Conversion Practices Prohibition Legislation Bill

Submission

Patrick Parkinson AM

Professor of Law, University of Queensland

Introduction

I am an expert on family law and child protection with 35 years' experience in these fields. Inter alia, I have chaired Australia's Family Law Council (2004-07), led a major review of its child support system (2004-05), and been President of the International Society of Family Law (2011-2014).

I have written several articles now in the medical and legal literature on legal issues concerning gender dysphoria. My particular focus is on children and young people. I have been in the forefront of debates in Australia on similar legislation, and work closely with paediatricians, psychiatrists, psychologists and others on these issues.

I would ordinarily not get involved on a matter of NZ law and policy unless invited to do so by the Law Commission or other body considering changes to the law. However, given the considerable controversy about this Bill in NZ, and my expertise in the Australian context, it may be helpful to the Committee to have this submission.

Executive summary

1. This Bill is based upon two assumptions that need to be challenged. The first is that there is now a need to ban practices that seek to change or suppress sexual orientation, decades after, it seems, such practices ceased. The second is that therapies endeavouring to address issues of gender identity are as harmful as those that years ago sought to change sexual orientation.
2. There is little evidence to support the claim that gender identity is innate and immutable, making any efforts to 'change' or 'suppress' that gender identity both futile and damaging. Even progressive therapists argue that gender is fluid and that gender identity can change in an individual over time. There are now a lot of 'detransitioners' all over the western world, many of whom deeply regret their decision to take cross-sex hormones and to seek irreversible surgeries. The detransitioners alone are sufficient evidence that gender identity is not innate and immutable.
3. There is no evidence to support the claim that therapists who seek to assist children and young people to become more comfortable with their natal sex cause harm by so doing. Rather, the evidence is that with expert, cautious therapeutic support, some 75-85% of children with gender identity issues can be assisted to become comfortable with their natal sex. The majority of them grow up to be gay or lesbian as adults.

4. The Bill creates a draconian offence, punishable by three years' imprisonment, for engaging in a conversion practice in relation to a child under 18. Even though the definition of a conversion practice allows for more diversity in therapeutic approach than in the Australian versions, the law is likely to have a chilling effect. This will mean that some mental health professionals refuse to see young patients with sexual orientation or gender identity issues who have other serious mental health concerns. This could lead to an increase in the mental health burden on already very troubled young people, and may lead to increased suicide attempts.
5. Parents who act upon expert medical advice in helping their children with gender identity issues risk prosecution and jail sentences under the law as currently drafted. This is likely to lead to huge distress for parents who are already experiencing very difficult circumstances. It could lead to very grave harms.
6. In summary, the Bill is very likely to cause harm to the NZ community. The tragedy which is now unfolding, not only in NZ but across the western world, will in time lead to investigative journalism exposés, Commissions of Inquiry and class action lawsuits. In NZ, this Bill, being enacted in late 2021 when the issues are already becoming widely known and top medical experts are warning of the consequences, is, in my view, reckless.
7. At the end of the submission I propose certain amendments to the Bill which will address the problems.

1. The Bill's flawed assumptions

This Bill is based upon an assumption that there is a need to ban practices that seek to change or suppress sexual orientation, decades after such practices seem to have ceased.

Section 5 makes it clear that it is copycat legislation. A note invites readers to compare the definition in this section with that in Queensland, the ACT and Victoria, all of which have passed such legislation in the last year or so. Without any clear indication that there is a present problem that needs to be addressed by the blunt instrument of the criminal law, advocacy groups have in the last three years or so been pressing for far-reaching legislation that is justified either because other jurisdictions have introduced it, or because some people report harmful experiences from a very long time ago.

It requires strong evidence of a serious problem before new criminal laws are enacted. Why this legislation and why now? As far as I am aware, the NZ Parliament is not seeking to ban smoking or violent porn, yet the present harms from these are widely known and almost universally accepted.

The second assumption is that there is a similar harm from practices that seek to assist children or adults with issues of gender identity as with past practices that sought, usually without success, to alter a fixed same-sex orientation. The claim that there is some connection between long-discontinued and unethical practices such as aversion therapy that attempt to change

sexual orientation, and treatment programs responding to those with gender identity concerns, is an erroneous one.

The connection between the two is based on an assumption that because LGBTQIA + advocacy groups bring together in a common cause the very different experiences and histories of those who are, or who identify as, gay, lesbian, bisexual, transgender, intersex, non-binary, asexual or queer, so any research on gay and lesbian population groups is automatically applicable to all those others who are in the same socio-political movement. There is no evidence to justify such a claim.

2. Gender identity is not immutable

There is little evidence to support the claim that gender identity is innate and immutable, making any efforts to 'change' or 'suppress' that gender identity both futile and damaging. Indeed, it is a widely held 'progressive' belief that gender is fluid. For example, Hidalgo and colleagues, who are clinicians at four specialist gender identity clinics in the United States, express the view that "gender may be fluid, and is not binary, both at a particular time and if and when it *changes within an individual* across time."[1]

The evidence that gender identity may be fluid and changeable is clear also from clinical studies. There is strong evidence of the value and importance of therapeutic counselling for adolescents who come to gender clinics identifying as transgender. For example, Anna Churcher Clarke and Anastassis Spiliadis, of the Tavistock Gender Identity Development Service in London, reported recently on twelve gender dysphoric adolescents who initially sought medical transition but who decided against hormone treatment after counselling.[2]

The idea that gender identity is innate and immutable comes from a belief that people can be born into the wrong body and that sex is 'assigned' at birth rather than observed at birth (or these days, by ultrasound at about 20 weeks gestation). I do not doubt the very real suffering of some people, mostly natal males, whose gender confusion was evident from early childhood and who have found a greater degree of peace in going through sex assignment surgery, but we still know little about the reasons for this condition.

The consensus in the medical and scientific literature is that there is little evidence to support the belief that people can be born in the wrong body.[3] Even clinicians who cite tentative

---

[1] M. Hidalgo and others, 'The Gender Affirmative Model: What we Know and What We Aim to Learn' (2013) 56 *Human Development* 285.

[2] Anna Churcher Clarke & Anastassis Spiliadis ''Taking the Lid Off the Box': The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties' (2019) 24(2) Clinical Child Psychology and Psychiatry 338.

[3] The research evidence is reviewed in Sven Mueller, Griet De Cuypere and Guy T'Sjoen, 'Transgender Research in the 21st Century: A Selective Critical Review from a Neurocognitive Perspective' (2017) 174(12) *American Journal of Psychiatry* 1155. The authors observe (at 1158): "Despite intensive searching, no clear neurobiological marker or "cause" of being transgender has been identified". See also Jack Turban and Diane Ehrensaft, 'Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies' (2018) 59 *Journal of Child*

indications from some studies to support a biological component to gender diversity, nonetheless acknowledge the need for "multiple-level explanations where the social and the biological intersect."[4]

No member of the NZ Parliament, surely, can be unaware of the number of young women, in particular, who have 'detransitioned', and bitterly regret life-changing and irreversible medical decisions they took in their teenage years. Academic studies are now beginning to emerge on detransitioners.[5] Yes, there are also many accounts of happy transitioners. Indeed, some 'trans' celebrities on YouTube present it as a great thing to do and play down or deny the complexities and risks. The problem is that because there is no neuro-biological marker, and no other objective diagnostic test (since we cannot even be remotely confident there is a genetic or hormonal cause), we cannot know at any point in time who will be glad they went on this medical journey and those who will regret it deeply.

While a couple of earlier studies suggested that rates of regret are very low,[6] and these are constantly quoted by activists to deny that there are many detransitioners, three factors now raise questions about the applicability of those findings to the current context. First, modes of treatment of children and adolescents have changed greatly over time. The Dutch Protocol is relatively new, only gradually spreading beyond the Amsterdam clinic which developed it, particularly over the last ten years. Secondly, gender clinics are dealing with a somewhat different population of adolescents seeking treatment than many years ago, only some of whom had recognised gender dysphoria earlier in childhood. Thirdly, a proportion of children and young people who have received the services of child and adolescent gender clinics are lost to follow up as they move to adult services, receive ongoing prescriptions for cross-sex hormones through general practitioners, or are otherwise lost through general mobility factors. Rates of desistence in that group are unknown. It is reasonable to assume that some detransitioners at

Psychology and Psychiatry 1228. Three authors express greater confidence that there is a physiological explanation: Aruna Saraswat, Jamie Weinand and Joshua Safer, 'Evidence Supporting the Biologic Nature of Gender Identity' (2015) 21(2) *Endocrine Practice* 199. However, the authors were unable to assign specific biological mechanisms for gender identity and noted the need for caution due to small sample sizes in the studies.

[4] Gary Butler, Bernadette Wren and Polly Carmichael, 'Puberty Blocking in Gender Dysphoria – Suitable for All?' (2019) 104(6) *Archives of Disease in Childhood* 509.

[5] Pablo Expósito-Campos, 'A Typology of Gender Detransition and Its Implications for Healthcare Providers', (2021) 47(3) *Journal of Sex and Marital Therapy* 270; Elie Vandenbussche, 'Detransition-related Needs and Support: A Cross-Sectional Online Survey' (2021) *Journal of Homosexuality* advance. For a different view, see Jack Turban et al, 'Factors Leading to ''Detransition'' Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis', (2021) *LGBT Health* advance.

[6] Cecilia Dhejne et al, 'An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets' (2014) 43(8) *Archives of Sexual Behavior* 1535; Wiepjes et al (n 101); Valeria Bustos et al, 'Regret After Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence', (2021) 9(3) *Plastic and Reconstructive Surgery* e3477: 1-12.

least will not be responsive to follow up attempts by a gender clinic.[7] There is very little longitudinal research in this area tracking those adolescents who have received cross-sex hormone treatment in the last ten years.

3. Therapeutic support assists most children to become comfortable in their natal sex

Criminalising the provision of therapy to children who are experiencing gender identity issues is particularly ill-advised, because the clear evidence is that the great majority of children who attend gender clinics because they experience serious discordance between natal sex and gender identity tend to resolve these issues when they go through puberty - as long as a cautious therapeutic approach is adopted.[8] Most grow up to become gay or lesbian adults.

These consistent clinical findings have been contested on theoretical grounds.[9] However, no clinical studies have been conducted that contradict these findings. If the findings of all previous scientific studies are accepted, there is absolutely no justification in passing this prohibition on therapeutic work with children who experience gender identity issues. Indeed, it is extraordinarily irresponsible.

4. The Bill's draconian offence

People acting in good faith and with the consent of the young person involved, are subject to prosecution if they engage in what the police consider to be a 'conversion practice', with a threat of jail for up to three years. The only safeguard is that a prosecution requires the consent of the Attorney-General. Medical practitioners and other professionals who are accused of 'conversion therapy' could also be subject to harassment through civil remedy channels as well.

The definition of 'conversion practice' is complex. On the one hand, it prohibits in broad terms practices intended to change or suppress a person's gender identity or gender expression. On the other hand, it creates exceptions which are also broadly drafted, and are not limited, as Victoria's legislation is, to practices that affirm someone's gender identity. On a natural reading, then, a mental health professional who engages in a practice which does lead a young person to abandon their belief that they are 'trans', will not be convicted or subject to civil remedies because he or she provided a health service 'in accordance with the practitioner's

---

[7] The evidence presented to the Court in *Re Kelvin* indicated that 96% of patients treated at the Royal Children's Hospital in Melbourne do not desist (at [56]). However, there is no indication of how many patients were lost to follow-up and the case stated (ibid) indicated that no longitudinal study is available.

[8] M. Wallien, & P. Cohen-Kettenis, 'Psychosexual Outcome of Gender-dysphoric Children' (2008) 47 *Journal of the American Academy of Child and Adolescent Psychiatry* 1413; J. Ristori and T. Steensma, 'Gender Dysphoria in Childhood' (2016) 28 *International Review of Psychiatry* 17; Entwistle K. 'Debate: Reality check – Detransitioner's Testimonies require us to Rethink Gender Dysphoria'. *Child & Adolescent Mental Health*, 2020. doi:10.1111/camh.12380.

[9] Julia Temple Newhook and others, 'A Critical Commentary on Follow-Up Studies and "Desistance" Theories About Transgender and Gender-Nonconforming Children' (2018) 19 *International Journal of Transgenderism* 212; see also the responses from Kenneth Zucker, Thomas Steensma & Peggy Cohen-Kettenis in the same issue.

scope of practice'.

However, since the whole point of the legislation is to scare health professionals away from providing therapy that does not simply affirm a young person's belief that he or she is 'trans', it may not really matter how carefully s.5(2) is drafted. The risk of criminal or civil action is likely to be a deterrent to responsible professionals seeking to assist children and young people with gender identity issues.

This has already been the experience in Australia. The final version of Queensland's legislation provides mental health professionals with a similar exception, but evidence is emerging that mental health professionals are turning away patients who present with gender identity issues, and referring them to practitioners who live in NSW, where no such laws exist.

The situation in Victoria, which passed perhaps the most extreme legislation in the world, is even more dire. I have learned of psychologists directly refusing referral of a patient for psychotherapy whose presentation was a deteriorating mental state in the context of their gender dysphoria. I have heard of psychiatrists also refusing to see patients presenting with gender identity issues of any kind. There have also been cases where young people who identify as same-sex attracted have been refused mental health support as a direct result of the legislation.

This is tragic because all the evidence is that many young people coming to gender clinics have a great range of psychiatric comorbidities or other mental health issues. The stories of happy and well-adjusted trans teenagers are atypical. A leading study of 204 children or adolescents seen at the Gender Identity Clinic in Amsterdam published in 2010 indicated that the rate of autism diagnoses among those with gender dysphoria were about ten times as high as the general population.[10] A study in Finland published in 2015 found that 26% of the 47 young people seen in the gender clinic had been diagnosed as being on the autism spectrum.[11] This strong association between autism and gender dysphoria has been found in other studies.[12] These children have other psychiatric comorbidities[13] that cannot all be explained by bullying,

---

[10] Annelou de Vries et al, 'Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents' (2010) 40(8) *Journal of Autism and Developmental Disorders* 930.

[11] Riittakerttu Kaltiala-Heino et al, 'Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development' (2015) 9 *Child and Adolescent Psychiatry and Mental Health* 9.

[12] Anna Van Der Miesen, Hannah Hurley & Annelou de Vries, 'Gender Dysphoria and Autism Spectrum Disorder: A Narrative Review' (2016) 28(1) *International Review of Psychiatry* 70; Vicky Holt, Elin Skagerberg and Michael Dunsford, 'Young People with Features of Gender Dysphoria: Demographics and Associated Difficulties' (2016) 164 *Clinical Child Psychology and Psychiatry* 108.

[13] Madeleine Wallien, Hanna Swaab and Peggy Cohen-Kettenis, 'Psychiatric Comorbidity Among Children with Gender Identity Disorder' (2007) 46(10) *Journal of the American Academy of Child and Adolescent Psychiatry* 1307; Norman Spack et al, 'Children and Adolescents with Gender Identity Disorder Referred to a Pediatric Medical Center' (2012) 129(3) *Pediatrics* 418.

discrimination, parental disapproval or other sources of minority stress.[14] Examples are attention deficit disorder, anorexia and body dysmorphia.[15] New Australian research shows that many of these children have disordered attachments, or have suffered from trauma, including child abuse. Others have a history of family dysfunction.[16]

The serious risk is that as a result of ill-considered laws based upon unscientific beliefs, many very troubled young people will be deprived of the help and care they need from mental health professionals, and will embark upon irreversible medical transitions that they later deeply regret. This risk arises because such laws have a chilling effect, driving professionals away from offering services that *might* be prohibited, however carefully drafted the laws may be. These are the unintended consequences of unnecessary legislation which is directed at scaring therapists away from providing therapy.

This is what lawyers call the 'chilling effect' of legislation. It has effects far beyond the actual prohibitions contained in the detail of the Act. People don't necessarily act upon the law as written. They act upon the law as they believe it to be, or from fear of what the law might be or how it might be misused. It is true that prosecution requires the Attorney-General's consent. In normal times, this ought to provide some reassurance. Unfortunately, there is a perception, at least in Australia, that certain left of centre parties have been captured by, or are influenced by, extremist ideologies. Such has been the fervour with which people like Germaine Greer and JK Rowling have been denounced, that the consent to prosecution of a 'progressive' Attorney-General can no longer provide much assurance.

5. The risk to parents of relying upon medical advice

Parents have good reason to be worried. Even if a health professional can rely on section 5(2)(a), that provides no such comfort to parents who rely upon their advice. Consider a 13 year old girl who decides, after exposure to teaching on gender identity at her school, and engaging with trans groups over the internet, that she is 'trans' and wants puberty blockers and testosterone. Her GP, knowing of the child's history of mental health problems, urges caution and taking it slowly. He refers the parent and child to a child psychiatrist, who gives similar

[14] This is often presented as the reason for depression and self-harming among gender dysphoric adolescents: M Hidalgo et al, 'The Gender Affirmative Model: What we Know and What We Aim to Learn' (2013) 56 *Human Development* 285. In Australia, see e.g. Michelle Telfer et al, 'Transgender Adolescents and Legal Reform: How Improved Access to Healthcare was Achieved Through Medical, Legal and Community Collaboration' (2018) 54(10) *Journal of Paediatrics and Child Health* 1096.

[15] Riittakerttu Kaltiala-Heino et al, 'Gender Dysphoria in Adolescence: Current Perspectives' (2018) 9 *Adolescent Health, Medicine and Therapeutics*, 31; Gemma Witcomb et al, 'Body Image Dissatisfaction and Eating-Related Psychopathology in Trans Individuals: A Matched Control Study', (2015) 23(4) *European Eating Disorders Review* 287.

[16] Kasia Kozlowska et al, 'Attachment Patterns in Children and Adolescents with Gender Dysphoria', (2021) 11 *Frontiers in Psychology* 582688: 1-21; Kasia Kozlowska et al, 'Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service' (2021) *Human Systems: Therapy, Culture and Attachments*, advance.

advice. The psychiatrist advises the parents to adopt a watchful waiting approach, allowing the girl to wear male clothing but not allowing her to change her name or identity at school. This is in accordance with the advice of the Royal College of Psychiatrists in the UK for pre-pubertal children presenting with gender dysphoria,[17] and other expert bodies. In the meantime, the psychiatrist undertakes therapy with the child to explore the reasons why she thinks she is 'really male'. Specifically, both the GP and psychiatrist advise strongly against taking the child to the nearest gender clinic because neither trusts it.

The psychiatrist may be protected under section 5(2)(a); but the child's parents have no such protection for acting upon the psychiatrist's advice in 'suppressing' the child's gender identity. I have known one mother of a girl who suddenly identified as a 'trans', who was driven to contemplate suicide, so awful was the situation. Consider now what NZ mothers will feel if told they could be sent to jail for three years for not affirming their daughter's new-found gender identity. The advice may not be accurate, but parents get a lot of inaccurate information and advice in these situations.

6. The unfolding tragedy

I recommend every MP to look for detransitioners on YouTube or to find the detransitioners' subreddit, and spend a few hours seeking to understand the experience of these deeply damaged young people, mostly natal females. They have irreversibly deep voices, may have had a double mastectomy, and may be unable to have children. Natal males will also be among the profoundly damaged.

Within the next decade, there will be journalistic exposés, class actions and commissions of inquiry. Given all that is now known about the issues, and given the multiple red flashing lights warning of danger, the senior judge or retired judge who chairs the Commission of Inquiry will wonder aloud how it was that so many activists, almost all of them identifying with the left of politics, treated a complex set of medical and psychological issues as matters of political allegiance which required unquestioning belief in unscientific ideas.

Medical professionals will also come under scrutiny. There will be serious questions about why an experimental medical practice, with very limited evidence to support its benefits and efficacy over the long-term, was not properly regulated by the government or by hospital ethics committees. The inquiry will explore why so few stood up to the intimidation and silencing, when they knew the damage being caused to young people. The Prime Minister of the day will eventually offer an abject apology from the floor of Parliament. This Bill, if enacted in its present form, will be part of the scandal.

[17] Supporting transgender and gender-diverse people: PS02/18. Royal College of Psychiatrists 2018. https://www.rcpsych.ac.uk/pdf/PS02_18.pdf

Recommendations

To avoid these harms, I recommend the following amendments:

Section 5 should be amended as follows:

Meaning of conversion practice
(1) In this Act, **conversion practice** means any therapeutic practice that—
(a) is directed towards an individual because of the individual's sexual orientation and
(b) is performed with the intention of changing the individual's sexual orientation.
Examples:

- 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 attraction.

However, **conversion practice** does not include—
(a) a health service provided by a health practitioner in accordance with the practitioner's scope of practice; or
(b) providing acceptance, support, or understanding of an individual; or
(c) the expression of a religious principle or belief made to an individual concerning same-sex sexual activity.

Conclusion

Eventually, the medical profession will take a more balanced and evidence-based view on these issues. Already, the Karolinska Hospital in Stockholm, a leader in the field in Sweden, has ceased to prescribe puberty blockers and cross-sex hormones for minors under age 16, with effect from April 2021, applying the precautionary principle. Treatment of 16 and 17 year olds is subject to very strict conditions and must occur in the context of a clinical trial.[18] Finland has also revised its practices, with psycho-social support to be the primary course of treatment for minors.[19] England, of course, has stopped puberty blockers and cross-sex hormones without court approval following the Keira Bell case.[20] Western Australia is reviewing its practices now.

Given the debates and uncertainty in the medical profession, this is no time for the NZ Parliament to pass legislation that will be understood as seeking to scare therapists away from

[18] The policy statement is available at: https://segm.org/sites/default/files/Karolinska%20_Policy_Statement_English.pdf.

[19] See <https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en.pdf/aaf9a6e7-b970-9de9-165c-abedfae46f2e/Summary_minors_en.pdf>.

[20] *Bell v Tavistock and Portman NHS Foundation Trust* [2020] EWHC 3274 (Admin) ('*Tavistock*').

providing therapy to very troubled adolescents who identify as ‘trans’ or ‘gender diverse’. There is no need for the rest of the Bill either; but at least these amendments will reduce the harm.

Prof. Patrick Parkinson AM, MA, LLM, LLD
University of Queensland