Submission to the Queensland Inquiry into Outlawing Conversion Therapy

Dianna Kenny PhD, MAPs [redacted]
Professor of Psychology, Consultant Psychologist
[redacted]
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Preamble

In the context of the *Health Legislation Amendment Bill 2019*, introduced into the Parliament on 28th November, the Queensland State Government proposes to render illegal what the proposed Bill describes as conversion therapy. The explanatory notes issued with the Bill state on page 4 that:

> Conversion therapy is a term used to describe treatments and practices that attempt to change or suppress a person's sexual orientation or gender identity.

Under the proposal, the *Public Health Act 2005* will be amended to incorporate a new Chapter 5B Conversion therapies. The proposed wording for the new Chapter 5B can be found on pages 15-20 of the Bill introduced into the Parliament.

The proposed Chapter 5B Conversion therapies, if passed into law, will have a highly detrimental impact on health service providers and potentially others who are involved in treating, counselling, caring for and advising individuals on matters related with their sexual orientation and gender identity.

If passed by the Parliament, it will create an important precedent for other Australian jurisdictions. Both the Victorian and the ACT Governments have indicated their intentions to pass similar laws. It is expected that Victoria will have a Bill before its Parliament early in 2020.

Issues with the proposed legislation

Definition of Conversion Therapy

The conversion therapy section of the Bill originated in a round table in 2018 that was advertised as sexual orientation conversion therapy. There was no mention of gender identity. Inexplicably, the Bill now focuses on gender identity. This section of the Bill is very poorly conceived and worded. It contains many inconsistencies and anomalies, is not evidence-based and has no scientific merit. Nonetheless, on the basis of these additional chapters to the Bill, health practitioners found to be non-compliant with its provisions will face a maximum penalty of 18 months imprisonment and/or a fine of $20,000 to $30,000. The following problems have been identified in the current wording around the term "conversion therapy."

(i) There is no evidence that the now discarded versions of "real" conversion therapy used to attempt to change an individual's sexual orientation from homosexual to heterosexual such as aversion therapy, electroconvulsive therapy, religiously-based intensive group therapies and the like, have ever been systematically practised on those claiming to be transgender.

(ii) In addition to aversion therapy, the definition of conversion therapy in the Bill includes psychoanalysis, hypnotherapy, "counselling" and "group activities," the precise nature of which have not been specified. Psychoanalysis is a non-directive therapy and has no fixed outcome. It is focused on process, not product (i.e., a pre-defined endpoint). It could under no circumstances be considered a "conversion" therapy which pre-empts the outcome at the commencement of the process. Similarly, "counselling" is a generic term that refers to a process of empathic listening. There are many forms of counselling and most of these provide unconditional positive regard and non-directive exploration of the material that the patient brings to the sessions with no preconceptions about the "desired" outcome of the process. Hypnotherapy is a minor form of therapy that is sometimes used to assist smokers to quit smoking, or people undergoing painful procedures to cope with the pain, among other applications. It is applicable only to certain patients who reach a threshold of suggestibility. Hypnotherapy does have a goal at the outset, but the goal is established by the patient and not the hypnotherapist e.g., I want to quit smoking. Group activities could include any team sport, cooperative games, psychodrama, group therapy, singing in choirs, book club etc. There is no specific therapy that falls under the generic heading of "group activities." This term is so vague as to be meaningless and has no place in legal documents. According to the report "Preventing harm, promoting justice,"[1] "conversion therapy teaching and practice remain pervasive in Australia's mainstream, conservative Protestant Christian communities, as well as in conservative Muslim, Jewish, Hindu and Buddhist communities (p. 11)." However, no specific reference is made to religiously based conversion therapies in the proposed Bill.

(iii) Prima facie, the universal call from the trans lobby for the practice of gender affirmation therapy (GAT) to the exclusion of all other therapies meets the definition of a conversion therapy. Although more data are needed regarding the spontaneous resolution of gender dysphoria, the available evidence indicates that there are no objective (laboratory,

[1] https://static1.squarespace.com/static/580025f66b8f5b2dabbe4291/t/5bd78764eef1a1ba57990efe/1540851637658/LGBT+conversion+therapy+in+Australia+v2.pdf

imaging etc) or psychological tests that can reliably diagnose a "true transgender child." By adulthood, between 61%-98% children desist from a transgender identity. There is no way of predicting who will remain gender dysphoric. Therefore, many children will be irreversibly harmed by the universal application of gender affirmation therapy. In addition, puberty blocking agents (PBA) derail the path of natural desistance – once children are placed on PBA, most, as adolescents, progress to cross-sex hormones because of the physiologic and/or psychological effects of PBA. Hence, GAT can be defined as a conversion therapy and according to the Bill, should be outlawed with severe penalties for those continuing to practise in this way.

An analogous situation is follows: A child or adolescent approaches her parent stating that she has a sore throat. The child advises her parent that she has done research on the internet and spoken with others who have had sore throats and had come to the conclusion that she was suffering from tonsillitis. The child demands that her parent find a surgeon willing to remove her tonsils as soon as possible to cure her sore throat. Her parent suggests that some medical exploration of other possible causes for her sore throat be undertaken before embarking on surgical removal of her tonsils. The child refuses convinced that she has tonsillitis and no other possible causes are valid. As with most medical procedures, parental consent is required for most surgical procedures for young people under the age of 18 years. The parent insists that the child consult a medical practitioner or wait a few days to see if the sore throat resolves. As in 90% of cases, the sore throat resolves spontaneously, and the child ceases to demand a tonsillectomy.

Need for the Bill

(i) What is the need for this Bill? Where are the data demonstrating the frequency with which "conversion therapies" are being practised on transgender identifying individuals? Who is the Bill purporting to protect? When questioned about the incidence of the use of conversion therapy on transgender identifying individuals in Queensland, Dr John Wakefield, Director General of Queensland Health was unable to provide figures.

(ii) The best available figure, which is woefully inadequate, comes from the report, "Preventing harm, promoting justice," which states that "research suggests that up to 10% of LGBT Australians are still vulnerable to harmful conversion therapy practices (p. 3)." This statement fails to identify the precise target group, that is, those who have actually been subjected to conversion therapy. Further, it does not specify how the figure of 10%

was derived to identify the "vulnerable" population of interest. What is the exact number of individuals thought to be vulnerable to conversion therapy?

(iii) The question arises as to whether the proposed legislation is warranted, given that there are no reliable data as to how many individuals would be protected, nor indeed, how many will be harmed by this Bill. I suggest that the latter would far outweigh the former.

Administration of the consequences of practising "conversion therapy"

A number of questions have not been addressed regarding the administration of this Bill. For example,

(i) Who would decide whether the therapy practised meets the definition of "conversion therapy," particularly in view of the vague, unsatisfactory and incorrect definitions of conversion therapy proposed in the Bill? Will a specially constituted body determine this? If so, how will "cases" come to their attention? Could this done via a complaints process to already established authorities like the Health Care Complaints Commission? How would conflicts between these professional bodies and the legislation be resolved?

(ii) Would this legislation to prosecute a psychologist or a psychiatrist for practising "conversion therapy" override the authority of professional bodies governing the ethical practice of these professions, such as the Australian Psychological Society, the National Association of Practising Psychiatrists, or the Australian Health Practitioners Registration Authority? How would conflicts between such bodies and those administering the legislation be resolved?

(iii) The proposed Bill will legislate one form of therapy and criminalise all other forms of therapy for the distress associated with gender dysphoria. Because there are no prescriptions in the Bill regarding the population to whom this legislation will apply, questions arise as to whether adults seeking psychological or psychiatric therapies for gender dysphoria rather than gender affirmation treatment could not be treated because the practitioner approached for such therapy would be committing an offence.

(iv) If, during the course of a non-directive therapy, the patient spontaneously changes their stance on their sexual orientation (unlikely) or gender identity (possible), would such a process be considered conversion therapy?

(v) How does this legislation intersect with other laws regarding individual human rights? This legislation will silence dissenting thought, quash valid scientific endeavour to understand the condition better and remove freedom of choice regarding treatment otpions for both patients and health practitioners.

Patient group

(i) A major oversight in this Bill is the failure to specify the relevant patient group. By far the largest growing subgroup in the transgender field are young people from early to late adolescence who present with Rapid Onset Gender Dysphoria. A second group are very young children who purportedly insist that they are the opposite sex from the preschool years. A third group are adults over the age of consent. Does the Bill apply to all of these groups?

(ii) If this Bill pertains to children and young people below the age of consent, it removes parental authority to make decisions regarding treatment for the children in their best interest. Treatment for gender dysphoria will become a state mandated practice for parents, practitioners and patients. Knowing that most children desist by late adolescence means that this legislation is not in the best interests of the child because they will be subjected to a potentially harmful and non-curative set of interventions that have as yet little long-term data attesting to their safety or efficacy. It will also inflict irrevocable harm on children who are not sufficiently mature to provide informed consent, thereby breaching the physician's oath to do no harm. Further, mandating only one type of therapy deprives parents of their parental authority to act in their child's best interest.

Timing of the Bill

Why is the Queensland government trying to pre-empt any national inquiry into the treatment of gender dysphoric children and young people that is urgently needed and which has been urgently called for?

Conclusion

This Bill lacks a scientific basis, has not established the need, overrides the basic human rights of parents, children and adolescents, deprives practitioners of ethical, autonomous clinical judgment, and has the potential to incur severe and irreversible harm on those receiving gender "affirming" therapy.

Recommendations

(i) The Bill needs to define the term "conversion therapy" with more rigour.

(ii) The Bill needs to specify the population to which it is directed.

(iii) The need for the Bill has not been established. There are no reliable statistics on the number of practitioners practising conversion therapy nor the number of individuals being

harmed by it. Obtaining figures on frequency will not be possible unless point (i) is addressed.

(iv) The Bill does not specify how these proposed changes to clinical practice in transgender therapy will be administered. There are a large number of professional bodies overseeing the work of health practitioners. How will these bodies interact with those administering the proposed legislation?

(v) There are a number of human rights violations implied in the proposed Bill, both for patients and therapists. How will these be resolved by the Bill in its current form?

Yours sincerely

Dianna Kenny