices which are known to cause serious harm to people does not undermine human rights, it promotes human rights. Religiously framed SOGI conversion practices, whether they are expressed through prayer or practices of discipleship or spiritual counselling, are expressions of beliefs which have been scientifically discredited and proven to be harmful to people. They are a form of spiritual abuse. In Christianity, they are

<sup>733</sup> Submissions 38, 94.

<sup>734</sup> Submission 37.

<sup>735</sup> Submissions 85, 104, 119, 148\*.

<sup>736</sup> Submission 170.

<sup>737</sup> Submissions 4, 5, 40, 94, 110, 105\*, 116, 129\*, 131, 134\*, 135\*, 138\*, 153\*, 156, 157\*, 163\*, 164\*, 165, 169, 173\*, 180\*.

<sup>738</sup> Submissions 110, 94, 105\*, 129\*, 131, 134\*, 135\*, 138\*, 153\*, 156, 157\*, 163\*, 164\*, 165, 169, 173\*, 180\*.

antithetical to the fundamental theological affirmations that all people are made in the image of God and that Jesus calls us to love each other without distinction. Banning such practices will challenge some whose religious beliefs include an understanding of LGBTQA+ people as sinful or broken but it will not harm them. It will, however, serve to protect LGBTQA+ people from harm.<sup>739</sup>

- C.5.9. Representatives across different medical bodies shared similar views in areas of mental health and general practice. For example, one general practitioner stated: ‘I do not believe conversion practices are ethical, evidenced based, helpful or lawful and should be made unconditionally illegal given the inherent pathologisation of sexual and gender diversity.’<sup>740</sup> An Associate Professor who specialises in the area of public health declared conversion practices as a ‘threat to health’ because of the immense harm these practices cause survivors.<sup>741</sup> A representative from Mental Health Council of Tasmania stated:

The processes of SOGI conversion practices have been recognised by psychological bodies as having no evidence to support change in sexual orientation and can cause psychological harm leading to self-harm, mental ill-health and subsequent economic disadvantage. For these reasons, MHCT suggests that SOGI conversion practices should be banned.<sup>742</sup>

- C.5.10. Members from community, social welfare and political advocacy groups alike drew heavily on harm, morality, and personal experiences with those who have suffered greatly from conversion practices to justify comprehensive law reform.<sup>743</sup> For example:

In light of the extensive and grievous harms caused by conversion practices to both survivors and their communities, based on false assertions and exercised in contravention of basic rights and dignity, there should be no question of permitting the practices for any person in any form.<sup>744</sup>

- C.5.11. There was a general consensus that comprehensive law reform, in whatever form this may take, would send a strong message to the community that conversion practices are unlawful and do not align with community expectations and values.<sup>745</sup>

## Support for a standalone act

<sup>739</sup> Submission 4.

<sup>740</sup> Submissions 40\*, 67.

<sup>741</sup> Submission 82.

<sup>742</sup> Submission 10.

<sup>743</sup> Submissions 58, 80, 82, 85, 86, 89, 124.

<sup>744</sup> Submission 80.

<sup>745</sup> Submissions 113, 104, 117, 119, 121, 175.

C.5.12. Submissions that supported a standalone act indicated that this approach would help capture the breadth and depth of how conversion practices are conducted.<sup>746</sup> Several respondents suggested that amending existing legislation would be too limiting. For example, amending public health laws alone would not protect LGBTQA+ people for informal, non-medical and/or religious settings, nor would amendments to the *Anti-Discrimination Act* be appropriate, as not all practices involve humiliation, intimidation, or ridicule.<sup>747</sup> The suggested advantage of a single statute was to provide the public with purposeful legislation, a comprehensive legal definition of conversion practices and the ability to outline exceptions to the offence or defences, whilst also sending the strongest possible message that conversion practices are unlawful and against human rights.<sup>748</sup> A single statute was viewed as the most comprehensive and well-equipped form of legislation which would be tailored to directly manage culturally embedded and systemic forms of conversion beliefs and practices, covering both broad and context-specific cases of conversion practices.<sup>749</sup>

## Opposed to law reform

- C.5.13. Ninety respondents were opposed to reforming the law to address SOGI conversion practices.<sup>750</sup> The main reason given by these respondents was that there is a lack of evidence that conversion practices have previously or currently occurring in Tasmania, and that there is therefore no need for any form of legislative change. Conversely, if they were occurring in Tasmania, any existing laws were appropriate to address them. Lastly, some of those opposed to law reform stated that they believed that any legislative change would infringe on religious freedom of expression and association, secular freedom of expression of views around gender identity (commonly known as ‘gender critical’ views), and/or parental decisions involving their children. Most of these responses were combined with or predicated on a narrow definition of SOGI conversion practices that limited them to physically abusive acts only. Any definition of SOGI conversion practices that included non-physical practices like prayer or speech would unduly limit freedom of (religious) expression.
- C.5.14. Notably, no respondent who opposed law reform around SOGI conversion practices did so on the basis that SOGI conversion practices are not harmful. Some respondents queried whether

<sup>746</sup> Submissions 94, 115, 122, 167.

<sup>747</sup> Submission 124C.

<sup>748</sup> Submissions 112, 113, 121.

<sup>749</sup> Submission 37.

<sup>750</sup> Submissions 2, 3, 7, 8, 9, 11, 12, 13\*, 14, 16, 17, 19, 20, 21, 22\*, 23\*, 24\*, 25, 26\*, 27, 28\*, 29C, 30, 31\*, 32, 33\*, 34\*, 35\*, 36, 39, 41, 43\*, 44, 45\*, 46, 48, 50, 51, 52, 54\*, 56, 57, 60\*, 61, 62, 63\*, 64\*, 65, 66, 67, 68\*, 69\*, 70\*, 71, 72, 73, 74, 76\*, 78\*, 81, 83C, 84\*, 87C, 88C, 95\*, 96C, 97, 99, 100\*, 101\*, 102\*, 103\*, 106, 107, 108, 109C, 110\*, 112\*, 116, 125, 133\*, 136\*, 137\*, 139\*, 141\*, 142\*, 143\*, 144C, 145\*, 146C, 147C, 149C, 152\*, 166\*, 171\*, 172\*, 176\*, 181C, 183\*.

gender identity conversion practices were harmful, and impliedly argued against law reform in relation to them for this reason.<sup>751</sup>

- C.5.15. Many of the submissions opposing law reform stated that the TLRI had already recommended or supported criminalisation of SOGI conversion practices. That was not the case. The Paper contained arguments for why Tasmanian law does not cover all forms of conversion practices, and possible options for responding to SOGI conversion practices, including no reform at all (this was set out in the wording of Question 4 itself). Those points were the basis for the community consultation discussion, not recommendations, support for or a conclusive statement that the law should be reformed or what form that reform should take.

### **Lack of evidence**

- C.5.16. Many who were opposed to law reform stated there was a lack of clear evidence that SOGI conversion practices had previously or are currently occurring in Tasmania. On this basis, respondents believed there was no need for dedicated legislation to address these practices. One respondent provided a view typical of many, stating:

I believe there are no current harmful practices in Australia, such as chemical castration as a form of ‘gay conversion therapy’, there is therefore no need to pursue this matter.<sup>752</sup>

- C.5.17. Another respondent stated that any new law on SOGI conversion practices would be ‘unnecessary and unasked for’.<sup>753</sup> Respondents who shared this sentiment almost always referred to conversion practices as historical, outdated practices which were once targeted at homosexuality but do not exist currently.<sup>754</sup> For some, the lack of evidence was combined with a claim that there are ‘more serious issues’ for the community and that this was a ‘waste’ of government time and resources.<sup>755</sup>

### **Existing laws are appropriate**

- C.5.18. Many of those opposed to law reform also stated that current laws were sufficient to address conversion practices and as such, there was no need to introduce new laws or amend current legislation. Some believed existing laws were appropriate stated that they addressed ‘abuse’ or ‘abusive practices’, without further elaboration.<sup>756</sup>

<sup>751</sup> Submission 18.

<sup>752</sup> Submission 14.

<sup>753</sup> Submission 172\*.

<sup>754</sup> Submissions 7, 14, 28\*, 31\*, 33\*, 41, 65, 69\*, 71, 73, 74, 78\*, 81, 144C, 152\*, 172\*, 183.

<sup>755</sup> Submissions 12, 74, 152\*.

<sup>756</sup> Submissions 33\*, 41, 69\*, 71, 76\*, 78\*, 141\*, 172\*.

- C.5.19. A small number of respondents referred to specific laws, such as the *Criminal Code* as already prohibiting SOGI conversion practices akin to assault or torture, or the *Anti-Discrimination Act*. A small number of respondents also stated that any amendments to the law would be ‘draconian’ or unnecessarily intrusive.<sup>757</sup>

## Parental rights

- C.5.20. Several respondents were concerned that any proposed legislation that targeted SOGI conversion practices would restrict parent–child relationships.<sup>758</sup> Many of these statements were connected to the respondent considering the definition of SOGI conversion practices in Question 1 as too broad. Some respondents expressed concern that any change in the law might cover conversations between parents and their children, with particularly frequent mention of children who are or might be gender dysphoric. One submission encapsulates this fear:

Parents should be able to make decisions on behalf of their dependent children. To avoid the risk of criminalizing ordinary Mums and Dads and creating legal pressure for them to encourage children into significant and life-altering treatment (even when this is not the right course of action), parents should be entirely exempted from any proposed legislation.<sup>759</sup>

- C.5.21. Those who were concerned about parental rights viewed legislation against SOGI conversion practices as a considerable infringement on parental–child relationships and privacy, as they believed conversion practices would include ‘discussions’ or ‘conversations’ about gender and sexuality within the home.<sup>760</sup> This can be illustrated by one respondent who stated:

There is no demonstrable need in Tasmania for legislation which at its worst, will criminalise conversations parents have in their homes with their children.<sup>761</sup>

- C.5.22. Many submissions did not explicitly mention parental rights when responding to Question Four on law reform, but instead made this point elsewhere in their response. These were often connected to views on parental ‘rights’ to raise children in accordance with particular religious values. For instance, ‘[t]here should not be anything which forbids parents or religious authorities teaching faith constructed morality to their children and others’.<sup>762</sup> Similarly: ‘[o]f equally great concern is the propensity for conversion laws to lead to the idea that loving parents are abusive if they do not affirm a non-conforming gender change with their children.’<sup>763</sup>

<sup>757</sup> Submissions 17, 31\*, 81.

<sup>758</sup> Submissions 2, 13\*, 23\*, 24\*, 26\*, 32, 39, 44, 54\*, 56, 65, 68\*, 67, 70\*, 84\*.

<sup>759</sup> Submission 68\*.

<sup>760</sup> Submissions 13, 16, 32, 69\*, 70\*, 77\*, 124, 141\*, 147C.

<sup>761</sup> Submission 70\*.

<sup>762</sup> Submission 13\*.

<sup>763</sup> Submission 68\*.



## Religious freedom

c.5.23. Most respondents who were opposed to law reform stated that restricting or banning SOGI conversion practices would infringe on their everyday religious practices. Some respondents felt that law reform would impinge on religious freedom generally or as part of an agenda to actively persecute religious people,<sup>764</sup> including, for example, concerns about how the law might restrict or regulate daily religious activities like ceremonies, masses, sermons or prayers,<sup>765</sup> or the criminalisation of prayer, preaching or the Christian Bible itself:

Will a consequence of SOGI conversion practice legislation be that the Bible is considered to be a ‘false publication’ which ought somehow to be proscribed? That seems to be the direction of the Issues Paper.<sup>766</sup>

c.5.24. One respondent provided a statement that is representative of these concerns:

[The] concern I have with the paper desires to criminalise the help that can be offered by the church ... I teach publicly from the bible [sic], I meet with people privately, I pray with them, and I seek to counsel them when they come to me asking for help ... this paper also suggests that religious practices such as offering pastoral care, counselling, praying, bible [sic] studies, and sermons, if directed to a person who is struggling with their sexual orientation and gender identity, should be a criminal offence’.<sup>767</sup>

c.5.25. Some respondents were concerned law reform would restrict their parental rights as a religious family:

Any law banning SOGI conversion practices which prevents parents from discussing and teaching their children a Biblical view of sexuality and gender identity is an unacceptable infringement upon the rights of parents to raise their children in accordance with their religious values and beliefs.<sup>768</sup>

<sup>764</sup> Submissions 2, 3, 9, 13\*, 14, 23\*, 26\*, 27, 28\*, 31\*, 33\*, 37, 41, 44, 46\*, 55C, 57, 58, 62, 68\*, 70\*, 71, 83C, 116, 139\*, 141\*, 149C, 178\*.

<sup>765</sup> Submission 145\*.

<sup>766</sup> Submission 3 at 3.

<sup>767</sup> Submission 62.

<sup>768</sup> Submission 44.

## **C.6. Question 5: Should SOGI Conversion Practices be Criminalised?**

**Should some or all forms of SOGI conversion practices be criminalised in Tasmania? If so, which, if any, should be dealt with as serious (indictable) crimes and which, if any, should be dealt with as less serious (summary) offences?**

- c.6.1. Fifty<sup>769</sup> individual and 377 petition submissions expressed strong support for the criminalisation of SOGI conversion practices in Tasmania. Respondents in favour of criminalisation did not believe that current Tasmanian legislation is sufficient to rectify or manage the harms caused by conversion practices, nor could they be addressed by amending existing laws for these circumstances.<sup>770</sup>
- c.6.2. Overall, there was considerable support for SOGI conversion practices to be criminalised, with some specific practices being made summary or indictable offences. Respondents generally wanted criminal sanctions not to fixate solely on the actions of individual SOGI practitioners but also extend to their affiliated members, supporters, groups, collectives, or organisations.<sup>771</sup>

<sup>769</sup> Submissions 25, 37, 42, 58, 66, 79, 80, 82, 86, 89, 91, 93, 94, 104, 111\*, 113, 114, 115, 117, 118, 120, 121, 124, 127, 129\*, 130\*, 131, 138\*, 148\*, 150, 153\*, 154C, 156, 157\*, 158C, 159\*, 161\*, 162, 163C, 164\*, 165, 167, 168, 169, 170, 173\*, 175, 177, 179\*, 180\*, 182C.

<sup>770</sup> Submission 79.

<sup>771</sup> Submissions 37, 42, 93, 113, 114, 148\*, 180\*.

## **Justification for criminalisation: harm and moral wrongness**

- C.6.3. Many emphasised that criminalisation was necessary because of the harm that conversion beliefs and practices have caused others<sup>772</sup> or because they were morally wrong.<sup>773</sup> Some respondents believed all forms of conversion should be treated equally before the law and criminalised severely.<sup>774</sup> These respondents tended to justify this on the basis that they had been personally affected by SOGI conversion practices, or knew or had experienced someone else endure significant harm due to SOGI conversion practices.<sup>775</sup>
- C.6.4. Other submissions stated that the more serious form of an indictable offence should be legislated and used to prosecute people who administer or perpetuate conversion ideology in formal, clinical, and informational settings on the basis of the serious, sometimes life-threatening harm these practices can cause.<sup>776</sup> These respondents generally concluded that maximum penalties would be appropriate where the victim is under the age of 18 or has decision-making impairments.<sup>777</sup>
- C.6.5. A final reason was that making conversion practices criminal offences would act as a deterrent by simultaneously banning the practices themselves and also reaffirming the Tasmanian Government's support for LGBTQA+ people in the community.<sup>778</sup>

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<sup>772</sup> Submissions 37, 42, 66, 79, 117, 118, 121, 124, 129, 153\*, 161\*, 168, 169, 175, 177, 179\*.

<sup>773</sup> Submission 131.

<sup>774</sup> Submissions 58, 79, 124, 129, 130\*, 175.

<sup>775</sup> Submissions 89, 121.

<sup>776</sup> Submissions 85, 94, 124C.

<sup>777</sup> Submission 124C.

<sup>778</sup> Submissions 175, 179\*.

## Support for criminalisation from legislation elsewhere in Australia

- C.6.6. Many submissions that supported the criminalisation of SOGI conversion practices drew from a range of current Australian legislation to inform their perspectives. Some requested law reform follow recent reforms in Queensland and Victoria, particularly around the text of provisions, and the circumstances, penalties, and sanctions provided in those statutes. One submission advocated following the Queensland amendment approach to conversion practices, using existing frameworks in the *Public Health Act 1997 (Tas)* and the *Anti-Discrimination Act 1998 (Tas)* to support a new criminal offence into the *Criminal Code*.<sup>779</sup>
- C.6.7. Other submissions drew from the recent Victorian legislation, at the point of consultation the Change or Suppression (Conversion) Practices Prohibition Bill 2020 (Vic), as a useful reference for creating a new law or for amending the Tasmanian *Criminal Code* on what practices should be prohibited.<sup>780</sup> One respondent praised the Victorian legislation as ‘the most comprehensive and effective legislation in the world’.<sup>781</sup>

## Suggested actions to be criminalised

- C.6.8. Collating a number of suggestions from the submissions,<sup>782</sup> respondents suggested the following actions should be considered criminal, either as one individual or a group of individuals:
- Engaging in SOGI conversion practices, whether forced or coercive or not, that cause injury, or serious injury;
  - Engaging in activities that are SOGI conversion practices whether paid or unpaid;
  - Engaging in SOGI conversion practices in formal or formal settings,
  - Referring a person (formally or informally) to an individual or service which administers SOGI conversion practices;
  - Removing adults, children, and people with impaired agency from a jurisdiction for the purpose of SOGI conversion practices; and
  - Advertising SOGI conversion practices.

## Application to healthcare practitioners

- C.6.9. Some respondents emphasised that there was a need to penalise conversion practices in a wide range of formal and informal settings, such as religious and health settings, where services of

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<sup>779</sup> Submission 104.

<sup>780</sup> Submissions 37, 121, 167.

<sup>781</sup> Submission 111.

<sup>782</sup> Submissions 42, 37, 42, 58, 79, 85, 91, 113, 118, 120, 150, 173\*, 179\*, 167, 169, 186\*.

counselling, psychology practices or psychotherapy are offered.<sup>783</sup> Others suggested that criminal offence provisions should apply to health and medical practitioners only.<sup>784</sup> One submission explicitly suggested a summary offence was appropriate to discourage medical professionals from ‘crossing the line’ into SOGI conversion practices.<sup>785</sup>

- C.6.10. In contrast, an anonymous submission from a respondent who had been subjected to SOGI conversion practice through hypnotherapy requested that any ‘therapies’ which suggest that being gay or transgender are wrong, are themselves dangerous and should be criminalised.<sup>786</sup> Another respondent stated that the most severe form of criminal penalties should be reserved for people who hold positions of power and authority, such as healthcare providers, counsellors, social workers, and religious leaders.<sup>787</sup>
- C.6.11. As these examples demonstrate, the responses were broad and diverse, with some respondents taking a very formal approach that referenced current laws and *Criminal Code* provisions in detail, while others expressed their support in more general terms, without explicitly stating what should or should not be an indictable or a summary offence.<sup>788</sup>

### *Healthcare providers*

- C.6.12. Several peak medical bodies made submissions on criminalisation and healthcare providers.
- C.6.13. The Australian Psychological Society endorsed a comprehensive ban, similar to that in the ACT or Victoria, and rejected the Queensland approach of only regulating healthcare providers, but also encouraged a good ‘Code of Ethics’ to ensure that practices which might otherwise seem like SOGI conversion practices (especially around transgender health) are supported by a sound evidence base, and ‘boundaries in legislation’ would avoid risks of regulation or criminalisation of genuine care.<sup>789</sup>
- C.6.14. The Australian Professional Association for Trans Health endorsed both criminal and civil penalties.<sup>790</sup>
- C.6.15. The Australian Medical Association Tasmania raised a number of concerns about criminalisation in general, and the Victorian approach specifically. AMA Tasmania also reported concerns by some of its members that the Victorian legislation went ‘too far’, in that

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<sup>783</sup> Submissions 37, 85.

<sup>784</sup> Submission 25.

<sup>785</sup> Submission 90.

<sup>786</sup> Submission 130\*.

<sup>787</sup> Submission 167.

<sup>788</sup> Submissions 82, 157\*, 158C, 159\*, 163C, 165, 170.

<sup>789</sup> Submission 18 at 3 and 4.

<sup>790</sup> Submission 114.

‘the perception being that it forbids anyone from ever saying anything other than agreeing with the person’s statement on their gender identity’.<sup>791</sup>

C.6.16. AMA Tasmania noted the concerns of the psychiatric and psychological community in Victoria that the new law may constrain legitimate psychiatry/psychotherapy practice to treat gender dysphoria which might lead to psychiatrists declining to do so.<sup>792</sup> AMA Tasmania stated that its members ‘want to ensure that doctors are not left open to criminal prosecution for asking what they consider to be necessary questions to understand their patients’ needs and desires’.<sup>793</sup> Criminal sanctions should never apply to healthcare professionals ‘acting in good faith and in accordance with reasonable standards of diagnostic assessment, clinical counselling and patient management’.<sup>794</sup>

C.6.17. AMA Tasmania suggested that if there is a criminal offence it should:

[Be] a summary offence rather than a criminal offence [because] [p]roving intent sufficient to satisfy the elements of a crime would be harder to achieve and a summary offence would strongly discourage any doctor from using such practices, while also ensuring that sanctions, such as fines or placing restrictions on a person’s practice, could be placed on any person who crossed the line into conversion therapy.<sup>795</sup>

## Application to corporations and organisations

C.6.18. Several submissions emphasised the importance of ensuring that criminal offences applied to organisations, particularly religious organisations and other incorporated bodies, that have often been exempt from individual-focused criminal laws.<sup>796</sup>

C.6.19. One respondent stated that any law reform that focused on criminal sanctions needed to include not only the individual who carried out, facilitated, or promoted the SOGI conversion practices, but also any organisation or institution that permitted, endorsed, or encouraged such practices, either explicitly or implicitly.<sup>797</sup> For corporate/agent offenders, sentencing should take into consideration a range of factors, including:

- the extent of the authority and duty of care between the SOGI conversion practitioner and the victim, including any existing power dynamics (e.g. influential senior minister of very

<sup>791</sup> Submission 90 at 2.

<sup>792</sup> Submission 90 at 2.

<sup>793</sup> Submission 90 at 2.

<sup>794</sup> Submission 90 at 2.

<sup>795</sup> Submission 90 at 2–3.

<sup>796</sup> Submission 173\*.

<sup>797</sup> Submission 86.

large congregation, counsellor, pastoral care worker) or other circumstances of unequal authority;<sup>798</sup>

- whether the person is a licensed, paid professional;
- whether the corporation organised, endorsed, or supported the SOGI conversion practices; and
- the frequency of the occurrence of the practices.<sup>799</sup>

## Penalties

C.6.20. Some submissions suggested criminal penalties should be scaled depending on harm caused and by whom. For example, one submission stated they believed practices that cause serious injury should be scaled, allowing for up to 10 years imprisonment or fines up to 6000 penalty units (approximately \$1 million), and apply to both individual and corporate entities, as stated in the Victorian legislation.<sup>800</sup> Another drew on the ACT legislation to guide what they considered a reasonable penalty for conversion practices which depends on whether the victim is an adult (\$15,000 or up to 12-months imprisonment or both) or a child or vulnerable person (\$25,000 or 12–24 months imprisonment or both).<sup>801</sup>

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<sup>798</sup> Submission 93.

<sup>799</sup> Submissions 37, 42, 93, 167.

<sup>800</sup> Submission 37.

<sup>801</sup> Submission 66.

## Opposition to criminalisation

C.6.21. Respondents who opposed any legislative change also rejected the criminalisation of SOGI conversion practices. Only 18 respondents of the 90 who opposed law reform made submissions on the question of criminalisation specifically. These responses tended to repeat points made in relation to Question 4 on reforming the law, such as that:

- There was insufficient evidence that SOGI conversion practices are occurring in Tasmania,<sup>802</sup>
- Criminalisation would impinge on religious freedom,<sup>803</sup> and
- Criminalisation would lead to prosecution of people who did not support current affirmative treatment pathways for gender dysphoria/incongruence.<sup>804</sup>

C.6.22. The main new point raised by law reform opponents in relation to criminalisation was that if SOGI conversion practices were occurring they could be appropriately dealt with by existing criminal laws, and anything beyond that should be left outside of government intervention.<sup>805</sup> Those opposed to criminalisation stated that current legislation was sufficient for those harmed by conversion practices to seek compensation and justice.<sup>806</sup> Notably, Tasmania Police stated that they support the strength of existing criminal laws to address SOGI conversion practices that take place outside of the health and medical fields.<sup>807</sup> Other respondents echoed this. One respondent stated that ‘[t]he existing Tasmanian criminal code is sufficient to deal with any issues of abuse, torture, stalking, bullying or torment.’<sup>808</sup> Another submission argued that only ‘coercive and aversive conversion practices’ should be potentially criminalised in Tasmania and:

[Any] criminalisation or penalty provisions which are introduced should be linked to the severity of the crime and reflect existing criminal provisions and offences. Any broader scope of SOGI conversion practices should not be criminalised in Tasmania.<sup>809</sup>

C.6.23. There was a general view among opponents that current legislation was sufficient because it allowed for institutionally context-dependent avenues for sanctions, such as the regulations present in the Australian Health Practitioners Registration Authority.<sup>810</sup>

<sup>802</sup> Submissions 44, 116.

<sup>803</sup> Submissions 31\*, 71, 178\*.

<sup>804</sup> Submissions 8, 51, 52, 72, 73.

<sup>805</sup> Submissions 2, 8, 31\*, 34, 41, 49, 50, 52, 76, 77, 78, 81, 90, 99, 101, 109, 125, 140.

<sup>806</sup> Submissions 73, 76\*, 78\*, 116.

<sup>807</sup> Submission 25.

<sup>808</sup> Submission 41.

<sup>809</sup> Submission 116.

<sup>810</sup> Submission 90.

## **C.7. Question 6: Should SOGI Conversion Practices be made a civil wrong?**

**Should some or all forms of SOGI conversion practices be made civil wrongs in Tasmania? If so, what sort of practices should people be liable for and how should those subject to such practices be compensated?**

- C.7.1. Many submissions did not answer this question, with only 68 submissions providing a relevant answer. Thirty-seven respondents supported amending the law on civil wrongs to cover SOGI conversion practices,<sup>811</sup> with a suggested mixture of criminal and civil penalties.<sup>812</sup> Twenty-two respondents opposed amending the law on civil wrongs.<sup>813</sup>

### **Support for civil wrongs**

- C.7.2. Submissions that advocated for SOGI conversion practices to be made civil wrongs gave varied responses, with most suggesting that a combination of civil and criminal penalties should be available to victims, and that the severity of civil penalties should depend on the gravity of the actions and harm suffered.<sup>814</sup>

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<sup>811</sup> Submissions 25, 49, 58, 79, 80, 93, 94, 111\*, 113, 114, 115, 118, 120, 121, 122, 124, 127, 130\*, 131, 134\*, 138\*, 150, 153\*, 154C, 156, 158C, 159\*, 162, 163C, 164\*, 165, 168, 169, 170, 173\*, 175, 182C.

<sup>812</sup> Submissions 80, 114, 115, 117, 118.

<sup>813</sup> Submissions 2, 8, 31\*, 34\*, 37, 41, 42, 65, 67, 71, 73, 76\*, 77\*, 78\*, 86, 89, 99, 116, 161\*, 177, 179\*, 180\*. The remaining 7 submissions stated either 'uncertain/don't know' or misunderstood the question (for example, discussing an area of law that was not civil wrongs).

<sup>814</sup> Submissions 80, 118, 169.

## Aspects of civil claims

- C.7.3. The most common specific suggestions for civil claims were that they should include:
- Physical harms arising from the SOGI conversion practices,
  - Mental harms that arose as a result of the physical harm (consequential harm),
  - Future loss of earning capacity as a result of physical or mental harm,
  - Pure mental harms from non-physical SOGI conversion practices
  - Compensatory damages for loss economic losses suffered to a plaintiff,
  - Compensatory damages for non-economic losses such as pain and suffering,
  - Aggravated/exemplary damages for serious/repeated conduct
  - Orders (e.g. injunctions) to stop continuing SOGI conversion practices by the defendant,
  - Orders to destroy, rectify or take down materials relating to SOGI conversion practices controlled by the defendant, or
  - Orders to publicly and/or privately apologise to the plaintiff.
- C.7.4. Some respondents included only one or more of the above,<sup>815</sup> with many respondents indicating that all these options should be part of reforming the civil law.<sup>816</sup>

## Timing considerations

- C.7.5. One important disagreement among those who supported a civil wrongs approach to SOGI conversion practices was over the time limits within which a person could make a claim for compensation. One respondent drew a parallel with other legislation, namely the *Ant-Discrimination Act*, to argue that the law does not provide victims with enough time to claim compensation. Identification of the conduct as being grounds for a complaint under this Act may take years, but that Act requires that complaints to be lodged within 12 months.<sup>817</sup>
- C.7.6. In contrast, a number of submissions stated three years after conversion practices occurred was appropriate for consenting adults.<sup>818</sup> Given people who have been exposed to conversion practices may not be aware for some time after the fact, some were in favour of extending the limitation period for a civil claim extend further, to go beyond three years to 12 years,<sup>819</sup> with

<sup>815</sup> Submissions 91, 127, 130\*, 157\*, 158, 168 .

<sup>816</sup> Submissions 129\*, 131, 134\*, 138\*, 148\*, 150, 153\*, 156, 158C, 159\*, 162, 163C, 164\*, 165, 169, 173\*, 182C.

<sup>817</sup> Submission 117.

<sup>818</sup> Submissions 58, 138\*, 154C, 159\*, 165.

<sup>819</sup> Submissions 79, 130\*, 134\*, 140\*, 162.

most stating there should be no time period within which a claim must be brought, particularly for victims who are children.<sup>820</sup>

- c.7.7. Providing an ‘indefinite’ time for claims was to allow survivors of conversion practices the time to reconcile with harm done to them, particularly if consent was given under coercive means or they were subjected to false information.<sup>821</sup> One respondent suggested that the time limit on all claims should be ‘indefinite’ because enforcing a time limit suggests there is a time limit on trauma, which grossly disempowers victims.<sup>822</sup> Another strong example of this sentiment was one respondent who stated claims should be indefinite due to their personal experience:

a person who is brainwashed and come out it could take years for the penny to drop to realize what has been done to them and wanting an apology. In my situation it took 10 years from leaving to start to realize what had been done to me was wrong’.<sup>823</sup>

- c.7.8. These responses often mistakenly read ‘civil wrongs’ as meaning statutory investigations and the time limits around them (eg, under the *Anti-Discrimination Act*), but the general concerns and points nonetheless apply to the question of whether the current statute of limitations on civil compensation claims of six years is appropriate for conversion practices.

### **Civil wrongs read as statutory body investigations**

- c.7.9. Some respondents interpreted the ‘civil wrongs’ question as primarily about investigations by government bodies who might be empowered to issue civil penalties like fines. These submissions advocated for government bodies investigating SOGI conversion practices to either impose civil penalties or decide to charge and prosecute more serious offences.<sup>824</sup> Some submissions suggested this could take the form of a response scheme similar to the Victorian legislation, which uses the Victorian Equal Opportunity and Human Rights Commission to conduct investigations through both civil and criminal courts.<sup>825</sup> One respondent stated that conversion practices that are serious or systemic should be referred to the civil investigation process.<sup>826</sup> The most important reason for these respondents was the ability for survivors to receive financial compensation, without experiencing the numerous barriers and obstacles

<sup>820</sup> Submissions 58, 130\*, 127, 129, 131, 134\*, 138\*, 148\*, 150, 153\*, 158C, 159\*, 162, 163C, 164\*, 165, 168, 169, 173\*, 182C.

<sup>821</sup> Submission 173\*.

<sup>822</sup> Submission 177.

<sup>823</sup> Submission 165.

<sup>824</sup> Submission 122.

<sup>825</sup> Submissions 91, 93, 120, 122.

<sup>826</sup> Submission 94.

associated with criminal trials.<sup>827</sup> Many respondents who supported civil wrongs emphasised that they must be accompanied by a comprehensive redress scheme, funded by government, with fines for perpetrators.<sup>828</sup>

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<sup>827</sup> Submissions 79, 93, 124C, 177.

<sup>828</sup> Submissions 80, 113.

## Opposition to civil wrongs

- C.7.10. Most respondents who specifically opposed reforming the law on civil wrongs to cover SOGI conversion practices did so because they were already against any reforms at all.<sup>829</sup>
- C.7.11. Some respondents who supported law reform generally were opposed to using a civil wrongs approach at all as part of that reform, mostly because using the civil law was seen as ‘diluting’ the importance of banning or criminalising SOGI conversion practices.<sup>830</sup> Some of these respondents stated that fines and civil penalties were not appropriate because they focus on injury prevention or compensation, which is not an effective way of addressing harm done to current survivors, and would not deter future offenders.<sup>831</sup>
- C.7.12. Other submissions opposed extending the law on civil wrongs because of procedural concerns, namely the significant challenges associated with pursuing compensation claims, the distress and further harm that can be caused by the process itself, and the resource burden placed on survivors to seek compensation with limited resources.<sup>832</sup> Finally, some of these respondents stated that the burden of proof of harm for survivors of conversion practices was difficult to discharge in most cases, regardless of whether these were criminal or civil cases.<sup>833</sup>

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<sup>829</sup> Submissions 2, 8, 31\*, 34, 41, 65, 76\*, 78\*.

<sup>830</sup> Submissions 42, 89.

<sup>831</sup> Submission 37.

<sup>832</sup> Submissions 42, 71, 79, 86, 177, 179.

<sup>833</sup> Submissions 79, 118, 161\*, 177.

## C.8. Question 7: Legislative Instruments: Consumer Law, Healthcare Law, Anti-Discrimination

### Should any existing Tasmanian laws (besides criminal laws or the *Civil Liability Act 2002 (Tas)*) be amended to cover SOGI conversion practices? If so, which ones and in what way?

- c.8.1. As with responses to Question 6, many submissions did not provide an answer to this question. Many of those respondents who did respond to this question often expressed general support for using legislative instruments without detailed suggestions for particular amendments.

#### Support for legislative instrument reform

- c.8.2. Thirty-two respondents supported amending existing legislative instruments.<sup>834</sup> Many of these suggested amending Tasmanian anti-discrimination, health practitioner regulation and consumer protection laws together.<sup>835</sup> The general aim here was to update legislation to be more aligned to community standards<sup>836</sup> and to successfully ‘bridge’ regulation to ensure the law covered both formal (medical) and informal (non-medical or religious) conversion practices.<sup>837</sup>
- c.8.3. Some respondents who supported legislative instrument reforms suggested that these should incorporate the SOGICE Survivor Statement and that TLRI should seek guidance from the Brave Network to formulate a survivor-informed approach.<sup>838</sup>
- c.8.4. Some respondents stated they were unfamiliar or insufficiently familiar with existing laws to provide an informed answer, and noted that the Tasmanian government should consequently create a stand-alone act specific to SOGI conversion practices.<sup>839</sup> Others believed that multiple amendments to several statutes would be too complicated, and a stand-alone statute would be easier.<sup>840</sup> One respondent noted that a solely complaints-based system did not seem appropriate to provide redress for those harmed by SOGI conversion practices, or sufficient for preventing future harm.<sup>841</sup>
- c.8.5. Some respondents who advocated for using legislative instruments noted that existing legal regimes like the *Anti-Discrimination Act*, consumer law and healthcare practitioner laws were

<sup>834</sup> Submissions 25, 58, 79, 80, 93, 94, 104, 113, 114, 117, 121, 124, 127, 131, 138\*, 148\*, 150, 153\*, 159\*, 161\*, 162, 163, 164\*, 165, 168, 169, 160, 173\*, 175, 176\*, 179\*, 180\*.

<sup>835</sup> Submissions 93, 138\*, 148\*, 150, 153\*, 159\*, 162, 163, 164, 168, 169, 170, 173\*.

<sup>836</sup> Submission 176\*.

<sup>837</sup> Submission 93.

<sup>838</sup> Submissions 79, 80.

<sup>839</sup> Submission 111C.

<sup>840</sup> Submission 104.

<sup>841</sup> Submission 117.

not sufficient for dealing with SOGI conversion practices and needed to be complemented by a general Tasmanian Human Rights Act. These respondents argued that this could provide a workable mechanism to address and prohibit SOGI conversion practices more comprehensively.<sup>842</sup> Some respondents argued that a Human Rights Act could also deal with and balance religious freedom concerns, providing greater protection for all rights and freedoms.<sup>843</sup> Among the responses to Question 7 were strong recommendations to complement any legislative instrument amendments with other initiatives to address SOGI conversion practices through community support (see Questions 8 and 9 below).

- c.8.6. The remainder of this section analyses more specific respondent comments by the area of statutory regime: consumer law, health practitioner laws and anti-discrimination laws.

### Consumer law

- c.8.7. Some respondents suggested that SOGI conversion beliefs and practices should be included within consumer laws as a form of false and/or misleading claims.<sup>844</sup> Consumer affairs and consumer protection laws were suggested to assist in regulating pseudo-scientific publications and promotion of SOGI conversion practices. One respondent argued that:

SOGI [conversion] practices are fringe pseudo counselling at best. They need to be called out for that and apart from appropriate dedicated legislation that should be reflected in consumer and health legislation.<sup>845</sup>

Another respondent argued:

People who claim to be a practitioner of Conversion Practice regardless of profession or faith should be considered charlatans like the snake oil sellers in days of old, because it's deceptive marketing and really is just a scam, giving people false hope. Now people can be jailed for scamming and so should people who promote and practice Conversion Practice.<sup>846</sup>

### Health practitioner laws

- c.8.8. Some respondents suggested that amendments to Tasmanian health practitioner laws could be used to deal with SOGI conversion practices. One suggestion was to incorporate the mandatory deregistration of any health practitioner who directly or indirectly offers, refers or conducts SOGI conversion practices.<sup>847</sup> This suggestion took the form of a specific clause in the *Health*

<sup>842</sup> Submission 117.

<sup>843</sup> Submissions 113, 121, 161\*.

<sup>844</sup> See, eg, Submission 93.

<sup>845</sup> Submission 153\*.

<sup>846</sup> Submission 58.

<sup>847</sup> Submission 94.

*Practitioner Regulation National Law (Tasmania) Act 2010* (Tas) to specifically target and regulate transphobic ideology by framing it as ‘medical malpractice’ in addition to categorising it as a SOGI conversion practice.<sup>848</sup> One submission suggested that any law reform should be explicitly limited to apply only to health practitioners.<sup>849</sup>

- C.8.9. Healthcare professional bodies and individual healthcare practitioners made submissions to the TLRI Inquiry that expressed various concerns. Submissions from a range of peak health and medical bodies to the Inquiry expressed a desire for the law to be appropriately tailored to avoid overreach into legitimate assessment, care and treatment of mental health symptoms relating to prolonged gender dysphoria/incongruence.
- C.8.10. These bodies generally supported using professional agencies, bodies and codes,<sup>850</sup> which would involve baseline prohibitions for professionally inappropriate care, but otherwise leaving the evaluation of what was appropriate healthcare to the present professional associations, namely the Royal Colleges.<sup>851</sup> Other respondents who were not medical practitioners also mentioned and supported the involvement of health regulators.<sup>852</sup>

### **Assessment mechanisms, professional regulation, and ‘reasonable professional judgement’**

- C.8.11. Several submissions made points about the possible applicability of current professional regulation to SOGI conversion practices. The Royal Australian and New Zealand College of Psychiatrists expressed concern about recent reforms in other States and cautioned that they had ‘been a cause of concern for psychiatrists and other mental health professionals, due to their potential for unintended consequences’.<sup>853</sup>
- C.8.12. The Australian Psychological Society stated that SOGI conversion practices are:
- harmful to all people subjected to them and ... lack efficacy. As such, any psychologist attempting to use conversion practices is likely to be in breach of our Code of Ethics’.<sup>854</sup>
- C.8.13. The Australian Medical Association Tasmania’s members would prefer that any investigation of health professionals for possible SOGI conversion practices take place through the

<sup>848</sup> Submission 93.

<sup>849</sup> Submission 66.

<sup>850</sup> Submissions 18 at 4, 114.

<sup>851</sup> Submission 90 at 3.

<sup>852</sup> Submission 93 at 5–6.

<sup>853</sup> Submission 5 at 2.

<sup>854</sup> Submission 18 at 2.

Australian Health Practitioners Regulation Agency procedures for ‘further investigation and sanction’.<sup>855</sup>

## **Consensus on prohibiting sexual orientation assessment and treatment**

- C.8.14. All health professional bodies agreed that sexual orientation conversion practices should be proscribed. The Royal Australia and New Zealand College of Psychiatry stated that it ‘does not support the use of sexual orientation change efforts of any kind’ because of a lack of scientific evidence and a risk of causing significant harm.<sup>856</sup> The TLRI notes that the formulation used by the Royal College here restricts its rejection to ‘sexual orientation’ only and does not include ‘gender identity’.
- C.8.15. The Australian Psychological Society rejected the possibility of consent to conversion practices in any situation.<sup>857</sup> The Australian Medical Association Tasmania reiterated the national Australian Medical Association’s longstanding rejection of sexual orientation ‘reparative’ or ‘conversion’ therapy premised on the assertion that homosexuality is a mental disorder.<sup>858</sup> AMA Tasmania noted that it had consulted with its membership who expressed a ‘strong view’ that SOGI conversion practices ‘are harmful and should be banned’.<sup>859</sup>
- C.8.16. The Australian Professional Association for Trans Health supported a ban on SOGI conversion practices, noting that they should only be regarded as ‘lawful under strict conditions in which the individuals targeted are adult and give free and fully informed consent, after provision of a factsheet resource explaining what conversion practices are and what the evidence says about impact’.<sup>860</sup>

## **Need to protect and promote good medical practice around gender dysphoria/incongruence**

- C.8.17. Several submissions noted that genuine medical treatment of gender dysphoria/incongruence must not be covered by any definition of SOGI conversion practices, and that healthcare professionals working with potentially gender dysphoric/incongruent patients be able to assess and treat them without fear of contravening the law.

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<sup>855</sup> Submission 90 at 2.

<sup>856</sup> Submission 5 at 1.

<sup>857</sup> Submission 18 at 3.

<sup>858</sup> Submission 90 at 1.

<sup>859</sup> Submission 90 at 1.

<sup>860</sup> Submission 114 at 3.

C.8.18. The Royal Australian and New Zealand College of Psychiatrists was concerned that the definition contain clear exclusions for genuine medical treatments:

It is crucial that legitimate psychiatric treatment and the work of health professionals is not banned by any legislation. It is important that individuals questioning their gender or considering treatment can be appropriately counselled and supported using an evidence-based approach with reference to accepted professional standards.<sup>861</sup>

C.8.19. The College was also concerned that evidence-based mental health care and support not be captured under the definition of SOGI conversion practices:

[reform must] ensur[e] that all conversion therapies are captured, while removing any association with evidence-based mental health care and support. Initial legislation in other jurisdictions could have, under some circumstances, been perceived to include some evidence-based psychiatric practice, even though the intent of the treatment may not be to change, suppress or eliminate an individual's sexual-orientation or gender identity.<sup>862</sup>

C.8.20. The Chief Civil Psychiatrist of Tasmania supported the TLRI definition, and stated that 'any language around these practices that suggests they are therapies or educational programs of any kind or based on any medical evidence, best practice or shared philosophy' should be avoided, as 'there is simply no compelling evidence that this is the case'.<sup>863</sup>

C.8.21. The Australian Medical Association Tasmania supported a ban on SOGI conversion practices but emphasised that 'it must not come at the cost of good patient care'.<sup>864</sup> AMA Tasmania also noted that 'there was also some concern as [to] where the line is drawn on what constitutes conversion practices, when seeing a person with dysphoria', and noted that AMA Queensland had raised this in its submissions on Queensland's bill.<sup>865</sup>

C.8.22. AMA Tasmania emphasised that its members viewed SOGI conversion practices as a 'clinical and health issue', and stated 'there must be a safe space for doctors together with their patient to be able to explore issues relating to the patient's sexual orientation or gender identity'.<sup>866</sup> AMA Tasmania's submission appears to quote an anonymous member to the effect that the 'goal' of consultations with gender dysphoric/incongruent patients 'is to ensure that they are

<sup>861</sup> Submission 5 at 2.

<sup>862</sup> Submission 5 at 2.

<sup>863</sup> Submission 104 at 2.

<sup>864</sup> Submission 90 at 3.

<sup>865</sup> Submission 90 at 1.

<sup>866</sup> Submission 90 at 2.

sure, given the permanent nature of gender reassignment and the potential for significant harm, but questioning is sometimes necessary in the course of getting to that point'.<sup>867</sup>

- c.8.23. Other submissions emphasised a distinction between genuine medical treatments and conversion practices that merely resembled genuine psychiatric practices. The Australian Psychological Society noted that because most conversion practices take place in religious contexts and under a banner of 'pastoral care', they are unregulated and may 'look similar in modality to that provided by psychologists', such as 'talking therapy', albeit without the necessary professional training, accreditation, oversight, code of ethics, or informed consent requirements.<sup>868</sup> The Society thus endorses avoiding harm caused by practices while also 'preserv[ing] the integrity of the modality of practices commonly conducted by psychologists'; consequently a unilateral ban is warranted.<sup>869</sup>
- c.8.24. Other submissions pointed out that the shift to 'gender incongruence' reflected a wider depathologisation of gender identity generally and the broader move to allow gender dysphoric/incongruent people to make medical decisions about their own bodies without having to prove they are mentally 'disordered'.
- c.8.25. The Australian Professional Association for Trans Health noted the ICD-11 revision which moved 'gender incongruence' from a mental disorder to a condition related to sexual health, and removed a block of diagnoses around 'disorders of sexual preference' that 'pathologized same-sex orientation and gender diversity'.<sup>870</sup> The Association supported this new revised definition and restructuring, stating that it 'believe[s] that these diagnostic revisions, in every case based on a developing scientific knowledge base on sexual and gender diversity, remove the last vestiges of any rational[e] for SOGI [conversion practices]'.<sup>871</sup>
- c.8.26. An expert respondent who is an Associate Professor of Health Science and clinical psychologist specialising in trans health and wellbeing made a series of similar points to the Australian Professional Association for Trans Health's submission: endorsing the ICD-11 definition revisions, stating they rested on current scientific knowledge, and stating they 'remove any last vestiges of any rationale for SOGICE'.<sup>872</sup> The expert respondent also noted and endorsed the statement of the World Professional Association for Transgender Health on gender identity

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<sup>867</sup> Submission 90 at 2

<sup>868</sup> Submission 18 at 2.

<sup>869</sup> Submission 18 at 2.

<sup>870</sup> Submission 114 at 2.

<sup>871</sup> Submission 114 at 2.

<sup>872</sup> Submission 82 at 3.

treatments that ‘treatment aimed at trying to change a person’s gender identity and expression to become more congruent with sex assigned at birth ... is no longer considered ethical’.<sup>873</sup>

## Anti-discrimination law

- C.8.27. Many respondents commented on whether anti-discrimination law might be an appropriate mechanism for responding to SOGI conversion practices. One respondent stated that amending Tasmania’s Anti-Discrimination law was the easiest option.<sup>874</sup> This was supported by other submissions that suggested expanding this legislation to capture SOGI conversion practices broadly. For example, one respondent stated that a benefit of amending Tasmania’s *Anti-Discrimination Act* would be to allow the Commissioner the power to investigate and potentially conciliate and remedy cases of conversion through the aid of third parties, with or without a specific complaint from a survivor to prevent re-traumatisation.<sup>875</sup> Most respondents who answered Question 7 and supported law reform were supportive of amending Tasmanian anti-discrimination law, but not all of these respondents indicated which elements should change, how or why.<sup>876</sup>
- 10.3.11. The language of ‘discrimination’ was used in approximately 40 submissions. Most of these respondents used the concept in its general meaning, rather than its specifically legal meanings, and few submissions mentioned or examined Tasmania’s *Anti-Discrimination Act*. ‘Discrimination’ was invoked by submissions that supported or opposed SOGI conversion practices alike. Two respondents who indicated they ‘don’t know’ if current laws are sufficient but did mention ‘anti-discrimination law’ in their comments.
- 10.3.12. Of the 90 respondents opposed to law reform generally, only four specifically mentioned ‘discrimination’ or anti-discrimination law.<sup>877</sup> These reasons included that banning conversion practices ‘discriminates’ against people who wish to voluntarily access them,<sup>878</sup> that there is no evidence they are taking place in Tasmania, and that current laws on informed consent and anti-discrimination offer sufficient protection for non-consensual or harmful practices.<sup>879</sup>

<sup>873</sup> Submission 82 at 2, quoting WPATH, *Standards of Care* (n 565).

<sup>874</sup> Submission 165.

<sup>875</sup> Submissions 85, 91, 79, 124C.

<sup>876</sup> Submissions 117, 127, 131, 148\*, 154, 158C, 168, 169, 170, 175.

<sup>877</sup> Submissions 33\*, 116, 141\*, 176\*.

<sup>878</sup> Submission 176\*.

<sup>879</sup> Submissions 33\*, 116 and 141\*.

10.3.13. Other submissions made broader arguments using the language of discrimination to suggest that any reforms to ban or regulate conversion practices would discriminate against religious people.<sup>880</sup> For example, one anonymous respondent wrote:

The suggested law reforms in relation to SOGI will give opportunity for discrimination and vilification of the Christian Church and other religious institutions. Potentially criminalizing teachings central to multiple systems of faith.<sup>881</sup>

C.8.28. Some religious respondents referred to ‘discrimination’ to distinguish between the focus on conversion practices on individuals, and more general ‘ethical’ or ‘religious’ codes around sexuality. One senior pastor wrote

some of the religious practices which the [Issues Paper] implies as needing regulation is the religious activity of ‘prayer’ for those with desires or attractions that are seen by the faith community as ‘incompatible with the faith and inclusion in the religious community’ (1.2.6.2). This implied suggestion fails to distinguish between a religious group’s unfair discrimination of an individual (bigotry) and a view of human sexuality that is grounded in a moral code and is therefore, instead, an *ethical* concern.<sup>882</sup>

C.8.29. Similarly, the Archbishop of Hobart wrote that the Catholic Church teaches that:

The number of men and women who have deep-seated homosexual tendencies is not negligible. This inclination, which is objectively disordered, constitutes for most of them a trial. They must be accepted with respect, compassion, and sensitivity. Every sign of unjust discrimination in their regard should be avoided. These persons are called to fulfill God’s will in their lives and, if they are Christians, to unite to the sacrifice of the Lord’s Cross the difficulties they may encounter from their condition.<sup>883</sup>

C.8.30. Finally, others used discrimination to discuss their opposition to reform in relation to transgender healthcare issues and/or the operation of the *Anti-Discrimination Act* categories relevant to sexual orientation and gender.<sup>884</sup> For example, one respondent wrote:

The proposed changes would likely give unequal protection to persons promoting a single controversial practice in relation to issues of sexual orientation and gender identity and discriminate in favour of gender transition treatments that involve chemicals and hormones and invasive surgical practices.<sup>885</sup>

<sup>880</sup> Submissions 133\*, 139\*, 149C.

<sup>881</sup> Submission 133\*.

<sup>882</sup> Submission 41 at 7 (emphasis in original).

<sup>883</sup> Submission 125.

<sup>884</sup> Submissions 74, 116, 154.

<sup>885</sup> Submission 116.

- C.8.31. Others thought that any reform that made it impossible to consent to conversion practices might be discriminatory:

It depends on the person, age or circumstances ... Given the complexity of the issue, the person who wants to explore different therapies should be at least allowed to discuss it. If they have a preference to try, should they not be given the opportunity? Not to offer and opportunity at least to discuss it, even if to dissuade them, seems discriminatory.<sup>886</sup>

### Support for anti-discrimination law reform

- C.8.32. Several submissions wrote in direct support of changing Tasmanian anti-discrimination law.<sup>887</sup> One respondent noted that potential benefits might include access to established dispute resolution procedures, fewer barriers/lower costs to bringing a dispute, a greater range of remedies, including apologies, and the ability for the Anti-Discrimination Commissioner to investigate conversion practices without a specific complaint from a survivor.<sup>888</sup> Another submission echoed these advantages, and also emphasised the advantages of established conciliation processes, and the ability for Equal Opportunity Tasmania to engage in public education about the discriminatory aspects of conversion practices.<sup>889</sup> Other submissions endorsed simplicity of using established anti-discrimination laws and processes to cover conversion practices.<sup>890</sup> Finally, one respondent endorsed anti-discrimination law, but noted that amending the existing *Anti-Discrimination Act* might not be sufficient, and that a full Human Rights Act might be necessary.<sup>891</sup>
- C.8.33. Some respondents supportive of reforms to anti-discrimination law used the language of ‘discrimination’ to make general points about the treatment of LGBTQA+ people or their own experiences as an LGBTQA+ person. One anonymous survey respondent who had been involved in ministries wrote:

I have seen in action the unintended discrimination against the LGBTQI+ sector of our society. I have also seen the intended and active efforts, particularly in evangelical and pentecostal churches to quash and convert.<sup>892</sup>

- C.8.34. Another used the language of anti-discrimination law and human rights:

<sup>886</sup> Submission 176\*.

<sup>887</sup> Submissions 79, 104, 124, 165.

<sup>888</sup> Submission 79.

<sup>889</sup> Submission 124.

<sup>890</sup> Submissions 104, 165.

<sup>891</sup> Submission 177.

<sup>892</sup> Submission 153\*.

our concerns about SOGI conversion practices are much more fundamental than the issue of whether or not they ‘work’. The right to equality and non-discrimination are core principles of human rights, enshrined in international and domestic law and these guarantees apply to all people, regardless of sex, sexual orientation and gender identity just as it is unlawful to discriminate against a person based on their skin colour, race, sex, religion or any other status.<sup>893</sup>

C.8.35. Similarly a respondent noted that:

Research has demonstrated more broadly that a disproportionate number of LGBTI people experience poorer mental health outcomes and have a higher risk of suicidal behaviours than their peers. These health outcomes are directly related to experiences of stigma, prejudice, discrimination and abuse on the basis of being LGBTI.<sup>894</sup>

C.8.36. The Royal Australian and New Zealand College of Psychiatrists wrote:

The RANZCP is supportive of the intent behind such legislation which seeks to prohibit the practice of conversion therapies. Members of the LGBTIQ+ community are valued members of society with rights to equal access to health care, marriage and procreation and bringing up children. They should experience life free from harassment or discrimination in any sphere and a right to protection from therapies that are potentially damaging, particularly those that purport to change sexual orientation.<sup>895</sup>

C.8.37. Several respondents invoked discrimination and human rights concepts in their domestic and international forms to argue in support of banning or regulating SOGI conversion practices, emphasising that in addition to a healthcare issue, SOGI conversion practices are more broadly a human rights and anti-discrimination issue.<sup>896</sup> For example, one respondent wrote:

This stigma, exclusion, discrimination, and harassment is perpetuated by a range of cultural and societal norms which characterises LGBTIQ+ people as ‘less than’ and as ‘other’. Much of this is born out of religious doctrine. While there is now more acceptance and understanding, many faith groups continue to perpetuate a narrative that is harmful to LGBTIQ+ people. It also denies LGBTIQ+ people of faith the right to live healthy and authentic lives. This submission is based on our interactions and experience with our fellow LGBTIQ+ community members.<sup>897</sup>

<sup>893</sup> Submission 86 at 1.

<sup>894</sup> Submission 10 at 2.

<sup>895</sup> Submission 5.

<sup>896</sup> Submissions 4 at 2, 42, 86, 115, 122 at 2.

<sup>897</sup> Submission 42.

C.8.38. Several respondents discussed or cited the positions of national and international human rights bodies and rapporteurs in support of using anti-discrimination law to respond to conversion practices.<sup>898</sup> For example, the Commissioner for Children and Young People wrote:

Under the UN Convention on the Rights of the Child, children are afforded the rights to identity, health and development and to freedom of thought, conscience and religion. They are also afforded the rights to be protected from violence and harmful practices such as torture or other cruel, inhuman or degrading treatment. Importantly, it is a core principle of the Convention that in all actions concerning children, the best interests of the child shall be a primary consideration. The Committee on the Rights of the Child (the Committee) has emphasised ‘the rights of all adolescents to freedom of expression and respect for their physical and psychological integrity, gender identity and emerging autonomy’. The Committee has specifically condemned practices designed to change sexual orientation and has urged States to eliminate them those practices. ... In a report to the UN Human Rights Council, the UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity (Independent Expert) found that subjecting children to so called ‘conversion therapies’: runs counter to States’ obligation to protect them from violence, harmful practices and cruel, inhuman or degrading treatment, to respect the right of the child to identity, physical and psychological integrity, health and freedom of expression and to uphold the core principle of taking the best interests of the child as a primary consideration at all times.<sup>899</sup>

C.8.39. Several respondents also mentioned anti-discrimination law in connection with social or community support and education campaigns that they saw as necessary for reducing discrimination.<sup>900</sup> For example, the Tasmanian Council of Social Service wrote:

Community awareness or education campaigns should also be parallel activities worth considering with the aim of educating the community of the inefficacy of the practices, combating harmful rhetoric and narratives in public statements, and tackling the discrimination and prejudice which sits at the heart of conversion practices.<sup>901</sup>

C.8.40. Several respondents in favour of reforming anti-discrimination law also made comments on religious freedoms. For example, the Tasmanian Council of Social Service stated that it

does not believe this legislation threatens religious freedom because it does not prohibit religious or spiritual activity, only those practices which seek to change or suppress an

<sup>898</sup> Submissions 80 at 5, 82 at 2, 85 at 6, 114 at 2, 120 at 3–4.

<sup>899</sup> Submission 120 at 3–4.

<sup>900</sup> Submissions 66, 79, 80.

<sup>901</sup> Submission 80 at 7.

individual's sexual orientation or gender identity and cause harm or injury to that individual. Nowhere in Australian law or in international human rights covenants does there exist an absolute right to act on religious conviction in any circumstance; the International Covenant on Civil and Political Rights, to which Australia is a signatory, recognises 'that the right to manifest religious or other beliefs may be subject to limitations that are prescribed by law and necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others.' International human rights law seeks to ensure that individuals are subject to both freedom of, and freedom from discrimination based on, 'religion or belief'.<sup>902</sup>

### Clinical and statutory bodies on anti-discrimination law

- C.8.41. Clinical and statutory bodies provided close analysis of how Tasmanian anti-discrimination law might apply to SOGI conversion practices.
- C.8.42. The Chief Civil Psychiatrist of Tasmania wrote in support of the Queensland approach to regulating healthcare, and suggested anti-discrimination law might be used to achieve a similar result:

I support the amendment approach that Queensland has taken to prevent any SOGI [conversion] practices occurring in registered or unregistered healthcare settings, community settings, or religious groups. In the Tasmanian context, this, as outlined in (section 4.2.9) of the Issues Paper could use existing legislative frameworks such as the *Public Health Act 1997* (Tas) or the *Anti-Discrimination Act 1998* (Tas) to include definitions of SOGI [conversion] practices within these Acts, and to also insert a new criminal offence into the *Criminal Code Act 1924*. This option, as you have suggested within your Issues Paper, would be simpler than creating a new stand-alone statutory instrument.<sup>903</sup>

- C.8.43. Equal Opportunities Tasmania submitted a detailed examination of how anti-discrimination law might apply to SOGI conversion practices. Equal Opportunity Tasmania identified several barriers in the current *Anti-Discrimination Act* that might mean it does not presently cover SOGI conversion practices.

A significant barrier for individuals is the identification of the treatment they are subject to during SOGI conversion practices as being 'less favourable', let alone unlawful. The same can arguably be said for prohibited conduct under section 17(1) [*Anti-Discrimination Act*], where a person must subjectively feel offended, humiliated, intimidated, insulted or

<sup>902</sup> Submission 80 at 5.

<sup>903</sup> Submission 104.

ridiculed in order to allege a breach of this provision. SOGI conversion practices are generally presented to individuals as helpful, supportive and coming from a place of compassion, and the conduct is not framed as being harmful or detrimental to an individual's health ... such practices are generally recommended by people an individual trusts, further impacting their ability to identify the conduct as harmful.<sup>904</sup>

- C.8.44. Equal Opportunity Tasmania also noted that the harms from SOGI conversion practices often do not manifest for several years, which may mean the time limitations on bringing anti-discrimination claims may preclude the Commissioner from investigating a complaint:

At the time SOGI conversion practices are experienced they may not be interpreted as being injurious to a person. Evidence shows that the negative effects of such practices can emerge some years after experiencing them. A person undergoing SOGI conversion practices would therefore experience certain barriers to seeking justice under the Act before even lodging a complaint, the first being identification of the conduct as potentially unlawful, and the second being lodging the complaint within the time constraints ... The Act places limitations on the Commissioner's ability to accept a complaint for investigation within a certain time period.

...

As set out in the Issues Paper, evidence shows that SOGI conversion practices have long term negative effects, including guilt, shame, severe anxiety and depression, internalised homophobia and PTSD [post-traumatic stress disorder] ... These effects all create barriers for a person lodging a complaint within 12 months. Identification of the conduct as being grounds for a complaint under the Act may take years. The Commissioner's discretion to extend time can only be exercised where certain criteria is met.<sup>905</sup>

- C.8.45. Finally Equal Opportunity Tasmania cautioned against the inclusion of provisions to take into account 'consent' within a discrimination framework:

In circumstances where the effects are largely harmful and the extent to which a person may be negatively affected by SOGI conversion practices is unknown, It is difficult to see how informed consent can be given... being able to provide consent to submit to SOGI conversion practices would then undermine any possible legal avenue where a person seeks a remedy after experiencing harm. It would be legally problematic if a person could consent to a service which another person may make a complaint under the [*Anti-Discrimination Act*] about. It is inconsistent to label the service discriminatory in some circumstances, but not others. Insofar as people can purportedly consent to SOGI conversion practices existing

<sup>904</sup> Submission 117.

<sup>905</sup> Submission 117.

discriminatory attitudes regarding LGBTIQ+ people will continue to be upheld making social change and equality far more difficult to achieve.<sup>906</sup>

### **Opposition to legislative instrument reform**

C.8.46. Twenty respondents were opposed to amending Tasmanian legislative instruments to address SOGI conversion practices and reiterated that opposition in response to this question.<sup>907</sup> Again, this was due to general beliefs that there was insufficient evidence of SOGI conversion practices in Tasmania, and that if they were occurring then existing Tasmanian criminal and civil laws are sufficient to respond to them.<sup>908</sup>

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<sup>906</sup> Submission 117.

<sup>907</sup> Submissions 2, 8, 9C, 30, 31\*, 34, 41, 50, 52, 65, 66, 71, 73, 74, 76\*, 78\*, 99, 116, 130\*, 177.

<sup>908</sup> Submissions 71, 78\*, 99.

## C.9. Question 8: Other Complements to Law Reform

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

- C.9.1. Respondents who supported law reform to address SOGI conversion practices also largely agreed that law reform must be complemented by a robust support mechanism for survivors and a strong focus on community awareness to inform the healthcare, LGBTQA+ and religious communities, discourage practitioners, encourage survivors to come forward, and ultimately reduce and stop SOGI conversion practices.
- C.9.2. These submissions expressed a range of views and suggestions on schemes and support models that might accompany law reform. One suggestion was to take an entirely non-legal approach to conversion practices, instead providing public, online education.<sup>909</sup> Most respondents, however, advocated for support programs to complement changes in the law, because, in the words of one respondent, legislation alone would not combat ‘the ills of sexual orientation and gender identity conversion practices’.<sup>910</sup> For example, the Australian Professional Association for Trans Health urged that law reform be:

accompanied by, but most certainly not replaced by, initiatives to ensure adequate education and training for professionals and the organisations in which they work; amendments, where necessary, to codes of conduct and membership practices for professional bodies; and properly implemented comprehensive sexuality education in schools.<sup>911</sup>

- C.9.3. Generally, this support scheme should include ongoing services like counselling and a redress scheme for victims,<sup>912</sup> collaboration between peak bodies and stakeholders to develop codes of practice and self-regulation frameworks, and educational schemes for organisations, leaders, healthcare practitioners and individuals.<sup>913</sup> Collating a number of submissions,<sup>914</sup> common examples included one, several, or all of the following:

- Industry code(s) of practice,
- Dedicated telephone/online support hotlines,
- Anonymous complaint mechanisms,
- Community education,

<sup>909</sup> Submission 68\*.

<sup>910</sup> Submission 79.

<sup>911</sup> Submission 114 at 3.

<sup>912</sup> Submission 85.

<sup>913</sup> Submissions 111\*, 115, 133\*, 140\*, 146C, 178\*.

<sup>914</sup> Submissions 58, 85, 129, 130, 131, 134, 138, 141, 140, 142, 144, 148, 150, 152, 153, 154, 156, 157, 158, 159, 161, 162, 164, 165, 166, 167, 168, 169, 170, 173, 175, 176, 177, 179, 180.

- SOGI conversion practice survivor support / counselling.<sup>915</sup>
- c.9.4. Many submissions that advocated strongly for support schemes were informed by or endorsed the Victorian model, in particular the claim that voices of survivors should be central to any decisions made regarding the support mechanisms they require.<sup>916</sup> One suggestion was to appoint an independent public officer to investigate evidence of conversion practices, instead of relying on existing commissions and officers.<sup>917</sup> Others suggested this investigative function should be comprised of an expert panel of at least 50 per cent survivors of SOGI conversion practices who can assist in reviewing and investigating allegations of SOGI conversion practices. The justification for this was that their perspective as survivors enables them to fully consider compensation, harm, and the subsequent social and economic impacts adequately.<sup>918</sup>

### Redress schemes

- c.9.5. A redress scheme for survivors of SOGI conversion practices was the most common suggestion for complements to law reform. Many respondents stated that this should be survivor-focused, trauma-informed and guided by the *SOGICE Survivor Statement*.<sup>919</sup> However, it was noted that a redress scheme would need to be adaptive and responsive to the differing kinds of support and assistance depending on the different levels of severity of their exposure, and their stage of recovery from SOGI conversion practices.<sup>920</sup> Respondents suggested that minor changes to existing support services could be useful, such as a Medicare subsidy for psychologist sessions and funding for mental health support workers.<sup>921</sup>
- c.9.6. Some respondents emphasised that survivors require consistent and diverse support services due to recovery taking years and involving multiple forms of assistance, such as general practice doctors, individual sessions with psychologists and psychiatrists, and group support sessions, among other things, to help heal from complex trauma.<sup>922</sup> One respondent suggested that any redress scheme should provide funding for support groups where survivors are surrounded by affirming friends and peers. This was because support groups equipped survivors with the resources to help them develop new understandings of themselves and the relationship between their faith, gender identity and sexuality.<sup>923</sup> Another respondent also stated

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<sup>915</sup> Submissions 58, 85, 140\*.

<sup>916</sup> Submissions 86, 111\*, 120, 126C, 180\*.

<sup>917</sup> Submissions 86, 91.

<sup>918</sup> Submission 8.

<sup>919</sup> Submissions 8, 92, 115.

<sup>920</sup> Submissions 38, 80, 85.

<sup>921</sup> Submissions 80, 94, 126.

<sup>922</sup> Submissions 92, 94, 124C, 126C, 177.

<sup>923</sup> Submissions 38, 126.

that, at a minimum, a redress scheme should prioritise the diverse lived experiences of LGBTQA+ people in Tasmania who have survived SOGI conversion practices, understand their needs, and provide respect and dignity to them by ensuring access to the medical and legal assistance they need to heal from their trauma and access justice.<sup>924</sup>

## Education

- c.9.7. Most respondents to Question 8 stated that law reform would be best accompanied and made effective by community education programs.<sup>925</sup> Because conversion practices can be covert, education efforts within the health professions, faith communities and the general public will assist in explaining the ideology behind these practices and the harm they cause.<sup>926</sup> This is especially important because some SOGI conversion practice survivors still want to remain part of a faith community and maintain strong relationships within that community. Therefore, education around these practices and their impact needs to include all members of the community.<sup>927</sup> Some respondents noted that education must, however, pay careful attention to different experiences of SOGI conversion practices, in particular whether they were aimed at a person's sexuality or their gender identity. For example, cisgender lesbian women may experience a different type of SOGI conversion practices and harm than transgender or gender diverse people, and the education surrounding SOGI conversion practices needs to reflect this.<sup>928</sup>
- c.9.8. Respondents noted that public health campaigns and community education and awareness programs should be created with input from both faith-based and LGBTQA+ advocacy groups to inform members of the public on what conversion practices are, how they are harmful, why law reform was necessary, and what the new laws require of individuals and organisations.<sup>929</sup> The Australian Psychological Society endorsed a 'good evidence-based peer support model' to complement law reform and minimise harm, namely by targeting psychologists and associated workers to ensure good clinical governance.<sup>930</sup> The Society emphasised that psychosocial support is important, but 'this should not occur at the expense of, or at odds with, appropriate clinical mental health care/treatment'.<sup>931</sup>

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<sup>924</sup> Submission 115.

<sup>925</sup> Submissions 37, 42, 58, 68\*, 91, 93, 94, 105\*, 113, 115, 121, 180\*.

<sup>926</sup> Submission 124.

<sup>927</sup> Submission 126.

<sup>928</sup> Submission 126.

<sup>929</sup> Submissions 37, 68\*, 93, 94, 113, 115.

<sup>930</sup> Submission 18 at 3.

<sup>931</sup> Submission 18 at 3.

- C.9.9. Some respondents expressed a concern that without widespread community education there may be misinformation, non-compliance or deliberate resistance to these laws, which might lead to their effectiveness being undermined or repealed in the future.<sup>932</sup> Some respondents specifically noted that any implications for sex and gender education in schools<sup>933</sup> and codes of conduct for professionals and their organisations on what are and are not SOGI conversion practices<sup>934</sup> would be useful.
- C.9.10. Respondents emphasised that these types of outreach programs require sustained collaboration from all stakeholders, including medical and healthcare professions, faith-based organisations, and educational institutions, and that there must be continuous campaigns to raise awareness for parents, families, faith communities and the general public to send the message that SOGI conversion practices are ineffective, harmful and a violation of human rights.<sup>935</sup>
- C.9.11. Overall, submissions that addressed Question 8 expressed the need to address SOGI conversion practices from a social and cultural perspective. A response that is grounded in a human rights, restorative justice and survivor-centric approach was deeply important for some submissions.<sup>936</sup> Through sustained community education, fully funded and sustained redress schemes, diverse support services and organizational change, these practical, social structures were equally as important in addressing conversion practices as changes to the law.<sup>937</sup>

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<sup>932</sup> Submissions 42, 58.

<sup>933</sup> Submissions 2, 104.

<sup>934</sup> Submissions 65, 114.

<sup>935</sup> Submission 115.

<sup>936</sup> Submission 91.

<sup>937</sup> Submissions 71, 85, 91, 115.

## C.10. Question 9: Any Other Matters

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

- C.10.1. Most submissions via the survey instrument did not directly address this question. Many respondents either left Question 9 unanswered or reiterated points made earlier in their submission, usually around their general support for or opposition to law reform. Written submissions often did not follow the questions asked, and made points that would fall under ‘other matters’ in their introductions, conclusions or throughout. No significant new points were raised in responses to Question 9 that have not been covered above.
- C.10.2. Other respondents did mention a range of points that fell under the rubric of ‘other matters’ in their responses to other questions. For example, those who held strong views about topic wanted to provide supporting literature or alternative views towards gender and sexuality, which have been covered thematically elsewhere in this Appendix,<sup>938</sup> often made these points in response to Question 1. Several respondents who strongly supported legislative change used this question to reaffirm the reasons why conversion practices should be prohibited, rather than provide more detail on the form those changes should take.<sup>939</sup> Some respondents made criticisms of the Issues Paper in their answers to various questions. These included suggestions that some literature within the Issues Paper was incorrectly interpreted but did not provide appropriate evidence or expertise to back up this claim, such as suggesting an individual seeking gender affirmation was evidence of ‘dysfunction’.<sup>940</sup> A small number of submissions suggested the time allocated for the public to submit their responses was too narrow, and others raised issues of governance including distortion, bias, and a lack of scientific rigour in the Issues Paper.<sup>941</sup>

<sup>938</sup> Submissions 2, 7, 8, 20, 27, 55C, 58, 62, 65, 73.

<sup>939</sup> Submissions 4, 5, 10, 18, 37, 38, 40, 42, 58, 73, 78\*, 80, 82, 85, 86, 89, 90, 93, 94, 104, 105\*, 111\*, 113, 114, 120, 121, 124, 137\*, 153\*, 164\*, 173\*, 179.

<sup>940</sup> Submissions 12, 141\*.

<sup>941</sup> Submissions 21, 29C, 30, 76\*. TLRI raises and responds to these points in the Final Report: see 1.1.3, 1.3, 4.4.

## Appendix D

# SOGI Conversion Practice Reform Legislation Extracts

### D.1. Queensland: *Health Legislation Amendment Act 2020* (Qld), amending Part 5 of the *Public Health Act 2005* (Qld):

#### 28 Insertion of new ch 5B [of the *Public Health Act*]

After chapter 5A—

*insert—*

#### **Chapter 5B Conversion therapies**

##### **213E Definitions for chapter**

In this chapter—

*conversion therapy* see section 213F.

*gender identity*, of a person, see section 213G.

*health service provider* see the *Health Ombudsman Act 2013*, section 8.

*sexual orientation*, of a person, means the person's capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different gender, the same gender or more than 1 gender.

##### **213F Meaning of conversion therapy**

- (1) Conversion therapy is a practice that attempts to change or suppress a person's sexual orientation or gender identity.

*Examples—*

a practice attempting to change or suppress a person's sexual orientation or gender identity by—

- inducing nausea, vomiting or paralysis while showing the person same-sex images
- using shame or coercion to give the person an aversion to same-sex attractions or to encourage gender-conforming behaviour
- using other techniques on the person encouraging the person to believe being lesbian, gay, bisexual, transgender or intersex is a defect or disorder

- (2) **Conversion therapy** does not include a practice by a health service provider that, in the provider's reasonable professional judgement—
- (a) is part of the clinically appropriate assessment, diagnosis or treatment of a person, or clinically appropriate support for a person; or
  - (b) enables or facilitates the provision of a health service for a person in a manner that is safe and appropriate; or
  - (c) is necessary to comply with the provider's legal or professional obligations.
- (3) Without limiting subsection (2), the following are examples of the types of practices to which that subsection may apply—
- (a) assisting a person who is undergoing a gender transition;
  - (b) assisting a person who is considering undergoing a gender transition;
  - (c) assisting a person to express the person's gender identity;
  - (d) providing acceptance, support or understanding of a person;
  - (e) facilitating a person's coping skills, development or identity exploration, or facilitating social support for the person.

*Examples of the types of practices—*

- exploring psychosocial factors with a person or probing a person's experience of sexual orientation or gender identity
- providing a speech pathology or gender transition service for a trans-gender or gender-diverse person wishing to alter the person's voice and communication to better align with the person's gender identity
- advising a person about the potential side effects of sex-hormonal drugs or the risks of having, or not having, surgical procedures

**213G Meaning of gender identity**

- (1) Gender identity, of a person, is the person's internal and individual experience of gender, whether or not it corresponds with the sex assigned to the person at birth.
- (2) Without limiting subsection (1), the gender identity, of a person, includes—
- (a) the person's personal sense of the body; and
  - (b) if freely chosen—modification of the person's bodily appearance or functions by medical, surgical or other means; and
  - (c) other expressions of the person's gender, including name, dress, speech and behaviour.

**213H Prohibition of conversion therapy**

- (1) A person who is a health service provider must not perform conversion therapy on another person.

Maximum penalty—

- (a) if the other person is a vulnerable person—150 penalty units or 18 months imprisonment;  
or
- (b) otherwise—100 penalty units or 12 months imprisonment.

(2) An offence against subsection (1) is a misdemeanour.

(3) In this section—

**vulnerable person** means—

- (a) a child; or
- (b) a person who has impaired capacity within the meaning of the *Guardianship and Administration Act 2000* for making decisions about a particular service offered by a health service provider; or
- (c) a person with an impairment that is likely to significantly limit the person's ability to understand a particular service offered by a health service provider.

### **213I Proceedings for indictable offence**

- (1) A proceeding for an offence against section 213H(1) may, at the prosecution's election, be taken summarily or on indictment.
- (2) A magistrate must not hear a proceeding for an offence against section 213H(1) summarily if, at any stage of the hearing, the magistrate is satisfied on the application of the defendant, the offence should not be heard summarily because of exceptional circumstances.

*Examples of exceptional circumstances—*

- There is sufficient connection between the offence the subject of the charge, and other offences allegedly committed by the defendant and to be tried on indictment, to allow all the offences to be tried together.
- There is an important issue of law involved.
- An issue of general community importance or public interest is involved, or the holding of a trial by jury is justified in order to establish contemporary community standards.

(3) If subsection (2) applies—

- (a) the magistrate must proceed by way of an examination of witnesses for an indictable offence; and
- (b) a plea of the person charged at the start of the proceeding must be disregarded; and
- (c) evidence brought in the proceeding before the magistrate decided to act under subsection (2) is taken to be evidence in the proceeding for the committal of the person for trial or sentence; and

- (d) before committing the person for trial or sentence, the magistrate must make a statement to the person under the *Justices Act 1886*, section 104(2)(b)

[end]

## D.2. Australian Capital Territory: *Sexuality and Gender Identity Conversion Practices Act 2020 (ACT)*

### 5 Offences against Act—application of Criminal Code etc

Other legislation applies in relation to offences against this Act.

#### *Note 1 Criminal Code*

The Criminal Code, ch 2 applies to all offences against this Act (see Code, pt 2.1).

The chapter sets out the general principles of criminal responsibility (including burdens of proof and general defences), and defines terms used for offences to which the Code applies (eg *conduct*, *intention*, *recklessness* and *strict liability*).

#### *Note 2 Penalty units*

The Legislation Act, s 133 deals with the meaning of offence penalties that are expressed in penalty units.

### 6 Objects of Act

The objects of this Act are—

- (a) to affirm that—
  - (i) all people have characteristics of sexuality and gender identity; and
  - (ii) no combination of those characteristics constitutes a disorder, disease, illness, deficiency, disability or shortcoming; and
- (b) to recognise and prevent the harm caused by sexuality and gender identity conversion practices.

*Note* A person may make a complaint to the human rights commission about sexuality and gender identity conversion practices (see *Human Rights Commission Act 2005*, s 43 and div 4.2D).

## Part 2 Sexuality and gender identity conversion practices

### 7 Meaning of sexuality or gender identity conversion practice

- (1) In this Act:

*sexuality or gender identity conversion practice* means a treatment or other practice the purpose, or purported purpose, of which is to change a person's sexuality or gender identity.

- (2) However, sexuality or gender identity conversion practice does not include a practice the purpose of which is to—
- (a) assist a person who is undergoing a gender transition; or
  - (b) assist a person who is considering undergoing a gender transition; or
  - (c) assist a person to express their gender identity; or
  - (d) provide acceptance, support or understanding of a person; or
  - (e) facilitate a person’s coping skills, social support or identity exploration and development.

**Examples—s (2)**

- diagnosis and assessment of a person with gender dysphoria or gender non-conforming behaviour or identity
- support for a person with social adjustments related to gender dysphoria
- gender-affirming hormone treatment
- other gender transition services, for example, speech pathology services for a transgender or gender-diverse person who wishes to alter their voice and communication to better align with their gender identity ...

- (3) Also, sexuality or gender identity conversion practice does not include a practice by a health service provider that, in the provider’s reasonable professional judgment, is necessary to—

- (a) provide a health service in a manner that is safe and appropriate; or
- (b) comply with the provider’s legal or professional obligations.

- (4) In this section:

*health service*—see the *Health Act 1993*, section 5.

*health service provider*—see the *Health Act 1993*, section 7.

**8 Offence—performing conversion practice on protected person**

- (1) A person commits an offence if—
- (a) the person performs a sexuality or gender identity conversion practice on another person (the recipient); and
  - (b) the recipient is a protected person.

Maximum penalty: 150 penalty units, imprisonment for 12 months or both.

- (2) A person commits an offence against subsection (1) whether or not the recipient, or a parent or guardian of the recipient, consented to the practice.

**9 Offence—removing protected person from ACT for conversion practice**

A person commits an offence if—

- (a) the person removes another person (the recipient) from the ACT; and
- (b) the recipient is a protected person; and
- (c) the removal is for the purpose of a sexuality or gender identity conversion practice being performed on the recipient.

Maximum penalty: 150 penalty units, imprisonment for 12 months or both.

## **Schedule 1 Human Rights Commission Act 2005—Consequential amendments**

### **[1.1] New section 21 (1) (c) (vi)**

*insert*

- (vi) a conversion practice complaint;

### **[1.2] New section 42 (1) (ec)**

*insert*

- (ec) a conversion practice complaint;

### **[1.3] Commission’s obligation to be prompt and efficient New section 45 (2) (eb)**

*insert*

- (eb) if the complaint is a conversion practice complaint and the commission decides not to refer the complaint for conciliation—tell the complainant, in writing, that the complaint will not be referred for conciliation and include a conversion practice referral statement with the notice; and

### **[1.4] New division 4.2D**

*insert*

## **Division 4.2D Conversion practice complaints to ACAT [ACT Civil and Administrative Tribunal]**

### **53Z Meaning of person complained about—div 4.2D**

In this division:

***person complained about*** means the provider of a sexuality or gender identity conversion practice.

### **53ZA Conversion practice complaints—referral**

- (1) This section applies if—
  - (a) either—
    - (i) a complainant is given a conversion practice referral statement under section 45 (2) (eb); or

- (ii) a statement under section 82C (1) is included in a final report in relation to a complaint; and
- (b) within 60 days after the day the statement is given, the complainant requires the commission to refer the complaint to the ACAT.
- (2) The commission must—
  - (a) refer the complaint to the ACAT; and
  - (b) tell the complainant and the person complained about, in writing, about the referral.

*Note* The commission must also close the complaint (see s 78 (2) (d)).

### **53ZB Conversion practice complaints—late application in exceptional circumstances**

- (1) This section applies if—
  - (a) a complainant has been given a statement under section 45 (2) (eb) or section 82C (1); and
  - (b) the complainant has not required the commission to refer the complaint to the ACAT within 60 days after the day the statement is given to the complainant.
- (2) The complainant may apply to the ACAT for the complaint to be heard by the ACAT.
- (3) The ACAT may grant the application only if satisfied on reasonable grounds that exceptional circumstances prevented the complainant from requiring the complaint to be referred to the ACAT within the 60-day period.
- (4) If the ACAT grants the application, the complaint is, for this Act, taken to have been referred to the ACAT.

### **53ZC Conversion practice complaints—parties to ACAT proceeding**

The following are parties to a complaint referred to the ACAT under this division:

- (a) the complainant;
- (b) the person complained about;
- (c) if, on application by the commission, the ACAT joins the commission as a party to the complaint—the commission.

### **53ZD Conversion practice complaints—commission to give information etc to ACAT**

The commission must give the ACAT (if asked by it) any information or copies of documents in relation to a complaint referred to the ACAT under this division, other than—

- (a) a communication or document to which section 66 (Admissibility of evidence) applies; or

- (b) information, a document or something else relevant to a consideration in relation to a complaint given to the commission under section 73 (Power to ask for information, documents and other things); or
- (c) information given to the commission under section 74 (Requiring attendance etc).

### **53ZE Conversion practice complaints—ACAT orders**

- (1) This section applies if—
  - (a) the commission refers a complaint to the ACAT under this division; and
  - (b) the ACAT is satisfied that the person complained about engaged in a harmful practice.
- (2) The ACAT may make 1 or more of the following orders:
  - (a) that the person complained about not repeat or continue the harmful practice;
  - (b) that the person complained about perform a stated reasonable act to redress any loss or damage suffered by a person because of the harmful practice;
  - (c) unless the complaint has been dealt with as a representative complaint—that the person complained about pay to a person a stated amount by way of compensation for any loss or damage suffered by the person because of the harmful practice; (d) any other order the ACAT considers appropriate.
- (3) In making an order under subsection (2) (c), the ACAT—
  - (a) must consider—
    - (i) the inherent dignity of all people and the impact of the sexuality or gender identity conversion practice on the person’s dignity; and
    - (ii) the nature of the sexuality or gender identity conversion practice; and
    - (iii) any mitigating factors; and
  - (b) may consider any other matter the ACAT considers relevant.

#### **Examples—par (a) (i)—impact of sexuality or gender identity conversion practice**

distress, humiliation, loss of self-esteem, loss of enjoyment of life

#### **Example—par (a) (iii)**

a public apology

- (4) In this section:

***harmful practice*** means a sexuality or gender identity conversion practice that caused, or is likely to cause, harm to a person or otherwise has adversely affected, or is likely to adversely affect, a person’s rights, interests or welfare.

***representative complaint*** means a complaint that is dealt with by the commission as a representative complaint under section 71.

**53ZF Conversion practice complaints—no monetary limit on jurisdiction of ACAT**

The ACAT is not, in exercising the jurisdiction conferred on it by this division, limited in the amount of money that it may order to be paid.

...

**[1.9] Dictionary, new definitions**

*insert*

***conversion practice complaint*** means a complaint about a sexuality or gender identity conversion practice that may be made, or is made, under section 43.

***conversion practice referral statement***—see section 88C.

...

[end]

## **D.3. Victoria: *Change or Suppression (Conversion) Practices Prohibition Act 2021 (Vic)***

### **1 Purposes**

The main purposes of this Act are—

- (a) to denounce and prohibit change or suppression practices; and
- (b) to establish a civil response scheme within the Victorian Equal Opportunity and Human Rights Commission that will—
  - (i) promote understanding of the prohibition on change or suppression practices under this Act and matters relating generally to change or suppression practices; and
  - (ii) consider and resolve reports of change or suppression practices; and
  - (iii) investigate serious or systemic change or suppression practices; and
- (c) to prohibit engaging in change or suppression practices, including through creating offences in relation to engaging in change or suppression practices and certain related activities; and
- (d) to amend the definitions of sexual orientation and gender identity in the Equal Opportunity Act 2010; and
- (e) to include sex characteristics as a protected attribute under the Equal Opportunity Act 2010; and
- (f) to make consequential amendments to certain Acts.

### **3 Objects of this Act**

(1) The objects of this Act are—

- (a) to eliminate so far as possible the occurrence of change or suppression practices in Victoria; and
- (b) to further promote and protect the rights set out in the Charter of Human Rights and Responsibilities; and
- (c) to ensure that all people, regardless of sexual orientation or gender identity, feel welcome and valued in Victoria and are able to live authentically and with pride.

(2) In enacting this Act, it is the intention of the Parliament—

- (a) to denounce and give statutory recognition to the serious harm caused by change or suppression practices; and
- (b) to affirm that a person's sexual orientation or gender identity is not broken and in need of fixing; and

- (c) to affirm that no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming; and
- (d) to affirm that change or suppression practices are deceptive and harmful both to the person subject to the change or suppression practices and to the community as a whole.

#### **4 Definitions**

**[Definitions on conversion practices, sexual orientation, gender identity, from ss 4, 5 and the later pt 5 div 1 amendments to the Equal Opportunity Act collected here:**

change or suppression practice has the meaning given by section 5;

#### **5 Meaning of change or suppression practice**

- (1) In this Act, a change or suppression practice means a practice or conduct directed towards a person, whether with or without the person's consent—
  - (a) on the basis of the person's sexual orientation or gender identity; and
  - (b) for the purpose of—
    - (i) changing or suppressing the sexual orientation or gender identity of the person; or
    - (ii) inducing the person to change or suppress their sexual orientation or gender identity.
- (2) For the purposes of subsection (1), a practice or conduct is not a change or suppression practice if it—
  - (a) is supportive of or affirms a person's gender identity or sexual orientation including, but not limited to, a practice or conduct for the purposes of—
    - (i) assisting a person who is undergoing a gender transition; or
    - (ii) assisting a person who is considering undergoing a gender transition; or
    - (iii) assisting a person to express their gender identity; or
    - (iv) providing acceptance, support or understanding of a person; or
    - (v) facilitating a person's coping skills, social support or identity exploration and development; or
  - (b) is a practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary—
    - (i) to provide a health service; or

(ii) to comply with the legal or professional obligations of the health service provider.

(3) For the purposes of subsection (1), a practice includes, but is not limited to the following—

- (a) providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy;
- (b) carrying out a religious practice, including but not limited to, a prayer based practice, a deliverance practice or an exorcism;
- (c) giving a person a referral for the purposes of a change or suppression practice being directed towards the person.

(4) For the purposes of subsection (1), a practice or conduct may be directed towards a person remotely (including online) or in person.

...

**person affected by a change or suppression practice** means a person towards whom a change or suppression practice is being, or has been, directed;

...

**sexual orientation** has the same meaning as it has in the Equal Opportunity Act 2010; [s 59 of the Bill amends the meaning of ‘sexual orientation’ in the Equal Opportunity Act 2010 as follows]

**sexual orientation** means a person’s emotional, affectional and sexual attraction to, or intimate or sexual relations with, persons of a different gender or the same gender or more than one gender.

...

**gender identity** has the same meaning as it has in the Equal Opportunity Act 2010; [s 59 of this Bill amends the meaning of ‘gender identity’ in the Equal Opportunity Act 2010 as follows]

**gender identity** means a person’s gender-related identity, which may or may not correspond with their designated sex at birth, and includes the personal sense of the body (whether this involves medical intervention or not) and other expressions of gender, including dress, speech, mannerisms, names and personal references;.

**Sex characteristics:**

[s 59 of this Bill inserts the following definition of ‘sex characteristics’ into the Equal Opportunity Act 2010]

**sex characteristics** means a person’s physical features relating to sex, including—

- (a) genitalia and other sexual and reproductive parts of the person’s anatomy; and

(b) the person's chromosomes, genes, hormones, and secondary physical features that emerge as a result of puberty;"

...

**[Corporate responsibility definitions in s 4:]**

In this Act—

**associate**, in relation to a body corporate, means the following—

- (a) an employee or agent of the body corporate to the extent that the employee or agent is acting within the actual or apparent scope of their employment or within their actual or apparent authority;
- (b) an officer of the body corporate;

...

**corporate culture** of a body corporate means an attitude, policy, rule, course of conduct or practice existing within the body corporate or within a part of the body corporate, as the case requires;

**organisation** means an unincorporated body or association, whether the body or association—

- (a) is based in or outside Australia; or
- (b) is part of a larger organisation;

**7 Contravention does not create civil or criminal liability**

A contravention of this Act does not create any civil or criminal liability except to the extent expressly provided by this Act.

**8 Extra-territorial application**

(1) This section applies if—

- (a) a person engages in conduct outside, or partly outside, Victoria; and
- (b) there is a real and substantial link between the conduct and Victoria.

(2) This Act has effect in relation to the conduct as if it had been engaged in wholly within Victoria.

(3) For the purposes of subsection (1), there is a real and substantial link with Victoria if—

- (a) a significant part of the conduct occurs in Victoria; or
- (b) the conduct occurred wholly outside Victoria, but the effects of the conduct occurred wholly or partly in Victoria.

## **Division 2—Change or suppression practices are prohibited**

### **9 General prohibition on change or suppression practices**

A person or organisation contravenes this Act if the person or organisation engages in a change or suppression practice.

#### **Note**

A contravention of this Act by a person or organisation may result in a report being made under Part 3, which sets out the civil response scheme.

## **Part 2—Offences relating to change or suppression practices**

### **Division 1—Offences**

#### **10 Offence of engaging in one or more change or suppression practices that cause serious injury**

- (1) A person (A) commits an offence if—
- (a) A intentionally engages in a change or suppression practice directed towards another person (B); and
  - (b) the change or suppression practice causes serious injury to B; and
  - (c) A is negligent as to whether engaging in the change or suppression practice will cause serious injury to B.

**Penalty:** In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

- (2) A person (A) commits an offence if—
- (a) A intentionally engages in change or suppression practices directed towards another person (B); and
  - (b) any or all of the change or suppression practices, considered as a group, cause serious injury to B; and
  - (c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause serious injury to B.

**Penalty:** In the case of a natural person, level 5 imprisonment (10 years maximum) or a level 5 fine (1200 penalty units maximum) or both;

In the case of a body corporate, 6000 penalty units maximum.

## **11 Offence of engaging in one or more change or suppression practices that cause injury**

(1) A person (A) commits an offence if—

- (a) A intentionally engages in a change or suppression practice directed towards another person (B); and
- (b) the change or suppression practice causes injury to B; and
- (c) A is negligent as to whether engaging in the change or suppression practice will cause injury to B.

**Penalty:** In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum. (2) A person (A) commits an offence if—

(2) A person (A) commits an offence if—

- (a) A intentionally engages in change or suppression practices directed towards another person (B); and
- (b) any or all of the change or suppression practices, considered as a group, cause injury to B; and
- (c) A is negligent as to whether engaging in any or all of the change or suppression practices will cause injury to B.

**Penalty:** In the case of a natural person, level 6 imprisonment (5 years maximum) or a level 6 fine (600 penalty units maximum) or both;

In the case of a body corporate, 3000 penalty units maximum.

## **12 Offence of taking a person from Victoria for a change or suppression practice**

(1) A person (A) commits an offence if—

- (a) A takes another person (B) from Victoria, or arranges for B to be taken from Victoria; and
- (b) A intends that a change or suppression practice directed towards B will be engaged in outside Victoria (whether by A or another person); and
- (c) a change or suppression practice directed towards B is engaged in outside Victoria; and
- (d) the change or suppression practice causes injury to B; and
- (e) A is negligent as to whether the change or suppression practice will cause injury to B.

**Penalty:** In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

(2) A person (A) commits an offence if—

- (a) A takes another person (B) from Victoria, or arranges for B to be taken from Victoria; and
- (b) A intends that change or suppression practices directed towards B will be engaged in outside Victoria (whether by A or another person); and
- (c) change or suppression practices directed towards B are engaged in outside Victoria; and
- (d) any or all of the change or suppression practices, considered as a group, cause injury to B; and
- (e) A is negligent as to whether any or all of the change or suppression practices, considered as a group, will cause injury to B.

**Penalty:** In the case of a natural person, level 7 imprisonment (2 years maximum) or a level 7 fine (240 penalty units maximum) or both;

In the case of a body corporate, 1200 penalty units maximum.

### **13 Offence of advertising a change or suppression practice**

(1) A person commits an offence if—

- (a) the person publishes or displays, or authorises the publication or display of, an advertisement or other notice; and
- (b) the advertisement or other notice indicates, or could reasonably be understood as indicating, that the person or any other person intends to engage in one or more change or suppression practices, other than for the purposes of warning of the harm caused by such practices.

**Penalty:** In the case of a natural person, level 9 fine (60 penalty units maximum);

In the case of a body corporate, 300 penalty units maximum.

(2) It is a defence to a charge under subsection (1) if the accused proves that the accused took reasonable precautions and exercised due diligence to prevent the publication or display.

### **14 Production of documents relating to advertising offence**

- (1) For the purpose of proceedings under section 13, the Commission may, by written notice, require any person to produce any documents specified in the notice to the Commission.
- (2) A person must not refuse, without reasonable excuse, to produce a document referred to in subsection (1) to the Commission.

**Penalty:** In the case of a natural person, level 9 fine (60 penalty units maximum);  
In the case of a body corporate, 300 penalty units maximum.

### **15 Corporate criminal responsibility for offence against this Part**

- (1) For the purposes of a proceeding against a body corporate for an offence against this Part, the following must also be attributed to the body corporate—
  - (a) relevant conduct engaged in by an associate of the body corporate;
  - (b) knowledge of an associate of the body corporate;
  - (c) intention—
    - (i) of the body corporate’s board of directors; or
    - (ii) of an officer of the body corporate; or
    - (iii) of any other associate of the body corporate if a corporate culture existed within the body corporate that directed, encouraged, tolerated or led to the formation of that intention.
- (2) If an officer of a body corporate engages in conduct that constitutes an offence against this Part, the body corporate must be taken to have also engaged in conduct constituting the offence, and may be proceeded against and found guilty of the offence whether or not the officer has been proceeded against or found guilty of that offence.
- (3) In a proceeding against a body corporate for an offence against this Part brought in reliance on subsection (2), it is a defence to the charge for the body corporate to prove that it exercised due diligence to prevent the conduct engaged in by the officer.

### **16 Who may bring proceedings for an offence under section 13**

Proceedings for an offence under section 13 may be brought by—

- (a) the Commission; or
- (b) a police officer; or
- (c) a person who is authorised to do so, either generally or in a particular case, by the Commission.

## **Part 3—Civil response scheme**

## **Division 1—Functions and powers of Commission**

### **17 Functions and powers of Commission**

- (1) The Commission has the following functions—
- (a) to develop and provide education in relation to change or suppression practices;
  - (b) to receive reports about change or suppression practices from any person;
  - (c) to request further information regarding reports of change or suppression practices from persons who make a report and persons or organisations alleged to be engaging in change or suppression practices;
  - (d) to determine appropriate responses to reports on the basis of information provided and the wishes of persons affected where those persons are involved in making reports;
  - (e) to offer education to persons and organisations engaged in change or suppression practices;
  - (f) to establish processes for facilitating an outcome in relation to matters in certain reports that meet the needs of persons affected by change or suppression practices;
  - (g) to focus on ensuring that persons affected by change or suppression practices receive support by directing them to appropriate support services;
  - (h) to support persons who are or may be victims of criminal offences under this Act to voluntarily report these to police.
- (2) The Commission has all the powers necessary to enable it to perform its functions.

### **18 Functions of Commission—educative function**

- (1) The Commission must—
- (a) establish and undertake information and education programs in relation to change or suppression practices; and
  - (b) promote and advance the objects of this Act and be an advocate for this Act.
- (2) The Commission must undertake programs to disseminate information and educate the public with respect to—
- (a) the objects of this Act; and
  - (b) any other matters relevant to the provisions of this Act.

### **19 Functions of Commission—research function**

- (1) The Commission may undertake research into any matter arising from, or incidental to, the operation of this Act that it considers would advance the objects of this Act.

- (2) The Commission may collect and analyse information and data relevant to the operation and objects of this Act.

## **20 Commission may report on educative or research functions**

The Commission may, at any time, submit a report to the Attorney-General on any matter arising from the performance of the Commission's functions under section 18 or 19.

### **Division 2—Reporting change or suppression practices to Commission**

#### **24 Reporting change or suppression practices**

- (1) A person affected by a change or suppression practice, or any other person, may make a report to the Commission in relation to an alleged change or suppression practice.
- (2) A report must be in the prescribed form (if any).

#### **25 Principles for responding to reports**

The principles for the Commission responding to reports are—

- (a) a response should be provided to the person who made the report; and
- (b) a response should be informed by the needs and wishes of persons affected by change or suppression practices; and
- (c) a response should be appropriate to the report; and
- (d) a response should be fair to all persons; and
- (e) a response should be consistent with the objects of this Act.

#### **26 Commission may request more information**

The Commission may request a person who makes a report or a person or organisation who is alleged to be engaging in a change or suppression practice to provide any further information that the Commission considers necessary to assist in determining its response to a report.

#### **27 Consideration of reports**

- (1) This section applies if, in considering a report, the Commission is satisfied that a person or organisation is engaging in, or has engaged in, a change or suppression practice.
- (2) In responding to the report, the Commission must as far as practicable have regard to the following matters, to the extent that information about the matters is reasonably available to the Commission—

- (a) the wishes of the person or persons affected by the change or suppression practice;
- (b) whether the change or suppression practice was a one-off event or a pattern of behaviour;
- (c) the number of people affected by the change or suppression practice;
- (d) the nature and extent of the harm caused by the change or suppression practice;
- (e) any steps taken by a person or organisation to stop engaging in the change or suppression practice or to address the harms caused by the change or suppression practice.

## **28 Responding to reports**

- (1) The Commission, after considering a report, may do one or more of the following—
  - (a) offer targeted education to persons or organisations reported to have engaged in change or suppression practices;
  - (b) in the case of reports made by persons affected by a change or suppression practice, offer facilitation of an outcome in relation to the matters in the report;
  - (c) refer the report to another person or body under section 29;
  - (d) decline to respond to the report in accordance with section 30.
- (2) Participation in facilitation of an outcome in relation to matters in a report is voluntary.

## **31 Withdrawal from facilitation of an outcome**

If the Commission is facilitating an outcome in relation to a matter in a report, any person involved in the facilitation may withdraw at any time by informing the Commission that the person no longer wishes to participate.

## **32 Agreements resulting from facilitation**

- (1) This section applies if, after the Commission facilitates an outcome in relation to a matter in a report, the persons engaged in the facilitation (the parties) reach agreement with respect to any of the matters.
- (2) Any party may request that a written record of agreement be prepared by the parties or the Commission.
- (3) A request must be made within 30 days after the agreement is reached.
- (4) If a record of agreement is prepared by the Commission following a request under subsection (2)—
  - (a) the record of agreement must be signed by or on behalf of each party; and

- (b) the Commission must certify the record of agreement.
- (5) If a record of agreement is prepared by the parties following a request under subsection (2)—
  - (a) the record of agreement must be signed by or on behalf of each party; and
  - (b) on the request of a party, the Commission may certify the record of agreement.
- (6) If the Commission certifies a record of agreement under subsection (4)(b) or (5)(b), the Commission must give each party a copy of the signed and certified record of agreement.
- (7) The refusal of the Commission to certify a record of agreement does not affect the validity of the agreement.

### **Division 3—Investigations**

#### **34 When investigation may be conducted**

The Commission may conduct an investigation under this section into any matter relating to this Act—

- (a) that raises an issue that is serious in nature or indicates change or suppression practices that are systemic or persisting; and
- (b) that indicates a possible contravention of this Act; and
- (c) that relates to a class or group of persons; and
- (d) that would advance the objects of this Act.

#### **35 Commission to conduct investigation as it considers fit**

- (1) Subject to this Division, the Commission may conduct an investigation in the manner it considers fit.
- (2) In conducting an investigation, the Commission is bound by the principles of natural justice, unless otherwise expressly provided in this Division.

#### **36 Power to compel provision of information and production of documents**

- (1) If the Commission reasonably believes that—
  - (a) a person is in possession of information or a document that is relevant to an investigation; and
  - (b) the information or document is necessary for the conduct of the investigation—
 the Commission may by written notice require the person to provide the information or document or both.

- (2) A notice referred to in subsection (1) must specify that the person must do either or both of the following within a reasonable period specified in the notice, or on a reasonable date and at a reasonable time specified in the notice—
- (a) give the Commission a document containing information required by the notice;
  - (b) produce to the Commission the documents specified in the notice.
- (3) A document referred to in subsection (2)(a) must be signed by the person or, in the case of a notice served on a body corporate, an officer of the body corporate.
- (4) If a document is produced to the Commission in accordance with a notice under this section, the Commission may—
- (a) take possession of the document; and
  - (b) make copies of the document or take extracts from the document; and
  - (c) retain possession of the document for as long as is necessary for the purposes of the investigation to which the document relates.
- (5) The Commission must allow a document retained under this section to be inspected, at all reasonable times, by any person who would be entitled to inspect the document if it were not in the possession of the Commission.

### **37 Power to compel attendance**

- (1) The Commission by written notice may require a person to attend before the Commission, at a reasonable time and place, to answer questions if the Commission reasonably believes that—
- (a) the person has information that is relevant to an investigation; and
  - (b) the information is necessary for the conduct of the investigation.
- (2) A person who is required under this section to attend before the Commission—
- (a) is entitled to be paid a reasonable sum for the person's attendance; and
  - (b) is entitled to have a legal or personal representative present.

### **38 Compliance with notice requiring attendance or production of documents**

A person must not, without reasonable excuse, fail to comply with a notice of the Commission under section 36 or 37.

**Penalty:** In the case of a natural person, level 9 fine (60 penalty units maximum);  
In the case of a body corporate, 300 penalty units maximum.

**39 Protection against self-incrimination**

It is a reasonable excuse for a natural person to refuse to give information, answer a question or produce a document under this Act if the giving of the information, the answering of the question or the production of the document would tend to incriminate the person.

**40 Disclosure of identity of persons who give information or documents**

- (1) This section applies to a person who has given or who will give evidence, information or documents to the Commission as part of an investigation, whether or not the person is compelled to do so under section 36 or 37.
- (2) The Commission may give directions prohibiting the disclosure of the identity of the person, or prohibiting the disclosure of information that would be reasonably likely to identify the person, if the Commission considers that preservation of the person's anonymity is necessary—
  - (a) to protect the person's security of employment, privacy or any right protected by the Charter of Human Rights and Responsibilities Act 2006; or
  - (b) to protect the person from victimisation.

**41 Publication of evidence, information or documents**

- (1) The Commission may give directions prohibiting or limiting the publication of—
  - (a) any evidence given before the Commission or any information given to the Commission as part of an investigation; or
  - (b) the contents of any document produced to the Commission as part of an investigation.
- (2) Subsection (1) applies whether or not a person was compelled to give the evidence or produce the information or document under section 36 or 37.
- (3) In deciding whether or not to give a direction under subsection (1), the Commission must have regard to the need to prevent such of the following as are relevant to the circumstances—
  - (a) prejudice to the relations between the Government and the Commonwealth Government or between the Government and the Government of another State or a Territory;
  - (b) the disclosure of deliberations or decisions of the Cabinet, or of a Committee of the Cabinet;
  - (c) prejudice to the proper functioning of the Government;

- (d) the disclosure, or the ascertaining by a person, of the existence or identity of a confidential source of information in relation to the enforcement of the criminal law;
- (e) the endangering of the life or physical or psychological safety of any person;
- (f) prejudice to the proper enforcement of the law or the protection of public safety;
- (g) the disclosure of information the disclosure of which is prohibited, absolutely or subject to qualifications, by or under another Act;
- (h) the unreasonable disclosure of the personal affairs of any person or organisation;
- (i) the unreasonable disclosure of confidential commercial information.

#### **42 Outcome of an investigation**

- (1) After conducting an investigation, the Commission may take any action it considers fit.
- (2) Without limiting subsection (1), the Commission may do any of the following—
  - (a) take no further action;
  - (b) enter into an agreement with a person about action required to comply with this Act;
  - (c) accept an enforceable undertaking;
  - (d) issue a compliance notice to a person.

### **Division 4—Remedies**

#### **43 Enforceable undertakings**

If, following an investigation, the Commission believes that a change or suppression practice has occurred, is occurring or is likely to occur, the Commission may accept a written undertaking from a person under which the person undertakes to take certain actions or refrain from taking certain actions to comply with this Act.

#### **45 Compliance notices**

- (1) If, following an investigation, the Commission believes that a change or suppression practice has occurred or is occurring, the Commission may issue a compliance notice to a person who is wholly or partly responsible for the change or suppression practice.
- (2) A compliance notice must set out the following—
  - (a) the basis for the Commission's belief that a change or suppression practice has occurred or is occurring;

- (b) the provisions of this Act (if any) that the Commission believes the person has contravened;
  - (c) the date by which the person must take or refrain from taking specified actions in relation to the change or suppression practice;
  - (d) the further action that the Commission may take if the person does not take or refrain from taking specified actions;
  - (e) that the person may apply to the Tribunal for review of the issuing of the notice or any term of the notice.
- (3) A person may, within 28 days of receiving the compliance notice, apply to the Tribunal for a review of the issuing of the compliance notice or of any term of the compliance notice.

#### **46 Failure to comply with enforceable undertaking or compliance notice**

- (1) This section applies if—
- (a) the Commission has accepted an enforceable undertaking from a person; or
  - (b) the Commission has issued a compliance notice to a person.
- (2) If the person fails to comply with the enforceable undertaking or the compliance notice—
- (a) the Commission may apply to the Tribunal to enforce the undertaking or the notice; and
  - (b) the Tribunal may make an order requiring the person to comply with the undertaking or notice.

Note Under section 133 of the Victorian Civil and Administrative Tribunal Act 1998, non-compliance with an order of the Tribunal is an offence.

#### **47 Vicarious liability**

- (1) For the purposes of this Part, if a natural person engages in a change or suppression practice in the course of employment (including as a volunteer) or while acting as an agent—
- (a) subject to subsection (2), both the natural person, and the employer or principal, as the case requires, are taken to have engaged in the change or suppression practice; and
  - (b) the person towards whom the change or suppression practice was directed or another person may make a report under section 24 in respect of—
    - (i) the natural person; or

- (ii) the employer or principal; or
  - (iii) both the natural person and the employer or principal.
- (2) The employer or principal is not taken to have engaged in the change or suppression practice if the employer or principal proves, on the balance of probabilities, that the employer or principal took reasonable precautions to prevent the natural person engaging in a change or suppression practice.

#### **49 Reports etc. that relate to organisations**

If a report under this Act relates to change or suppression practices alleged to have been engaged in by an organisation—

- (a) the Commission may request information under section 26 from the president, secretary or other similar officer of the organisation; and
- (b) the Commission may offer targeted education to the president, secretary or other similar officer of the organisation; and
- (c) the president, secretary or other similar officer of the organisation may be a party to facilitation of an outcome for the purposes of Division 2 of this Part.

#### **Division 2—Provisions relating to certain proceedings**

##### **53 Commission not to prejudice certain proceedings or investigations**

- (1) The Commission must not perform the functions or duties or exercise the powers of the Commission under this Act in a manner that would prejudice any—
- (a) criminal proceedings or criminal investigations; or
  - (b) investigations by the IBAC [Independent Broad-Based Anti-Corruption Commission] or the Victorian Inspectorate.

#### **Division 3—Annual report and review of Act**

##### **56 Annual report**

In its report of operations for a financial year under Part 7 of the Financial Management Act 1994, the Commission must include a description of the performance of its functions in relation to change or suppression practices during the financial year.

##### **57 Review of this Act**

- (1) The Attorney-General must ensure that an independent review of the operation and effectiveness of this Act commences 2 years after the commencement of this Act and is completed within 6 months.
- (2) The Attorney-General must ensure that the review is conducted by a person who, in the opinion of the Attorney-General, possesses appropriate qualifications and expertise related to change or suppression practices.
- (3) The person conducting the review must consider the following—
  - (a) whether the criminal offences contained in this Act are effective;
  - (b) whether the civil response scheme is effective, including whether broader investigation and enforcement powers are required;
  - (c) whether a redress scheme should be developed.
- (4) A person who undertakes the review must give the Attorney-General a written report of the review as soon as practicable after completing the review.
- (5) The Attorney-General must cause a copy of the review to be laid before each House of the Parliament within 15 sitting days of that House after receiving the written report.

#### **Division 4—Regulations**

##### **58 Regulations**

- (1) The Governor in Council may make regulations for or with respect to the following matters—
  - (a) forms to be used for the purposes of this Act;
  - (b) any other matter or thing required or permitted by this Act to be prescribed or necessary to be prescribed to give effect to this Act.
- (2) Regulations made under this Act—
  - (a) may be of limited or general application; and
  - (b) may differ according to differences in time, place or circumstance; and
  - (c) may confer powers or impose duties in connection with the regulations on any specified person or specified class of persons; and
  - (d) may apply, adopt or incorporate, with or without modification, any matter contained in any document, code, standard, rule, specification or method formulated, issued, prescribed or published by any person—
    - (i) wholly or partially or as amended by the regulations; or
    - (ii) as formulated, issued, prescribed or published at the time the regulations are made or at any time before then; or
    - (iii) as formulated, issued, prescribed or published from time to time.

## **Part 6—Consequential amendment of Acts**

[The Bill makes ‘sex characteristics’ a protected attribute for the purposes of Victorian anti-discrimination law]

### **60 Attributes**

After section 6(o) of the Equal Opportunity Act 2010 insert—

“(oa) sex characteristics;”

## **Division 2—Amendment of the Family Violence Protection Act 2008**

### **64 Meaning of emotional or psychological abuse**

In section 7 of the Family Violence Protection Act 2008, after the second dot point under the heading “Examples—” insert—

“• an adult child repeatedly denigrating an elderly parent’s sexual orientation, including by telling them it is wrong to be same-sex attracted and that they must change or the adult child will no longer support them;”

## **Division 3—Amendment of the Personal Safety Intervention Orders Act 2010**

### **65 Meaning of harassment**

In section 7 of the Personal Safety Intervention Orders Act 2010, at the end of the paragraphs under the heading “Examples” insert—

“A repeatedly leaves pamphlets in B’s mailbox that state that it is wrong to gender transition and that everyone’s gender expression should match the sex they were assigned at birth.”.

## D.4. New Zealand: *Conversion Practices Prohibition Legislation Act 2022 (NZ)*

The Parliament of New Zealand enacts as follows:

### 1 Title

This Act is the Conversion Practices Prohibition Legislation Act 2022.

### 2 Commencement

(1) This Act, except the provisions specified in subsection (2), comes into force on the day after the date on which it receives the Royal assent.

(2) The following provisions come into force 6 months after the date on which this Act receives the Royal assent:

- (a) subpart 2 of Part 2:
- (b) Part 3.

### Part 1 Preliminary provisions

#### 3 Purpose of this Act

The purpose of this Act is to—

- (a) recognise and prevent harm caused by conversion practices; and
- (b) promote respectful and open discussions regarding sexuality and gender.

#### 4 Interpretation

In this Act, unless the context otherwise requires,—

**conversion practice** has the meaning given to it in section 5

**health practitioner** has the same meaning as in section 5(1) of the Health Practitioners Competence Assurance Act 2003

**health service** has the same meaning as in section 5(1) of the Health Practitioners Competence Assurance Act 2003

**serious harm**, in relation to an individual, means any physical, psychological, or emotional harm that seriously affects the health, safety, or welfare of the individual.

#### 5 Meaning of conversion practice

(1) In this Act, **conversion practice** means any practice, sustained effort, or treatment that—

- (a) is directed towards an individual because of the individual's sexual orientation, gender identity, or gender expression; and
- (b) is done with the intention of changing or suppressing the individual's sexual orientation, gender identity, or gender expression.

(2) However, **conversion practice** does not include—

- (a) any action that a health practitioner takes when providing a health service if the health practitioner—
- (i) considers in their reasonable professional judgement it is appropriate to take that action; and
  - (ii) complies with all legal, professional, and ethical standards when taking the action; or
- (b) assisting an individual who is undergoing, or considering undergoing, a gender transition; or
- (c) assisting an individual to express their gender identity; or
- (d) providing acceptance, support, or understanding of an individual; or
- (e) facilitating an individual's coping skills, development, or identity exploration, or facilitating social support for the individual; or
- (f) the expression only of a belief or a religious principle made to an individual that is not intended to change or suppress the individual's sexual orientation, gender identity, or gender expression.

### **Examples of conversion practices**

The following are examples of a conversion practice if each practice, sustained effort, or treatment described is directed towards an individual because of that individual's sexual orientation, gender identity, or gender expression:

using shame or coercion intending to give an individual an aversion to same-sex attractions or to encourage gender-conforming behaviour:

encouraging an individual to believe that their sexual orientation, gender identity, or gender expression needs changing because it is a defect or disorder:

carrying out a prayer-based practice, a deliverance practice, or an exorcism intending to change or suppress an individual's sexual orientation, gender identity, or gender expression.

Compare: Public Health Act 2005 s 213F (Qld); Sexuality and Gender Identity

Conversion Practices Act 2020 s 7 (ACT); Change or Suppression (Conversion) Practices

Prohibition Act 2021 s 5 (Vic)

### **6 Transitional, savings, and related provisions**

The transitional, savings, and related provisions (if any) set out in Schedule 1 have effect according to their terms.

### **7 Act binds the Crown**

This Act binds the Crown.

## **Part 2 Offences and civil liability in relation to conversion practices**

Subpart 1—Offences relating to conversion practices

### **8 Offence to perform conversion practice on person under age of 18 years or lacking decision-making capacity**

(1) A person commits an offence if the person performs a conversion practice on an individual and knows that, or is reckless as to whether, the individual—

- (a) is under the age of 18 years; or
- (b) lacks, wholly or partly, the capacity to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to their health or welfare.

(2) A person who commits an offence under subsection (1) is liable on conviction to a term of imprisonment not exceeding 3 years.

Compare: Public Health Act 2005 s 213H (Qld); Sexuality and Gender Identity Conversion Practices Act 2020 s 8 (ACT)

### **9 Offence to perform conversion practice that causes serious harm**

(1) A person commits an offence if the person performs a conversion practice on an individual that causes serious harm to the individual and the person—

- (a) knew that performing the conversion practice would cause serious harm to the individual; or
- (b) was reckless as to whether the performance of the conversion practice would cause serious harm to the individual.

(2) A person who commits an offence under subsection (1) is liable on conviction to a term of imprisonment not exceeding 5 years.

Compare: Change or Suppression (Conversion) Practices Prohibition Act 2021 s 10 (Vic)

### **10 Consent not defence**

It is not a defence to a charge under section 8 or 9 that—

- (a) the individual on whom the conversion practice was performed, or a person on behalf of that individual, consented to the performance of that practice; or
- (b) the person charged believed that such consent was given.

Compare: 1961 No 43 ss 204A(6), 204B(4)

### **11 Person on whom conversion practice performed not party to offence**

A person on whom a conversion practice is performed may not be charged as a party to an offence committed on them under section 8 or 9.

Compare: 1961 No 43 ss 204A(7), 204B(5)

**12 No prosecution without Attorney-General's consent**

No prosecution for an offence against section 8 or 9 may be instituted without the consent of the Attorney-General.

Compare: 1993 No 82 s 132

**Subpart 2—Civil liability relating to conversion practices****13 Complaint may be made under Human Rights Act 1993**

A person may make a complaint under the Human Rights Act 1993 alleging that there has been a breach of section 63A of that Act.

**Part 3 Amendment to Human Rights Act 1993****14 Principal Act**

This Part amends the Human Rights Act 1993.

**15 New section 63A inserted (Conversion practices)**

After section 63, insert:

63A Conversion practices

(1) It is unlawful for any person to—

(a) perform a conversion practice on any other person; or

(b) arrange for a conversion practice to be performed on any other person.

(2) In this section, **conversion practice** has the same meaning as in section 5 of the Conversion Practices Prohibition Legislation Act 2022.

**Schedule 1 Transitional, savings, and related provisions****Part 1 Provisions relating to this Act as enacted**

There are no transitional, savings, or related provisions relating to this Act as enacted.

**Legislative history**

30 July 2021	Introduction (Bill 56–1)
5 August 2021	First reading and referral to Justice Committee
2 February 2022	Reported from Justice Committee (Bill 56–2)
8 February 2022	Second reading
9 February 2022	Committee of the whole House
15 February 2022	Third reading
18 February 2022	Royal assent

This Act is administered by the Ministry of Justice.



## **D.5. Canada: Bill C-24 2021: *An Act to Amend the Criminal Code (Conversion Therapy)***

**An Act to amend the Criminal Code (conversion therapy)**

**S.C. 2021, c. 24**

Assented to 2021-12-08

An Act to amend the Criminal Code (conversion therapy)

### SUMMARY

This enactment amends the Criminal Code to, among other things, create the following offences:

- (a) causing another person to undergo conversion therapy;
- (b) doing anything for the purpose of removing a child from Canada with the intention that the child undergo conversion therapy outside Canada;
- (c) promoting or advertising conversion therapy; and
- (d) receiving a financial or other material benefit from the provision of conversion therapy.

It also amends the Criminal Code to authorize courts to order that advertisements for conversion therapy be disposed of or deleted.

### **Preamble**

Whereas conversion therapy causes harm to the persons who are subjected to it;

Whereas conversion therapy causes harm to society because, among other things, it is based on and propagates myths and stereotypes about sexual orientation, gender identity and gender expression, including the myth that heterosexuality, cisgender gender identity, and gender expression that conforms to the sex assigned to a person at birth are to be preferred over other sexual orientations, gender identities and gender expressions;

And whereas, in light of those harms, it is important to discourage and denounce the provision of conversion therapy in order to protect the human dignity and equality of all Canadians;

Now, therefore, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

R.S., c. C-46

Criminal Code

**1 (1) Subsection 164(1) of the Criminal Code is amended by striking out “or” at the end of paragraph (d), by adding “or” at the end of paragraph (e) and by adding the following after paragraph (e):**

(f) the representation, written material or recording, copies of which are kept in premises within the jurisdiction of the court, is an advertisement for conversion therapy.

2018, c. 29, s. 12(2)

**(2) Subsections 164(3) to (5) of the Act are replaced by the following:**

**Owner and maker may appear**

(3) The owner and the maker of the matter seized under subsection (1), and alleged to be obscene, child pornography, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, may appear and be represented in the proceedings to oppose the making of an order for the forfeiture of the matter.

**Order of forfeiture**

(4) If the court is satisfied, on a balance of probabilities, that the publication, representation, written material or recording referred to in subsection (1) is obscene, child pornography, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, it may make an order declaring the matter forfeited to Her Majesty in right of the province in which the proceedings take place, for disposal as the Attorney General may direct.

**Disposal of matter**

(5) If the court is not satisfied that the publication, representation, written material or recording referred to in subsection (1) is obscene, child pornography, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, it shall order that the matter be restored to the person from whom it was seized without delay after the time for final appeal has expired.

2014, c. 25, s. 46(4)

**(3) Subsection 164(7) of the Act is replaced by the following:**

**Consent**

(7) If an order is made under this section by a judge in a province with respect to one or more copies of a publication, a representation, written material or a recording, no proceedings shall be instituted or continued in that province under section 162, 162.1, 163, 163.1, 286.4 or 320.103 with respect to those or other copies of the same publication, representation, written material or recording without the consent of the Attorney General.

**(4) Subsection 164(8) of the Act is amended by adding the following in alphabetical order:**

*advertisement for conversion therapy* means any material — including a photographic, film, video, audio or other recording, made by any means, a visual representation or any written material — that is used to promote or advertise conversion therapy contrary to section 320.103; (publicité de thérapie de conversion)

2014, c. 25, s. 46(5)

**2 (1) The portion of subsection 164.1(1) of the Act before paragraph (a) is replaced by the following:**

**Warrant of seizure**

164.1 (1) If a judge is satisfied by information on oath that there are reasonable grounds to believe that there is material — namely, child pornography as defined in section 163.1, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, or computer data as defined in subsection 342.1(2) that makes child pornography, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy available — that is stored on and made available through a computer system as defined in subsection 342.1(2) that is within the jurisdiction of the court, the judge may order the custodian of the computer system to

2014, c. 25, s. 46(6)

**(2) Subsection 164.1(5) of the Act is replaced by the following:**

**Order**

(5) If the court is satisfied, on a balance of probabilities, that the material is child pornography as defined in section 163.1, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, or computer data as defined in subsection 342.1(2) that makes child pornography, the voyeuristic recording, the intimate image, the advertisement of sexual services or the advertisement for conversion therapy available, it may order the custodian of the computer system to delete the material.

2014, c. 25, s. 46(7)

**(3) Subsection 164.1(7) of the Act is replaced by the following:**

**Return of material**

(7) If the court is not satisfied that the material is child pornography as defined in section 163.1, a voyeuristic recording, an intimate image, an advertisement of sexual services or an advertisement for conversion therapy, or computer data as defined in subsection 342.1(2) that makes child pornography, the voyeuristic recording, the intimate image, the advertisement of sexual services or the advertisement for conversion therapy available, the court shall order that the electronic copy be returned to the custodian of the computer system and terminate the order under paragraph (1)(b).

3 Paragraph (a) of the definition offence in section 183 of the Act is amended by

(a) adding the following after subparagraph (xlv):

(xlv.1) section 273.3 (removal of child from Canada),

(b) adding the following after subparagraph (liii):

(liii.1) section 320.102 (conversion therapy),

2019, c. 25, s. 98

**4 Paragraph 273.3(1)(c) of the Act is replaced by the following:**

(c) under the age of 18 years, with the intention that an act be committed outside Canada that if it were committed in Canada would be an offence against section 155, subsection 160(2) or section 170, 171, 267, 268, 269, 271, 272, 273 or 320.102 in respect of that person; or

**5 The Act is amended by adding the following after section 320.1:**

## **Conversion Therapy**

### **Definition of *conversion therapy***

320.101 In sections 320.102 to 320.104, conversion therapy means a practice, treatment or service designed to

- (a) change a person's sexual orientation to heterosexual;
- (b) change a person's gender identity to cisgender;
- (c) change a person's gender expression so that it conforms to the sex assigned to the person at birth;
- (d) repress or reduce non-heterosexual attraction or sexual behaviour;
- (e) repress a person's non-cisgender gender identity; or
- (f) repress or reduce a person's gender expression that does not conform to the sex assigned to the person at birth.

For greater certainty, this definition does not include a practice, treatment or service that relates to the exploration or development of an integrated personal identity — such as a practice, treatment or service that relates to a person's gender transition — and that is not based on an assumption that a particular sexual orientation, gender identity or gender expression is to be preferred over another.

### **Conversion therapy**

320.102 Everyone who knowingly causes another person to undergo conversion therapy — including by providing conversion therapy to that other person — is

- (a) guilty of an indictable offence and liable to imprisonment for a term of not more than five years; or
- (b) guilty of an offence punishable on summary conviction.

### **Promoting or advertising**

320.103 Everyone who knowingly promotes or advertises conversion therapy is

(a) guilty of an indictable offence and liable to imprisonment for a term of not more than two years; or

(b) guilty of an offence punishable on summary conviction.

**Material benefit**

320.104 Everyone who receives a financial or other material benefit, knowing that it is obtained or derived directly or indirectly from the provision of conversion therapy, is

(a) guilty of an indictable offence and liable to imprisonment for a term of not more than two years; or

(b) guilty of an offence punishable on summary conviction.

**Coming into Force**

**30th day after royal assent**

**6 This Act comes into force on the 30th day after the day on which it receives royal assent.**

## **D.6. Germany: *Gesetz zum Schutz vor Konversionsbehandlung [A Law to Protect Against Conversion Therapy] 2020***

### **§ 1 Scope of the Law**

- (1) This law applies to all treatments carried out on humans that result in the change or suppression of sexual orientation or self-perceived gender identity ('conversion treatment').
- (2) This Act does not apply to treatment of medically recognized sexual preference disorders.
- (3) Conversion treatments do not include surgical medical interventions or hormone treatments aimed at expressing a person's self-perceived gender identity or a person's desire for a more masculine or more feminine physical appearance corresponding thereto.

### **§ 2 Prohibition of Performing Conversion Treatments**

- (1) It is prohibited to carry out a conversion treatment on a person who is under 18 years of age.
- (2) For persons over age of 18, it is prohibited to carry out a conversion treatment on a person who has not consented to it.

### **§ 3 Prohibition of Advertising, Offering and Brokering**

It is forbidden to advertise, offer or mediate conversion treatment.

### **§ 4 Establishment of an Advisory Service**

- (1) The Federal Center for Health Education will establish a telephone and online advice service. The advice service is aimed at
  1. all persons who are or may be affected by conversion treatments and their relatives and
  2. all persons who, for professional or private reasons, dealt with or advise on sexual orientation or self-perceived gender identity.
- (2) Counseling will be offered anonymously and in several languages.

### **§ 5 Penal Provisions**

- (1) Anyone who violates § 2 performs a conversion treatment

- (2) Paragraph 1 does not apply to persons who act as parents or legal guardians, provided the act does not involve a gross violation of their duty of care.

**§ 6 Regulations on Fines**

- (1) An administrative offense is committed by anyone who, contrary to § 3, advertises or offers conversion treatment.
- (2) The administrative offense can be punished with a fine of up to €30,000

**§ 7 Entry into Force**

This law comes into force on the day after its promulgation. [end]

## **D.7. Malta: An Act to Prohibit Conversion Therapy, as a Deceptive and Harmful Act or Practice Against a Person's Sexual Orientation, Gender Identity and, or Gender Expression, and to Affirm Such Characteristics 2015**

BE IT ENACTED by the President, by and with the advice and consent of the House of Representatives, in this present Parliament assembled, and by the authority of the same, as follows: —

### **Title.**

1. The title of this Act is the Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act, 2015.

### **Definitions.**

2. In this Act, unless the context otherwise requires:

**“conversion therapy”**, means treatment that aims to change, repress and, or eliminate a person's sexual orientation, gender identity and, or gender expression. Provided that any counselling related to the exploration of one's identity with regard to any of the characteristics being affirmed by this Act is excluded from this definition;

**“gender expression”** refers to each person's manifestation of their gender identity, and/or the one that is perceived by others;

**“gender identity”** refers to each person's internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance and, or functions by medical, surgical or other means) and other expressions of gender, including name, dress, speech and mannerisms;

**“professional”** refers to a person who is in possession of an official qualification and, or a warrant to practice as a care worker, counsellor, educator, family therapist, medical practitioner, pathologist, psychologist, psychotherapist, psychiatrist, social worker, and, or youth worker;

**“sexual orientation”** refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different gender or the same gender or more than one gender;

**“mental disorder”** shall have the meaning assigned to it in the Mental Health Act;

**“vulnerable person”** means any person:

- (a) under the age of 18 years;

- (b) suffering from a physical or mental infirmity;
- (c) considered by the court to be particularly at risk when taking into account the person's age, maturity, health, disability, social or other conditions including any situation of dependence, as well as physical or psychological consequence of the offence on that person.

**The Affirmation of Sexual Orientation, Gender Identity and Gender Expression.**

In accordance with the provisions of this Act all persons have a sexual orientation, a gender identity and a gender expression, and no particular combination of these three characteristics constitutes a disorder, disease, illness, deficiency, disability and, or shortcoming.

**Unlawful Conversion Therapy.**

3. (1) It shall be unlawful-

(a) For any person to:

- i. perform conversion therapy on a vulnerable person;
- ii. perform involuntary and, or forced conversion therapy on a person;
- iii. advertise conversion therapy;

(b) For a professional to:

- i. offer conversion therapy on any person irrespective of whether monetary compensation is received in exchange;
- ii. refer any person to other professionals and, or to any other person to perform conversion therapy.

**Criminalisation of Conversion Therapy**

4. (1) Those found guilty under subarticle (a) of the previous article shall on conviction be liable to a fine (multa) of not less than one thousand Euros (€1,000) and not exceeding five thousand Euros (€5,000) or to imprisonment for a term from 1 month to 6 months, or both such fine and imprisonment;

(2) Those found guilty under subarticle (b) of the previous article shall on conviction be liable to a fine of not less than two thousand (€2,000) and not more than ten thousand Euros (€10,000) or to imprisonment for a term from 3 months to 1 year, or both such fine and imprisonment;

Provided that if a professional is found guilty under subarticle (2) the Court shall direct the Registrar of the Criminal Courts and Tribunals to transmit a copy of the judgment to the council or body regulating that profession.

(3) the punishments prescribed in this article shall be increased by 1 to 2 degrees in those instances where any person performs conversion therapy on a vulnerable person;

**Objects and Reasons**

The main object of this bill is to provide for a ban on professional conversion therapy against variations of sexual orientation, gender identity and, or gender expression; and an outright ban on conversion therapy on vulnerable persons, as well as to affirm and protect these characteristics of a person.

[end]

## Appendix E

### List of further publications submitted by respondents

- Robert Withers, 'Transgender Medicalization and the Attempt to Evade Psychological Distress' (2020) 65 *Journal of Analytical Psychology* 865–889.
- Kirsty Entwistle, 'Debate: Reality Check — Detransitioners' Testimonies Require Us to Rethink Gender Dysphoria' (2020) 26 *Child and Adolescent Mental Health* 15–16.
- Lawrence S Mayer and Paul R McHugh, 'Special Report: Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences', *The New Atlantis* (online, 2016) <<https://www.thenewatlantis.com/publications/preface-sexuality-and-gender>>.
- Canadian Gender Report, 'From Trans to Detransitioner — What Can We Learn from This Growing Trend' (17 October 2019) <<https://genderreport.ca/detransitioners-what-can-we-learn/>>.
- Roberto D'Angelo et al, 'One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria' (2020) 50 *Archives of Sexual Behavior* 7–16.
- Mary Margaret Olohan, 'UK High Court Rules Children under 16 "Unlikely to be Able to Give Informed Consent" to Puberty Blockers', *Daily Caller* (online, 1 December 2020) <<https://dailycaller.com/2020/12/01/transgender-children-puberty-blockers-united-kingdom-high-court/>>.
- Sari M van Anders, 'Beyond Sexual Orientation: Integrating Gender/Sex and Diverse Sexualities via Sexual Configurations Theory' (2015) 44 *Archives of Sexual Behavior* 1177–1213.
- Roy Baumeister, 'Gender Differences in Erotic Plasticity: The Female Sex Drive as Socially Flexible and Responsive' (2000) 126 *Psychological Bulletin* 347–74.
- Lisa M Diamond, 'What Does Sexual Orientation Orient? A Biobehavioral Model Distinguishing Romantic Love and Sexual Desire' (2003) 110 *Psychological Review* 173–92.
- Ritch Savin-Williams, *Mostly Straight: Sexual Fluidity among Men* (Harvard University Press, 2017).

- Lisa M Diamond and Clifford J Rosky, 'Scrutinizing Immutability: Research on Sexual Orientation and US Legal Advocacy for Sexual Minorities' (2016) 53 *Journal of Sex Research* 363–91.
- Ritch C Savin-Williams and Geoffrey L Ream, 'Prevalence and Stability of Sexual Orientation Components during Adolescence and Young Adulthood' (2007) 36 *Archives of Sexual Behavior* 385–94.
- Johnny Berona et al, 'Trajectories of Sexual Orientation from Adolescence to Young Adulthood: Results from a Community-Based Urban Sample of Girls' (2018) 63 *Journal of Adolescent Health* 57–61.
- Ryan T Anderson, *When Harry Became Sally* (Encounter Books, 2018).
- Association for Reformed Political Action Canada, 'Conversion Therapy' (2019) <<https://arpacanada.ca/wp-content/uploads/2019/11/ARPA-PolicyReport-ConvTherapy-CIT-PR-hyperlinked.pdf>>.
- James E Phelan, Neil Whitehead and Philip M Sutton, 'What Research Shows: NARTH's Response to the APA Claims on Homosexuality: A Report of the Scientific Advisory Committee of the National Association for Research and Therapy of Homosexuality' (2009) 1 *Journal of Human Sexuality* 1–128.
- Joseph Nicolosi, A Dean Byrd and Richard W Potts, 'Retrospective Self-Reports of Changes in Homosexual Orientation: A Consumer Survey of Conversion Therapy Clients' (2000) 86 *Psychological Reports* 1071–88.
- Douglas C Haldeman, 'The Practice and Ethics of Sexual Orientation Conversion Therapy' (1994) 62 *Journal of Consulting and Clinical Psychology* 221–7.
- Douglas C Haldeman, 'Gay Rights, Patient Rights: The Implications of Sexual Orientation Conversion Therapy' (2002) 33 *Professional Psychology: Research and Practice* 260–4.
- Stanton L Jones and Mark A Yarhouse, 'A Longitudinal Study of Attempted Religiously Mediated Sexual Orientation Change' (2011) 37 *Journal of Sex and Marital Therapy* 404–27.