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7 January 2021

Hon Jaclyn Symes MP
Attorney-General
Government of Victoria

Dear Attorney,

Change or Suppression (Conversion) Practices Prohibition Bill 2020

We are writing to you, as two of the most senior members of our respective professions, to urge you to make major changes to the *Change or Suppression (Conversion) Practices Prohibition Bill 2020*. We do so for three reasons.

1. The Bill is based to a very large extent on erroneous and unscientific beliefs insofar as it concerns issues of gender identity.
2. The Bill lacks any evidential basis for criminalising the treatment by mental health professionals of those who experience gender incongruence issues. Indeed, providing such therapeutic exploration of gender incongruence in a way that may lead a patient to decide not to proceed with puberty blocking medication, cross-sex hormone treatment and sex-reassignment surgery is an ethical obligation for a health professional.
3. The exceptions applicable to mental health professionals in the Bill are wholly inadequate.

We conclude this letter by making practical proposals for amendment.

In making these points, we must emphasise that we do not support long-discontinued and unethical practices, including aversion therapy, that attempt to change sexual orientation. At the same time, we do not think there is any credible evidence that such unethical practices are being provided by any mental health professional today. Whatever may have occurred in Australia or elsewhere prior to the mid-1980s, this country is now a very different place. It is the better for it.

This letter will be made available publicly.

1. Erroneous beliefs about gender identity

The Bill is premised on the idea that gender identity is fixed and unchangeable, making attempts to change or suppress it futile. The press release accompanying the legislation put out by the Department of Justice and Community Safety makes this explicit. It says: “there is

no evidence that…gender identity can be changed." This is an extraordinary proposition and is contradicted by a large body of medical and scientific evidence.

Reflecting a widely held view amongst gender theorists, 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. The overwhelming 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.[2] These consistent clinical findings have been contested on theoretical grounds.[3] However, no clinical studies have been conducted that contradict these findings.

Furthermore, there is strong evidence of the value and importance of therapeutic counselling for adolescents who come to gender clinics identifying as transgender. 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.[4] This is the psychotherapy counselling your Bill seeks to discourage by threatening practitioners with jail terms.

There is a compelling case for the most thorough mental health assessment before a child or teenager should be given medical assistance to transition, and this may suggest exploring other reasons why a young person may experience gender discordance or dysphoria other than that they were 'born in the wrong body'. As Finnish experts have advised:[5]

> [F]or the majority of adolescent-onset cases, [gender dysphoria] presented in the context of severe mental disorders and general identity confusion. In such situations, appropriate treatment for psychiatric comorbidities may be warranted before conclusions regarding gender identity

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

[2] 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.

[3] 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.

[4] 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.

[5] R. Kaltiala-Heino and others, 'Gender Dysphoria in Adolescence: Current Perspectives' (2018) 9 *Adolescent Health, Medicine and Therapeutics*, 31 at 38.

can be drawn. Gender-referred adolescents actually display psychopathology to the same extent as mental health–referred youth.

The National Association of Practising Psychiatrists has endorsed this cautious approach,[6] as has the Royal College of Psychiatrists in the UK for pre-pubertal children presenting with gender dysphoria.[7]

In many parts of the world, including Victoria, the number of young people presenting at specialist clinics with gender identity concerns has increased exponentially over a short period of time. In contrast to historic patterns, it is now mostly teenage girls who are going to gender clinics. A great many of them have autism diagnoses[8] and a range of mental health issues that cannot be explained by minority stress.[9]

There are huge and important debates about these issues in the medical and scientific literature, with mounting evidence that the rise in transgender identification amongst troubled teenage girls is being fuelled by social media and YouTube celebrities.[10] The High Court in London, with a bench comprised of three senior judges, has recently delivered a major decision in the Keira Bell case,[11] endorsing many of the medical and scientific concerns about the current approach to treatment of young people in these very difficult cases.

The serious risk, if the *Change or Suppression (Conversion) Practices Prohibition Bill 2020* is passed in its present form, is that 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.

2. *The Bill lacks any evidential basis for criminalising treatment by mental health professionals*

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[6] Management of gender dysphoria. National Association of Practising Psychiatrists 2020. https://napp.org.au/2020/11/management-of-gender-dysphoria/.

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

[8] A. de Vries and others, 'Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents' (2010) 40(8) *Journal of Autism and Developmental Disorders* 930. See also A. van der Miesen and others, 'Autistic Symptoms in Children and Adolescents with Gender Dysphoria' (2018) 48(5) *Journal of Autism and Developmental Disorders* 1537.

[9] TA Becerra-Culqui and others, 'Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers' (2018) 141(5) *Pediatrics* e20173845; G.L. Witcomb and others, 'Body Image Dissatisfaction and Eating-Related Psychopathology in Trans Individuals: A Matched Control Study, (2015) 23(4) *European Eating Disorders Review* 287.

[10] Lisa Littman, 'Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria' (2018) 13(8) *Plos One* e0202330; Elin Lewis, 'Transmission of Transition via YouTube' in Michele Moore and Heather Brunskell-Evans (eds), *Inventing Transgender Children and Young People* (Newcastle, UK: Cambridge Scholars Publishing, 2019), 180.

[11] *R (on the application of) Quincy Bell and A -v- Tavistock and Portman NHS Trust and others* [2020] EWHC 3274 (Admin).

In what is surely a first in Australian history, a state government has introduced legislation that specifically criminalises the practice of psychiatry and psychotherapy. Section 5(3) provides that the prohibited "change or suppression practice" includes, but is not limited to "providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy".

There is no credible evidence to support this in relation to therapeutic interventions addressing issues of gender incongruence. The claim of harms from so-called 'conversion practices' is based almost entirely upon long-discontinued practices to seek to alter sexual orientation, not gender identity. There is no reliable evidence that psychiatric or psychological therapies to help a person explore and address issues of gender incongruence have had harmful effects.

By contrast, there is plenty of evidence of very beneficial effects from wise and supportive therapy that explores sensitively and thoroughly the reasons why a patient or client may be experiencing a discordance between their natal sex and gender identity. This may lead the person to conclude that they are not 'transgender' and do not need to go through irreversible processes to masculinise or feminise their bodies.

3. *The defences available to mental health professionals in the Bill are wholly inadequate*

The Bill (s.5(2)) does provide that it is not a prohibited practice if the conduct of a health service provider 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.

The problem here is the word 'necessary'. There could be considerable room for argument whether a particular treatment approach is 'necessary'. It ought to be an absolute defence for any mental health professional that the treatment approach is, in the mental health professional's reasonable professional judgement, clinically appropriate. This is indeed what the Queensland legislation provides, after strong criticisms of the Queensland government's original Bill from lawyers and mental health professionals.

There is no medical justification for Parliament to stipulate that a therapeutic program supporting a person to transition is lawful while an intervention which aims to help a patient explore other explanations for their gender identity concerns risks a jail term. It is not for Parliament to dictate practices in the clinician's room or to try to resolve controversies in the medical and scientific communities by force. It is for the medical and scientific communities to resolve the enormous controversies now surrounding the proper support and treatment of those who present with gender incongruence issues. Parliament should recognise the limits of its competence to make informed judgments about such matters.

Necessary reforms

With respect, the Government has made out no case whatsoever for including gender identity in a Bill concerned with 'conversion therapy'. Our primary recommendation is that all references to gender identity should be deleted from the Bill. If gender is fluid, it is fluid in

more than one direction; and the growing number of those who are now detransitioning, having made irreversible changes to their bodies such as loss of fertility or the removal of healthy breast tissue, indicates how changeable gender identity can be.

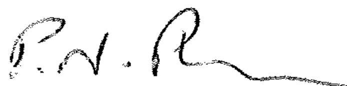
If the Government is unpersuaded that it has got the science wrong on this, we propose that it set up an expert medical and scientific commission, led by eminent people who do not have a stake in this field that might affect their dispassionate assessment of the evidence. That commission could examine the relevant medical and scientific evidence and make recommendations to the Government accordingly.

If the Government continues to insist, against the science, that gender identity is fixed and unchangeable, then we request that the reference in s.5(3) to "providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy" be deleted. In its place section 5(2)(b) should provide:

For the purposes of subsection (1), a practice or conduct is not a change or suppression practice… if it involves "providing a psychiatry or psychotherapy consultation, treatment or therapy, or any other similar consultation, treatment or therapy that is, in the reasonable professional judgment of the person, a clinically appropriate practice."

Yours sincerely,

Dr Philip Morris AM
President, National Association of Practising Psychiatrists



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