SEARCHING THE REINS AND HEARTS: CONVERSION PRACTICES REFORMS IN AUSTRALIA

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Conversion practices seek to change or suppress a person's sexual orientation or gender identity. There is no scientific evidence to support the efficacy of these practices, and considerable evidence that they can cause serious physical, mental and social harm. Despite this, conversion practices have taken and continue to take place across Australia. Recently, Queensland, the Australian Capital Territory and Victoria statutorily proscribed conversion practices, and almost all other States and Territories have committed to reforming their laws. This article analyses recent and proposed law reform models, and considers the best-practice regulatory approach to reducing the incidence of conversion practices and their risks to individuals and the community. We argue for a dual, non-carceral approach that targets conversion practices as a form of pseudo-medical malpractice under existing healthcare laws, and the promotion of the beliefs underlying the practices as a form of discriminatory incitement under anti-discrimination or human rights laws.

I SEARCHING THE REINS AND HEARTS

In the Book of Revelation, John reports Christ's admonition to the church in Thyatira that it 'sufferest that woman Jezebel' – the now emblematic scorned woman who refused to repent her promotion of sex – who 'teach[es] and … seduce[s] my servants to commit fornication'.[1] Christ says 'I will cast her into a

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bed', demands repentance from her lovers, and issues a violent warning: 'And I will kill her children with death; and all the churches shall know that I am he which searcheth the reins and hearts'.[2] In early biblical translation and interpretation, 'reins' were the kidneys, thought to be the organs that produced desire and longing, examinable by God to judge the individual, with contemporary translations replacing 'reins' with 'minds', indicating a person's thoughts or soul.[3] 'Searching the reins and hearts' means, then, examining the emotions, desires, and loyalties of one's followers or one's community.

Conversion practices seek to change or suppress the sexual orientation or gender identity of another person. In a broad sense, they try to affect how a person feels about themselves – their gender identity, their own sense of their sexual orientation – or how they feel about others: the kinds of people to whom they are attracted. While they could in principle relate to any orientation or identity, historically and today, conversion practices target non-heterosexual and non-cisgender people: gay, lesbian, bisexual or asexual identities, and/or non-binary or transgender identities. 'Conversion' here means converting gay to straight or trans to cis, which may take the form of attempts to change, suppress or eradicate those desires and identities.

A range of conduct may constitute a conversion practice. In general, they are unified by their attempts to convince people with LGBTQA+ attributes that those attributes are the result of a fault, dysfunction, past trauma or brokenness, and that it is possible and desirable to change, suppress or eradicate those attributes through a program of interventions. These include individual or group counselling, pseudo-cognitive behavioural therapy programs, prayer groups, scriptural study, and many other activities besides. In this sense, these practices involve searching the reins and hearts; identifying desires, attempting to correct them, and signalling to the community that these are not acceptable ways to live.

Contemporary conversion practices in Australia predominantly occur within religious organisations.[4] Conversion practices have their origins in medicine, especially psychiatry and psychology, and it was only from the 1990s onwards that they began to gain prominence within some religious organisations. The remainder of conversion practices take place in medical settings, and it would be a mistake to consider them solely a religious phenomenon. The consensus view among Australian and international peak medical bodies is that conversion practices are unsupported by scientific evidence and are both dangerous and unethical.[5] This

1 *The Holy Bible*, Revelation 2:20 (King James Version).

2 Ibid 2:22–2:23.

3 Garabed Eknoyan, 'The Kidneys in the Bible: What Happened?' (2005) 16(12) *Journal of the American Society of Nephrology* 3464 <https://doi.org/10.1681/ASN.2005091007>. Cf 'And all the churches shall know that I am he who searches mind and heart': *The Holy Bible*, Revelation 2:23 (Revised Standard Version Catholic Edition, 1966).

4 See, eg, Tasmania Law Reform Institute, *Sexual Orientation and Gender Identity Conversion Practices* (Final Report No 32, April 2022) 43 [3.4.1] ff ('*TLRI Final Report*').

5 See, eg, Australian Psychological Society, 'Use of Psychological Practices that Attempt to Change or Suppress a Person's Sexual Orientation or Gender' (Position Statement, February 2021) ('Use of Psychological Practices'). The Australian Psychological Society also published a 2015 statement, 'APS

consensus position has been reached relatively recently and relatively slowly – not least for those who have suffered profound trauma and harm from apparently 'medical' conversion practices – but nonetheless, conversion beliefs and practices endure within fringes of the medical profession. This is especially the case in relation to gender identity, which has not experienced the same degree of social normalisation as homosexuality has over recent decades, and remains subject to significant religious and secular discrimination, including by those in the health professions. Regardless of setting, characterisation or motivation, conversion practices are ineffective and dangerous. Documented harms to subjects include long-term anxiety, depression and alienation from family and community, suicidal ideation and attempts, and suicides.[6]

Because they are no longer medically or scientifically sanctioned, conversion practices in clinical contexts tend to be hidden or obscured within otherwise legitimate assessments or treatments. More common now are conversion practices by or on behalf of religious leaders, who rely partly on religious doctrine, but also tend to borrow heavily from discredited legacy medical literature and language as part of their practices. These practices are also often hidden, albeit more because they are conducted within closed communities and target people who have been led to believe they are 'broken' and thus 'consent' to the practices themselves. In religious or ultra-conservative community contexts, this conduct is also accompanied by the threat of expulsion if a person does not accept the need for such programs and 'successfully' change their LGBTQA+ attributes through undertaking them. Recently, some public-facing promotion of religious conversion practices has taken place: proselytising and advertising them to the wider public through flyers, newspapers or internet pages, usually using misleading pseudo-medical information mixed with religious doctrine.[7]

A substantial body of recent qualitative research indicates that Australians have been, and continue to be, subjected to many forms of harmful conversion practices.[8] Consequently, in the past decade, a range of national and international governmental bodies have sought to prohibit or regulate conversion practices.[9]

Position Statement on the Use of Psychological Practices that Attempt to Change Sexual Orientation', though this is no longer publicly available on the internet, but is on file with the authors. See also Chris Johnson, 'No Place for Conversion Therapy' (Media Release, Australian Medical Association, 10 September 2018), archived at <https://web.archive.org/web/20190507085133/https://ama.com.au/ausmed/no-place-conversion-therapy>; Australian Medical Association, 'LGBTQIA+ Health: 2021' (Position Statement, 2021) 2, 9–10.

6 On these points, see below Part II.

7 For example, newspapers promoting conversion practices were delivered in Tasmania during the TLRI's investigation, and indeed one of the authors received a copy at his address: see, eg, Jessi Lewis, '"Newspaper" Promoting Conversion Practices Delivered in Tasmania', *Star Observer* (online, 29 October 2020) <https://www.starobserver.com.au/news/newspaper-promoting-conversion-practices-delivered-in-tasmania/198293>.

8 See, eg, Sexual Orientation and Gender Identity Change Efforts Survivors, 'SOGICE Survivor Statement' (Statement, July 2020) 3 ('SOGICE Survivor Statement'); *TLRI Final Report* (n 4) chs 3–4, detailing both scientific and clinical studies, and testimony of survivors and their friends and family on both the nature of the practices and their effects.

9 See, eg, *Affirmation of Sexual Orientation, Gender Identity and Gender Expression Act, 2016* (Malta) Act No LV of 2016 ('*Affirmation Act* (Malta)'); *Gesetz zum Schutz vor Konversionsbehandlungen* [*A Law to*

These reforms have used a range of definitions, offence provisions and approaches to reform. Following advocacy by LGBTQA+ organisations and conversion practices survivor groups, Queensland, the Australian Capital Territory ('ACT') and Victoria legislated to ban and regulate conversion practices using criminal and human rights processes.[10] In 2022, Tasmania's peak independent law reform body, the Tasmania Law Reform Institute ('TLRI') concluded a two year inquiry into conversion practices, making 14 recommendations for reform.[11] The state's government has broadly accepted these recommendations,[12] although a bill is yet to be circulated in draft or debated by the Tasmanian Parliament.[13] All other states and mainland territories (besides the Northern Territory) have publicly committed to reforms, albeit mostly without details of their planned models or bills.[14] These implemented and proposed reforms have drawn objections and opposition from different quarters, particularly conservative religious groups and secular gender critical activist groups.[15] So far, the new laws have not yet been used or applied

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Protect against Conversion Therapy] (Germany) 12 June 2020, BGBl I, 2020, 1285 ('*A Law to Protect against Conversion Therapy* (Germany)'); *An Act to Amend the Criminal Code (Conversion Therapy)*, SC 2021, c 24 ('*An Act to Amend the Criminal Code* (Canada)'); *Conversion Practices Prohibition Legislation Act 2022* (NZ) ('*Conversion Practices Prohibition Legislation Act* (NZ)'). At the international level, urging domestic law reform, see Victor Madrigal-Borloz, *Protection against Violence and Discrimination Based on Sexual Orientation and Gender Identity*, UN Doc A/73/152 (12 July 2018); Victor Madrigal-Borloz, *Practices of So-Called 'Conversion Therapy'*, UN Doc A/HRC/44/53 (1 May 2020) 13.

10 *Health Legislation Amendment Act 2020* (Qld), amending *Public Health Act 2005* (Qld); *Sexuality and Gender Identity Conversion Practices Act 2020* (ACT) ('*Conversion Practices Act* (ACT)'); *Change or Suppression (Conversion) Practices Prohibition Act 2021* (Vic) ('*Conversion Practices Act* (Vic)').

11 The *TLRI Final Report* (n 4) was initiated by a community reference: at 1–2.

12 Adam Holmes, 'Targeted Campaign against Conversion Therapy Ban as Tasmania Looks to Outlaw Practice', *ABC News* (online, 11 November 2022) <https://www.abc.net.au/news/2022-11-11/targeted-campaign-against-conversion-therapy-ban-tasmania/101638094>.

13 See Simon McGuire, 'Rodney Croome Concerned about State Government Delay in Banning Conversion Laws', *The Examiner* (online, 19 February 2023) <https://www.examiner.com.au/story/8091179/lgbtiqa-rights-activist-concerned-about-conversion-law-delay/>.

14 In South Australia, the then-opposition Labor party pledged to ban conversion practices in July 2020, but has not yet made further announcements since taking office: Stephanie Richards and Angela Skujins, 'SA Move to Outlaw Conversion Therapy', *InDaily* (online, 16 July 2020) <https://indaily.com.au/news/2020/07/16/sa-move-to-outlaw-conversion-therapy/>. Western Australia committed to banning conversion practices in December 2022 but is yet to introduce a bill: Government of Western Australia, 'Government to Ban LGBTIQA+ Conversion Practices in WA' (Media Release, 1 December 2022). In New South Wales, independent MP Alex Greenwich announced in February 2023 that he has written a draft bill that he plans to introduce soon, and which received public bipartisan support (though at the time of writing, that bill is yet to be publicly circulated): Jessica Kidd, 'Bipartisan Support Pledged in New South Wales to Ban Gay Conversion Practices', *ABC News* (online, 17 February 2023) <https://www.abc.net.au/news/2023-02-17/nsw-bipartisan-support-in-for-gay-conversion-ban/101988632>. The Northern Territory Government has not made any public comments on conversion practices.

15 For a critical overview of the gender critical movement, see Grace Lavery, 'Gender Criticism Versus Gender Abolition: On Three Recent Books about Gender', *Los Angeles Review of Books* (Review, 31 July 2023) <https://lareviewofbooks.org/article/gender-criticism-versus-gender-abolition-on-three-recent-books-about-gender/>. For a symposium discussion on transgender law and politics, see Catharine A MacKinnon et al, 'Exploring Transgender Law and Politics' (Philosophy, Law and Politics Colloquium, University of Oxford, 2022) <https://signsjournal.org/exploring-transgender-law-and-politics/>. On religious opposition to conversion practices reforms in Australia, see, eg, Lucy MacDonald and James Dunlevie, 'Christian Lobby Weighs in Ahead of Potential Tasmanian Ban on Conversion Practice', *ABC News* (online, 17 July 2022) <https://www.abc.net.au/news/2022-07-17/christian-lobby-weighs-in-on-

by a human rights body or court, though investigations and matters may be in preparation or underway. Despite extensive public debate, Australian (legal) academic literature examining these reforms (as opposed to the general occurrence of conversion practices)[16] is only just beginning to emerge.[17]

This article analyses recently enacted and proposed reforms around conversion practices in Australia. We focus solely on comparing and analysing approaches in Australia, namely the legislation in Queensland, the ACT and Victoria, and the proposed Tasmanian model. While Australian reforms share some similarities with overseas approaches, particularly in broad definitions, the specificities of our state-federal system and the interaction with regimes of criminal, health and human rights laws mean that Australian reforms differ substantially from these bills.[18]

In Part II, we introduce a history of the changing meanings and understandings of conversion practices to sketch a general definition. We then focus on three themes that we contend pose the most significant challenge for law reform around conversion practices, and on which the various approaches differ considerably: definitions and criminalisation, (mental) health law, and anti-discrimination.

Part III assesses the difficult definitional question of what is and is not a conversion practice at law, introducing the meanings used in recent law reform efforts. We contend that an adaptive, principles-based definition of conversion practices is preferable to a fixed one, and argue against a carceral approach to conversion practices that relies on these fixed definitions.

Part IV deals with the reins or mind: the relation of conversion practices to (legitimate) mental healthcare. We argue that conversion practices are primarily

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tas-gay-conversion-therapy-ban/101244570>; Kat Wong, 'Lobby's Law Reform Claim Doesn't Stand Up to Scrutiny', *AAP Factcheck* (Web Page, 1 December 2022) <https://www.aap.com.au/factcheck/lobbys-law-reform-claim-doesnt-stand-up-to-scrutiny/>; Tasmania Law Reform Institute, 'Statement on Conversion Practices Report' (Statement, 27 June 2022) <https://www.utas.edu.au/law-reform/news-and-events/tlri-news/statement-on-conversion-practices-report>, responding to Catherine Sheehan, 'Report Seeks to Ban Treatment of Gender Dysphoria', *Catholic Standard* (Hobart, 12 June 2022) 8.

16 On which see, eg, Jennifer Power et al, 'Better Understanding of the Scope and Nature of LGBTQA+ Religious Conversion Practices Will Support Recovery' (2022) 217(3) *Medical Journal of Australia* 119 <https://doi.org/10.5694/mja2.51441>. For the most recent United States ('US') literature, see Douglas C Haldeman (ed), *The Case Against Conversion 'Therapy': Evidence, Ethics, and Alternatives* (American Psychological Association, 2022) <https://doi.org/10.1037/0000266-000>.

17 See, eg, Patrick Parkinson and Philip Morris, 'Psychiatry, Psychotherapy and the Criminalisation of "Conversion Therapy" in Australia' (2021) 29(4) *Australasian Psychiatry* 409 <https://doi.org/10.1177/10398562211014220>; Christopher J Ryan and Sascha Callaghan, 'New Laws that Prohibit Conversion Therapy Pose No Material Risk to Evidence-Based and Clinically Appropriate Practice' (2022) 30(3) *Australasian Psychiatry* 362 <https://doi.org/10.1177/10398562211057070>; Patrick Parkinson, 'Adolescent Gender Dysphoria and the Informed Consent Model of Care' (2021) 28(3) *Journal of Law and Medicine* 734. Outside of Australia, see Craig Purshouse and Ilias Trispiotis, 'Is "Conversion Therapy" Tortious?' (2022) 42(1) *Legal Studies* 23 <https://doi.org/10.1017/lst.2021.28>. The comparatively recent focus of activist and community groups on conversion practices is part of a longer history of LGBTQA+ anti-discrimination reform: see, eg, Noah Riseman, 'Transgender Activism and Anti-discrimination Reform in 1990s New South Wales and Victoria' (2022) 46(3) *Journal of Australian Studies* 321 <https://doi.org/10.1080/14443058.2022.2078858>.

18 See, eg, *Affirmation Act* (Malta) (n 9); *A Law to Protect against Conversion Therapy* (Germany) (n 9); *An Act to Amend the Criminal Code* (Canada) (n 9); *Conversion Practices Prohibition Legislation Act* (NZ) (n 9). The New Zealand Bill in particular is substantially similar to parts of some Australian models.

a problem of purported mental health assessment and treatment. The boundaries between harmful and acceptable (but likely discriminatory) conduct are best examined and assessed by peak medical bodies applying contemporary care standards, rather than police or human rights commissions alone.

Part V deals with the heart: responding to the beliefs and motivations underlying conversion practices, and freedom of religious and political expression and parental rights. Beliefs that underlie and motivate conversion practices are best approached through anti-discrimination law as an extension of prohibitions on incitement, as opposed to offensive speech.

Whether medical or religious, conversion practices are a form of searching the reins and hearts; they are an inquisition into the feelings and desires of a congregant or patient, an imposition of the doctor or pastor's views of gender and sexuality onto another, or a false 'promise' that the person is in need of help and that they can be helped. That conversion practices ought to be banned seems to be close to a consensus across Australian states; but the question remains what kinds of law reforms are best suited to seeking them out. Law reform is also a searching of the reins and hearts. Medical practitioners, religious leaders and secular organisations that attempt to mould the minds and feelings of LGBTQA+ people in Australia must be shown how and why these practices are dangerous and unacceptable. This is not best achieved through the retribution of criminal prosecutions, but the searching investigations of medical and human rights bodies.

II CONVERSION PRACTICES: HISTORY, TERMINOLOGY AND CONTEMPORARY FORMS

This Part introduces the complexities of conversion practices through a brief history of their changing meanings and associations, first as medical and then as religious practices, by examining the general and scientific literature on them. Phrases such as 'gay conversion therapy', 'reparative therapy', the 'ex-gay movement', and the contemporary terminology of 'conversion practices' all broadly coalesce in any program that attempts to change or suppress LGBTQA+ sexual orientation or gender identity in a specific person.

While conversion practices can be dated as far back as the 1870s, they came to mainstream prominence in the 1950s as psychological 'treatments' for homosexuality, then defined as a mental illness, and included electroshock and aversion therapies that promised to 'cure' homosexuality.[19] Despite homosexuality

19 See, eg, Kenji Yoshino, 'Covering' (2002) 111(4) *Yale Law Journal* 769, 783–802 <https://doi.org/10.2307/797566>, on conversion practices in America; Jack Drescher, 'A History of Homosexuality and Organized Psychoanalysis' (2008) 36(3) *American Academy of Psychoanalysis and Dynamic Psychiatry* 443 <https://doi.org/10.1521/jaap.2008.36.3.443>; Jack Drescher, 'I'm Your Handyman: A History of Reparative Therapies' (1998) 36(1) *Journal of Homosexuality* 19 ('I'm Your Handyman') <https://doi.org/10.1300/J082v36n01_02>; Timothy W Jones et al, Human Rights Law Centre, *Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia* (Report, 2018) 11–20 <https://doi.org/10.26181/22826633.v1> ('*Preventing Harm, Promoting Justice*'), on the history of religious conversion practices in Australia, 1950–present.

being deregistered as a mental illness in the United States and other western countries from the 1970s onwards,[20] conversion practices by doctors and within hospitals, especially against gender divergent/non-conforming people, continued. Following the expansion of psychotherapy in the 1960s, the emergence of 'twelve step' programs, and the victories of the gay liberation movement from the late 1960s onwards, religious forms of conversion practice began to emerge, first in texts like Scientology's *Dianetics* and then moving into broader proliferation.[21]

By the 1990s, religious conversion practices expanded considerably: 'ex-gay ministries' and the 'ex-gay movement' emerged as a transnational network of religious programs to suppress and change sexual orientation, and spiritual and psychiatric arguments for conversion practices were fused in the works of major American practitioners.[22] Throughout the 2000s and 2010s, nations in the Global North saw increased social acceptance of LGBTQA+ people, particularly around reforms to legalise same-sex marriage.[23] Around the same time, clear clinical evidence began to emerge that these practices had no scientific basis to their claims to efficacy, and that they carried serious risks of harm to those subjected to them. The terminology of 'therapy' gave way to 'efforts' or 'practices', to refute any suggestion that there was a medical, clinical or scientific basis to the practices.[24]

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20 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (2nd ed, 1973) removed homosexuality as a disorder. Distress associated with being homosexual was removed in American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed, 2013). See Sara E McHenry, '"Gay is Good": History of Homosexuality in the *DSM* and Modern Psychiatry' (2022) 18(1) *American Journal of Psychiatry Residents' Journal* 4, 5 <https://doi.org/10.1176/appi.ajp-rj.2022.180103>.

21 Drescher, 'I'm Your Handyman' (n 19) 26–30; L Ron Hubbard, *Dianetics: The Modern Science of Mental Health* (Hermitage House, 1st ed, 1950) 103–4, discussing the pseudoscientific medico-religious 'treatment' of homosexuality as a 'psycho-somatic … illness of sexual perversion', and that '[i]n short and in brief, psycho-somatic ills can now be cured. All of them': at 108. For psychotherapy texts, see, eg, Irving Bieber et al, *Homosexuality: A Psychoanalytic Study of Male Homosexuals* (Basic Books, 1962) 44–117; Albert Ellis, *Homosexuality: Its Causes and Cure* (Lyle Stuart, 1965); Lionel Ovesey, *Homosexuality and Pseudohomosexuality* (Science House, 1969); Sandor Rado, *Adaptational Psychodynamics: Motivation and Control* (Science House, 1969); Charles W Socarides, *Homosexuality: Psychoanalytic Therapy* (Jason Aronson, 1978); Charles W Socarides, *The Overt Homosexual* (Grune and Stratton, 1968).

22 Drescher, 'I'm Your Handyman' (n 19) 34, discussing Joseph Nicolosi, *Reparative Therapy of Male Homosexuality: A New Clinical Approach* (Jason Aronson, 1991): 'Nicolisi's (1991) approach marks a significant shift in the reparative therapy literature. This reparative therapist offers a deliberate fusion of spiritual and psychoanalytic thought'. Nicolisi was a foundational figure in reparative therapy advocacy in the United States.

23 See, eg, Jones et al, *Preventing Harm, Promoting Justice* (n 19).

24 Major studies on efficacy and harm include, in approximate chronological order: Douglas Haldeman, 'Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination' in John C Gonsiorek and James D Weinrich (eds), *Homosexuality: Research Implications for Public Policy* (SAGE Publications, 1991) 149 <https://doi.org/10.4135/9781483325422>; Ariel Shidlo and Michael Schroeder, 'Changing Sexual Orientation: A Consumers' Report' (2002) 33(3) *Professional Psychology: Research and Practice* 249 <https://doi.org/10.1037/0735-7028.33.3.249>; A Lee Beckstead, 'Can We Change Sexual Orientation?' (2012) 41(1) *Archives of Sexual Behavior* 121 <https://doi.org/10.1007/s10508-012-9922-x>; Annesa Flentje, Nicholas C Heck and Bryan N Cochran, 'Experiences of Ex-Ex-Gay Individuals in Sexual Reorientation Therapy: Reasons for Seeking Treatment, Perceived Helpfulness and Harmfulness of Treatment, and Post-Treatment Identification' (2014) 61(9) *Journal of Homosexuality* 1242 <https://doi.org/10.1080/00918369.2014.926763>; Kate Bradshaw et al, 'Sexual Orientation

From the 2010s to today, the focus appears to have shifted again. Conservative and extremist religious groups shifted from anti-homosexual campaigns and towards anti-transgender campaigns,[25] arguably in response to the success of gay rights campaigners shifting mainstream attitudes towards homosexuality. Contemporary society has not similarly advanced, at least at the same pace, in its acceptance of transgender human rights, leaving that attribute much more vulnerable to populist morality campaigns.

A second major group is the anti-transgender 'gender critical feminist' movement, which rejects the possibility of transgender identity, insists on the essentialist equivalence between natal sexual biology and gender identity, and contends that legal recognition of transgender people threatens and degrades women's 'sex-based' rights, for example, to women's only spaces and programs.[26]

Religious and secular anti-transgender groups, while apparently holding otherwise divergent politics, have held joint events,[27] rehashing forms of old anti-homosexual campaign slogans: that transgender people are destroying the 'traditional' family, corrupting the youth by 'converting' them to gender diversity (or, in the gender critical version, eradicating the possibility of lesbianism by convincing otherwise homosexual women that they are transmen), and that this will have lasting and irreversible detrimental physical and mental effects on otherwise heterosexual cisgender young people and society at large.[28] This reaction also coincides with the circulation of the compound 'sexual orientation *and* gender

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Change Efforts through Psychotherapy for LGBQ Individuals Affiliated with the Church of Jesus Christ of Latter-Day Saints' (2015) 41(4) *Journal of Sex & Marital Therapy* 391 <https://doi.org/10.1080/0092623X.2014.915907>; Steven Meanley et al, 'Lifetime Exposure to Conversion Therapy and Psychosocial Health among Midlife and Older Adult Men Who Have Sex with Men' (2020) 60(7) *The Gerontologist* 1291 <https://doi.org/10.1093/geront/gnaa069>; Travis Salway et al, 'Prevalence of Exposure to Sexual Orientation Change Efforts and Associated Sociodemographic Characteristics and Psychosocial Health Outcomes among Canadian Sexual Minority Men' (2020) 65(7) *Canadian Journal of Psychiatry* 502 <https://doi.org/10.1177/0706743720902629>.

25 See Cait Kelly and Mostafa Rachwani, 'What's behind the "Terrifying" Backlash against Australia's Queer Community?', *The Guardian* (online, 25 March 2023) <https://www.theguardian.com/australia-news/2023/mar/25/whats-behind-the-terrifying-backlash-against-australias-queer-community>.

26 See, eg, Serena Bassi and Greta LaFleur, 'TERFs, Gender-Critical Movements, and Postfascist Feminisms' (2022) 9(3) *Transgender Studies Quarterly* 311 <https://doi.org/10.1215/23289252-9836008>.

27 For example, the 'Gender Identity in Law' forum in Hobart held in February 2022: see Sarah Maunder, 'LGBTIQ+ Advocates Rally in Hobart against Bill Excluding Trans People from Single-Sex Sport', *SBS News* (online, 26 February 2022) <https://www.sbs.com.au/news/article/lgbtiq-advocates-rally-in-hobart-against-bill-excluding-trans-people-from-single-sex-sport/s73gto2w8>; Catherine Sheehan, 'Women Speak Out against the Oppression of Gender Ideology', *Archdiocese of Hobart* (Web Page, 7 March 2022) <https://hobart.catholic.org.au/2022/03/07/women-speak-out-against-the-oppression-of-gender-ideology/>.

28 The TLRI acknowledged this: see *TLRI Final Report* (n 4) 72–3 [4.4.25]. Some recent scientific studies are beginning to note a trend towards an increase in gender diverse subjects: see, eg, Madison Higbee, Eric R Wright and Ryan M Roemerman, 'Conversion Therapy in the Southern United States: Prevalence and Experiences of the Survivors' (2022) 69(4) *Journal of Homosexuality* 612, 625 <https://doi.org/10.1080/00918369.2020.1840213>: 'The finding that transgender and non-binary respondents also are more likely to report having experienced conversion therapy is consistent with previous studies supporting the finding that gender minority individuals are more likely to undergo the practice than cisgender individuals'.

orientation' or 'SOGI' by survivor-advocate groups, replacing the singular focus on anti-homosexual practices that predominated until at least the early 2000s. This shift is reflected in the commonality of the term 'sexual orientation conversion therapy' in studies into the 2000s, which has recently given way to 'sexual orientation and gender identity'.

Much of the clinical literature that began to emerge in the 1990s reported studies in the United States, but in recent years, studies from across the world have been published. Among these are recent surveys, reports, and investigations into the nature and effects of conversion practices within Australia.[29] Together, these studies provide a consistent picture of what conversion practices commonly involve.

Conversion practices largely take the form of one-to-one sessions between the practitioner and subject akin to counselling, psychological or psychiatric therapy sessions or spiritual 'guidance' sessions between subjects and religious leaders. Another common form in religious settings is group practices, including prayer groups, scriptural study groups, or other group discussion sessions, sometimes likened to '12-step' addiction recovery program formats.[30] While these are usually multiple-year programs, some 'intensive' practices condense retreats, camps, conferences or online courses. Although most conversion practices are talk-based and non-physical, some survivors have reported being involved in exorcisms and deliverance rituals, which often last for prolonged periods of up to days at a time and can be stressful or harmful.[31]

Clinical evidence on the effectiveness and harms of conversion practices has been consistent and clear. Since at least the early 2000s, scientific and clinical evidence has consistently shown that there is no evidence that conversion practices are 'effective' in their capacity to effect a change or suppression of sexual orientation or gender identity. There is also consistent evidence that conversion practices carry clear risks of harmful effects on those subjected to them, including physical and psychological harms, such as increased suicidality, self-harm, post-traumatic stress disorders, anxiety and depression, feelings of alienation, loneliness and exclusion, sexual dysfunction, substance abuse, internalised homophobia and feelings of failure, and reluctance to seek medical treatment. These effects often manifest only several years after the (unsuccessful) conclusion or withdrawal from the practices.[32] Consequently, the majority of relevant peak medical bodies within

29 Jones et al, *Preventing Harm, Promoting Justice* (n 19); 'SOGICE Survivor Statement' (n 8); Tiffany Jones et al, 'Religious Conversion Practices and LGBTQA+ Youth' (2022) 19(3) *Sexuality Research and Social Policy* 1155 <https://doi.org/10.1007/s13178-021-00615-5>; *TLRI Final Report* (n 4) ch 3.

30 Power et al (n 16) 119, 121.

31 *TLRI Final Report* (n 4) chs 3–4. Reports of exorcisms at the Esther Foundation in Western Australia preceded the Western Australian Government's (renewed) commitment to ban conversion practices there: Government of Western Australia, 'Government to Ban LGBTIQA+ Conversion Practices in WA' (Media Release, 1 December 2022) <https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/12/Government-to-ban-LGBTIQA-conversion-practices-in-WA.aspx>; Alicia Bridges, 'Esther House Inquiry Uncovers Allegations of Exorcism and Sexual Assault', *ABC News* (online, 1 December 2022) <https://www.abc.net.au/news/2022-12-01/esther-foundation-inquiry-report-findings/101721828>.

32 See, eg, John R Blosnich et al, 'Sexual Orientation Change Efforts, Adverse Childhood Experiences, and Suicide Ideation and Attempt among Sexual Minority Adults, United States, 2016–2018' (2020) 110(7) *American Journal of Public Health* 1024 <https://doi.org/10.2105/AJPH.2020.305637>; Amy E Green et

Australia have issued statements that they are not genuine healthcare practices.[33] Over the past decade, a range of law reform initiatives have taken place across Australia, culminating in legislation in three jurisdictions (Queensland, the ACT and Victoria), with a fourth (Tasmania), committing to recommendations from its Law Reform Institute to prohibit the practices. These are discussed below.

III SEARCHING FOR A DEFINITION OF CONVERSION PRACTICES

With this history of changing terminology and nature of the practices, and the current picture of their use and effects in Australia in mind, we turn now to evaluate definitions used in law reform efforts. This Part contends that rigid, prescriptive and single definitions are not useful for effective law reform. Instead, conversion practices are a class of activities with common elements, purposes and beliefs. Multiple definitions adapted to the legislative frameworks best suited to respond to different forms and aspects of conversion practice harm are needed.

The first, foundational point of comparison for recent Australian reforms on conversion practices is their approach to the difficult question of what, legally, is and is not a conversion practice. Australian jurisdictions have largely opted for the 'change or suppress' formulation, and with slightly different treatments of the purpose or intention that motivate the practices.

Queensland defined conversion practices as 'a practice that attempts to change or suppress a person's sexual orientation or gender identity',[34] using the language of 'attempts', which suggests the importance of intention or aim in defining the practices, while also reflecting their inefficacy and that they need not (and will not) achieve their stated aims.

The ACT defined them as 'a treatment or other practice the purpose, or purported purpose, of which is to change a person's sexuality or gender identity',[35] using the broader term 'sexuality' rather than 'sexual orientation', including the term 'treatment', and also using 'purposes' and 'purported purposes' to deal with the pseudo-medical nature of the practices.

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al, 'Self-Reported Conversion Efforts and Suicidality among US LGBTQ Youths and Young Adults, 2018' (2020) 110(8) *American Journal of Public Health* 1221 <https://doi.org/10.2105/AJPH.2020.305701>; Caitlin Ryan et al, 'Parent-Initiated Sexual Orientation Change Efforts with LGBT Adolescents: Implications for Young Adult Mental Health and Adjustment' (2020) 67(2) *Journal of Homosexuality* 159 <https://doi.org/10.1080/00918369.2018.1538407>. In Australia, see especially *TLRI Final Report* (n 4) pt 4.5 'What are the Effects of SOGI Conversion Practices'; Jones et al, 'Religious Conversion Practices and LGBTQA+ Youth' (n 29) 1159–61.

33 See, eg, Australian Psychological Society, 'Use of Psychological Practices' (n 5); Johnson (n 5); Australian Medical Association (n 5). See above n 5 and accompanying text.

34 *Public Health Act 2005* (Qld) s 213F(1), as inserted by *Health Legislation Amendment Act 2020* (Qld) s 28. Note that Queensland defines and prohibits 'conversion therapy' (see sections 213F and 213H) and uses that terminology, though the substantive definition in section 213F(1) uses the word 'practice': '[c]onversion therapy is a practice that attempts to change or suppress a person's sexual orientation or gender identity'.

35 *Conversion Practices Act* (ACT) (n 10) s 7(1).

Victoria has legislated a slightly more complex definition of conversion practices. In a 2019 investigation that predated Victoria's reforms, the Health Complaints Commissioner used a wide definition of

> [a]ny practice or treatment that seeks to change, suppress or eliminate an individual's sexual orientation or gender identity … including efforts to reduce or eliminate sexual and/or romantic attractions or feelings toward individuals of the same gender, or efforts to change gender expressions.[36]

Victoria's eventual legislation adopted a slightly narrower formulation of

> a practice or conduct directed towards a person, whether with or without the person's consent
> (a) on the basis of the person's sexual orientation or gender identity; and
> (b) for the purpose of
> (i) changing or suppressing the sexual orientation or gender identity of the person; or
> (ii) inducing the person to change or suppress their sexual orientation or gender identity.[37]

This does not use 'elimination' of sexual orientation or gender identity, and uses 'conduct' rather than 'treatment', clarifies the irrelevance of purported consent, and articulates two purposes of either attempting to change or suppress, or inducing the person to do so.

Each reform bill also included illustrative examples. Queensland used examples of aversion therapies (inducing negative reactions to same-sex images, using shame or coercion), and a broader illustration of 'techniques' that encourage a person to believe that being LGBTQA+ is a 'defect or disorder'.[38] Victoria provided a much broader illustration of what is included in (but not limited to) its definition: psychiatric or psychotherapy consults, treatments or therapies 'or any other similar consultation, treatment, or therapy', carrying out religious practices including 'prayer based practice', deliverances or exorcisms, and giving referrals for conversion practices, and that these could occur remotely, online or in person.[39]

Each jurisdiction also specified forms of conduct that are not conversion practices. A first area involved clarifying that some healthcare practices are excluded from the definition, using the language of a 'reasonable professional judgment'. Queensland excluded from its definition

> a practice by a health service provider that, in the provider's reasonable professional judgment
> (a) is part of the clinically appropriate assessment, diagnosis or treatment of a person, or clinically appropriate support for a person; or
> (b) enables or facilitates the provision of a health service for a person in a manner that is safe and appropriate; or
> (c) is necessary to comply with the provider's legal or professional obligations.[40]

36 Karen Cusack, Health Complaints Commissioner, *Report on the Inquiry into Conversion Therapy: Executive Summary* (Report, 1 February 2019). Note that the full report has not been publicly released.

37 *Conversion Practices Act* (Vic) (n 10) s 5(1).

38 *Public Health Act 2005* (Qld) s 213F(1).

39 *Conversion Practices Act* (Vic) (n 10) ss 5(3)–(4). The Australian Capital Territory only provided examples of what is not a conversion practice: *Conversion Practices Act* (ACT) (n 10) s 7(2).

40 *Public Health Act 2005* (Qld) s 213F(2).

The ACT mimicked the 'reasonable professional judgment' standard, but omitted the clinically appropriate assessment, diagnosis and treatment point. It excluded

> a practice by a health service provider that, in the provider's reasonable professional judgment, is necessary to
> (a) provide a health service in a manner that is safe and appropriate; or
> (b) comply with the provider's legal or professional obligations.[41]

Victoria likewise took up the 'reasonable professional judgment' framing, providing that a conversion practice did not include

> a practice or conduct of a health service provider that is, in the health service provider's reasonable professional judgement, necessary
> (i) to provide a health service; or
> (ii) to comply with the legal or professional obligations of the health service provider.[42]

Given conversion practices lack clinical efficacy and pose significant risks to subjects, they are not genuine or valid health services. The 'reasonable professional judgment' approach thus attempts to ensure appropriate exceptions for, for example, gender dysphoria assessments and treatments, so that these could not be conflated with conversion practices, while also ensuring that health practitioners know they must abide by current professional standards.[43]

The second area of exemption was support activities for LGBTQA+ people, and more specifically, people undergoing or contemplating gender transition. These are framed widely, and again include references to purposes of that conduct to distinguish them from conversion practices. Queensland, the ACT and Victoria all used identical language of 'assisting' a person who is or is considering undergoing gender transition,[44] 'assisting' a person to express their gender identity,[45] 'providing acceptance, support or understanding of a person',[46] and facilitating a person's coping skills, social support or identity exploration and development.[47]

Queensland included examples to cover some aspects of medically appropriate psychiatric care that are neutral as to a person's gender or may be misinterpreted as non-affirmative. They include exploring psychosocial factors or 'probing' a person's experience of their sexual orientation or gender identity and advising on risks or side effects of hormone or surgical treatments, as well as speech pathology support.[48]

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41 *Conversion Practices Act* (ACT) (n 10) s 7(3).

42 *Conversion Practices Act* (Vic) (n 10) s 5(2)(b).

43 We return to and critique the reasonable professional judgment approach below in Part IV.

44 *Public Health Act 2005* (Qld) ss 213F(3)(a)–(b); *Conversion Practices Act* (ACT) (n 10) ss 7(2)(a)–(b); *Conversion Practices Act* (Vic) (n 10) ss 5(2)(a)(i)–(ii).

45 *Public Health Act 2005* (Qld) s 213F(3)(c); *Conversion Practices Act* (ACT) (n 10) s 7(2)(c); *Conversion Practices Act* (Vic) (n 10) s 5(2)(a)(iii).

46 *Public Health Act 2005* (Qld) s 213F(3)(d); *Conversion Practices Act* (ACT) (n 10) s 7(2)(d); *Conversion Practices Act* (Vic) (n 10) s 5(2)(a)(iv).

47 *Public Health Act 2005* (Qld) s 213F(3)(e); *Conversion Practices Act* (ACT) (n 10) s 7(2)(e); *Conversion Practices Act* (Vic) (n 10) s 5(2)(a)(v).

48 *Public Health Act 2005* (Qld) s 213F(3).

The ACT's support examples included contemporary practices around transition: the 'diagnosis and assessment of a person with gender dysphoria or gender non-conforming behaviour or identity'; support for social adjustments around gender dysphoria; hormone treatment; and other transition services, including speech pathology.[49]

Victoria did not provide examples to illustrate support services that are not conversion practices. The provisions and examples clarify that support, counselling, and a wide variety of medical services around gender transition are not covered and that this is because such services assist, support, accept or facilitate things around sexual orientation and gender identity, as opposed to suppressing or changing those things.

Exploring these definitions in detail is necessary for assessing the Queensland, ACT and Victorian reform models because the primary mechanism for responding to conversion practices in those jurisdictions is the creation of new criminal offences. In Queensland, the offence provision applies to any health service provider who performs a conversion practice on 'another person' as a misdemeanour with a maximum penalty of 100 penalty units or 12 months imprisonment, with a more severe penalty if the person is a vulnerable person (150 units or 18 months), and with no specification of a requisite mental state.[50]

In the ACT, while any person can be subject to conversion practices, the offence provision only applies where it is practised on a 'protected person', defined in the amending Act as a 'child' or 'person who has impaired decision-making ability in relation to a matter relating to the person's health or welfare',[51] or where such a person is removed from the ACT for the purposes of undergoing conversion practices.[52] The ACT *Criminal Code*'s general principles around criminal responsibility on burdens of proof, defences and mental requirements apply to conversion practices offences.[53]

Victoria introduced a range of criminal offences that apply to any practitioner and any subject and also require proof of causing injury or serious injury.[54] These carry much heavier penalties of a maximum of 10 years imprisonment and/or a 1,200 penalty unit fine (cause serious injury) or 5 years imprisonment and/or a 600 penalty unit fine (cause injury), with a mental requirement of negligence as to whether the conversion practice will cause (serious) injury to the other person.[55] Victoria also introduced several other offences covering other aspects of contemporary conversion practices: removing a person from the jurisdiction for conversion practices, advertising conversion practices, and corporate criminal liability.[56]

Victoria and the ACT also expanded their human rights procedures to respond to conversion practices by some clarification and expansion in the powers of human

49 *Conversion Practices Act* (ACT) (n 10) s 7(2).

50 *Public Health Act 2005* (Qld) s 213H.

51 *Conversion Practices Act* (ACT) (n 10) s 8(1) (definition of 'protected person').

52 Ibid s 9.

53 Ibid s 5.

54 *Conversion Practices Act* (Vic) (n 10) ss 10–11.

55 Ibid.

56 Ibid ss 12–15.

rights commissions to receive, investigate, mediate and make orders in relation to complaints of conversion practices. While the ACT and Victorian reforms contain strong criminal offence provisions, it may be that these schemes envisage that human rights complaints, rather than criminal investigations, will be the primary and initial mode of responding to conversion practices. Both jurisdictions establish a rights-based civil response scheme, that allows reporting, and resolution through conciliatory, enforceable administrative or (by referral) punitive remedies.[57] These mechanisms rely on the same definition of 'conversion practices' that undergirds the offence provisions in these regimes.[58] As we argue below, anti-discrimination mechanisms are better suited to responding to the promotion of the beliefs motivating conversion practices, rather than the practices themselves, which requires an adapted definition.[59] They adopt similar civil response approaches to the Victorian and ACT models, even in non-charter jurisdictions.[60]

The ACT seems to envisage a strong role for human rights complaints because its criminal offences are limited to where the potential subjects of a conversion practice offence are children or those with impaired decision-making capacity. It appears an ACT human rights complaint process could still be brought by an adult with unimpaired decision-making capacity who has been subjected to conversion practices,[61] but where no criminal offence has been committed yet in the ACT. Although survivor groups report that minors are often exposed to 'conversion ideology', these groups also state that conversion practices are most often reserved until those children become adults.[62] Consequently, in the ACT, adult-adult conversion practices, which apparently make up the vast majority of actual conversion practices, could only be reported and investigated by the ACT Human Rights Commission.

Going further than the ACT's complaints procedure, the Victorian scheme also involves a 'civil response' that expanded the powers and responsibilities of the Victorian Equal Opportunity and Human Rights Commission around conversion practices, including receiving and investigating reports of conversion practices, facilitating dispute resolution, supporting survivors, and educating the public and

57 This includes powers to undertake targeted education, conciliation (described in Victoria as a facilitation), mandate undertakings, refer to compensation, or referral to other statutory agencies including enforcement bodies. As for compensation, see *Human Rights Commission Act 2005* (ACT) s 53ZE(2)(b), as inserted by *Conversion Practices Act* (ACT) (n 10) sch 1. As for referral to other statutory agencies, see *Conversion Practices Act* (Vic) (n 10) s 1; *Human Rights Commission Act 2005* (ACT) div 4.2D, as inserted by *Conversion Practices Act* (ACT) (n 10) sch 1.

58 *Conversion Practices Act* (ACT) (n 10) pt 2; *Conversion Practices Act* (Vic) (n 10) div 1.

59 See below Part V.

60 See, eg, *Anti-Discrimination Act 1977* (NSW) pt 9; *Anti-Discrimination Act 1998* (Tas) pt 6.

61 *Human Rights Commission Act 2005* (ACT) div 4.2D, as inserted by *Conversion Practices Act* (ACT) (n 10) sch 1.

62 That distinction may likely be in the process of breaking down. Gender identity conversion practices aimed at adolescents to discourage them from seeking gender affirming health treatment (such as raising the spectre of 'irreversible surgeries' and 'hormonal interventions', and indeed labelling these assessments and treatments as 'conversion therapies') would need to begin to target children on the basis that, by the time they reach adulthood, they will have completed their transition. See Florence Ashley, 'Homophobia, Conversion Therapy, and Care Models for Trans Youth: Defending the Gender-Affirmative Approach' (2020) 17(4) *Journal of LGBT Youth* 361 <https://doi.org/10.1080/19361653.2019.1665610>.

organisations, and a raft of new powers and procedures to support that work.[63] While Victoria has no ACT-style limitation on who can be the complainant in a conversion practice offence and has a wide array of different offences to capture individual and corporate conduct, it also has an extensive set of human rights commission reforms and a comprehensive model for investigation, reporting and remedying harms. At the least, Victoria seems to envisage human rights mechanisms working alongside or prior to criminal ones, indicated by Commission powers to refer reports to a range of agencies including Victoria Police.[64] For survivors, the former would undoubtedly be the easier first step.

The TLRI adopted a different approach to both its definition of conversion practices and the wider issue of a definition itself. Initially, its Issues Paper used a single definition of conversion practices as 'acts or statements' that 'are aimed at changing, suppressing, or eradicating the sexual orientation or gender identity of another person' and 'are based on a claim, assertion or notion that non-conforming sexual orientation or gender identity is a physical or psychological dysfunction that can be suppressed or changed'.[65] Following that consultation, the TLRI amended its general definition to replace 'acts or statements' with 'course of conduct' to reflect the need for sustained acts or statements, to focus on the conduct as a whole and the connection to the purpose or intention behind the practices, and for congruity with other areas of the law, such as offences of stalking and bullying.[66]

Most significantly, the TLRI did not propose a single statutory definition of conversion practices. That is because Tasmania lacks either a human rights charter or human rights commission that might be involved in hearing claims (in contrast to the ACT and Victoria),[67] and because the TLRI recommended amendments to Tasmanian statutes on criminal law, anti-discrimination law, civil law and health law to address legal redress for conversion practices in each of these domains. Instead, the TLRI model used facially similar definitions of conversion practices, albeit ones that were adapted to the different regulatory schemes that would deal with different aspects of them, namely health law, anti-discrimination law and, as a backstop, criminal law.[68] Regarding corporate liability, the TLRI opted to extend civil law redress avenues by bringing conversion practices under the umbrella of child abuse organisational and vicarious liability, which was also recently reformed.[69] Finally, and unlike Queensland, the ACT and Victoria, the proposed Tasmanian *Criminal Code* offence does not have any recommended or prescribed minimum or maximum sentences: any Tasmanian code offence, from robbery to murder, can

63 *Conversion Practices Act* (Vic) (n 10) pt 3 ('*Civil Response Scheme*').

64 Ibid s 29(2)(d).

65 Tasmania Law Reform Institute, *Sexual Orientation and Gender Identity Conversion Practices* (Issues Paper No 31, November 2020) 13 [1.3.23]. This was not a proposed legislative definition but rather a general definition for the purposes of that discussion paper and the community consultation that would follow its publication.

66 *TLRI Final Report* (n 4) 36–7 [2.7.12]–[2.7.14].

67 Ibid pt 5.5. Queensland has both a human rights charter and commission, though the sole focus on health law means these bodies are not mentioned explicitly in the recent reforms.

68 We return to these in the next Parts.

69 *TLRI Final Report* (n 4) 168–9 [8.4.9]–[8.4.12].

carry a maximum penalty of up to 21 years imprisonment, with the penalty to be judicially determined.[70]

The consequence of making a singular definition of 'conversion practices' central to law reform is the overreliance on criminal offence provisions to signal community disapprobation and attempt to reduce harm. The criminal offence provisions in Queensland, the ACT and Victoria turn largely (as offences often do) on the definitions in those reforms.

Victoria provides the most comprehensive set of criminal offences with the heaviest penalties. However, Victoria also arguably sets the proof requirements at the highest level, requiring proof of both negligence as to harm, and of injury or serious injury to the survivor.

Tasmania's proposed law reform also extends to a code offence. The TLRI considered non-carceral approaches, such as anti-discrimination and health law, to be more suitable guides to appropriate social behaviour, especially behaviour that has become predominantly hidden within close-knit communities. Hence, it recommended that criminal law should only operate as a backstop where genuine harm was foreseeable, recklessness as to the harm was involved, or for practitioners repeatedly warned to cease the practices. It also recommended that any criminal offence exempt medical professionals acting in good faith and in compliance with relevant medical standards.[71]

We contend that criminal law is unlikely to offer an effective or useful avenue for preventing or punishing conversion practices. Police and prosecutors are the bodies that must assess alleged conversion practices conduct and conclude that it is likely to fall within the definition in criminal statutes.[72] Health regulation bodies and offices are far better equipped with the professional expertise necessary for making those judgments.[73] It is possible that a criminal prosecution might follow, say, the disciplining or deregistration of a mental health practitioner who was found by a medical regulation body to have engaged in conversion practices repeatedly. However, that means following regulatory interventions as the first set of responses.

Perhaps the most significant difficulty that goes against the usefulness of criminal offences to respond to conversion practices is around evidence and procedure. It may be difficult to investigate and gather sufficient evidence to prove a conversion practice offence beyond a reasonable doubt. While healthcare body investigations must accord procedural fairness and a balance of probabilities standard of evidence, the criminal trial standard of beyond reasonable doubt is considerably higher. The difficult nature and timing of conversion practices harm emergence dovetails with these evidentiary problems.

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70 *Criminal Code 1924* (Tas) s 389, subject to *Sentencing Act 1997* (Tas).

71 *TLRI Final Report* (n 4) 176 [9.3.1]–[9.3.2].

72 On the need to pay attention to criminal procedure in assessing justifications for criminalising and punishing conduct, see Alice Ristroph, 'The Thin Blue Line from Crime to Punishment' (2018) 108(2) *Journal of Criminal Law and Criminology* 305.

73 We explore this in detail in the next Part.

Conversion practices carry significant risks of serious mental and physical harms that can be clearly attributed to the practices, but because these harms tend to manifest years later, and because people subject to them may be subject to conduct that may add to those physical and mental harms (such as general socialised homophobia and transphobia), prosecutors may likely have a difficult time convincing a judge or jury that an injury like post-traumatic stress disorder, suicidal ideation or suicide attempts were caused, beyond a reasonable doubt, by exposure to conversion practices, or finding witnesses who could give testimony on changes in behaviour or harm that began years ago. Criminal burdens of proof are much higher than scientific or clinical standards. These evidentiary difficulties could, in some cases, be overcome by making exceptions to limitation periods and the rules of evidence, and medical expert witnesses can provide both guidance and testimony on professional standards (though this can be time consuming and expensive). An offence that carries a significant carceral penalty should require evidence beyond reasonable doubt that an injury has been suffered by the complainant. It nonetheless seems unlikely that many prosecutions of conversion practices would be able to meet that threshold.

The second set of arguments against criminalisation is around a genuine commitment to anti-carceralism in responding to social problems. Taking a non-carceral approach to any social problem means not relying on the blunt instrument of criminal law to respond to a social scourge, but instead assessing what is needed to prevent or end the problem.[74] In the instance of conversion practices, that means medical and human rights supportive mechanisms are the more appropriate and nuanced mechanisms that allow remedies and consequences to be better tailored to the practices and their harms. That applies not just to conversion practices as a social problem, but also in the difficulty of coming to a clear definition of what they are and what the law should prohibit. Given conversion practices largely happen in private and semi-closed communities, criminalisation and harsh penalties may both drive the practices further underground, and make investigations still more difficult. The points that recommend the introduction of a conversion practices criminal offence are to clearly criminalise repeat or egregious behaviours, to signal community disapprobation of the practices, and to signal the severity of the harms that they may cause – namely, up to and including death of those subjected to them – as reflected in the severity of the maximum punishments that may be delivered upon a finding of guilt. But whether this is the most appropriate means to prevent and end the practices – the key commitment of abolitionist approaches to law reform – remains to be seen.

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74 On questions of LGBTQA+ rights and connection to policing and criminalisation, see especially Emma K Russell, *Queer Histories and the Politics of Policing* (Routledge, 2020) ch 6, critically examining the move to carceralism and criminalisation by some LGTBQA+ activists in Australia. On abolition and anti-carceral approaches to law and crime (from the United States in particular), see, eg, Dorothy E Roberts, 'Abolition Constitutionalism' (2019) 133(1) *Harvard Law Review* 1; Michelle Brown and Judah Schept, 'New Abolition, Criminology and a Critical Carceral Studies' (2017) 19(4) *Punishment and Society* 440 <https://doi.org/10.1177/1462474516666281>; Derecka Purnell, *Becoming Abolitionists: Police, Protests, and the Pursuit of Freedom* (Verso, 2021); Angélica Cházaro, 'The End of Deportation' (2021) 68(4) *UCLA Law Review* 1040.

In our view, instead of single definitions, conversion practice reforms require targeted definitions that connect the practices to the regimes best suited to their different manifestations: the question of pseudo-medical treatment and healthcare law and the role of beliefs or aims or purposes in identifying conversion practices relevant to anti-discrimination law. These are debates that cannot be resolved by a neat, universal, definition, but rather in the design of law reform and particularly the interaction of new provisions with other statutory regimes. An overreliance on criminal offence provisions exacerbates the problem of statutory definitions. In particular, whether or not a particular medical practice amounts to a conversion practice depends in large part on the changing state of professional medical knowledge, which cannot be easily codified or placed within regulations or statutory provisions as and when it changes and shifts. We turn now to using medical oversight bodies and offices to investigate conversion practices.

IV THE REINS: DELINEATING CLINICAL AND PSEUDOSCIENTIFIC PRACTICES IN MENTAL HEALTHCARE

In our view, the most salient issue in preventing and responding to conversion practices is delineating genuine healthcare from pseudoscientific conversion practices. This means creating procedures for investigating and determining which acts, statements and courses of conduct can be considered genuine healthcare and which cannot. A central reason for making this the main focus is that it helps to divide up the different settings in which a conversion practice may take place, and the different ways in which those kinds of conversion practices must be approached.

Plainly, a religious leader, who has no medical training or qualifications, is not competent to deliver healthcare services. For example, a religious leader may not purport to assess or diagnose whether a person has gender incongruence or to treat that condition if the person does have a proper diagnosis. This is not because of the religious leader's beliefs, views or motivations. If they lack medical training and are not registered health practitioners, then they cannot offer any purported assessments and treatments; if they do have such training and accreditation, any conversion practice provision would be a form of false and misleading medical practice, and further ethical guidelines would counsel them against treating their congregants or children.[75] Whether, say, a psychologist who holds anti-transgender views, whether secular or religious, has or has not engaged in conversion practices in the course of assessing a potential patient with gender dysphoria is more difficult to assess, even though the gender affirmative approach is settled in Australian medicine and law, including in relation to children.[76]

75 See, eg, Medical Board of Australia, 'Good Medical Practice: A Code of Conduct for Doctors in Australia' (Code of Conduct, October 2020) 13 [4.15]: 'Whenever possible, avoid providing medical care to anyone with whom you have a close personal relationship … [including] close friends, those you work with and family members'.

76 *Re Imogen [No 6]* (2020) 61 Fam LR 344. Note that the approach there has been criticised strongly: see Steph Jowett, Georgina Dimopoulos and Fiona Kelly, 'Reforming the Law on Consent to Medical

Queensland, the ACT and Victoria each dealt with identifying genuine healthcare in a broad-brush approach through the 'reasonable professional judgment' definitional exception. Queensland fixed its statutory regime on healthcare practitioners alone, meaning anyone who is not a healthcare practitioner is not covered by the legislation, and presumably is entitled to offer and conduct conversion practices. The ACT and Victorian reforms apply to any person, with Victoria explicitly clarifying that psychiatric and psychotherapy consults, treatments and therapies can nonetheless still be conversion practices under its definition if they do not meet the 'reasonable professional judgment' exception.

The 'reasonable professional judgment' approach makes delineating clinical and pseudoscientific practices primarily a question of definition: any clinical work that, in the healthcare professional's 'reasonable professional judgment' is appropriate or necessary to comply with their professional or legal obligations is not and cannot be defined as a conversion practice. Because this remains a definitional question central to offence provisions, the approach is not well suited to dealing with the complexity of determining whether conduct by a medical practitioner is or is not likely to lie within the 'reasonable professional judgment' standard, partly because that decision is to be made by police, prosecutors and/or human rights commissions in deciding whether to pursue a report of alleged conversion practices.[77]

The second problem is that the 'reasonable professional judgment' standard is not part of existing professional healthcare regulation and thus seems to apply only to conversion practices, raising questions about the continuity of this approach to healthcare exceptions and existing regulatory structures for healthcare services. The TLRI noted that 'reasonable professional judgment' is not a phrase used in the *Health Practitioner Regulation National Law*, which uses 'professional misconduct' (requiring conduct 'substantially below the standard' than 'reasonably expected of a registered health practitioner of an equivalent level of training or experience') and 'unprofessional conduct' (requiring conduct 'of a lesser standard' than 'might reasonably be expected' by professional peers).[78] It is also not similar to professional negligence civil liability standards throughout Australia, such as

Treatment for Trans Youth: A Renewed Call for Legislative Intervention' (2022) 11(4) *Laws* 56 <https://doi.org/10.3390/laws11040056>; Matthew Mitchell, 'Ontological Governance: Gender, Hormones, and the Legal Regulation of Transgender Young People' (2023) 31(3) *Feminist Legal Studies* 317 <https://doi.org/10.1007/s10691-023-09518-9>.

77 Note that Victoria provides that the Commission may refer a report to the Victorian Health Complaints Commissioner, the Australian Health Practitioner Regulation Agency and the Ombudsman, but is also not limited to only those bodies: *Conversion Practices Act* (Vic) (n 10) ss 29(2)(a)–(c). Victoria's pre-reform scheme of health complaints could also be used to report and investigate conversion practices: see also Email from Health Complaints Commissioner (Vic) to Director of the Tasmania Law Reform Institute, 15 January 2021 <https://www.utas.edu.au/__data/assets/pdf_file/0005/1425605/038_Health-Complaints-Commissioner-Victoria.pdf>. The Victorian reforms did not amend or expand the powers of the Health Complaints Commissioner.

78 *TLRI Final Report* (n 4) 190–1 [A.2.1]–[A.2.3]. See, eg, *Health Practitioner Regulation National Law Act 2009* (Qld) s 5 (definitions of 'professional conduct' and 'unprofessional conduct'). On obligations to notify of conduct that places the public at risk by departing from professional standards, and obligations on health practitioners to report on the conduct of other practitioners, see sections 140(d), 141.

medical tort liability. For example, in Tasmania, that requires that the professional 'acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice'.[79] 'Reasonable professional judgment' is, however, used 'in case law in connection with professional standards for accountants, legal practitioners, town planners, and social services job capacity assessors, among other professions'.[80] The TLRI concluded that any healthcare exemption should not use the 'reasonable professional judgment' standard because it introduces uncertainty of application and a potential divergence, in that healthcare practices that might be conversion practices would seem to be assessed differently than other kinds of professional misconduct.[81]

Taking up the 'reasonable professional judgment' approach may likely also exacerbate confusion among healthcare professionals who have already expressed concerns around bringing their professional practice into line with both current medical professional standards and new laws on conversion practices.[82] Finally, it is unclear what kind of expert evidence would be needed to assess whether a person had met the standard or not.

The Tasmanian model instead framed and responded to conversion practices as part of Tasmanian health law. Conversion practices are thus primarily framed as a question of proper and improper medical care, as a question of either

(a) health practitioners not offering care in accordance with proper evidence-based healthcare and guidance on care and treatment; or
(b) laypersons without medical training or accreditation purporting to offer healthcare services, which are also not supported by scientific or clinical evidence.

Thus, whether they take place in a healthcare or religious setting, regardless of whether the practitioner is a religious leader, a medical practitioner, or any other citizen, the TLRI conceived of conversion practices as primarily pseudo-medical and pseudoscientific conduct that risks causing serious harm. The TLRI thus approached conversion practices in medical settings as conduct that is '[n]ot supported by contemporary health care standards; and/or [n]ot undertaken by appropriately trained and registered health professionals; and [l]ikely to cause harm, regardless of who it is conducted by'.[83] In this register, conversion practices within the medical setting are forms of improper healthcare provision: assessments, diagnoses and treatments that do not conform to contemporary standards, and are thus 'false and misleading

79 *TLRI Final Report* (n 4) 190 [A.2.4]–[A.2.5]; *Civil Liability Act 2002* (Tas) s 22(1).

80 *TLRI Final Report* (n 4) 192 [10.3.4].

81 Ibid 192 [10.3.7].

82 Ibid. General concerns have already been raised by peak medical bodies in response to the Victorian reforms, though this seems to be more around definitions and criminalisation in general rather than a specific lack of clarity on the healthcare exception mechanism: see, eg, Email from Tasmanian Branch Chair, Royal Australian and New Zealand College of Psychiatrists Tasmanian Branch Committee to Director of the Tasmania Law Reform Institute, 18 December 2020 <https://www.utas.edu.au/__data/assets/pdf_file/0010/1425583/005_RoyalAustralianNZCollegeofPsychiatrists.pdf>.

83 *TLRI Final Report* (n 4) 120 [6.1.2].

assessments and treatments'.[84] Outside of medical settings, they are akin to people impersonating doctors without training or accreditation.

Going beyond a singular general definition, the TLRI's recommendations included a series of targeted, adapted definitions to fit the *Mental Health Act 2013* (Tas). This included clarifying that sexual orientation cannot be assessed or treated, and that gender identity must be depathologised: 'a person must not purport to or actually undertake an assessment or treatment of another person's sexual orientation' and that 'a person is not to be taken to have a mental illness by reason only of that person's gender identity or expression'.[85] The TLRI also tasked the State's Chief Civil Psychiatrist – the senior most public health officer responsible for mental health care standards – with prescribing which professionals can treat gender identity or expression-related mental health conditions and the clinical guidelines they must follow,[86] with the following prohibition:

> a person must not purport to or undertake any assessment or treatment of another person in relation to their sexual orientation or gender identity unless they are expressly authorised to do so under a Standing Order and they act consistently with Clinical Guidelines under the *Mental Health Act*.[87]

Whereas the Queensland, ACT and Victorian models leave it to the police, prosecutors and human rights bodies to consider whether the 'reasonable professional judgment' carve-out has likely been established, the Tasmanian model places the bodies that currently receive and investigate reports of substandard healthcare and publish and enforce proper healthcare standards as the first avenues for receiving and investigating reports of conversion practices. Tasmania's Chief Civil Psychiatrist would set practice guidelines and may receive reports of conversion practices. The Health Complaints Commission (and in some instances, the police) would investigate reports of medical conversion practices.[88]

The TLRI reforms would expand the power of the Chief Civil Psychiatrist to cover non-clinical contexts of laypersons purporting to offer assessments and treatments of sexual orientation and gender identity. They would also task that officer with issuing standing orders to clarify which classes and qualifications of health professionals can assess and treat people who may have sexual orientation or gender identity related mental health conditions, and issue clearer clinical guidelines that articulate the standard of care reflecting current best practice.[89]

The Tasmanian approach would deal with this unauthorised healthcare provision as a 'purported assessment or treatment' in a similar way to the existing offence of unlawful treatment,[90] and using a scheme of issuing notices to cease conduct, with a series of exceptions clarifying that it does not extend to the mere expression of beliefs or to supportive activities.[91]

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84 Ibid 123 [6.3.7].
85 Ibid 126 [6.3.19] Recommendation 2, 128–9 [6.3.29] Recommendation 3.
86 Ibid 129 [6.3.30] Recommendation 4.
87 Ibid 132 [6.4.13] Recommendation 5.
88 On the use of these existing statutory frameworks and offices, see *TLRI Final Report* (n 4) pt 6.5.
89 Ibid 125–6 [6.3.16].
90 *Mental Health Act 2013* (Tas) s 213.
91 *TLRI Final Report* (n 4) 131–4 [6.4.7]–[6.4.20].

In this way, conversion practices outside of healthcare contexts can be investigated and sanctioned as a type of unlicensed healthcare service. The risks of conversion practice conduct emanate from a lack of appropriate training, qualification or regulatory oversight, which would otherwise ensure that conduct that might appear to laypersons to be a conversion practice or which when improperly practised might indeed amount to a conversion practice (eg, substandard assessments or treatments for gender dysphoria/incongruence) remain within the bounds of acceptable medical practice.[92] Healthcare professionals might make that defence; religious leaders cannot.

Tasmania's proposed reforms also envisage a scheme of conscientious objection. Any healthcare practitioner who objects to assessing and treating a patient in accordance with contemporary standards and issued guidelines could refuse those patients and place themselves on a list of conscientious objectors; this ensures patients can exercise their right to the highest standard of medical care and be assured that their healthcare practitioner has not objected to providing that care.[93]

The first major advantage of Tasmania's adaptive healthcare approach is that peak medical bodies are best suited to announcing, investigating and applying contemporary care standards to ensure practitioners abide by them, and drawing the boundaries between harmful and acceptable (but likely discriminatory) conduct. The difficult questions of whether conduct amounts to a conversion practice is approached by bodies and offices already well-versed in investigating healthcare practices, in weighing expert evidence, in assessing standards, compliance and appropriate sanctions for behaviour that falls short of clinical best practice, and who are themselves responsible for announcing and updating guidelines on best practice.

Under the Tasmanian approach, the Chief Civil Psychiatrist is tasked with publishing clear guidelines, and either the Civil Psychiatrist or the Health Complaints Commissioner may investigate reports of inappropriate healthcare, and other agencies, including the anti-discrimination commission and the police, may act on the outcome of those reports. Like other administrative determinations and processes, investigations into and reports on individual practitioners may also be open to judicial or merits review, ensuring natural justice and procedural fairness for alleged conversion practitioners.

Tasmania's approach relies less on prosecution and criminal enforcement, but instead insists on clear clinical guidance, backed up by stringent reporting and investigation mechanisms, and invested in an existing public health body that already deals with reports of mental health malpractice. In doing so, the Tasmanian model offers continuity with ordinary regulation and oversight mechanisms already familiar to healthcare practitioners.

Some medical bodies and practitioners in Victoria expressed concerns about confusion over whether a practitioner might potentially be prosecuted under the new Victorian offences if they provided substandard care, and that this may lead to practitioners refusing to take patients with potential gender identity related

92 See ibid 131–2 [6.4.7]–[6.4.9].
93 Ibid 135 [6.4.21]–[6.4.24].

disorders at all.[94] Although these expressions of concern did not mention this point explicitly, they are presumably at least partly motivated by a concern that police officers and prosecutors are unlikely to have the appropriate training, resources or time to carefully weigh and evaluate healthcare practices, especially those that are predominantly speech-based. The line between clinically appropriate statements that could be interpreted as falling within the meaning of conversion practices,[95] and genuine conversion practices can be hard to draw.[96] Medical experts certainly may disagree on what constitutes (in)appropriate practices, but they are more appropriately tasked to have those discussions than either police or indeed human rights commissioners.

Some elements of the Tasmanian approach may draw criticism. First, fixing on conversion practices as primarily questions of medical practices turns on clinical and scientific evidence for those practices. This in turn risks placing too much reliance on technocratic expertise, rather than, say, substantive political positions like the right of LGBTQA+ people to freedom from discrimination in all areas of life, including healthcare. As with relying on a single office, relying on a profession's support for a marginalised community makes the protection and autonomy of LGBTQA+ people contingent on the views and commitments of medical professionals as a professional class. The liberal-progressive commitments that are thought to largely (and currently) bind that class may not necessarily include an enduring commitment to protecting and supporting, in particular, transgender and gender diverse people.[97]

LGBTQA+ social movements have had an often fraught relationship with medical practitioners – especially those in mental health – and this did not end with delisting homosexuality in the 1970s, but endured into the AIDS/HIV crisis and the long collaborations between the medical profession and carceral policing (particularly in relation to involuntary mental health treatments).[98] That history continues today in the difficult relationship between transgender people, the healthcare professions and the state in general as regards recognition, support, and protection, each themselves contested and problematic categories.

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94 See, eg, 'Psychiatrists Raise Concerns Regarding Conversion Practices Bill', *Royal Australian and New Zealand College of Psychiatrists* (Web Page, 2 February 2023), archived at <https://web.archive.org/web/20221210012812/https://www.ranzcp.org/news-policy/news-archive/news-archive-2021/psychiatrists-raise-concerns-regarding-conversion>.

95 For example, asking a patient to think about events that led to their feelings of distress, which could veer into suggesting or ascribing aetiological causes.

96 Tasmania Police raised a similar concern that police officers would likely lack the capacity or expertise to investigate any offence that required proof of adherence to conversion 'ideology' as part of its elements: see *TLRI Final Report* (n 4) 175–6 [9.2.15].

97 See, eg, Zoe Belinsky, 'A Dialogue on Deleuze and Gender Difference' in Jules Joanne Gleeson and Elle O'Rourke (eds), *Transgender Marxism* (Pluto Press, 2021) 200 <https://doi.org/10.2307/j.ctv1n9dkjc.15>. On sex, law, medicine, science, social order and political economy more broadly, see Michel Foucault, *The History of Sexuality: Volume 1*, tr Robert Hurley (Pantheon Books, 1978) pt 3, 51–73.

98 See, eg, Katie Batza, *Before AIDS: Gay Health Politics in the 1970s* (University of Pennsylvania Press, 2018); John-Manuel Andriote, *Victory Deferred: How AIDS Changed Gay Life in America* (University of Chicago Press, 1999); John L M McDaniel, 'Reconciling Mental Health, Public Policing and Police Accountability' (2018) 92(1) *Police Journal: Theory, Practice and Principles* 72 <https://doi.org/10.1177/0032258X18766372>.

Tasmania's proposed conscientious objection option may also draw some criticism for potentially suggesting that there are legitimate objections to treating transgender patients. Doctors must work impartially and be capable of distancing themselves from the lives and preferences of their patients. Conversely, however, the conscientious objection list may force some healthcare professionals to consider whether indeed they do harbour such strong views about transgender patients that they would need to publicly profess those positions and make the tacit admission that they are incapable of acting professionally in relation to a subset of the general population. More to the point, the risk to LGBQTA+ patients receiving mental health treatment from a health professional who holds undisclosed conversion practice beliefs appears to outweigh the risks of providing a regulatory avenue for disclosure to the patient and the public.

With these risks in mind, we nonetheless conclude that medical regulatory bodies and offices offer the most promising option for identifying and sanctioning conversion practices. Their expertise in the professional regulation of healthcare makes them far better suited than police and prosecutors, and substantially better than human rights bodies, for that task. Using these existing frameworks ensures healthcare practitioners will be familiar and comfortable with the mechanisms and standards that they must meet. Finally, it reinforces and draws a clear line that untrained and unregulated people purporting to offer the assessment and treatment of gender dysphoria/incongruence is a source of unacceptable risk of harm to the LGBTQA+ population.

V THE HEARTS: BELIEF PROMOTION, FREEDOM OF RELIGION, PARENTAL RIGHTS AND ANTI-DISCRIMINATION LAW

Conversion practices within religious and family settings raise a different set of difficult debates that resemble general public discourse as opposed to technocratic expertise; where the sources and standards of judgment are much vaguer, and the leeway for freedom and state non-interference are considerably higher. Australian law has long provided that freedom of conscience is 'complete',[99] in that no religious belief itself can be banned, but that manifestations of beliefs may be legitimately limited by law for the 'protection of the community and in the interests of social order'.[100] The demarcation between theology and ideology is difficult to draw: religions may have significant internal diversity about what is or is not part of its beliefs, beliefs and practices are difficult to separate 'either from politics or from ethics', and because it is difficult to compare theologies and ideologies across religions.[101]

99 *A-G (NSW) v Grant* (1976) 135 CLR 587, 600 (Gibbs J).

100 *Adelaide Company of Jehovah's Witnesses Inc v Commonwealth* (1943) 67 CLR 116, 155 (Starke J).

101 Ibid 125–6 (Latham CJ). See also *Church of the New Faith v Commissioner of Pay-roll Tax* (1983) 154 CLR 120.

Survivor-advocates have consistently contended that 'conversion ideology' – the worldview that it is possible and necessary for LGBTQA+ people to change their sexual orientation and gender identity, and that being LGBTQA+ is due to trauma, spiritual brokenness, and can be fixed by prayer – is central to defining and understanding conversion practices.[102] These beliefs are used to compel or convince a person to undergo conversion practices.[103] Some survivor-advocates emphasise that expressions of 'conversion ideology' are not themselves conversion practices, which should be defined as focused on an individual or small group of LGBTQA+ people, as opposed to expressing beliefs to a larger group (that might not necessarily be exclusively LGTBQA+ people), like a congregation or public meeting. An example of a common distinction is between a private one-to-one counselling session discussing how to reduce homosexual desire (conversion practice) and a sermon to a congregation explaining why being transgender is a 'spiritual defect' and how it can be 'healed' (conversion ideology). For survivor-advocates, common indicators of conversion ideology are claims that LGBTQA+ people are disordered, broken or spiritually incomplete, that LGBTQA+ status can be changed through conversion practices, that LGBTQA+ people should undergo such a change, and that non-LGBTQA+ people, like family members or other church members, should encourage LGBTQA+ people to do so. According to survivor-advocate groups, the inculcation of these beliefs in congregants is important for smoothing the path for them taking part in actual conversion practices. These beliefs can be secular, though many of the examples given by survivor-advocates are religious.

No Australian model deals specifically with belief expression or religious or parental settings, instead subsuming these settings under general definitions and prohibitions. The Queensland model does not apply outside of healthcare professional settings and thus does not cover religious or family settings, and may potentially exclude even, say, a Queensland psychologist expressing public support for conversion practices in a speech or newspaper article. This is a serious weakness of that model. Most conversion practices in Australia appear to occur in religious settings, and there is no suggestion that only conversion practices in healthcare settings carry a risk of harm. The general application of the ACT, Victorian and Tasmanian models mean they would apply to religious and family settings; whether or not a conversion practice offence or reportable complaint has occurred depends on the intention of the practice, not its underlying motivations or setting.

While the ACT and Victorian reforms both expanded the powers of their respective human rights commissions to receive and investigate complaints about conversion practices, these still focus primarily on whether the Commission is satisfied that a person has engaged in a conversion practice in relation to the complainant,[104] and thus they do not squarely apply to expressions of belief,

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102 For the full account of 'conversion ideology', with examples of several interlocking and related views, see 'SOGICE Survivor Statement' (n 8) 2.

103 See especially ibid.

104 *Human Rights Commission Act 2005* (ACT) s 53ZE, as inserted by *Conversion Practices Act* (ACT) (n 10).

ideology or general support for conversion practices. Victoria's legislation does explicitly include organisations, and allows for corporate criminal responsibility where an associate of the body corporate engages in conduct amounting to conversion practices, where the intention element can be fulfilled by, among other things, the existence of a 'corporate culture' that 'directed, encouraged, tolerated or led to the formation of [the associate's] intention'.[105] This may provide some link that uses the expression of conversion beliefs within an organisation that connects the conduct of individual conversion practitioners to a larger organisation like a church or school. The use of 'culture' seems to point to expressing or tolerating conversion beliefs, but it could equally be interpreted restrictively to only supporting, promoting or tolerating conversion practices as practices, as opposed to the beliefs related to them alone. Victoria's advertisement offence relates to notices that show a person 'intends to engage' in conversion practices, and thus likely applies only to advertising the provision of actual conversion practice services offered by a specific person,[106] as opposed to the general promotion of conversion practices or the beliefs underlying them.

Finally, while it is possible that the expression of conversion beliefs may fall within current anti-discrimination law in Queensland, the ACT and Victoria, these jurisdictions have opted to pick up the practices within public health or human rights frameworks and were principally concerned with clarifying how they constituted a public health or human rights breach – and by consequence how the ordinary procedures for investigating, punishing or remediating such breaches will occur.[107] The reforms did not include any explicit expansion in relation to beliefs or views. Consequently, it seems that there has been no change to the law around the expression of conversion beliefs in Australian states.

There are several ways in which conversion beliefs might be approached in law reform. First, as the promotion of 'false or misleading information' about sexual orientation or gender identity, namely as information that aims to convince both LGBTQA+ people specifically, as well as the public at large, that LGBTQA+ people are dysfunctional or disordered and that LGBTQA+ status can and should be changed, suppressed or eradicated, as the promotion of both self-hatred and wider public pressure to convince LGBTQA+ people to engage in conversion practices.[108] Second, expressing these beliefs might amount to 'conduct which offends, humiliates, intimidates, insults or ridicules another person' on the basis

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105 *Conversion Practices Act* (Vic) (n 10) s 15(1)(c)(iii).

106 Ibid s 13(1):

> A person commits an offence if
> (a) the person publishes or displays … an advertisement or other notice; and
> (b) the advertisement or other notice indicates, or could reasonably be understood as indicating, that the person or any other person intends to engage in one or more change or suppression practices, other than for the purposes of warning of the harm caused by such practices.

107 See *Health Legislation Amendment Act 2020* (Qld); *Conversion Practices Act* (ACT) (n 10); *Conversion Practices Act* (Vic) (n 10).

108 *TLRI Final Report* (n 4) 57 [3.6.7]–[3.6.9], 142 [7.1.1].

of their sexual orientation, lawful sexual activity, or gender identity.[109] The TLRI doubted whether this would or could cover most conversion practices, given they are presented in 'helpful' rather than derogatory language, involve some 'voluntariness' that is problematic for anti-discrimination law (the impossibility of genuine consent notwithstanding), and most importantly because the harms are neither immediate nor emotional but rather manifest long after the conduct and involve physical and psychological conditions.[110]

The third option, taken up by the TLRI, is to treat conversion belief expression as a form of public incitement of serious contempt for, or severe ridicule of, a person or group of persons.[111] Rather than use 'ideology', the TLRI drew a conceptual distinction that divided conversion practices into 'direct' and 'indirect' forms. 'Direct practices' are those in medical settings or religious groups that aim to change, suppress or eradicate sexual orientation or gender identity. 'Indirect conversion practices' include the promotion of ideas, beliefs and values that aim to convince or induce a person to submit to direct conversion practices. The TLRI characterised these as a set of 'false or misleading information' about sexual orientation and gender identity, namely that LGBTQA+ attributes are due to a fault or dysfunction and that they can and should be changed, suppressed or eradicated through conversion practices.[112] In its general definition, the TLRI's Final Report emphasised that all forms of conversion practices are motivated by three interlinked beliefs: there is a 'normative archetypal sexual orientation and gender identify for each human biological sex'; that the sexual orientation or gender identity of people who do not conform to that normative archetype 'can be changed by intervention'; and that such people 'should pursue or accept such interventions to return them to a "normal" or "natural" (archetypal) SOGI status'.[113] Indirect conversion practices are expressions, promotions or disseminations of these beliefs, while direct conversion practices put them into effect in focused, targeted practices. This move removes any substantive distinction between 'practices' and 'ideology', and then replaces 'ideology' with 'belief'. Whereas direct practices might be the subject of complaints and investigations under new provisions in Tasmania's *Mental Health Act 2013* (Tas) or criminal statutes, indirect conversion practices would only be dealt with through Tasmania's anti-discrimination scheme.

To effect these points, the TLRI offered a definition adapted to Tasmanian anti-discrimination law on incitement to squarely cover the targeting of LGBTQA+ traits by clarifying that sexual orientation and gender identity is a protected trait, namely as a public act that

109 *Anti-Discrimination Act 1998* (Tas) ss 16(c)–(d), (ea), 17; *TLRI Final Report* (n 4) 145–6 [7.1.16]–[7.1.18].

110 *TLRI Final Report* (n 4) 146 [7.1.18].

111 Ibid 157 [7.3.10] Recommendation 10; *Anti-Discrimination Act 1998* (Tas) ss 19(c), (e).

112 *TLRI Final Report* (n 4) 28 [2.6.13].

113 Ibid 11–12 [2.2.2], with each belief examined in more detail at 25–7 [2.6.1]–[2.6.11].

> [c]haracterises the protected attribute as the product of a fault or disorder; and [s]tates or implies that the protected attribute can be changed, suppressed or eradicated; and [s]tates or implies that the person or group of persons should change, suppress or eradicate the attribute.[114]

This definition captures the public nature of much (but not all) conversion practice belief expression, and the use of 'incitement' indicates that the harm comes from urging a wider audience to do further harmful acts, namely pressuring LGBTQA+ people to undertake conversion practices. The 'serious contempt and ridicule' relates to both individual LGBTQA+ people and the LGBTQA+ community as a whole because it contends that their way of life, both individual and collective, is an aberration, should not exist, and can be eradicated. Again, the anti-discrimination focus on offence, humiliation and individual feelings does not properly capture the 'helpful' or 'healing' rhetoric often employed. An overall objective of the elimination of a group of people, even couched in 'positive' rhetoric, inescapably expresses contempt for them, because it asserts they should not exist. Although the TLRI did not use this language, this approach makes the promotion of conversion practices akin to incitement to eradicate an ethnic or religious group;[115] the expression of views that they can and should cease to exist as they currently do by undergoing a program that purports to be able to remove those attributes. Despite the rhetoric around 'help', 'confusion' and 'healing' that accompanies contemporary conversion practices, the connection to eradication provides the most serious reminder of what these beliefs and practices actually envisage; a world that has eradicated the real, natural diversity in sexual orientation or gender identity.

This approach is well suited to dealing with the difficulties of mediating disagreements around the expression of ideas, is non-carceral, and allows for investigations rather than always requiring survivor-initiated complaints, which, for example, might follow a Health Complaints Commission investigation into direct conversion practices. While the Victorian approach covers conversion beliefs in its provisions on institutional and corporate cultures, Tasmania provides a stronger and direct response through an expansion of anti-discrimination law, which is well-suited to deal with the difficult balances of expression, hate speech and belief.

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114 Ibid 156 [7.3.7].

115 Note the TLRI did raise a parallel with racist assimilationist and segregationist arguments: see ibid 143 [7.1.5]. The TLRI also gestured towards eradication/elimination of a group in its general and legal definitions that use 'suppress, change or eradicate': see, eg, at 27 [2.6.8]. Some of these points are starting to emerge explicitly in anti-transgender rhetoric in the US: see, eg, Peter Wade and Patrick Reis, 'CPAC Speaker Calls for Eradication of "Transgenderism": And Somehow Claims He's Not Calling for Elimination of Transgender People' (online, 6 March 2023) *Rolling Stone* <https://www.rollingstone.com/politics/politics-news/cpac-speaker-transgender-people-eradicated-1234690924/>. According to some advocacy groups, there is a wave of US state bills targeting LGBTQA+ people, including criminalising healthcare and parental support for gender diversity affirmation and likening it to child abuse, and five bills seeking to 'define transgender people out of existence': American Civil Liberties Union, 'Over 120 Bills Restricting LGBTQ Rights Introduced Nationwide in 2023 So Far' (Press Release, 19 January 2023) <https://www.aclu.org/press-releases/over-120-bills-restricting-lgbtq-rights-introduced-nationwide-2023-so-far>.

Law reform must be attentive to the precise locations and forms of conversion practices, and be adapted to respond to them in those forms, which in Australia is predominantly within religious organisations. However, there is no obvious reason why the religious tenor of contemporary practices would need any special singling out in a law reform model. Whether the practice took place in a secular or religious setting makes no difference to the risk or severity of harm. The Tasmanian model only nuances this by adding medical settings to affect which statutory bodies and officers are responsible for investigating conversion practices. Two areas of activity create additional complexity that compounds the difficulties of dealing with conversion practices in religious and parental settings. The first is conduct and activities that are religious or counselling sessions which are less thoroughly medicalised, may involve legitimate expressions of religious doctrine, but also still amount to conversion practices. The second is the expression of conversion beliefs in religious or family settings. The remainder of this Part shows how an anti-discrimination approach is well suited to both of these settings.

A first additional difficulty in regulating conversion practices is that many are labelled as, or take the guise of, religious activities. There is a need to draw distinctions between genuine expressions of prayer and religious doctrine that should not be prohibited by law. In medical settings, and in each of the Queensland, ACT, Victorian and Tasmanian models, whether conduct amounts to a conversion practice depends in a general sense on the state of professional clinical knowledge. For example, a doctor denying to their patient that it is possible to be non-binary, advising the patient that this is a symptom of depression, and that these feelings will pass, is not in line with contemporary professional clinical standards, and would amount in each jurisdiction to suppressing a person's gender identity because it denies the possibility of that identity. In religious settings, a pastor stating that being non-binary is a result of spiritual brokenness that can be healed by prayer is still pseudoscientific in its diagnosis of purported causes, its prescriptions for activities to 'heal' something that is not a recognised mental illness, but without a level of technical detail or thoroughly medical language, and with a connection to the kinds of social or personal virtues that religious doctrines commonly relate, such as prescribing and enforcing norms around gender roles. A religious leader may adopt the language of 'trauma', 'treatment', or 'wellness' in explaining to conversion practice subjects that something is disordered or wrong with them and can be fixed.[116] The contrast for conversion practices is that the risk of harm is much more clearly evidenced in scientific and clinical studies. Wellness counselling or 'alternative medicines' like reiki may be pseudoscientific, ineffective, and may resemble recognised treatments, but there is also no base of evidence that they cause harm.

It is notoriously difficult to design laws that draw an appropriate line between the legitimate free expression of religious doctrines and beliefs, however much they may offend or harm others, and harmful or hate speech that goes beyond the

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116 This raises a wider question about the (lack of) regulation of the counselling, wellbeing and wellness industries, some of which use pseudo-medical language and techniques akin to genuine mental health assessments and treatments that may be potentially harmful.

bounds of legal protection. Religious and socially conservative advocacy groups have contended that conversion practice reforms seek to criminalise beliefs or their expression.[117] The overreliance on criminalisation in the Queensland, ACT and Victorian reforms arguably exacerbates this problem, particularly because those offence provisions contain no explicit defences or carve outs that relate to the mere expression of belief. Tasmania's criminal reform model does recommend including a clarification that conduct which amounts to no more than 'an expression of an opinion, idea or belief' or falls within the acceptance, assistance, facilitation of support or care exceptions does not constitute a conversion practice.[118] Arguably, a free expression exception is unnecessary. Following the Tasmanian approach to general definitions, the expression of a conversion belief or speech acts that might be part of a conversion practice (eg, that a person should change their sexual orientation) is a conversion practice if and only if it is a course of conduct that has a pseudo-medical character akin to the assessment, diagnosis and treatment of a mental illness. Conversion practices will likely be primarily evidenced by speech acts, but this speech will go well beyond merely expressing opinions, political views, or beliefs, and instead the targeted phrases, conduct, contexts, repetition, and other factors, with the overall aim of attempting to change or suppress a person's sexual orientation or gender identity that make them amount to a conversion practice. This is akin to harassment or racial vilification consisting of speech acts that could be labelled as mere 'belief statements' but move well past protected speech because of their harmful effects. Nonetheless, and again taking criminal offences as serving a guiding or condemnatory function, this clarification placed within the offence provision itself for the avoidance of doubt or misinformation would serve to counter concerns of advocacy groups or the general public that they may be imprisoned for the expression of their beliefs, and for the guidance of police, prosecutors and human rights bodies.

Parental rights are perhaps more simply dealt with than religious doctrinal defences, partly because these concerns tend to rest on general misconceptions about the actual extent of legal protection for parental control over their children. Various conservative and religious advocacy groups have raised the spectre of parents being imprisoned for merely talking to their children about sex and gender.[119] As noted above, discussions and expressions of beliefs about sex and gender, even if they might amount to conversion beliefs, are not themselves conversion practices, and Tasmania's criminal offence provision clarifies this explicitly. A medical approach to conversion practices also reinforces the need for parents to seek appropriate healthcare for reports of potential gender dysphoria, as opposed to attempting to assess or treat it themselves or send their child to a religious leader for purported treatment. This is a function of a parent's general duty to seek medical attention for any serious injury or distress a child might

117 See, eg, Wong (n 15), which analyses claims from the Australian Christian Lobby's Facebook post about the *TLRI Final Report* (n 4).

118 *TLRI Final Report* (n 4) 178–9 [9.3.14].

119 See, eg, MacDonald and Dunlevie (n 15).

report, regardless of their views on – or whether that injury or distress has anything to do with – sexual orientation or gender identity. Anti-discrimination only applies to public acts, so private family conversations would not be covered by the new incitement approach. Intra-family expressions of conversion beliefs may still be covered by general anti-discrimination or child welfare protections.

Finally, taking a primarily medical approach to conversion practices and leaving belief expression to anti-discrimination law sidesteps many of the apparent difficulties around religious doctrine and belief expression. Approaching conversion practices as either medical practitioners failing to adhere to the standard of care they are obligated to provide or of unlicensed, untrained laypersons purporting to offer services akin to mental health assessments, diagnoses and treatments means that any purported religious or belief justification for the latter becomes irrelevant. The line is much more clearly drawn when it is investigated by bodies and officers trained in healthcare, which requires them to assess whether the conduct is pseudo-medical and pseudoscientific. That is the ultimate source of the risks and harms of conversion practices.

VI CONCLUSION: LOVE AND ENSLAVEMENT

This article examined four efforts to reform Australian state laws to respond to conversion practices. It contended that singular definitions of conversion practices are less important than they may appear, and that comprehensive law reform to respond to the practices in their varieties, settings and belief-formation stages requires using a variety of statutory regimes. An overreliance on criminalisation in Queensland, the ACT and Victoria leads to an overreliance on statutory definitions, with resulting uncertainty and confusion both about what conversion practices are and are not, and who may be criminally liable for providing them. The Tasmanian model of an adaptive health services approach to defining, investigating, and regulating healthcare that may verge on conversion practices, and sanctioning non-healthcare conversion practitioners on the basis that they offer pseudo-medical and pseudoscientific 'treatments' that carry a risk of serious harm, is to be preferred over carceral and human rights body responsibility for dealing with direct conversion practices. While human rights and anti-discrimination law in Queensland, the ACT and Victoria will likely provide useful avenues for dealing with complaints, Tasmania's model tackles the difficult issue of conversion practice belief expression by appropriately treating it as a form of incitement to serious contempt or public ridicule. While a number of criticisms can be made of the details of Tasmania's approach, there are compelling responses to these issues, and the responses scheme remains, overall, compelling. It is adapted to the peculiarities of Tasmania's legal and human rights framework, and other jurisdictions weighing bans, whether they have human rights charters or not, would do well to consider adapting it.

The TLRI ended its report with a short note on the material and social support aspects that must accompany law reform; that funding for individual and community

support for children and adults seeking to live as they are is imperative.[120] Being cut off from the church and family structure is a serious risk – one that dangles over the heads of LGBTQA+ youth who may be yet to make any connections or community beyond their church, school and family. The flip side of this is the material conditions that motivate the provision of conversion practices: moral panics around transgender people, threats to the family unit, parental authority, the 'need' for single-sex and/or religious private education to prevent this social decay, and the resistance among many parents, teachers, and religious leaders to grant and respect the real autonomy of children and young people. That is in turn a function of the damage wrought on these adults by the often violent and terrifying suppression of any suggestion that they might explore their sexuality or their gender identity, which may have led them to find a different truth to who they think they are in this world. In the same way that the phrase 'feminism is for everybody' reminds us that patriarchy hurts and limits men in the ways they may be human,[121] even as it does the worst harm to women, conversion practices and conversion beliefs are never just targeted at LGBTQA+ people, even as they do their worst harms to them.

The beliefs and internalisation of feelings that cisgender heteronormativity is the standard, and deviations are sins volunteered and punishable at judgment day, lies deep in the structure of many Australian minds, and harms everyone.[122] Linked here is the sense that LGBTQA+ status is, as Eve Sedgwick pointed out in 1993, a question of personalised 'will' and 'voluntariness' (as opposed to a wide, structural freedom to be and live as you wish), and the historical connections between the emergence of the category of homosexual and of addict.[123] In this sense, conversion practices are a form of a 'twelve step' program of self-control that frames LGBTQA+ ways of living as socially-condemned addictions, posing LGBTQA+ adults and young people alike as incapable of controlling their – misdirected, self-misunderstood, excessive, dangerous – willing. This structure, where sexual orientation and gender identity do remain subjectively important for some people, and seem to them as individual choices, reminds us that those categories only gain importance to the extent that they are vital for that person's ordering of the world; that the misogynist must know whether a stranger is a man or woman, that a parent must know the sexuality of a child, because they will treat them (radically) differently on that basis. That is the essence of discrimination and a discriminatory way of being in the world. Conversion practices reforms are one part of the project to dismantle that world.

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120 *TLRI Final Report* (n 4) ch 10. See especially at 185 [10.3.3].

121 See especially bell hooks, *Feminism is for Everybody: Passionate Politics* (South End Press, 2000) chs 12–13.

122 On these points, albeit in relation to homophobia generally in Euro-American social and legal orders, see especially Francisco Valdes, 'Queers, Sissies, Dykes, and Tomboys: Deconstructing the Conflation of "Sex," "Gender," and "Sexual Orientation" in Euro-American Law and Society' (1995) 83(1) *California Law Review* 1 <https://doi.org/10.2307/3480882>.

123 Eve Kosofsky Sedgwick, *Tendencies* (Duke University Press, 1993) 130–5 <https://doi.org/10.2307/j.ctv11hpmxs.10>.

At the end of the passage in Revelation that frames this article, Christ acknowledged that many in Thyatira did not adhere to the practices against which he spoke:

> I will give unto every one of you according to your works. But unto you I say, and unto the rest in Thyatira, as many as have not this doctrine, and which have not known the depths of Satan, as they speak; I will put upon you none other burden. But that which ye have *already* hold fast till I come.[124]

Conversion practice reforms that focus on adaptive healthcare oversights place no further burdens on medical practitioners than those they already labour under. They clarify and reinforce professional oversight of activities around sexual orientation and gender identity that ought to be welcomed by all health practitioners, especially as scientific advancement around best treatment – and likely social controversy – continues to advance. The passage ends, '[a]nd he that overcometh, and keepeth my works unto the end, to him will I give power over the nations: And he shall rule them with a rod of iron … He that hath an ear, let him hear what the Spirit saith unto the churches'.[125] Churches and religious organisations, like schools and care homes, must hear what has been said to them. They are not to be ruled by the state with a rod of iron, but the limits to their ability to set social and moral demands on individuals as regards their sexual orientation and gender identity are clear. Expressing doctrines articulating the ineffable good life, and guidance to achieve it, are religious prerogatives, as much as their current iterations might seem like just another set of wellness scams or pyramid schemes; living by the word requires much more, and dedication to activities is far more important than attempting to control the reins and hearts of children and young people.

In a collection titled for that task – *Living by the Word* – African American writer and activist Alice Walker wrote that '[i]f you are not free to express your love, you are a slave; and anyone who would demand that you enslave yourself by not freely expressing your love is a person with a slaveholder's mentality'.[126] This, more so than the reins and hearts, should become the image of conversion practices following their prevention and disappearance: that they seek to enslave others by convincing them to enslave themselves into a mould that removes their sexuality, their identities, their loves, and in turn, the possibility that they might love themselves as they truly are, and others as they wish to be.

124 *The Holy Bible*, Revelation 2:23–2:25 (King James Version) (emphasis in original).

125 Ibid 2:26–2:29.

126 Alice Walker, 'In the Closet of the Soul' in *Living by the Word: Selected Writings, 1973–1987* (Harcourt Brace Jovanovich, 1988) 78, 91.