

Conversion Practices Prohibition Bill 2026 (Tas.)

Submission

Emeritus Professor Patrick Parkinson AM

Thankyou for the invitation to comment on the draft Bill. To provide some context for this response, I am a recently retired Professor of Law, and sometime Dean of Law at UQ, living now permanently in Tasmania. My particular expertise is in family law and child protection, and it is in the latter context that I have been involved in recent years in the debates about the provision of 'gender-affirming care' to minors.

While I want to make brief comments on the need for the Bill, the main purpose of this submission is to offer commentary on the detail of the drafting, assuming that the Bill, in some form or other, moves forward.

A key point of my commentary is to show how the Bill might be interpreted and applied in future in ways that its proponents do not expect and which may be the opposite of what they intend. Once a Bill passes Parliament and receives the Royal Assent, Parliament loses control of it. The application and enforcement of the law is in the hands of people who must apply the ordinary meaning of the enacted words, having due regard to the legislation's stated purposes.

Any Bill, once passed, can be amended by a differently constituted Parliament in ways that may change the targets of its provisions. The erosion of fundamental civil liberties, as proposed in this Bill, will become a precedent for their erosion in other legislation too, and this could impact adversely on minority groups, including Indigenous and LGBTQ+ groups. The abandonment of limitation periods for suing for damages, as proposed in this Bill, will be a precedent for their abandonment in more and more situations - again having repercussions that the proponents of the Bill do not expect or intend.

It follows that the Bill's detail requires very careful scrutiny. In my view, and for reasons I will explain, I consider the Bill to be deeply flawed. These comments could equally be made about similar legislation in other Australian states that this Bill copies.

The purposes of the Bill

I do not support this Bill for two reasons. First, I see no need for it. Conversion therapy, as it was practised a few decades ago to try to change a person's fixed sexual orientation, has ceased to exist. There has never been a well-documented issue about therapy concerning 'gender identity' that has caused significant harm. The only issue has been debate about the role of psychotherapy in treating gender dysphoria or incongruence. On this issue, medical practitioners differ. That treatment, which some call 'conversion

therapy', is now the mainstream option for gender dysphoric minors in Scandinavia, Britain and elsewhere, following expert medical reviews of the evidence for the efficacy of hormonal treatments in addressing gender dysphoria.

The Parliament of Tasmania should not put its thumb on the scale on what is an intense debate in the medical and mental health professions internationally. That debate should take its course without political interference.

Second, I have seen similar legislation have seriously harmful effects, particularly in Victoria where even LGBTQ+ focused mental health clinicians are extremely reluctant to provide mental health treatment to any minor who has a gender identity that is incongruent with their natal sex. The great majority of the children and young people who attend gender clinics such as RCH, Melbourne, have significant mental health issues. As is well-known, children and young people who are on the autism spectrum are greatly over-represented in gender clinic patient cohorts. Others attending the clinics have anorexia, body dysmorphia, ADHD or bipolar disorder, as well as more common conditions such as clinically significant anxiety or depression. A great many have had adverse childhood experiences, including family breakdown and physical or sexual abuse.

It may not be possible to treat these comorbid conditions without exploring issues concerning trans-identification. Human beings are complex and often these various issues in the lives of children and young people are interrelated. Of course, this Bill seeks to provide protection for clinicians engaging in good faith exploration of these issues from a mental health perspective (s.5(3)); but that is so in other jurisdictions in Australia also, and it has not prevented the legislation causing a chilling effect that prevents some children and young people getting the mental health support they need.

This is because the legislation, particularly in Victoria, is so draconian that it has a chilling effect, however much reassurance it purports to give to clinicians. Child and adolescent psychologists and psychiatrists are very busy people. Demand for their services exceeds supply. It is easier to turn someone away than risk that the clinician will later be accused of 'conversion therapy' by a mentally unstable teenager.

This legislation will have the same chilling effect – possibly even more, for the reasons I will explain.

The definitions of sexual orientation and gender identity

I recognise that this definition is essentially a copy and paste from legislation elsewhere; but it is important to identify the drafting problems, so that we do not import into Tasmania difficulties that will, sooner or later, emerge elsewhere.

The definition of conversion therapy in s.5 of the Bill rests upon two other definitions, which are to be found in the *Anti-Discrimination Act 1998*. The first is the definition of sexual orientation. The second is the definition of gender identity.

(i) *Sexual orientation*

This is as follows:

Sexual orientation includes –

- (a) heterosexuality; and
- (b) homosexuality; and
- (c) bisexuality.

The first two do not give rise to difficulties, but the third one does. What does it mean to seek to change, suppress or eradicate someone's bisexuality? Does this mean that the prohibited conduct is to seek to change, suppress or eradicate their sexuality in its entirety? Who would wish to do that?

Bisexuality is an important issue, because a lot of women are bisexual up until the age of about 30 before, usually, settling into a heterosexual marriage or de facto relationship. Other women enter same-sex relationships after a heterosexual relationship ends. Some men are also bisexual, but it seems to be far less common.

Bisexuality gives people some level of choice about their sexual relationships. What if a woman is comfortable with her heterosexual attractions, but, for whatever reason, wants not to have sexual feelings for other women? There could be a range of reasons for that, including cultural or religious reasons. Tasmania is an increasingly multicultural society and we have people who adhere to a range of faiths. Does the Tasmanian Parliament want to prohibit those who are bisexual from asking for such help as may be available to them to be able to act upon one kind of sexual attraction rather than another? If so, why is this a sufficiently important public policy objective to justify criminal sanctions?

(ii) *Gender identity*

The relevant definition from the *Anti-Discrimination Act* is as follows:

Gender identity means the gender-related identity, appearance or mannerisms or other gender-related characteristics of an individual including gender expression (whether by way of medical intervention or not), with or without regard to the individual's designated sex at birth, and may include being transgender or transsexual.

On this definition, everyone in the world has a 'gender identity'. For the great majority of people, that gender identity is congruent with their sex. Their appearance, mannerisms and other gender-related characteristics are likewise congruent with their sex. However, for a few people, there is an incongruence between gender identity and sex.

The proposed legislation does not focus just on those few people. It says that it is a conversion practice to seek to change or suppress someone's cisgender identity.

(iii) The interrelationship between the two definitions

I suggest it is very important to consider how the two definitions might interact and with what effect. We know from overwhelming research evidence that most children who identify as transgender or who are 'gender diverse' will grow up to be same-sex attracted if they are left to develop and go through puberty normally without medical interventions. Those medical interventions, so far as children and young people are concerned, are very controversial in the medical professions. Internationally, the tide is turning against these practices. Lawsuits against clinicians for malpractice are beginning to succeed overseas. Some medical insurers are getting nervous. The Medical Defence Union in Australia won't insure treatment of minors with puberty blockers or cross-sex hormones as a response to gender dysphoria.

A likely consequence of this legislation, if enacted, is that clinicians who practice "gender-affirming care" will find themselves on the wrong side of this law unless they can claim the benefit of the health professionals' exemption in s.5(3). Clinicians in the Tasmanian Gender Service, and private practitioners, could well be accused of engaging in conduct that changes or suppresses the sexual orientation of an individual who has received irreversible treatments and has now come to understand himself or herself as a cisgender, but same-sex attracted, adult.

The nature of the irreversible treatments of hormone therapy and surgery is that the body is changed to be congruent with the sex with which the person identifies. The effect of that, in turn, is to change their sexual orientation. This is because the natal male who is same-sex attracted will have been irreversibly changed to conform to a female identity. They may legally register themselves as female. If they continue to be attracted to men (the hormonal treatments won't change that) then, once homosexual, they are now heterosexual. There has been a change in their sexual orientation consequent upon transitioning to a female presentation and a legally recognised female status.

It has been a very common complaint of those who regret their gender-affirming care that the treating clinicians did not recognise that their gender non-conformity was really just an emerging same-sex orientation. The adolescent years are a time of identity formation and development, and all the research shows that sexual orientation, at this stage, is quite fluid and changeable.

What if the clinician didn't realise that the gender non-conforming child is showing an emerging same-sex orientation? According to the Bill, that is no defence, because s.5(2) says this:

For the purposes of subsection (1), it is irrelevant whether a practice or conduct directed towards a person on the basis of the person's sexual orientation or gender identity is based on an incorrect assumption or belief about the person's sexual orientation or gender identity.

The clinician who wrongly assumes a child has an incongruent gender identity when really they are just gender non-conforming and same-sex attracted, will have no defence of mistake as a consequence of this subsection.

Gender-affirming care practitioners are covered by s.5(3) as long as they adhere to all legal, professional and ethical requirements. This subsection will be considered further below; but suffice it to say now that those professional and ethical requirements are in a state of considerable flux when it comes to treatment of children and young people. The most basic ethical requirement is *primum non nocere* ("first, do no harm").

It may no longer be adequate for practitioners to rely on WPATH or AusPATH guidance in circumstances where, as is quite likely at some future time, their treatment practices come under sustained critical examination. The Cass report has already given a very negative evaluation of the RCH Melbourne/AusPATH Standards of Care. Although updated in 2023, it did not include reference to any studies published after 2018, and there has been voluminous research published since then. It is a professional requirement for specialists to keep up with developments in their field such as significant new research either concerning the efficacy of treatment or side-effects and unwanted consequences of that treatment. Practitioners now are relying on guidelines that have no official status and are seriously out of date when it comes to the available research. The WPATH SOC 8 guidelines have also come under severe criticism, especially after the revelations in the US of political interference in guideline development under the Biden administration.

Either as passed, or as a result of subsequent legislative amendments by a differently-minded Parliament, this legislation may well come back to bite clinicians engaged in gender affirming care. This would no doubt be an unwelcome consequence for the LGBTQ+ advocacy groups promoting this legislation and the politicians supporting them in enacting it.

A conversion practice

It is necessary now to consider the meaning of a conversion practice, given the definitions discussed above.

(i) Inducing change in a vulnerable cisgender young person

It should be noted that as drafted, the legislation could capture the activities of gay, lesbian and transgender activists, including students in schools, who induce or pressure a vulnerable person to change or suppress their heterosexual orientation or cisgender identity, by identifying as 'queer'. Being LGBTQ+ or 'queer' can be a source of meaning,

belonging and popularity in the school context. Vulnerable students may be persuaded into believing they are gay, lesbian or trans when they are not.

The queer teenagers at school who actively seek to persuade a vulnerable young person to believe that they are really 'trans' and so induce them to change their gender identity could find themselves on the wrong side of this law. If the vulnerable young person acts upon the belief that these other students have induced, and takes testosterone or estrogen after obtaining the drugs from an internet source, it is very likely that serious harm will occur. Likewise, if, persuaded that they are really gay, they are induced to engage in same-sex activity when their consent is compromised by their vulnerability, they may suffer psychological harm as the result of sexual experiences they come to regret.

Consequently, these teenagers who induced the false belief in a vulnerable young person that they are gay or 'trans' could be charged with a criminal offence of engaging in a conversion practice years later. Furthermore, they could be sued decades later for damages under provisions in Schedule 1 of this Bill that remove the statute of limitations for this conduct (discussed below). Note, of course, that s.5(2) deprives them of any defence they might have that they did not realise the young person was not 'trans'.

Queer adults who induce a belief in a vulnerable person that they are really 'trans' when they are not, could also fall foul of this law. In other words, it could become a source of harm to the very people who are now seeking that the legislation be passed.

(ii) Suppressing a gender identity

What does it even mean to "suppress" a sexual orientation or gender identity? In Victoria, the VEOHRC has got itself into quite a muddle about this. Its educational material confuses suppressing a sexual orientation with suppressing the desires that flow from our sexual orientation (be that heterosexual or same-sex).

That is most evident in its highly problematic advice on what people are allowed to pray for. VHEOHRC has advised that any prayer to help someone remain celibate is a breach of the law. Yet in all faiths, control over our sexual feelings is a core element of living a moral life, and celibacy before or outside marriage is traditionally a virtue. Praying for someone (at their request) not to act on their sexual feelings is prayer to suppress one's sexual expression, not one's orientation. The vagueness of the legislation contributes to this conceptual confusion, especially as the Victorian Act, like this Bill, defines sexual orientation (by cross-reference to another Act) to include both same-sex and heterosexual orientation.

(iii) *What about gender-fluid people?*

The whole premise of the idea of a 'conversion practice' is that sexual orientation and gender identity are fixed and innate, and cannot be changed. With respect to gender identity, people, it is said, can be 'born in the wrong body' and this justifies criminalising any attempts to help them to become comfortable with their natal sex.

That may be true of a small number of people, mainly natal males; but the evidence for a genetic or hormonal explanation is quite weak. It is not widely accepted by experts in the field, although some accept it as a partial explanation along with other factors. There is a lot of evidence now that many children and young people who identify as 'trans' have had adverse childhood experiences, including dysfunctional family environments, experiences of family breakdown or being victims of child sexual abuse. The evidence for this is much stronger than for a hormonal or genetic explanation, although it is possible that both have some explanatory power.

Whether or not some people are born with a disposition to be transgender, it is widely accepted that many young people are "gender-fluid". They move between cisgender, transgender, non-binary and other identifications over time as they work out their identity and sexual orientation.

When is someone's gender identity so fixed that it is a breach of the criminal law to seek to 'change, suppress or eradicate' that identity? This is a fundamental question, and if there is not a clear answer to it, I don't think this Bill should attempt to criminalise changing or suppressing a gender identity at all. The interpretative problems to which this gives rise are immense, and much injustice to defendants could result.

It is particularly problematic to say of any given child or young person that they have a fixed and innate gender identity. We really don't know until much later in their lives whether a transgender identification will persist. There are medical experts who say that no gender-affirming surgery should be performed before the age of about 26, because the brain is not fully mature until around this age.

(iv) *What is not a conversion practice?*

Section 5(3) seeks to define what is not a conversion practice.

The exemption for health professionals

The carve-out for health professionals is copied from legislation elsewhere. The concerns that gender-affirming care clinicians ought to have about reliance upon this subsection have been discussed above.

Section 5(3) will also provide limited comfort to other mental health professionals, many of whom are extremely anxious about being accused of conversion therapy. They fear losing their licence to practice, or having to defend against a criminal prosecution or civil suit. The defence in s.5(3) only applies when the person has complied with all relevant legal, professional and ethical requirements (s.5(3)(a)(ii)). In a situation where so much is contested concerning gender-affirming care, there could be enormous room for doubt about what those professional and ethical requirements are. For that reason, this subsection is unlikely to be sufficient to prevent the chilling effect on mental health services that has been seen elsewhere.

There is also some vagueness also about the paragraph (s.5(3)(b)) that refers to "genuinely facilitating" coping skills or exploration etc. Who determines genuineness? If the answer is that the court will do so, either by a judge sitting alone or with a jury, that is no comfort at all. The punishment is in the process of being charged with a criminal offence, or facing civil action, and having to defend oneself.

For these reasons, it is very likely that this legislation will make therapists more reluctant to take on clients or patients for therapy that involves exploration of adverse childhood experiences or other sources of distress, when the client or patient also has a gender identity that is incongruent with their natal sex. To take on a client or patient in these circumstances is to expose themselves to considerable risk, and there are plenty of other people who are on a waiting list for their services.

The exemptions for parents and people of faith

Section 5(3)(c) addresses issues that are of particular concern to people of faith and to parents. This is a reasonable attempt to respond to legitimate concerns about legislation of this kind. However, the subsection cannot remain in its present form. The opening words of the subsection say this:

(3) A conversion practice does not include ...

(c) the following conduct, provided the conduct is not engaged in as part of a conversion practice.

The problems of this drafting ought to be evident. The Bill says in effect: "The following is not a conversion practice unless it is a conversion practice." I have no idea what this section means.

The heart of the problem: the lack of clarity about what is prohibited

Apart from this, the real problem with this part of the Bill is that while it tries to be explicit about what is not a conversion practice, the reader is not much wiser in

understanding what is a conversion practice. If the real concern is that some residue of discredited conversion therapies to try to change sexual orientation may have survived, then it is best to identify what those are. Queensland's legislation (s.213F of the *Public Health Act 2005*) is better because it gives specific examples of what is intended to be banned. It includes inducing nausea, vomiting or paralysis while showing the person same-sex images; using shame or coercion to give the person an aversion to same-sex attractions or to encourage gender-conforming behaviour; and using other techniques on the person encouraging the person to believe that being lesbian, gay, bisexual, transgender or intersex is a defect or disorder. These examples highlight unethical therapeutic 'techniques', as opposed to mere counselling.

It is particularly important to identify clearly what therapies relating to gender identity the Parliament seeks to ban. There is not the same history of therapeutic conversion practices in relation to gender identity as there is for sexual orientation. Treatment of children and young people who presented as gender incongruent in the past involved advice to parents and 'watchful waiting' rather than therapeutic interventions to try to change the child. Most children naturally resolved their gender incongruence before or while going through puberty as a result of that cautious approach. The great majority of them grew up to be gay or lesbian adults. Since this kind of expert advice and support was not a conversion practice designed to change the child's gender identity, and no other therapeutic practices have been identified in the professional literature, the law is unclear about what exactly it is meant to prohibit in relation to transgender identification.

If the Parliament is going to make certain behaviour a criminal offence, it is morally imperative that it is crystal clear what behaviour is prohibited.

The criminal offences

An offence is committed if the person intentionally engages in a conversion practice and causes injury to the recipient, or is reckless as to whether engaging in the conversion practice will cause injury to the recipient. Injury includes 'harm to mental health', which could be merely temporary. To understand that definition requires reference to another definition:

harm to mental health includes psychological harm, but does not include an emotional reaction (including distress, grief, fear or anger) unless it results in psychological harm.

The difficulty with this definition is that 'psychological harm' is not defined. It is distinguished to some extent from an emotional reaction, but then the definition becomes circular again since it can include an emotional reaction that results in

psychological harm. In effect, the definition says that an emotional reaction is not psychological harm unless it is.

These days, the term 'psychological harm' is sometimes used in a very expansive manner. It is largely subjective. If I am physically injured, that is something that a doctor can confirm, perhaps with the benefit of x-rays or scans; but there is no objective test for psychological harm. It may be that if the definition were limited to mental disorders as listed in the DSM-5, the concept of harm would be more constrained. Limited in that way, impacts that meet the diagnostic criteria for PTSD or major depressive disorder might be included; however, with something like depression, proving causation is highly problematic. Depressive episodes in our adult lives might have a variety of causes traceable back to childhood as well as to more recent adverse events such as a marriage breakup or an accident that leaves us in pain or impaired. The effects of different adverse experiences may be cumulative and hard to separate from one another.

So expansive is the current draft that in my view, this legislation will have a greater chilling effect than in Victoria. Victoria's law is currently seen as the most draconian legislation in the country, but its criminal offence provisions are more narrowly drafted than in this Tasmanian Bill.

The other criminal offences in the Bill all suffer from the problems that have been identified above. One good feature of the Bill is that prosecution requires the DPP's consent (s.18). At least that is some kind of filter, but it will not prevent the chilling effect of the law.

The Civil Response Scheme

Reports and investigations

Reports can be made by anyone, whether or not affected by the alleged conversion practice (s.25). That sets up a situation where a person may report to the Commissioner conduct that they believe to have occurred, without the knowledge and consent of the person alleged to be affected by that conduct.

This could be another source of difficulty for mental health practitioners. It could be damaging to the work of dedicated mental health professionals to have to respond to erroneous complaints made by busybodies or activists who believe that a professional is engaging in conversion practices when they have no means whatsoever of knowing what goes on in the privacy of the clinician's consulting rooms, and there have been no complaints. I have recently seen evidence from mental health practitioners in other States of precisely this kind of harassment based upon erroneous assumptions concerning their therapeutic practices.

This is also a problem in relation to 'own motion' investigations under s.34. If there is no complaint, it is very hard to see how the Commissioner has any reasonable basis for initiating an investigation, when in the vast majority of cases, the conduct alleged is said to have occurred in the privacy of a discussion between two people, whether in a therapeutic context or otherwise.

Tasmania should avoid passing laws that can be weaponised in the conflicts over gender-affirming care for minors and therapeutic support of adults who experience gender incongruence.

Duty to disclose documents

This is another matter that ought to worry mental health practitioners. One of the most difficult and contested areas of the criminal law, as well as family law, concerns the right to keep counselling notes confidential. This is particularly an issue in cases of sexual assault.

This Bill (s.37) gives the Commissioner an unfettered right to demand a therapist's notes without consent of the client, and without even needing to justify the intrusion on the client's privacy to a court. Section 39 does not provide a defence based upon therapist-patient privilege or any similar duty of confidentiality. It refers to a "reasonable excuse" as a defence, but there is no definition of this in the interpretation section (s.4).

The right to remain silent

The Bill is particularly worrying in that it abrogates the fundamental right to avoid self-incrimination (s.40). It requires people to provide documents or to answer questions that could then be used against them in a prosecution under this legislation. This is quite shocking. The right to remain silent, which is one aspect of the right to avoid self-incrimination, is a fundamental civil liberty. Daily, it is explained to every person who is arrested on suspicion of a criminal offence.

What is the reason, in public policy, to abrogate such a fundamental right in suspected 'conversion therapy' cases when we do not do so for the crime of murder? How could this set a precedent for a differently constituted Parliament to abrogate the civil liberties of minority groups, including members of the LGBTQ+ community?

The powers of the Commissioner

The Commissioner is given extraordinary powers under this Act and an open-ended discretion. She also has the benefit of a blanket immunity provision (s.61). That immunity is the same as a judge of the Supreme Court.

I make no criticism whatsoever of the recently appointed Commissioner; but there have been problems in the recent past, with highly controversial decisions of previous Tasmanian Commissioners that have ended up in adverse publicity and a level of public distrust of their office. If the Commissioner is now to be given such far-reaching powers in this legislation, thought must be given to how to constrain that discretion and ensure proper review of her decisions at a reasonable cost to complainants. It must be reasonably possible, and without great expense, to complain that the Commissioner has exceeded her powers, is abusing those powers, or is otherwise exercising discretions under this legislation that deny natural justice. The power to challenge a compliance notice in the Tribunal (ss.46-47) is appropriate, but there are discretions before that stage such as the power to obtain documents or compel answers to questions that are not similarly subject to appeal or review.

I do not believe the Commissioner should be given such powers; but if they are to remain, then a right to challenge those decisions by reference to some higher authority, together with a specific statutory power of oversight of these discretions by the Ombudsman or a Parliamentary committee, ought to be considered.

The Commissioner should not be given a blanket immunity. She should be fully accountable for the exercise of such wide powers.

Vicarious liability

Section 49 imposes vicarious liability on employers, subject to a reasonable precautions defence. This liability also applies to the engagement of 'volunteers'. Again, this is not defined.

There is an important question of general principle about making organisations vicariously liable for volunteers. Consider the church context. There are a large number of volunteers in the life of any Church - flower arrangers, welcomers, people making the morning tea, people bringing biscuits or cake to eat after the morning service, people who read the lessons, people who lead the prayers, people who help out in the Sunday School or youth group, people who run mothers and toddlers playgroups during the week.

Is the church really to be liable for all these volunteers? How is it to exercise 'reasonable precautions' without having some formal process such as a letter of engagement or a contract? Do we really want this for everyone who helps out with the morning tea or brings a plate of biscuits? That is to change the whole culture of community organisations.

Vicarious liability has long related only to paid employment. The tort concerned must have happened in the course of that person's employment. The extension of vicarious

liability to volunteers in an open-ended and undefined way is a serious problem for churches, charities and other community groups.

Unlimited civil actions for personal injury that apply retrospectively

In Schedule 1 of the Bill there are consequential amendments to other legislation. Of particular concern is that the Bill allows people to sue for personal injury from conversion practices that occurred while they were minors without any limitation period. This is achieved by adding this provision to the existing exemptions from limitation periods in relation to child sexual abuse or serious physical abuse (s.5B, Limitation Act).

The current legislation allowing for lawsuits to be brought decades after the events in relation to child abuse is already causing great difficulty to churches and welfare organisations. The longer the interval between the alleged events and the commencement of the lawsuit, the harder it can be to test the allegations or defend the claim. The alleged perpetrator may have died, witnesses may have died or be untraceable, and memories become more and more unreliable over time. To now add conversion therapy practices to the list of matters where there is no limitation period could cause considerable further difficulties.

A further issue is that the right to sue without limitation appears to be retrospective. The section refers to:

an action for damages for personal injury to a person arising from or related to a conversion practice, within the meaning of the Conversion Practices Prohibition Act 2026, directed towards that person when the person was a minor.

That is not limited to conduct that occurs after the legislation is passed. It could be interpreted to mean that if a person brings an application in negligence (or some other tort) and the conduct complained of happens to fall within the definition of a conversion practice as enacted in 2026 legislation, then the case may proceed without a limitation bar even though the conduct complained of happened fifty or more years earlier.

Section 5C, which concerns reopening settlements, redefines 'child abuse' to include conversion practices but this does not apply to "an act that is lawful at the time at which it occurs". There is no such carve out in relation to section 5B concerning actions for personal injury.

Conclusions

With respect, there are huge legal problems with this Bill, and these problems are fundamental. The criminal law must be crystal clear in defining what it is that is prohibited so that people can avoid that conduct. The civil law must be fair and seen to be so. Laws should not be retrospective. The rule of law requires that public servants such

as the Anti-Discrimination Commissioner are not given broad powers affecting such rights as the right to avoid self-incrimination that are vague and open to abuse.

It must be remembered that once a law like this is on the statute book it sets a precedent. If the Limitation Act can be waived to allow people to sue for personal injury arising out of alleged conversion practices, then it can be waived to allow people to sue for personal injury for gender-affirming care that they regret decades later. If people can be threatened with prosecution for questioning a child's "non-binary" identity and seeking to persuade them to be comfortable in their natal sex, then the same laws, or amended laws, can be used to prosecute 'queer' activists who seek to persuade vulnerable young people that they are really 'trans'.

This legislation should not be rushed through, as it has been in other jurisdictions. At the very least, it would be wise to wait to see what the Victorian Law Reform Commission says in its review of Victoria's legislation. Notwithstanding the severe constraints upon it from the Terms of Reference, I expect the Commission to raise several concerns about the Victorian Act.

My recommendation is that the Greens and others developing this Bill lower their ambition concerning its scope. If a law were passed criminalising conduct that seeks to change sexual orientation through such techniques as aversion therapy, the core justification for having such legislation would be satisfied and it would attract very little controversy. Any attempt to apply it to gender identity is fraught with problems. It will create legal uncertainty, undermine acceptance of trans and gender diverse people, and lead to division. It may, as I have explained, backfire on its proponents, if not in its originally enacted form then as a consequence of subsequent amendments passed through a differently constituted Parliament.

Emeritus Professor Patrick Parkinson AM

July 14th 2026