Submission to the Victorian Law Reform Commission:

Focused Review of How the Change or Suppression Practices Ban Is Working

Introduction

Genspect Australia is a health promotion charity focused on supporting evidence-based care for people experiencing gender-related distress, and on preventing harm and reducing adverse outcomes associated with gender-related medical interventions.

Our network brings together clinical professionals, including many working in mental health care, as well as parents and families of young people experiencing gender dysphoria and gender incongruence.

We thank you for the opportunity to contribute to this important review and offer the following responses to your specific questions.

Question 1: Has the Act reduced or stopped change or suppression practices.

No.

Using the Act's language, the question is whether the Act has reduced or stopped conduct directed at changing or suppressing a person's sexual orientation or gender identity. In our experience, it has not done so in any clear or reliable way. But it has, inadvertently, changed the form in which such pressures are experienced, while also creating confusion and hardship for families and a chilling effect across the healthcare and allied professions.

Genspect Australia has been active in Victoria in supporting parents and families of young people experiencing gender-related distress over a period marked by a sharp increase in transgender identification among young people and by the adoption of the gender-affirming model of treatment, including puberty blockers, cross-sex hormones and, in some cases, surgery. Through that work, we have had sustained contact with Victorian families navigating these complex issues in real time.

Since the Act came into force we have received a great many reports from parents that clinicians, schools and other professionals have invoked the Act to tell them that the law requires affirmation and leaves no lawful room for careful exploration, watchful waiting, or genuinely neutral therapeutic support. Parents have also directly reported to us many instances in which experienced health professionals, including psychiatrists, have been unwilling to take on children and young people presenting with complex mental health and developmental difficulties that include gender dysphoria, because they perceive the legal, professional and reputational risks of working in this area to be too great.

The effects of this especially concerning for same-sex attracted young people, because in some cases an automatic affirming response to gender distress may leave insufficient space for same-sex attraction to be recognised, understood and accepted by the young person or their family. They are also concerning for young people with autism, trauma, neurodiversity or other co-occurring conditions, because these are contexts in which careful, neutral assessment is especially important.

Whether the representations by clinicians and professionals that these parents have heard arise from misunderstanding, over-caution or deliberate overstatement, the effect on families is the same: parents feel intimidated, lawful options are obscured, and ordinary parental concern or support for exploratory care is treated as though it may itself be unlawful.

Genspect Australia has also seen growing interest in our network from clinicians concerned by the sharp increase in presentations of gender distress among young people and by growing uncertainty regarding the efficacy and evidence base underpinning the use of puberty blockers and other interventions. Since the Act came into force, many of those clinicians have also reported that it has, in practice, made lawful exploratory care and less invasive treatment pathways professionally hazardous, and contributed to a climate in which careful, neutral and evidence-based clinical work is increasingly difficult to provide.

These professionals include psychologists, psychiatrists, psychotherapists, counsellors, social workers, general practitioners, occupational therapists and others involved in the assessment and support of children and adolescents. Some feel they cannot now engage in gender-related therapy while others have limited their practice or adopted defensive approaches, such as narrowing the focus of their work because they fear complaint, reputational attack, professional repercussions or legal scrutiny. The consequence that we have observed is that many young people with gender-related distress now encounter clinical pathways in which alternative approaches are not explored, informed consent is undermined, and transition is promoted despite an unsettled gender identity.

Taken together, these effects on patients, families, clinical practice and access to care show that the Act is not operating effectively. In our view, its present operation is entrenching a new form of the very pressures it was intended to prevent.

Question 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 c. the harm caused by change or suppression practices.

Community awareness and understanding of these issues is developing in different ways across different groups. As our own community has grown, we have become increasingly aware of other groups, including online, discussing related concerns: gender dysphoria, detransition, desistance, and the medical treatment of gender-distressed young people. Many of these discussions reflect concern about the safeguards surrounding medical treatment and about whether, in practice, conversion ban laws are having unintended effects.

Within these communities, there is clear recognition that historic efforts to suppress same-sex attraction were harmful and wrong – and we must learn our history and not return to the practices of old. That history matters not only because it records real harms, but also because it reminds us that we must be careful not to substitute one form of rigidity for another, whether in law or in clinical practice.

But these concerns about the medicalisation of gender identity are not well understood across the broader community. Too often, questioning medical practices or calling for proper safeguards is treated as though it were inseparable from historic practices directed at changing or suppressing same-sex attraction. That conflation is obscuring the distinct nature of the present concerns and makes it harder to recognise that the Act as currently drafted is contributing to new forms of harm, including by narrowing the space for careful assessment, lawful psychological exploration and sound clinical judgment.

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

Genspect Australia believes the Act's operation and effectiveness could be greatly improved by clarifying the concepts on which the prohibition turns, ensuring greater consistency with related Victorian statutes and policies, and improving public and professional communication about what the Act does and does not prohibit.

Defining Harm

As currently framed, the Act is directed to the prevention of harm, yet it does not define harm as a general concept. That omission is striking because the Act's objects and civil response provisions depend upon the concept (even as the criminal offences separately define "injury" and "serious injury").

Genspect Australia submits that this lack of clarity in this key concept is a substantial driver of the chilling effect produced by the Act. In the absence of a clear definition of "harm", clinicians, parents, teachers and others are required to regulate their conduct by reference to an open-ended concept with uncertain boundaries in an area already marked by conceptual, clinical and social contestation.

Genspect Australia recommends therefore amending the Act to include a precise and workable definition of harm. That definition should avoid broad emotional or evaluative language that imports further subjectivity, and should instead tie the concept to objectively identifiable harm resulting in a material adverse effect.

For that reason, we recommend that harm be defined separately as follows:

> For the purposes of this Act, harm means physical injury, recognisable psychological injury, or a material adverse effect on a person's health, safety or capacity for independent decision-making, and does not include mere offence, disagreement, non-affirmation, lawful clinical assessment, therapeutic exploration, ordinary parental guidance, or the expression of a view or belief in good faith.

A definition of this kind would improve the Act's clarity, reduce uncertainty for those subject to it, and better align its stated purpose with its practical operation. It would also serve to reassure clinicians that competent and professional practice remains lawful.

Defining Gender Identity and Gender Expression

Genspect Australia considers that the Act's treatment of gender identity would benefit from clarification in two related respects.

First, as currently framed, the Act proceeds from an understanding of gender identity as fixed. That is at odds with other Victorian laws, including the *Birth Deaths and Marriages Registration Act* and its implementing arrangements which permit repeated applications over time to alter a person's birth record, implicitly recognising potential fluidity. The assumption of fixity is also at odds with the reality of the concept in clinical practice.

This matters especially in healthcare, including for children and young people, because gender identity may develop or change over time rather than existing as a fixed and settled characteristic from the outset. This in turn may impact the effective enjoyment of the human right to fully informed and freely given consent in relation to social or medical interventions with significant and potentially irreversible consequences.

Secondly, the Act also conflates gender identity with gender expression by treating dress, speech, mannerisms, names and personal references as defining identity itself (that language is incorporated by section 4 through its cross-reference to the Equal Opportunity Act 2010). We consider this definition problematic because a tomboy, feminine boy, distressed adolescent, or same-sex attracted young person may display gender-nonconforming expression without thereby establishing a fixed or enduring gender identity.

For that reason, we recommend that gender expression be defined separately as follows:

> gender expression means the external presentation of a person's sexed or gendered appearance, behaviour, dress, speech, mannerisms, names or pronouns, whether or not that presentation reflects a settled gender identity.

If gender expression is defined separately, gender identity can then be defined more clearly as follows:

> gender identity means a person's internal sense of being male, female or neither, which may or may not correspond with their sex at birth and may develop or change over time.

Defining gender transition and detransition

We also believe the Act should define gender transition and detransition. It currently refers to a person undergoing or considering gender transition, but does not define that term. A definition of gender transition would assist clarity by making clear that transition may involve social, legal, and medical steps, including medical interventions that may be irreversible.

A definition of detransition so that it is clearly understood to include the cessation, reversal, or modification of social, legal, or medical steps previously taken in a gender transition, would similarly serve the Act's educative purpose and acknowledge an existing clinical and social reality.

Question 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?

We believe section 5 requires urgent review and redrafting. The current drafting does not provide sufficient clarity as to what is, and what is not, a change or suppression practice, and in practice it has contributed to uncertainty among psychiatric, psychological and related therapeutic professions.

Section 5 is especially problematic because it appears to adopt a purpose-based test in section 5(1), prohibiting conduct directed at changing or suppressing a person's sexual orientation or gender identity, but then in section 5(3) singles out psychiatry and psychotherapy by name as examples of prohibited practices. Those profession-specific references are unnecessary and undesirable in a legal test that already turns on purpose, particularly when the Act itself recognises specialist professional regulators, including Ahpra and the Health Complaints Commissioner, in section 29.

The practical effect of this drafting is that it casts a shadow over legitimate clinical practice and discourages clinicians from providing care in an area where vulnerable people may most need skilled support. A clinician reading section 5(3) sees their profession named explicitly in connection with prohibited practices but finds much less explicit reassurance in section 5(2) that psychiatric or psychological assessment, exploratory therapy, differential diagnosis and treatment are protected.

Section 5 should therefore be redrafted to draw a clearer distinction between prohibited purpose-driven conduct and lawful clinical care. The more specific question of how the health service provider exclusion should be clarified is addressed in our response to Question 5.

Question 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 in section 5(2) is not sufficiently clear and creates unnecessary confusion and potential harm. The Act should more clearly protect legitimate, non-directive clinical care undertaken in the exercise of reasonable professional judgment, including assessment, exploratory therapy, differential diagnosis, treatment of distress, management of co-occurring conditions, and other non-directive therapeutic support.

Separately, the Act should also make clear that the exclusions allowed in s5(2) do not extend to intervention-related practice or conduct that is directive, coercive, manipulative, one-sided or emotionally pressuring in its purpose or effect. In the context of proposed medical or other significant clinical interventions, the Act should expressly require genuine informed consent.

In our experience, that concern is not merely theoretical. Parents have directly recounted instances in which gender services have discouraged exploratory therapy, failed to advise families of the potential for regret, and used suicide-based messaging to pressure families toward a particular identity or treatment pathway, including by asking whether they wanted 'a live son or a dead daughter'. Conduct of that kind undermines genuine informed consent and should not fall outside the Act merely because it is framed as supportive or affirming.

The Act should accordingly make clear that there is no genuine informed consent unless the person has been given enough clear information, in a way they can understand, and, where appropriate, so has their parent or guardian. That information should cover the main risks of the proposed treatment, what it is expected to do, what is still uncertain, how strong the evidence for it is, and what other options are available, including watchful waiting, exploratory therapy, checking for other possible explanations, treating other related conditions, and other non-directive forms of support.

Specifically we recommend the following amendments to Section 5:

- Clarify section 5(2)(b) to state expressly that the exclusion protects legitimate, non-directive clinical care undertaken in the exercise of reasonable professional judgment, including assessment, exploratory therapy, differential diagnosis, treatment of distress, management of co-occurring conditions, and other non-directive therapeutic support.
- Amend section 5(2) to provide that, in connection with a proposed medical or other significant clinical intervention, the exclusion does not extend to practice or conduct that is directive, coercive, manipulative, one-sided or emotionally pressuring in its purpose or effect.
- Amend section 5(2) to provide that, in connection with a proposed medical or other significant clinical intervention, the exclusion does not extend to practice or conduct undertaken without genuine informed consent.
- Specify that genuine informed consent in that context requires adequate disclosure, in a manner the person and, where relevant, the person's parent or guardian can understand, of the material risks, expected outcomes and uncertainties, evidentiary basis, and clinically available alternatives. Alternatives may include available watchful waiting and exploratory therapy.

We also recommend that section 5(2)(a) be amended to include express reference to supporting a person who is reconsidering, ceasing, reversing, or detransitioning from a gender transition, or who has experienced adverse outcomes from previous treatment. The current text expressly recognises support for a person undergoing or considering transition, but does not equally acknowledge that some people may later seek clinical support in the opposite direction or to manage unexpected sequelae.

Taken together, these amendments would clarify that the exclusion protects lawful, non-directive and professionally responsible care, but does not shelter conduct that undermines genuine informed consent or channels a person toward a fixed identity outcome without proper disclosure and meaningful alternatives.

Professional judgment

We note that the Consultation Paper canvasses whether the concept of "reasonable professional judgment" in the health service provider exclusion requires closer clarification. In our view, the Act must continue to recognise and protect the exercise of competent professional judgment by health service providers. Section 5(2)(b) should therefore be clarified in a way that preserves, rather than constrains, legitimate clinical judgment.

In particular, section 5(2)(b)(ii) should be clarified so that the reference to the legal or professional obligations of the health service provider is not read as an open-ended incorporation of non-binding guidance, policy documents, or position statements issued by professional bodies. The provision should instead be confined to obligations that are truly binding, while preserving reasonable professional judgment in areas where there is legitimate diversity of medical opinion.

Accordingly, we recommend that section 5(2)(b)(ii) be amended by replacing "legal or professional obligations" with "binding legal duties or mandatory professional requirements."

Question 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?

Genspect Australia does not hold a position on this question.

Question 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?

Whether or not it has been VEOHRC's intention, its awareness and education materials have contributed to the chilling effect on parents, patients and clinicians outlined earlier in this submission.

Critically, the website and other materials of which we are aware provide no explanation, and no illustrative examples, of the exclusions in the Act for health service providers. On the contrary, they simply assert harm without analysis and present an over-simplified account that fails to recognise that harm may also arise from social and medical interventions, particularly given the complexities of gender dysphoria and incongruence, its co-occurrence with other conditions, and the potential fluidity of gender identity.

Also conspicuously absent, for a human rights institution providing public-facing guidance concerning people who may be considering lifelong and potentially irreversible medical procedures, is any meaningful discussion of the fundamental basic human-rights principle of freely-given informed consent.

Genspect Australia believes that VEOHRC could significantly improve community understanding of, and compliance with, the Act by providing more balanced and less advocacy-oriented guidance, including a dedicated page explaining that exploratory therapy is not a conversion practice.

We would also like to suggest greater diversity in its illustrative examples, which might include:

- a young lesbian is encouraged to understand herself as transgender in a way that obscures or denies her sexual orientation;
- a parent is told that their child may be at risk of suicide unless immediate affirmation is given;
- a clinician is told that the CSP Act prevents open-ended exploratory therapy;

- a patient experiencing significant depression and anxiety is referred for gender-affirming surgery without adequate exploration of her co-occurring conditions or their possible effect on informed consent;
- a young man who had returned to identifying with his birth sex and attended a clinical appointment seeking support to cease hormonal treatment, but the clinician instead sought to persuade him to continue treatment.

Each of the examples above is based on an actual instance from Victoria. We would be pleased to provide further real-life examples from people with lived experience, including parents, clinicians, desisters and detransitioners.

Question 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.

Genspect Australia, and the people we support, perceive the Act, its civil enforcement framework, and VEOHRC's implementation of that framework as aligned to one understanding of harm and therefore not meaningfully available to them.

We note this with regret, because a human rights framework should be experienced as fair and accessible by all those whose lives it affects. We hope this review can help correct that by refining the Act along the lines set out above.

Question 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.

In addition to the benefits that would flow from a clearer and more balanced Act, VEOHRC would be better supported to carry out its functions, and the civil response scheme would be more effective, if it engaged in consultation with a broader range of affected people and communities, including clinicians, parents, desisters, detransitioners, who have experienced uncertainty about the scope of the Act.

We say this carefully because, in our experience, there is hesitation within some communities about engaging with VEOHRC. That hesitation reflects a genuine concern that the Act, its civil framework, and the public-facing implementation of that framework are aligned to one understanding of harm and may therefore not be experienced as meaningfully available to all those affected by these issues. Broader consultation would help build confidence that the scheme operates fairly and is genuinely accessible to a wider range of affected persons.

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

No. We do not consider the principal issue to be the existence of barriers to reporting, investigating or prosecuting offences as presently defined. Our concern is that the Act's current drafting, especially in section 5, does not draw a sufficiently clear distinction between prohibited conduct and lawful health service provision, creating uncertainty for clinicians, families and decision-makers alike.

In practical terms, we recommend that section 5, and in particular section 5(2), be redrafted along the lines set out in our response to Question 5.

We also recommend that sections 10 and 11 be amended to make clear that they do not apply to conduct consisting of lawful clinical assessment, therapeutic exploration, differential diagnosis, treatment of distress, management of co-occurring conditions, or other health service provision undertaken in the exercise of reasonable professional judgment In practical terms, we recommend the insertion of a new subsection to sections 10 and 11 along the following lines:

> This section does not apply to conduct consisting of lawful clinical assessment, therapeutic exploration, differential diagnosis, treatment of distress, management of co-occurring conditions, or other health service provision undertaken in the exercise of reasonable professional judgment.

Question 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?

Yes. The key limitation on the effective operation of the criminal offences in this Act is that current provisions do not deal coherently with the full range of potentially harmful conduct in this area, including conduct carried out under an affirming label without genuine informed consent.

As we set out in Question 5, the health service provider exclusion in section 5(2) is too broad and insufficiently defined. The Act needs specific amendment to ensure that the exclusion for healthcare practices does not apply where social or medical intervention is directive, coercive, manipulative, one-sided, or undertaken without proper disclosure of material risks, expected outcomes, evidentiary uncertainty and clinically available alternatives.

Question 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?

On current evidence, and for conduct as currently defined under the Act, existing avenues for redress appear adequate. The fact that VEOHRC has investigated only one matter and recommended no prosecutions under the scheme, together with the other existing pathways identified in the consultation paper and existing under the Act, does not establish a convincing need for an additional or separate redress mechanism.

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

Again, on current evidence, we do not consider the introduction of a civil cause of action to be necessary, particularly given the existing avenues of redress.