1. Has the Act reduced or stopped change or suppression practices? Describe any impact you think the Act has had on the occurrence or the nature of change or suppression practices.

It is difficult to determine whether the Act has reduced or stopped genuinely harmful "change or suppression practices," as there is limited publicly available data on their prevalence before or after its introduction.

However, based on lived experience and observations from families and clinicians, the Act appears to have significantly influenced the nature of clinical practice, rather than clearly demonstrating a reduction in harmful conduct.

There is a perception that the Act has contributed to a narrowing of acceptable therapeutic approaches, particularly for children and adolescents with gender-related distress. Clinicians may be uncertain about the boundary between prohibited practices and legitimate exploratory care, leading to reduced willingness to examine underlying factors such as trauma, neurodevelopmental conditions, or co-occurring mental health issues.

At the same time, approaches described as "affirming" are often treated as neutral. However, social interventions such as changes to name or pronouns may function as active psychological steps that shape identity development, particularly in young people. This raises questions about whether the framework adequately recognises that different approaches may carry different forms of influence and risk.

The overall effect appears to be a shift toward affirmation as the default, not necessarily because it is clinically indicated, but because it is perceived as the least legally risky option.

Accordingly, while the intention of the Act is to prevent harm, its current operation may be contributing to a more constrained clinical environment, rather than clearly reducing harmful practices.

2. To what extent do you think the community is aware of and understands: a. the Act and how it works b. what change or suppression practices are and c. the harm caused by change or suppression practices

Community awareness and understanding of the Act appear to be limited and uneven.

Among families, there is often little understanding of how the Act operates in practice, particularly the distinction between permitted therapeutic care and prohibited "change or suppression practices." The definitions are perceived as broad and difficult to apply, which contributes to uncertainty for both clinicians and parents.

In clinical settings, this lack of clarity appears to influence behaviour. From my own experience as a parent of a medically complex adolescent, clinicians were hesitant to explore underlying causes of distress—including autism, trauma and significant mental health issues—once gender-related

explanations were introduced. There was a clear reluctance to engage in open-ended therapeutic exploration, which felt constrained rather than supported.

Public understanding of harm also appears incomplete. Messaging has largely focused on harm arising from attempts to suppress identity. However, there is limited recognition that harm may also arise where clinical exploration is reduced, where complex presentations are not fully assessed, or where identity-affirming approaches are adopted without sufficient consideration of underlying conditions.

For families like mine, this is not theoretical. The absence of thorough exploratory care contributed to decisions and pathways with significant and potentially irreversible consequences for my child's health. The current framework does not appear to fully acknowledge these risks.

Overall, community understanding of both the Act and the nature of harm remains partial. Greater clarity, balanced public information, and recognition of the complexity of these presentations are needed to support safer outcomes.

3. Could the Act's operation and effectiveness be improved? If so, how?

Yes, the operation and effectiveness of the Act could be improved, particularly by addressing areas of uncertainty that affect clinical practice and patient care.

Greater clarity is needed in the definition of "change or suppression practices," especially in distinguishing prohibited conduct from legitimate, exploratory therapeutic care. Practical guidance with real-world examples would assist clinicians and families in understanding what is permitted, particularly for children and adolescents with complex presentations.

The Act would also benefit from explicitly recognising the importance of clinical neutrality and open inquiry. Clinicians should be able to explore underlying factors—such as mental health conditions, trauma, or neurodevelopmental differences—without concern that such exploration may be interpreted as a prohibited practice. This is a core component of evidence-based care.

Strengthening safeguards for vulnerable groups, including children with co-occurring conditions, should also be considered. This may include reinforcing expectations around comprehensive assessment and multidisciplinary care.

Improved communication and guidance for both clinicians and families would further support the effective operation of the Act, particularly in clarifying how it applies in practice.

Finally, there should be ongoing monitoring of unintended consequences, including whether the Act is influencing clinical behaviour in ways that limit access to appropriate care.

These changes would help ensure the Act more effectively prevents harm while supporting safe, evidence-based clinical practice.

4. How clear is the Act's definition of what is and what is not a change or suppression practice? If further clarity is needed, what forms of clarification would be most helpful?

The Act's definition of what constitutes a "change or suppression practice" is not sufficiently clear in practice, particularly in clinical contexts.

While the intent of the definition is understandable, its breadth and lack of practical guidance make it difficult to apply in real-world situations. In particular, there is uncertainty about where the boundary lies between prohibited practices and legitimate, exploratory therapeutic care.

This lack of clarity is especially problematic in the treatment of children and adolescents presenting with gender-related distress, many of whom have complex co-occurring conditions such as autism, trauma, or other mental health issues. In these cases, careful exploration of underlying factors is a standard and necessary part of good clinical practice. However, clinicians may be uncertain whether such exploration could be interpreted as an attempt to "change" or "suppress" identity.

The absence of clear, practical examples contributes to this uncertainty. As a result, there may be a

tendency to avoid certain lines of inquiry, leading to a narrowing of therapeutic approaches.

Further clarity would be most helpful in the form of detailed, clinically relevant guidance that clearly distinguishes between coercive or harmful practices and legitimate, evidence-based therapeutic exploration. This could include case-based examples demonstrating what is and is not permitted in different clinical scenarios.

Clearer articulation that neutral, exploratory therapy—including the discussion of identity development, underlying causes of distress, and alternative pathways—is not prohibited would also assist in supporting appropriate care.

Improving clarity in these areas would help ensure the Act can be applied consistently, while supporting clinicians to provide safe and comprehensive care.

5. How clear is the exclusion for health service providers? If further clarity is needed, how could this best be achieved?

The exclusion for health service providers is not sufficiently clear in practice, particularly in relation to the scope of permitted therapeutic care.

While the intention of the exclusion appears to be to allow legitimate clinical practice, there is ongoing uncertainty about how it applies in real-world settings. In particular, it is unclear how clinicians can safely engage in exploratory therapy where discussions involve identity, underlying causes of distress, or alternative pathways of care.

From a practical perspective, the distinction between accepted clinical care and prohibited conduct remains difficult to interpret. This is especially relevant for children and adolescents with complex presentations, where comprehensive assessment—including consideration of mental health conditions, trauma, and neurodevelopmental factors—is a standard part of care.

The lack of clarity may contribute to a cautious or risk-averse approach, where clinicians avoid certain forms of inquiry due to concern about potential legal implications. This may limit the availability of neutral, exploratory care.

Further clarity would be most effectively achieved through detailed, clinically relevant guidance that clearly outlines the scope of the health service provider exclusion. This should include practical examples demonstrating how the exclusion applies in different clinical scenarios, particularly in relation to exploratory therapy.

Explicit clarification that evidence-based, neutral clinical assessment—including discussion of identity development and contributing factors—is not prohibited would also assist clinicians in applying the Act with confidence.

Improving clarity in this area would support consistent application of the Act while ensuring that appropriate clinical care remains accessible.

6. Is greater clarity needed about how people of faith can hold and express their beliefs to support clear understanding and compliance with the Act? What forms of clarification would be most helpful?

Greater clarity would be beneficial regarding how people of faith—and more broadly, members of the community—can hold and express their beliefs while remaining compliant with the Act.

At present, there appears to be uncertainty about where the boundary lies between lawful expression of belief and conduct that may be considered a prohibited practice. This uncertainty may extend beyond religious contexts to include parents, carers, and others supporting individuals experiencing gender-related distress.

From a practical perspective, individuals may be unsure whether expressing views about sex, identity, or appropriate pathways of care—particularly where those views differ from an affirmation-based approach—could be interpreted as "suppression" or "change" practices. This lack of clarity may discourage open and respectful dialogue, even where it is intended to support the wellbeing of

the individual.

Further clarification would be most helpful in the form of clear, accessible guidance that distinguishes between the expression of personal or religious beliefs and conduct that constitutes a prohibited practice. This could include practical examples illustrating what types of conversations, support, or guidance are permitted.

It would also be beneficial to clarify that respectful discussion, the sharing of beliefs, and supportive conversations—particularly within families and communities—do not, in themselves, constitute prohibited conduct, provided they are not coercive or harmful.

Improving clarity in this area would support better understanding of the Act, promote compliance, and help ensure that individuals can engage in open, respectful, and supportive dialogue without fear of unintentionally breaching the legislation.

7. How effective are VEOHRC's awareness and education materials on change or suppression practices? What improvements, if any, could help strengthen community understanding and compliance?

VEOHRC's awareness and education materials appear to have increased general visibility of the Act; however, their effectiveness in supporting clear understanding and practical compliance is less certain.

The materials tend to focus on broad messaging about harm and prohibition, without sufficient detail on how the Act applies in real-world situations, particularly in clinical and family contexts. As a result, awareness does not necessarily translate into confidence in how to interpret and apply the law.

They also do not adequately reflect the complexity of working with children and adolescents experiencing gender-related distress, especially those with co-occurring mental health or developmental conditions. There is limited guidance on how clinicians and families can engage in legitimate, exploratory conversations while remaining compliant.

There is also concern that some approaches, often described as "affirming," are presented as neutral or inherently safe. However, early social interventions such as changes to name or pronouns may have a significant psychological impact, reinforcing identity in ways that are not easily reversible in young people. These potential effects are not clearly acknowledged.

As a result, the materials may present a partial view of harm, focusing primarily on suppression while not recognising risks associated with limited clinical exploration or early identity reinforcement.

Improvements could include clearer, practical guidance with case-based examples, and more balanced information about the range of clinical approaches and their potential impacts. This would strengthen understanding and support more effective compliance.

8. Are there any barriers to:

- a. reporting change or suppression practices to VEOHRC
- b. VEOHRC facilitating outcomes of reports
- c. VEOHRC conducting investigations.

If so, please describe what those barriers are.

There appear to be barriers affecting reporting, facilitation of outcomes, and investigations under the Act, particularly relating to awareness, confidence, and perceived balance.

For reporting, a key barrier is limited understanding of what constitutes a "change or suppression practice." Individuals may be uncertain whether their experience meets the threshold, particularly in complex clinical or family contexts. This uncertainty may discourage reporting.

There may also be hesitation to report where individuals are concerned about potential consequences for relationships, including within families or therapeutic settings. In clinical contexts, patients may be reluctant to report due to concerns about ongoing care or trust in providers.

In relation to facilitating outcomes, the complexity of these cases may present challenges. Situations involving gender-related distress often involve multiple contributing factors, including mental health conditions and family dynamics. A framework that is perceived as one-directional may not always support balanced or satisfactory outcomes for all parties.

From a clinician perspective, there may be concern about reputational or professional risk associated with complaints, particularly where definitions are unclear. This may contribute to a cautious approach to practice.

There is also a broader perception among some families that their experiences of harm—particularly where they relate to limited clinical exploration or concerns about treatment pathways—are not readily recognised within the current framework. This may reduce confidence in the reporting process.

Addressing these barriers may require clearer guidance, improved communication, and assurance that processes are balanced, transparent, and able to engage with the full complexity of these situations.

9. Are there changes that could help support VEOHRC to carry out its functions or improve the effectiveness of the civil response scheme? If so, please describe any changes.

Yes, there are changes that could support VEOHRC to carry out its functions more effectively and improve the operation of the civil response scheme.

A key priority is improving clarity around the scope of the Act. Uncertainty about what constitutes a "change or suppression practice," particularly in clinical and family contexts, appears to affect both reporting and the ability to resolve matters. Clearer definitions, supported by practical, case-based guidance, would assist all parties in understanding how the Act applies in real situations.

There is also a need to ensure the scheme is equipped to engage with the complexity of cases involving gender-related distress, particularly for children and adolescents with co-occurring mental health or developmental conditions. This may include access to relevant clinical expertise to support informed and balanced consideration of matters raised.

Improving confidence in the scheme is also important. Some families report that their experiences—particularly where concerns relate to limited clinical exploration or treatment pathways—are not readily recognised within the current framework. Ensuring that the scheme can engage with a broader range of experiences may strengthen trust and participation.

Enhanced communication and education would further support effectiveness. This could include clearer information for both the public and professionals about how the scheme operates, what outcomes are available, and how matters are assessed.

Finally, ongoing monitoring of how the scheme is functioning in practice, including identification of unintended consequences, would help ensure it continues to meet its intended purpose of preventing harm while supporting appropriate care.

10. Are there barriers to reporting, investigating and prosecuting criminal change or suppression offences? If so, what are they?

There appear to be several barriers to reporting, investigating, and prosecuting criminal offences under the Act, particularly relating to clarity, evidence, and confidence in the framework.

A key barrier is the lack of clear and practical definitions. Where it is uncertain what constitutes a prohibited practice, individuals may be unsure whether conduct meets the threshold for a criminal offence. This uncertainty may discourage reporting and complicate assessment by investigators.

Evidentiary challenges are also likely significant. Many interactions in this area occur in private settings, including therapeutic or family environments, making it difficult to establish clear evidence of intent, coercion, or harm to the standard required for criminal prosecution.

There may also be reluctance to engage with the criminal system due to the sensitive and complex

nature of these cases. Individuals may be concerned about the potential impact on family relationships or ongoing care, particularly where matters involve clinicians or parents.

From a clinical perspective, uncertainty about the boundaries of the Act may contribute to cautious practice, but may not translate into clear cases suitable for criminal investigation or prosecution. This may partly explain the absence of prosecutions to date.

There is also a perception among some families that the framework does not fully recognise the range of experiences of harm, which may reduce confidence in engaging with formal processes.

Addressing these barriers may require clearer definitions, practical guidance, and ongoing review of how the criminal provisions operate in practice, including whether they are appropriately targeted and workable.

11. Are there other aspects of the criminal offences in the Act that limit their effective operation? If so, what changes or supports could improve their operation?

There are aspects of the criminal offences that may limit their effective operation, particularly in relation to scope, clarity, and practical application.

The broad and somewhat indeterminate definitions make it difficult to identify conduct that clearly meets the threshold for a criminal offence. This creates uncertainty for both potential complainants and those responsible for investigation and prosecution, and may contribute to the absence of prosecutions to date.

There is also a risk that the current framework captures a wide range of interactions, including those occurring in clinical or family settings, without sufficiently distinguishing between coercive or harmful conduct and legitimate forms of support or discussion. This lack of differentiation may make the offences difficult to apply consistently and may reduce confidence in their use.

The sensitive and complex nature of these matters further complicates enforcement. Cases often involve private conversations, evolving identities, and co-occurring mental health issues, which can make it difficult to establish intent, causation, and harm to the standard required for criminal proceedings.

Improving the operation of the offences may require clearer and more narrowly defined thresholds, supported by practical guidance on how the provisions apply in different contexts. This could include examples that distinguish clearly between prohibited conduct and permissible support.

Consideration could also be given to whether additional safeguards or guidance are needed for cases involving minors and clinical care, where complexity is high and the risk of unintended consequences is significant.

These changes would help ensure that the criminal provisions are more targeted, workable, and effective in addressing genuinely harmful conduct.

12. Do existing avenues for redress adequately meet the needs of victim-survivors of change or suppression practices? Are there gaps, harms or barriers that require an additional or separate redress mechanism?

It is difficult to assess whether existing avenues for redress adequately meet the needs of victim-survivors of change or suppression practices, particularly given the complexity of these cases and the limited data available.

However, there appear to be gaps in how harm is currently recognised within the framework. Existing mechanisms are primarily designed to address harm arising from attempts to suppress or change identity. There is less clarity about whether individuals who experience harm in other contexts—such as where clinical exploration is limited or where particular treatment pathways are adopted without comprehensive assessment—are able to access appropriate redress.

From a lived experience perspective, there is a concern that some forms of harm may not be readily captured within the current framework. This may include situations where individuals, particularly

children and adolescents with complex presentations, proceed along clinical pathways without thorough exploration of underlying factors or co-occurring conditions, and later experience adverse outcomes.

In these circumstances, it is not clear that existing avenues provide a pathway for recognition, accountability, or support.

This raises the question of whether a more inclusive approach to redress is needed—one that is capable of responding to a broader range of experiences, including those arising from different models of care.

Consideration could be given to mechanisms that allow for independent review of clinical pathways and outcomes, particularly where concerns relate to assessment processes, informed consent, or long-term impacts.

Ensuring that redress frameworks are able to recognise and respond to the full range of potential harms would strengthen confidence in the system and better support those affected.

13. Should a civil cause of action be introduced under the Act? What distinct purpose would it serve compared to existing pathways?

The introduction of a civil cause of action may provide an additional pathway for individuals seeking redress; however, its effectiveness would depend on how clearly the underlying concepts and thresholds are defined.
In its current form, uncertainty around what constitutes a "change or suppression practice" may limit the practical utility of a civil cause of action. Without greater clarity, there is a risk that such a pathway could be difficult to apply consistently, potentially leading to further uncertainty for both claimants & respondents.
If introduced, a civil cause of action could serve a distinct purpose by providing a more accessible and less adversarial avenue than criminal proceedings for individuals seeking recognition of harm & accountability.
However, it is important that any such mechanism reflects the evolving clinical evidence base.
Internationally, there has been a shift toward more cautious, assessment-led approaches to gender-related distress in young people, with increased emphasis on comprehensive mental health evaluation & long-term outcomes. This reflects growing recognition that early, unqualified affirmation may not be appropriate in all cases, particularly where presentations are complex.
In this context, there is a need to ensure that any civil pathway does not unintentionally reinforce a single model of care or discourage legitimate, evidence-based clinical exploration.
Consideration should also be given to whether any new mechanism can respond to a broader range of experiences. As noted in earlier responses, some individuals & families report harm in contexts not clearly captured by the current framework, including concerns about limited assessment or treatment pathways adopted without sufficient exploration.
Ultimately, the effectiveness of a civil cause of action would depend on improved clarity, balanced application, and alignment with contemporary clinical evidence, ensuring it supports both accountability & appropriate care.