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.

At the time the Act was passed, religious gay conversion therapy (RGCT) was in decline (source: ABBI) but anti-trans conversion ideology was on the rise (source: Trans Justice Project). The Act may have contributed to the continued decline in RGCT and may have deterred at least some anti-trans practices. In my experience, however, it has been ineffective at stopping anti-asexual practices. In 2023, ACNC revoked charity registration due to double defaulter status. A 2017 archived copy of the website lists nine resources for Australians "affected by homosexuality", but by 2021, there were no Australian resources listed. As of 2026, the website is inaccessible. previously operated in Melbourne (source: Fairfax) but its website now lists chapters in only Sydney, Perth and Brisbane. Various other RGCT groups have also closed, moved offshore or gone underground.

The past few years has seen various interstate and international jurisdictions move to block or delay access to critical trans healthcare and to promote anti-trans "gender exploratory therapy". Victoria has to date proven largely resistant to this trend. Commentary from anti-trans groups suggests that the Act has merit in deterring these practices.

In February 2022, I became the first person to make a report under the Victorian C&SPP Act. I made this report as an asexual and aromantic person, in connection with a medical trial conducted within Victoria (and elsewhere).

In December 2025, I made a second report relating to a similar medical trial being run by the same researcher via the same institution, albeit testing a different drug. Since neither of my reports actually stopped the trials, nor did the first prevent reoccurrence, nor are any further regulatory actions underway to my knowledge, I conclude that the Act has been ineffective at stopping these particular 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

The Act has received little media attention since its passing, though it has been mentioned or advertised at some queer events, especially conferences. Anecdotally, queer media, events and community spaces have declined and fragmented in recent times, impacting the flow of information more generally.

The Healing Spiritual Harms report (Jones et al, 2021) found that past research into conversion practices has focused on the experiences of white, cisgender, gay and bisexual men of the global north, with little research into other groups. Mainstream media echoes this bias. Initial coverage in 2021 described the Act as a ban on "gay conversion therapy" (see e.g. ABC News), while later coverage of the Cass Report and so-called "gender exploration therapy" has sometimes described the harms of such practices but seldom labelled them "change or suppression practices".

Media reporting of the medical trials that were the subject of my reports did not mention asexuality and took for granted that low sexual interest was a "severe" and "traumatic" medical problem that had been ignored for far too long. In response to my two reports, the lead researcher also argued (via VEOHRC) that participants had fully consented to the trials, could not possibly be asexual and would

be “offended” if information about asexuality were provided to them.
In the 2022 Ace Community Survey Report, 43% of asexual participants said that they had experienced attempts or suggestions for how to “fix” or “cure” them, yet only 3.1% said they had been offered “conversion or reparative therapy” in connection with their asexual identity. 0.5% said they had undergone it. In the UK’s National LGBT Survey from 2018, 10% of cisgender asexual people said that they had either experienced or been offered “conversion therapy” and a further 3.7% said they were unsure if they had experienced or been offered it or not, compared to 8% (experienced/offered) and 0.9% (unsure) of gay/lesbian respondents.

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

The Act requires that a practice be “directed at an individual”. The VEOHRC have interpreted this to mean that reports must be submitted by or in reference to that individual, who must have been “directed, threatened or induced” by a third party.
Victim-survivors may take many years to come forward, in part due to shame over perceived complicity in their own trauma. The Act’s definition should be modified to allow for third-party reports by advocates, and ideally also cover “indirect” practices, e.g. those targeting the spouse or parents of a queer person.
From my own experience, the reporting process was slow, largely non-interactive, and – especially for my second report – draining, humiliating and disempowering. It was disconcerting to see the other party’s arguments uncritically reported back to me via the VEOHRC, e.g. that “people do seek treatment and they respect an individual’s decision”. I did have some hope that the first report would trigger further research, training and advocacy, yet my second report has felt like a further step backwards. I am unclear on whether any independent review or appeals process exists at present; if not, creating one may be warranted.
External support was briefly mentioned over the phone, but not in detail and not in writing. I note also that there are currently few safe and reliable support options available for aspec people impacted by medical conversion practices, and that psychology, psychiatry and even non-ace LGBTI support groups are risk areas for both primary and secondary trauma in this regard.
Finally, there may be benefit in VEOHRC working with the NHMRC in addition to other listed bodies such as AHPRA. NHMRC publishes guidelines for ethical approval of medical trials, though it does not regulate them or handle complaints. At present, there does not appear to be an independent complaints process for medical trials; this is an additional opportunity for improvement.

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 term “change or suppression” practice is not well known, and may not reflect the experiences of asexual or transgender people (e.g. asexual people might be encouraged to have unwanted sex rather than pushed towards celibacy). A better term might be “conversion practice”, which links to the better known term “conversion therapy” while avoiding the implication that such practices are therapeutic or therapy-like in nature.
The link between conversion practices and conversion ideology should be emphasised, noting that conversion practices can take many forms, but share a common ideology: that queer people are broken and must be fixed or reprogrammed. This ideology is the core source of harm, not necessarily the practice itself. Viewed in isolation, some practices may appear harmless, consensual or well-intended.
The examples given in the Act reflect common forms of conversion practice directed at cis gay men by other people. It may be worth clarifying whether the Act also covers the following, where the same underlying intent exists: self-paced eLearning, coercive control, “corrective” rape, couples/sex therapy, unnecessary and unsolicited medical tests/exams or withholding a necessary and wanted medical treatment.
Additionally, there is an opportunity to improve the definition of “sexual orientation” in the Equal Opportunity Act 2010. The current definition states that “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”. This should be modified to add “or no genders”, thus including asexual and aromantic people. Note the VEOHRC have interpreted the Act to mean that asexuality is already included (with similar statements recorded in Hansard from the time the Act was legislated), however I consider this plain language amendment to be a small but impactful move towards unambiguous inclusion.

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

This exclusion should be removed.
Conversion practices are based on hateful pseudoscience, not compassion or clinical evidence. There is no circumstance in which they would be medically helpful or necessary.
I note that the Act's criminal offences are only triggered in cases where the practice is intentional, causes serious injury and the practitioner is negligent in regards to that injury. Due to this high threshold combined with the burden of proof, it is unlikely that a genuine error on the part of a practitioner would lead to a successful prosecution; a more likely outcome is facilitation and education. Refining the definition of a conversion practice, as above, along with provision of training and resources, may also help to clarify where medical interventions do or do not constitute a conversion practice.
Australia is currently using ICD-10, which includes diagnoses of "sexual dysfunction" (F52), "gender identity disorders" (F64), "disorders of sexual preference" (F65) and "disorders associated with sexual development and orientation" (F66). ICD-11 removes most of these, but retains Hypoactive Sexual Desire Dysfunction (HA00). Regardless of whether a specific diagnosis is used, asexuality, aromanticism and related terms such as "low desire" and "low sexual interest" attract significant medical stigma, as does singlehood and a "lack" or reduction in sexual activity. Aspec people who are unaware of or unwilling to accept their own identity may also seek out medical help to "cure" themselves. Clinicians should not facilitate this process, any more than they should facilitate "treatment" of homosexuality.
During my initial report, the VEOHRC indicated that the medical exemption would not be relevant. This position appeared to change in my second report, with the VEOHRC referencing (verbally) the fact that HSDD is a recognised medical condition as relevant to their consideration that the Act's threshold had not been met. This should be clarified.

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?

Similar to the above, I believe the better approach here would be to clarify the definition of a conversion practice and to provide training and resources rather than attempt to legislate carveouts. If the practice aims to change, suppress, eliminate or "overcome" a person's orientation or gender identity, based on the false belief that their orientation or gender identity CAN and SHOULD be changed, suppressed, eliminated or overcome, then this would constitute a conversion practice. Otherwise, it would not.
Conversion ideology that is expressed aloud/online but which does not result in a conversion practice may be captured under separate hate speech laws. Those laws are not the subject of this review.
It is important to note that queer people can also be people of faith, and that many non-queer people of faith are queer affirming. Adherence to conversion ideology and resulting conversion practices are not an inherent requirement of any major religion. As such, there is no inherent conflict between the rights of queer people and the rights of people of faith.

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?

The VEOHRC website is inconsistent on whether it includes the "A" in its acronyms: the home page uses "LGBTIQ" while the main conversion practices page uses "LGBTQA" and some subsections of the latter use "LGBTQ". The "A" is a simple yet important sign of inclusive intent.
The case studies on the VEOHRC website are excellent; it would be great to see even more of these, with more variation. The explanation video is generally good, though some parts are sensationalist (e.g. the shattering doll at 2:43) and might not be consistent with the Mindframe national guidelines for depicting suicide and mental ill-health. The video also specifically refers to LGBTQA people of faith when offering support services, reflecting an underlying assumption that all conversion practices are religious in nature.
I would also like to see further advertising and outreach. In particular, the VEOHRC might engage with media organisations to ensure that the Act is mentioned in articles that describe "low libido" treatments or "gender exploration therapy". Organisations such as Switchboard and Rainbow Door could be provided with materials specific to conversion practices if needed. The VEOHRC might also work with external parties to obtain or create more targeted materials, e.g. Trans Justice Project has produced materials debunking common anti-trans arguments and AACAU provides free asexuality 101 materials. Australian Asexuals has a list of local community groups.
I would also strongly recommend that the VEOHRC offer free training on the Act, or at least a free

eLearning module. As of 9 March 2026, there are three options listed on the VEOHRC's "education" page, yet only the $2,250/person Coaching Program appears active. The $4,500/workshop page states that "there are currently no dates scheduled for this course" and the free Information Session page states that "There are no available dates for 2024 – please check back in 2025".

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.

The reporting process is simple enough, though somewhat analogue. It was also quite slow: my first report took four months to resolve, and I am currently (as of 20 March) waiting on an outcome letter for the second, which was submitted in late December. Few progress updates were provided. As noted above, VEOHRC advised that their powers are limited in connection with practices that are not "directed at an [identifiable] individual", e.g. where an advocate becomes aware of a practice and makes a report without having signed up for the practice themself.

The VEOHRC must ensure that it is properly resourced and that its staff are properly trained in conversion practices. This must include training on all parts of the LGBTQIA+ acronym and beyond, as well as the ability to recognise conversion ideology, understand the harm caused by conversion practices and understand that it is impossible to provide free and informed consent to such practices. I was not confident that these aspects were understood in my own dealings with the VEOHRC; this could indicate a general lack of capability, or could a more specific gap in relation to asexuality and the medical "grey area" of HSDD.

I remain unclear on VEOHRC's overall level of influence and ability/willingness to pursue proactive actions in regards to conversion practices. The actions taken in response to my two reports appear limited. This could be due to the "directed at an individual" requirement, the nature of the practice (that they were medical trials, which currently have limited regulatory oversight), the fact that asexuality remains formally pathologized and might trigger the health provider exclusion, or due to restrictions on the VEOHRC's powers to investigate and facilitate an outcome. VEOHRC may be able to provide further comments here. VEOHRC could also consider publishing further information about its scope and limitations.

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.

VEOHRC should engage proactively with advocates, community groups and health providers to grow its internal capability, share information about the Act and challenge the underlying ideology (which is, again, the core source of harm). Additional resourcing or budget may be required to facilitate this; VEOHRC should be consulted on this point. As noted further down, upfront investment here may reduce long term cost.

The Act states that VEOHRC will refer reports to relevant third parties as necessary to achieve the Act's core aims. This did not occur for either of my reports: VEOHRC contacted me, then contacted the subject of my report, then communicated the outcome to me with no further pathways offered. Relevant third parties may have included NHMRC (sets the guidelines for clinical trials), the Health Complaints Commissioner or AHPRA (complaints about and regulation of registered health providers) or the Victorian Ombudsman (since the trial was led by a Victorian university).

Regulation is a powerful tool. In early March 2026, AHPRA announced for example that it had imposed conditions on the registration of Queensland-based psychiatrist [redacted] who had spread anti-trans conversion ideology via social media. As Trans Justice Project's [redacted] remarked, it is pleasing that this action was taken, but "more needs to be done to prevent the spread of anti-trans disinformation in the health sector". The same is true of anti-asexual practices.

There may be an opportunity to implement new regulatory powers in regards to medical trials, which were the subject of my reports and could feasibly also be used to facilitate other conversion practices. This might impose additional requirements/checks on the ethics review process or may provide additional powers to shut down or enforce risk controls upon trials where an actual or potential conversion practice is identified.

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

As an advocate, my priority is to prevent these practices and to support survivors. Criminalisation is not relevant to those objectives, and there is a long and continuing history of police violence towards queer communities. As much as possible, I recommend that reports are addressed through the civil reporting process and through regulators such as AHPRA, not via police and prisons.
A survey conducted by the Victorian Pride Lobby in 2020 found that a majority of queer Victorians did not trust the police. 9 in 10 said that the police treat certain groups unfairly and 4 in 5 said that the police abuse their powers and harass or intimidate some groups without cause. 42% said that they would like to be able to ask for police assistance when they need it, however 76% said they would not be comfortable with disclosing their queer identity.
Since the date the survey above was conducted, I have witnessed and experienced continuing police violence and abuses of power at otherwise peaceful protests. Only recently, the Victorian Government legislated yet further anti-protest and pro-police powers. See analysis by Melbourne Activist Legal Support (MALS) for further details.
I have experienced police incompetence in response to breaches to an intervention order I hold. I have observed tepid police responses to the neo-nazi attack on Camp Sovereignty in Victoria, as well as the attempted bombing of the Perth Invasion Day rally. I watched as police investigated themselves and concluded they had done no wrong in regards to the raid on Hares & Hyenas. Famously, police bashed queer people at Mardi Gras (1978), detailed and strip-searched them at Tasty Nightclub (1994) and covered up the murder of Dr [redacted] in South Australia (1972).
I have no interest in speaking with or being spoken at by police in regards to the CSPP Act, and I believe this perspective is now quite common among queer Victorians, especially young, trans/gender diverse or non-white queer Victorians.

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?

Criminalisation requires the presumption of innocence and a high burden of proof. The Act also requires that the practice "causes serious injury" and that the person involved "intentionally engages in change or suppression practices directed towards another person" and "is negligent as to whether engaging in any or all of the change or suppression practices will cause serious injury".
These are significant thresholds requiring significant evidence. Criminalisation could fail at multiple stages. For example: a) the victim is not willing to pursue the case, b) the police do not believe the victim or do not think that serious injury has occurred, c) the police are unable to gather sufficient evidence, d) the perpetrator argues that the conduct was unintentional and prosecutors are unable to prove otherwise. I note that some forms of conversion practice, e.g. "corrective" rape, were already criminalised before the Act, and that these prosecutions may fail for similar reasons.
The Act also criminalises advertising of change or suppression practices. The trials that I reported had been advertised through multiple channels: websites, targeted ads via social media and reporting by traditional media outlets. Since the VEOHRC deemed that a "change or suppression practice" had not occurred the first place (e.g. that the practices had not been "directed at an individual"), no criminal prosecutions were pursued. In any case, it is possible that these channels might not have been covered. In particular, would media reports be considered "an advertisement or other notice" for this purpose?
Media outlets have played, and continue to play, a major role in proliferating and legitimising conversion ideology. See for example the 7News "De-Transitioning" special from September 2023, or Matty Silver's 2014 article titled "Asexuality: Don't be too hasty with labels" (SMH). I don't think criminalisation is the answer here. I'm not sure there is a good answer.

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?

Existing avenues listed in the VLRC consultation paper are unlikely to meet the needs of the victim-survivors that have called for a redress scheme, especially in regards to practices that took place before the Act came into effect (i.e. before they were criminalised) or which involve legal entities that no longer exist (noting many have recently closed). I note that conversion practices have a very long history within Australia and across the world, and that they have caused significant long-lasting harm. I will let other advocates comment further on the need for a retrospective redress scheme.
In terms of practices occurring after the Act came into effect: I agree with VLRC's comments as to the constraints of each option, per the consultation paper. There have been no successful prosecutions to date, and it would be difficult to achieve a successful prosecution in future. Facilitation might sometimes be a viable option, but only if the other party consents to it. Civil legal

cases require time away from work and would typically also involve legal fees. One option to reduce costs and improve access might be to add this to Victorian Legal Aid's suite of support services, but this only addresses part of the problem. Alternatively, VEOHRC or the relevant regulator(s) could pursue cases on the victim-survivor's behalf. As noted below, a civil cause of action would likely be simpler and provide better value for money than a civil case, but this does not necessarily remove the need for a separate redress scheme.

I note also that the call for a redress scheme arises from historic failures to prevent these practices and protect victim-survivors from injury. As above, anti-asexual practices are currently occurring in broad daylight, and ace-affirming support services are limited. The risk of anti-trans practices also appears to have increased. Investments made now will not erase harm already caused, but can reduce the need for future redress schemes.

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

Yes.

As above, existing pathways are flawed due to the requirement for either agreement from the other party or for successful criminal or civil litigation, which has a high burden of proof and requires a heavy investment of time and money. A civil cause of action via VCAT could be resolved much more quickly and with far less cost and trauma compared to those other paths – resulting in both a better outcome for the victim-survivor and better overall value for money for the State. It may also improve the Act's value as a deterrent, may provide additional incentive for respondents to settle outside of court, and may produce valuable information to facilitate future improvements to the Act and/or its enforcement.

None of the options for compensation are perfect, but an increased number of options makes it more likely that at least one will be viable. In practice, the number of CSPPA reports to date suggests actual usage will be relatively low, albeit deeply impactful for those who need it.