Submission to the Victorian Law Reform Commission

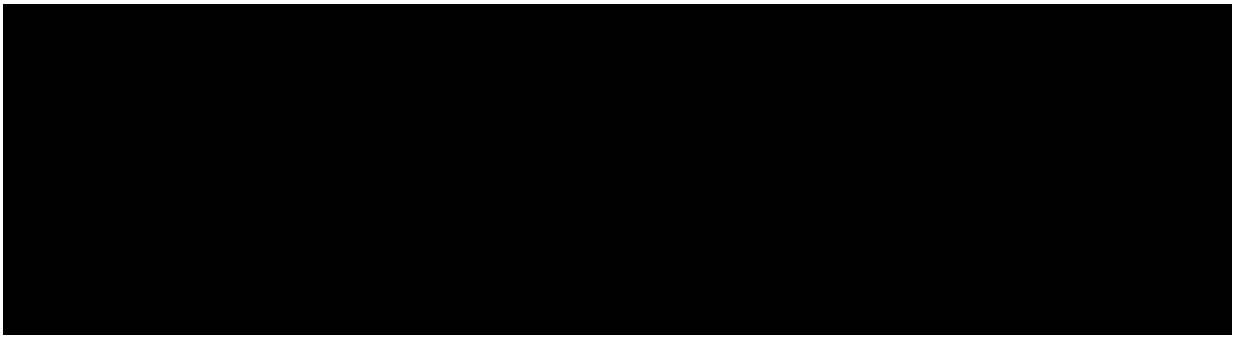
Focused Review of How the Change or Suppression Practices Ban Is Working

Please note that submissions must be relevant. We only review the matters detailed in the terms of reference. We recommend using the consultation paper and these questions to help guide your submission.

We will publish public submissions on our website, unless they are offensive, defamatory, or outside the scope of the review.

We will not publish the names of individuals who make a submission. We will also redact any information which may indirectly identify individuals.

The consultation paper relates to change or suppression practices, which can cause ongoing trauma and long-term health issues. If you need counselling or help you can get support by contacting the organisations on our support page or page 3 of the consultation paper.



Please provide your comments on the questions below. You may answer all or only some of the questions as relevant to you.

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.**

   There can be very little doubt that the legislation has had a chilling effect on the practices of clinical psychologists and psychiatrists in relation to trans-identifying or gender incongruent people. However, one unintended consequence, as I will explain below, is that clinicians in Victoria are extremely reluctant to accept as patients or clients any children and young people who identify as transgender, even to treat other mental health conditions. It has therefore had some negative consequences for trans-identifying children and youth.

   As for sexual orientation, I am unaware of any evidence that the legislation has had a chilling effect on the practices of mental health professionals in relation to conversion practices such as aversion therapy. This is because these practices died out a great many years ago. Such practices have long been condemned by professional organisations as unethical and futile. I am not aware of any reliable evidence that these clinical practices have occurred in Victoria in recent years. This is a likely explanation for the lack of enforcement action.

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.**

It is much easier to make professionals aware of a new law that affects them than it is to educate the general public. To have a law understood by the general population, what is prohibited must be very clear and accord with people's own common sense. To achieve a high level of compliance with a law, it must be intuitively reasonable and sensible.

The Victorian Act is not well-drafted to be well-understood by the general public or to achieve compliance amongst those groups that are the targets of perceived non-compliance.

Consider, for example, what it means to "suppress" a sexual orientation or gender identity. The Consultation Paper translates "suppress" as "hide", which is a much better word; but that is not what the Act says and nor does it fit well with the statutory language of a 'practice' or 'conduct' that has the purpose of achieving the prohibited result (s.5). 'Hiding' is something we do ourselves, but the Act is aimed mainly at conduct or practices done to us.

Furthermore, the VEOHRC educational material confuses suppressing a sexual orientation with suppressing the desires that flow from our sexual orientation (be that heterosexual or same-sex). That is most evident in its highly problematic advice on what people are allowed to pray for. That advice has been rewritten recently and is a little better than it was before; but it still sees any prayer to help someone remain celibate as a breach of the law. Yet in all faiths, control over our sexual feelings is a core element of living a moral life, and celibacy before or outside marriage is traditionally a virtue. Praying for someone (at their request) not to act on their sexual feelings is prayer to suppress one's sexual expression, not one's orientation. The vagueness of the legislation contributes to this conceptual confusion, especially as the Act defines sexual orientation (by cross-reference to another Act) to include both same-sex and heterosexual orientation.

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

It would be more effective legislation if it were more clearly drafted to address the identified problem and nothing more. It is a fundamental principle of statutory drafting that criminal offences should be defined clearly to say what conduct is prohibited so that members of the public can avoid the prohibited conduct.

This legislation overreaches by trying to do far too much, in particular by seeking to prohibit more than the conversion practices that caused harm to people in the past (such as aversion therapy for homosexual men). Its reach into transgender issues is particularly problematic, since there is not the same history of therapeutic conversion practices. Treatment of children and young people who presented as gender incongruent in the past involved advice to parents and 'watchful waiting' rather than therapeutic interventions to try to change the child. Most children naturally resolved their gender incongruence before or while going through puberty as a result of that cautious approach. The great majority of them grew up to be gay or lesbian adults. Since this kind of expert advice and support was not a conversion practice designed to change the child's gender identity, and no other therapeutic practices have been identified in the professional literature, the law is unclear about what exactly the 'mischief' is which it is meant to address in relation to transgender identification.

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?**

I have already explained the problems with the word "suppress". Queensland's legislation (s.213F of the Public Health Act 2005) is better generally because it gives specific examples of what is intended to be banned. It includes 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; and using other techniques on the person encouraging the person to believe being lesbian, gay, bisexual, transgender or intersex is a defect or disorder. These examples highlight unethical therapeutic 'techniques', as opposed to mere counselling.

The need for such clarity is demonstrated by the confusion about the legality of counselling that helps the patient to explore the reasons why they may be gender incongruent. In Re Devin, cited in the consultation paper, and in other family law cases in which I have been involved in Melbourne, senior clinicians have claimed that any therapeutic exploration of a child's gender identity is banned by the Act. Yet many adolescents who present with gender dysphoria and seek to transition to another gender presentation suffer from psychiatric comorbidities, disordered attachments and unresolved trauma. It is necessary, therefore to explore such causative or confounding factors very carefully. This is the basic medical requirement of 'differential diagnosis'. The medical literature provides many examples of how the process of exploring reasons why a young person may be experiencing gender dysphoria has assisted them to reach a different understanding of their distress.

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

Unfortunately, the law is not at all clear, and this has been damaging to LGBT children and young people. The reasons is that mental health clinicians have been most reluctant to take on any trans-identifying child or young person as a patient, even to treat other conditions. Section 5(2)(b) does not provide sufficient reassurance to clinicians, because it is limited to "necessary" treatment and there is plenty of room for argument about what is "necessary".

The judge in Re Devin alluded to the problem. I can confirm the observations made by the judge in that case from personal knowledge and from discussions with LGBTQI+ supportive clinicians practising in Victoria.

Young people who present as trans-identifying typically have a range of other mental health issues. As is well-known, children and young people who are on the autism spectrum are greatly over-represented in gender clinic patient cohorts. Others have anorexia, body dysmorphia, ADHD or bipolar disorder, as well as more common conditions such as clinically significant anxiety or depression. A great many have had adverse childhood experiences, including family breakdown and physical or sexual abuse.

It may not be possible to treat these comorbid conditions without exploring issues concerning trans-identification. Human beings are complex and often these various issues in the lives of children and young people are interrelated. Experienced clinicians either realise this, and for that reason, avoid taking on trans-identified children and young people, or are so afraid of losing their professional licence because of a complaint that they would rather not take the risk of treating these patients.

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?**

With respect, the question itself might need some clarification! The law cannot interfere with the beliefs that a person holds if it is to be consistent with Victoria's human rights framework. This is because it would breach Article 18 (1) of the ICCPR which is expressed in absolute terms. It is a right from which governments are not allowed to derogate even in times of national emergency. In any event, it is futile for Parliaments to try to change people's beliefs through legislation. Nor does this law, properly understood, prohibit the expression of people's beliefs. The Consultation Paper quotes the A-G of the time in the parliamentary debates to this effect. The law applies to 'practices' and 'conduct'.

The fundamental difficulty with the provision about prayer is that it is unclear how praying for someone relates to the actus reus of the offence, which is engaging in a practice or conduct that could have the effect of "changing or suppressing the sexual orientation or gender identity" of a person. The actus reus necessitates belief in a God who is willing and able to intervene in people's lives in this way in response to prayer. As a committed Christian, I happen to believe in a God who answers prayer; but a secular Parliament in a multicultural society can neither believe nor disbelieve in such a God. It certainly cannot premise a criminal offence on such a belief. So the question arises whether the actus reus can ever be shown, even if it can be proven that the person praying had the mens rea to cause change to someone's sexual orientation or gender identity by reason of their faith in the power of prayer. There cannot be an actus reus in relation to an act which is not rationally possible.

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?**

There have been problems with these materials, because the Commission has in some instances gone well beyond the letter of the law. This has caused unnecessary confusion and uncertainty.

For example, at one stage, VEOHRC's website claimed that failing to take your gender incongruent child to the RCH Melbourne gender service (or similar health provider) was a change or suppression practice. However, an omission to do something is not capable of being a "conduct or practice" that has the active purpose of changing or suppressing a transgender identification. This is because such an omission does not alter in any way the gender incongruence of the child or young person. A trans-identifying child or young person who does not receive puberty blockers or cross-sex hormones is no less a trans-identifying child or young person.

Another example of poorly thought through advice again concerns prayer. The Commission still claims that praying on your own for someone who identifies as gay, lesbian or transgender to change, or to remain celibate, is a contravention of the Act; but how could it cause harm to the other person if they don't even know about the prayer? And as I have pointed out above, how could it be conduct for the forbidden purpose unless the Parliament believes that such private prayer could have this outcome? And how could anyone prove what I pray for in the privacy of my own home? This sort of advice just invites disrespect - even ridicule - for the law and for the Commission.

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.

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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.**

To be successful in its work, the Commission needs to carry at least a substantial proportion of the population with it, as well as the professional communities to which the legislation is particularly directed. It must not appear to be either ideological or unreasonable. Unfortunately, it has lost the trust of faith communities, amongst others, because it has not carried out its responsibilities all that wisely.

The Commission needs to recognise that this legislation has been very controversial, not so much because of what it says about attempts to change sexual orientation, but because of its chilling effect upon the mental health support of gender incongruent children and young people. This is a matter of international controversy and huge public concern. The trend, internationally, is to move away from the practices pioneered in Amsterdam and extended in Australia by RCH Melbourne. Progressive countries such as Sweden and Finland, as well as the UK and New Zealand, are now prioritising the very therapeutic approach that this legislation seems to have been designed to discourage.

To carry out its functions better, the Commission needs to regain public and professional trust. It should not go beyond a faithful (and therefore confined) interpretation of the text of the Act. It should focus on the core 'mischief', which is the historical practice of conversion therapy by mental health clinicians.

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

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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?**

As I have said, the legislation needs to be clarified so that as far as possible, the Parliament makes clear to all its citizens, both professionals and ordinary people, what it is that it seeks to prohibit and why. Such legislation, to be successful in persuading people to comply, must be sensible, clear and reasonable. There is much that could be done to improve this legislation in order to support its more effective operation.

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?

Parliament should be very cautious about introducing any retrospective redress scheme for which organisations could not have insured themselves at the time of the alleged harm.

If the government wants to introduce a redress scheme for people harmed by previous clinical practices in government health services, that is another matter.

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

For the same reason, Parliament should be very cautious about introducing any retrospective civil action for which individuals or organisations could not have insured themselves at the time.

Issues of causation of harm are also very difficult, given the range of experiences earlier in our lives that can contribute to mental health problems many years later. Adverse outcomes are often the consequence of multiple adverse experiences.

Email your submission to csp@lawreform.vic.gov.au or send it by post to:
Victorian Law Reform Commission
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Submissions close on 24 March 2026

For more information on how we treat submissions see our **Submissions Policy**.

Find further information on this review and the consultation paper on the **project page**.