Genspect Australia

Submission on the draft

CONVERSION PRACTICES PROHIBITION BILL 2026 (TAS)

August 2026

Executive Summary

This Bill will freeze into law a treatment model for gender dysphoria and incongruence that requires acceptance of a young person's stated gender identity as settled, and will foreclose exploration of what else may be driving the distress.

Advocates present "gender-affirming care" as the compassionate response to gender dysphoria and incongruence, and treat clinical caution as itself a form of conversion practice. Acceptance of a stated identity overlooks the complex factors often bound up with a young person's distress, including comorbidities such as depression, autism and trauma, difficulty accepting same-sex attraction, and strong social influences. The gender model can fix in place something that may still be evolving, propelling a young person onto medical pathways whose physical effects are irreversible, and leave the original distress unaddressed.

This Bill includes carve-outs that in theory allow some health practitioners to treat gender dysphoria in ways that mitigate these risks. But the Bill also sets out interpretive principles that require a person's gender identity to be treated as settled and not open to clinical assessment, and that undermine each of the carve-outs.

New criminal offences and a civil complaint-and-investigation scheme reach into the ordinary clinical and family conversations the carve-outs no longer protect. The civil scheme rests on the unproven premise that cautious care is a form of identity harm rather than a treatment decision. The effect, whether or not any prosecution or investigation ever occurs, will be to drive the cautious, exploratory alternative treatment out of clinical practice in Tasmania, and expose to investigation parents who decline to affirm a stated identity or who seek exploratory therapy for a distressed child.

Genspect Australia urges the Tasmanian Parliament and Government to reject this Bill and the assumptions beneath it. The better course is no Bill of this kind at all; at a minimum, Tasmania should return to the more careful 2024 draft. Beyond that, the emerging evidence about the medicalisation of vulnerable young people should prompt serious attention to what is driving that distress, our responsibilities to those harmed by these interventions, and how professionals willing to offer careful exploratory care can be sustained.

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Genspect Australia

Genspect Australia Ltd is a Health Promotion Charity, active across Australia, including in Tasmania. We were established in response to the exponential growth in numbers of young people attending gender clinics in Australia, and the emergence of detransition and treatment regret. We support evidence-based care for people experiencing gender-related distress, and we work to prevent harm from gender-related medical interventions. Our network brings together clinical professionals, many of them working in mental health care, alongside parents and families of young people experiencing gender dysphoria and gender incongruence. A particular focus of our work is supporting detransitioners and others harmed by medical transition.

Background

Gender Medicine in Tasmania

Tasmania delivers gender treatment to children and adolescents through the Tasmanian Gender Service[1], and to adults largely through the private system. Both follow the gender affirmation model, though under different standards, and neither set of standards has been developed or approved by an independent Commonwealth body. Both are contested and unproven.

The gender affirmation model

The Tasmanian Gender Service works to the Royal Children's Hospital Melbourne's *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents*.[2] Under those standards, a child's stated gender identity is accepted as the fact to be treated, and the clinician's task is to move the child toward alignment with it through social affirmation and, where indicated, puberty blockers, cross-sex hormones and in some instances surgery. No comparable medical apparatus exists for sexual orientation, which is not a medical condition and past attempts to treat it as one have been rightly repudiated.

Government-commissioned reviews in Finland, Sweden, the UK and elsewhere have found the evidence of benefit of these medical interventions for children to be of low or very low certainty,[3] and not sufficient to

[1] Tasmanian Gender Service, https://www.health.tas.gov.au/health-topics/child-and-youth-health/tasmanian-gender-service-tgs

[2] Royal Children's Hospital Melbourne, Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (v1.4, 2023), https://www.rch.org.au/adolescent-medicine/gender-service/

[3] Finland's Council for Choices in Health Care (COHERE), "Medical treatment methods for dysphoria associated with variations in the gender identity of minors" (11 June 2020), https://palveluvalikoima.fi/en/recommendations
Sweden's National Board of Health and Welfare concluded "the risks of puberty blockers and gender-affirming treatment are likely to outweigh the expected benefits": Socialstyrelsen, December 2022, https://www.socialstyrelsen.se/contentassets/444af6c0a5fb429c9b56fd51b931a816/2023-1-8330.pdf

outweigh the risk of harm, including loss of fertility, reduced bone density, impaired sexual development, and unknown effects on the developing brain[4]. Each jurisdiction has since restricted these medical interventions in children, as have others after reviewing the evidence.

The Commonwealth Government has also recognised that healthcare in this area is "contested and evolving" and has instructed the National Health and Medical Research Council (NHMRC) to review the RCH standards and develop new practice guidelines for trans and gender diverse people under 18. These guidelines are expected to be completed by 2028.[5]

Comorbidities and same-sex attraction

Two aspects of the evidence base in gender medicine are especially relevant to the Bill. International research demonstrates elevated rates of comorbid conditions among children and young people presenting with gender distress, including depression, anxiety, trauma and neurodevelopmental conditions such as autism and ADHD.[6] The RCH Standards acknowledge this pattern in relation to autism, depression, anxiety and psychosis. The prevalence of these comorbid conditions raises the real possibility that, for many young people, gender distress is entangled with, or downstream of, them.

The principles of medical necessity and "first do no harm" should in theory guide clinicians to address these conditions before medical intervention. In practice, the RCH-authored Standards under which the affirmation model is delivered privilege medical intervention over psychological alternatives. Current guidelines direct that comorbidities including autism, depression, anxiety and psychosis should not prevent medical transition, and do not require clinicians to explore whether gender distress may be a manifestation of, or maintained by, an underlying condition.[7] Even these modest requirements have not consistently been observed: several gender clinics across Australia have been found to have departed from their own assessment protocols.[8]

England's Cass Review found no reliable evidence base upon which to make clinical decisions about medical interventions in pediatric gender medicine. Cass Review, Final Report (April 2024), https://cass.independent-review.uk/home/publications/final-report/

The US Department of Health and Human Services found "the evidence for the benefit of pediatric medical transition is very uncertain, while the evidence for harm is less uncertain": HHS, 2025, https://opa.hhs.gov/sites/default/files/2025-11/gender-dysphoria-report.pdf

[4] Baxendale,S., "The impact of suppressing puberty on neuropsychological function", Acta Paediatrica 113(6) (2024), https://pubmed.ncbi.nlm.nih.gov/38334046

[5] Press conference with Minister Butler, Melbourne, 12 November 2025, https://www.health.gov.au/ministers/the-hon-mark-butler-mp/media/press-conference-with-minister-butler-melbourne-12-november-2025

[6] Kallitsounaki and Williams, "Autism Spectrum Disorder and Gender Dysphoria/Incongruence: A Systematic Literature Review and Meta-Analysis", Journal of Autism and Developmental Disorders (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10313553/ Kaltiala-Heino, Sumia, Työläjärvi and Lindberg, "Two years of gender identity service for minors", Child and Adolescent Psychiatry and Mental Health (2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4396787/

[7] The RCH Standards direct that "the presence of ASD with confirmation of a diagnosis of gender dysphoria should not prevent access to medical treatment where indicated" (Standards p.12), and that other "psychiatric comorbidities such as depression, anxiety and psychosis may also increase the complexity associated with treatment and intervention decisions but should not necessarily prevent medical transition in adolescents with gender dysphoria" (Standards p.12). The Standards make the same points in relation to pre-pubertal children. (Standards, pp.9-10.)

[8] Reviews and audits of several public gender services have identified departures from proper practice. A review commissioned by Queensland Health into the Cairns paediatric gender service found children as young as 12 prescribed puberty blockers without

Current guidelines and practice similarly fall short on the question of same-sex attraction. Follow-up studies of boys diagnosed with gender dysphoria and left un-medicalised have consistently found that most desist by adulthood, and a high proportion grow up to be healthy, same-sex-attracted adults.[9] There is emerging recognition that puberty itself is the developmental process through which young people come to understand and accept their sexuality, and that suppressing puberty may foreclose that process.[10] The problem is compounded by the fact that the formal diagnosis of childhood gender dysphoria relies on stereotypes of male and female behaviour, such as a preference for the toys, games and clothing typical of the opposite sex, making ordinary gender-nonconforming behaviour in children evidence of a psychiatric condition.[11]

Consent and irreversibility

The interventions offered under the affirmation model are largely irreversible, and their most consequential effects cannot be sensibly weighed at the age at which consent is sought. Puberty suppression is typically commenced at around 12, and the overwhelming majority of adolescents placed on puberty blockers proceed to cross-sex hormones.[12] A 12-year-old on the blocker pathway is unlikely to want children and

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adequate psychiatric or psychological assessment, alongside a 'negative patient safety culture' and deficient clinical governance: 'Children prescribed puberty blockers without proper assessment at Cairns,' ABC News, 12 February 2026, https://www.abc.net.au/news/2026-02-12/qld-puberty-blockers-cairns-health-service/106336756
An audit of the Queensland Children's Gender Service found 45 per cent of children on puberty blockers had been prescribed them privately before engaging with the clinic, contrary to the Australian Standards of Care: Spencer et al., Australasian Psychiatry (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11982579
In South Australia, the Women's and Children's Hospital acknowledged that 22 children were prescribed gender-affirming treatment between July 2023 and July 2024 without the required prior psychiatric assessment, and its chief executive apologised and ordered an internal review: 'Review ordered into SA gender diversity service's compliance,' ABC News, 5 April 2025.Review ordered into SA gender diversity service's compliance with state guidelines - ABC News That review was completed but its report and recommendations were refused release under the Cabinet-documents exemption in the Freedom of Information Act 1991 (SA), Schedule 1 clause 1(b) (documents released under FOI 2025-00532);
In Western Australia the Perth Children's Hospital gender-service model of care, which refers under-18 patients to private surgeons for mastectomy, was disclosed only after months of refusals and a parliamentary motion to compel it: Bernard Lane, 'Western Australia gender clinic enables double mastectomies for teenage girls, secret document reveals,' The Australian, 9 January 2026.
Several state health departments have refused freedom-of-information requests for data on treatment and outcomes. Tasmania's, when asked, said the data was not held in any form it could produce. Tasmania's Department of Health refused a right-to-information request about patient numbers and outcomes, saying the information was not held in a searchable format: Gender Clinic News, June 2024, https://www.genderclinicnews.com/p/inquiring-mind

[9] Singh, Bradley and Zucker, "A Follow-Up Study of Boys With Gender Identity Disorder", Frontiers in Psychiatry (2021), https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full

[10] Cass Review, Final Report (April 2024), https://cass.independent-review.uk/home/publications/final-report
Hilary Cass, evidence to the Scottish Parliament Health, Social Care and Sport Committee, 7 May 2024, https://www.bbc.com/news/articles/c0de2p7wvd9o
Society for Evidence-Based Gender Medicine, "Puberty Suppression for Pediatric Gender Dysphoria and the Child's Right to an Open Future" (April 2024), https://segm.org/puberty-blockers-hormones-child-right-open-future

[11] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th edition, text revision (DSM-5-TR) (Washington, DC: American Psychiatric Association Publishing, 2022), Gender Dysphoria in Children, 302.6 (F64.2). https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

[12] In the largest cohort to date, 704 of 720 adolescents (98%) who began puberty suppression proceeded to gender-affirming hormones: van der Loos et al., "Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence," Lancet Child Adolesc Health 2023; 7: 869-875, https://pubmed.ncbi.nlm.nih.gov/36273487/ A UK cohort found 43 of 44 (98%) progressed from blockers to cross-sex hormones: Carmichael et al., "Short-term outcomes of pubertal suppression in

has not yet experienced adult sexual function, and so is not in a position to weigh their loss. By the time those wants emerge, the interventions have run for years and their effects are entrenched. The point is particularly stark for young natal females who undergo double mastectomy in their teenage years: the loss of the ability to breastfeed is one they cannot register even at 18 or 19, when the possibility of having children of their own is nowhere in view.[13]

Adults

The Bill applies equally to adults, and the shortcomings of adult practice in Tasmania are in some respects worse than in paediatric care. Young adults presenting with gender-related distress share many of the vulnerabilities of under-18s, including elevated rates of comorbid mental health conditions, unresolved trauma, and unexamined questions about sexuality. They are generally treated by general practitioners in isolation, without the multidisciplinary framework that theoretically applies in paediatric care.

Adults seeking cross-sex hormones in Tasmania are typically treated under the *Australian Informed Consent Standards of Care for Gender-Affirming Hormone Therapy,* issued by the Australian Professional Association for Trans Health (AusPATH*),* an advocacy body.[14] Under these *Standards,* GPs are guided to initiate treatment on the basis of the patient's self-reported gender incongruence or dysphoria, without a requirement for formal clinical diagnosis or independent psychological assessment.

Physical risks are presented as a tick-box acknowledgement, without any requirement that the clinician discuss the evidence base for each risk or its magnitude. Time horizons are provided for expected desired changes such as skin softening or voice deepening, but not for the serious physical risks such as blood clots, stroke, cardiovascular disease or cancers. The listed changes are also named in sanitised terms. 'Vaginal dryness' for example, understates the vaginal atrophy documented in the clinical literature.[15]

The *Standards* do not require clinicians to explain alternative treatments, or to explore whether a patient's distress about their body may reflect emerging same-sex attraction rather than a gender identity requiring medical intervention. Many young adults present for hormones in their late teens or early twenties, an age at which many same-sex-attracted people are coming to terms with their sexuality.

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a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK," PLoS ONE 2021; 16(2): e0243894, https://doi.org/10.1371/journal.pone.0243894

[13] Karleen D Gribble, Susan Bewley and Hannah G Dahlen, "Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm", Frontiers in Global Women's Health 4:1073053 (2023), https://doi.org/10.3389/fgwh.2023.1073053

[14] Australian Professional Association for Trans Health, *Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy* (2022), https://auspath.org.au/wp-content/uploads/2022/05/AusPATH_Informed-Consent-Guidelines_DIGITAL.pdf

[15] AusPATH is less specific than the World Professional Association for Transgender Health (WPATH) Standards of Care to which it refers: E Coleman et al, 'Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7', International Journal of Transgenderism 13(4) (2012) 165-232, https://doi.org/10.1080/15532739.2011.700873. The WPATH Standards have themselves been the subject of sustained criticism for minimising documented side effects See *Memorandum in Support of Its Motion to Dismiss, Federal Trade Commission v World Professional Association for Transgender Health, Inc.*, No 4:26-cv-00748-O (ND Tex, filed 28 July 2026). https://segm.org/sites/default/files/2026-08/WPATH%20Motion%20to%20dismiss_Aug%202026.pdf

The *Standards* also treat comorbid mental health conditions as compatible with, rather than a reason to pause, treatment: they state expressly that 'depression, anxiety, and suicidality are not contraindications to hormone therapy'. On the contrary, they assert that hormone therapy itself improves mental health. The evidence cited for that assertion is a 2016 systematic review whose authors rated the underlying studies as of low to moderate quality, an AusPATH public statement, and a 2022 cross-sectional study whose design cannot establish causation. That assertion is challenged by recent overseas evidence drawn from national registry records[16].

Requirements for surgery are a grey area but generally require a formal diagnosis of gender dysphoria or incongruence. The Medical Services Advisory Committee (MSAC), the Commonwealth's expert advisory body on the addition of medical services to the Medicare Benefits Schedule, has recently examined this diagnosis in the context of an application to fund adult gender surgeries through Medicare. MSAC noted the imprecision of the ICD-11 definition, in particular with respect to the severity and duration of the condition and criticised the current practice under which a single practitioner, usually a general practitioner, can assign an adult diagnosis.[17]

MSAC separately observed professional advice on the age at which frontal lobe development is considered complete, relevant to informed consent for irreversible procedures and to the risk of subsequent regret, with consultation input from healthcare professionals proposing 25 as the appropriate minimum age. MSAC noted that the NHMRC is developing clinical practice guidelines for trans and gender diverse people under 18, and considered that there is a corresponding need for "Australian evidence-based guidelines to inform management and treatment (including surgical intervention) for adults with gender incongruence and gender dysphoria".[18] Those guidelines do not exist, and do not seem to be in prospect.

In the absence of these guidelines, a Tasmanian as young as 19, living with an undiagnosed or untreated comorbid condition such as depression, anxiety, autism or trauma, or struggling with their sexuality, can secure referrals for irreversible surgery, including mastectomy, hysterectomy, phalloplasty, orchidectomy or vaginoplasty, on the strength of a single consultation with a general practitioner and the surgery proceeding on the basis of a readiness letter from a mental health professional. This Bill will leave these individuals more exposed than they currently are.

Long-term harms, regret, and legal redress

Medical interventions in this field produce outcomes that unfold over years, and in the case of interventions initiated in adolescence, over decades. Research now increasingly documents these harms: cardiovascular

[16] Ruuska S-M, Kaltiala R and colleagues, register-based cohort study of all under-23-year-olds who contacted specialised gender identity services in Finland 1996-2019 (n = 2,083, matched to 16,643 population controls). Severe psychiatric morbidity, measured through linked hospital and specialised-care records, rose from 9.8% to 60.7% in the feminising reassignment group and from 21.6% to 54.5% in the masculinising reassignment group over follow-up. https://doi.org/10.1111/apa.70533

[17] Medical Services Advisory Committee, Public Summary Document, Application 1754, April 2025, https://www.msac.gov.au/applications/1754 p.5

[18] MSAC. p.6

and metabolic complications, pelvic floor complications, infertility and sexual dysfunction and, in some large observational studies, markedly elevated psychiatric morbidity, suicide and self-harm rates.[19] These results contrast with the optimistic short-term survey responses on which advocates have relied.

Countries that saw a steep rise in adolescent enrolments in gender clinics, and in the prescription of cross-sex hormones for young people outside those clinics, are now seeing the emergence of regret, and in some instances detransition. This is manifest in the growth of online communities supporting those who have chosen to discontinue medical interventions or to "detransition" and to manage the consequences. The r/detrans forum now numbers some 60,000 members.[20] A growing number of people who previously transitioned now say the difficulties underlying their distress, including trauma, an untreated mental health condition, undiagnosed autism, or difficulty accepting same-sex attraction, were never properly examined before treatment began[21] NHS England is commissioning a service specifically to assist detransitioners with their health and mental health.[22]

Services now face legal exposure from former patients, including in Australia.[23] In the United States in February, a New York jury this year awarded $2 million to a woman who had undergone double mastectomy at 16, prompting the Economist to warn that lawsuits over transgender medicine could be huge.[24] In Australia, claims against services delivering gender-affirming care have been brought and, in every case to date, settled out of court, with terms not made public. Further cases are on foot. Since 2023, MDA National,

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[19] da Silva, L.M.B., Freire, S.N.D., Moretti, E. *et al*. Pelvic Floor Dysfunction in Transgender Men on Gender-affirming Hormone Therapy: A Descriptive Cross-sectional Study. *Int Urogynecol J* **35**, 1077–1084 (2024). https://doi.org/10.1007/s00192-024-05779-3

van Zijverden, Wiepjes, van Diemen, Thijs and den Heijer, "Cardiovascular disease in transgender people: a systematic review and meta-analysis", European Journal of Endocrinology (2024), https://academic.oup.com/ejendo/article/190/2/S13/7596368

Getahun et al., "Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons", Annals of Internal Medicine (2018), https://pubmed.ncbi.nlm.nih.gov/29987313/

Ruuska, Tuisku, Holttinen and Kaltiala, "Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996-2019: A Register Study", Acta Paediatrica (2026), https://pubmed.ncbi.nlm.nih.gov/41934366/

Dhejne et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden", PLOS ONE (2011), https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885

Straub, Paul, Bothwell et al., "Risk of Suicide and Self-Harm Following Gender-Affirmation Surgery", Cureus (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11063965/

[20] r/detrans, https://reddit.com/r/detrans

[21] Vandenbussche, E. (2022). Detransition-Related Needs and Support: A Cross-Sectional Online Survey. Journal of Homosexuality, 69(9), 1602–1620. https://doi.org/10.1080/00918369.2021.1919479

[22] NHS England, 'Call for Evidence: A Clinical Pathway for Adults Who Have Previously Undergone a Gender Transition and Who Wish to Detransition' (Web Page, 2025) https://www.england.nhs.uk/long-read/call-for-evidence-a-clinical-pathway-for-adults-who-have-previously-undergone-a-gender-transition-and-who-wish-to-detransition/

[23] To date, Australian claims have been settled out of court including claims against the Monash Gender Clinic in the early 2010s, https://kellyjames.substack.com/p/australian-detransition-stories-in In 2026 a New York jury found for a detransitioner, awarding $2 million over a double mastectomy performed when she was 16, in the first such case to reach a verdict. The New York Times, 3 February 2026.

[24] Lawsuits over transgender medicine for minors could be huge', The Economist, 6 February 2026, https://www.economist.com/united-states/2026/02/06/lawsuits-over-transgender-medicine-for-minors-could-be-huge

one of Australia's major medical defence organisations, has declined to indemnify general practitioners initiating cross-sex hormones for patients under 18.[25]

Tasmania's 2024 Conversion Ban Bill

Genspect Australia made a submission to the Tasmanian Government's 2024 consultation on the *Justice Miscellaneous (Conversion Practices) Bill*.[26] In it we supported prohibition of sexual-orientation conversion without qualification. We opposed the inclusion of gender identity in the same Bill and warned that sexual orientation and gender identity are separate matters that should not be conflated: sexual orientation is not a medical condition and requires no medical intervention, whereas gender identity is the basis on which potent and often irreversible medical treatments are administered under the gender-affirmation model. Conflating the two in a single prohibition risked deterring exploratory psychological care for people suffering gender dysphoria and incongruence, and funnelling vulnerable people toward those irreversible medical pathways. We also raised the problem of detransition and treatment regret. We reiterated these concerns to the Victorian Law Reform Commission in February 2026 in its review of Victoria's Change and Suppression Ban.[27]

The 2026 Bill extends significantly beyond the 2024 draft, at correspondingly greater cost to clinicians, young people and families alike.

Textual Analysis of the 2026 Bill

Definition of a conversion practice

The problems with this draft begin with its definition. The drafters have departed from the 2024 definition of a conversion practice, which was limited to attempts to "change" or "eradicate" an identity, and added, at clause 5(1), "suppress" - a far lower threshold.[28] In ordinary usage "suppress" means to prevent, restrain or inhibit. On that reading, a clinician who counsels caution, explores other causes of the distress, or declines to affirm immediately, or who pauses before endorsing social or medical intervention, falls within the definition even though they are not trying to change or eradicate anything. The same reach captures parents, whose ordinary conversations with their children may equally be characterised as suppression if they do not immediately endorse a change of name or pronouns.

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[25] MDA National, Cover for the treatment of Gender Transition in Minors (2023, updated 2026), at mdanational.com.au/notice/gender-transition-in-minors

[26] Available at genspect.org.au

[27] Submission 141 https://www.lawreform.vic.gov.au/change-or-suppression-practices-submissions/

[28] Justice Miscellaneous (Conversion Practices) Bill 2024 (Tas), Consultation Draft, Department of Justice Tasmania https://www.justice.tas.gov.au/__data/assets/pdf_file/0004/737653/Justice-Miscellaneous-Conversion-Practices-Bill-2024-Consutation-Draft.pdf
Conversion Practice Prohibition Act 2026 (consultation draft) https://cppbilltas.org/wp-content/uploads/2026/06/Conversion-Practices-Consultation-Draft.pdf

Clause 5(2) then makes explicit that "it is irrelevant whether a practice or conduct… is based on an incorrect assumption or belief about the person's sexual orientation or gender identity." The effect is to remove the correctness of the clinician's or parent's assessment from consideration. A clinician who explores whether a young person's distress is bound up with trauma, autism, or a passing developmental stage is in the same position under the Bill whether their exploration turns out to be right or wrong.

Clause 8: the interpretive principles

The Bill offsets the reach of clause 5(1) with a set of carve-outs at clause 5(3): for health practitioners, for identity exploration, and for parental discussion. Each is governed by clause 8, an interpretive provision with no equivalent in the 2024 draft. It sets principles "to be observed in the operation, administration and enforcement of this Act," and so governs how every other provision, including each carve-out, is to be read.

Two of these principles bear directly on the clinical concerns set out above:

> 8(c) a person's sexual orientation or gender identity is not broken and does not require fixing, changing or suppression;
>
> 8(d) no sexual orientation or gender identity constitutes a disorder, disease, illness, deficiency or shortcoming.

These principles conflate sexual orientation and gender identity, notwithstanding that sexual orientation is not a medical condition and no medical intervention is offered to change it, whereas gender identity, as this Bill and the Anti-Discrimination Act 1998 define it, is broader, may change over time, and is the basis on which irreversible medical treatments are administered to young people and vulnerable adults under the gender-affirmation model.

Read together, clauses 8(c) and 8(d) require the Act to be applied on the basis that a person's gender identity is not open to being changed and not open to clinical assessment. In substance, clause 8 elevates the contested gender-affirmation model of treatment into a statutory principle.

Clause 5(3)(a)

Clause 5(3)(a) excludes from the definition of a conversion practice a health service that a 'registered health practitioner' has assessed as clinically appropriate and that complies with all relevant legal, professional and ethical requirements. But the Bill defines 'registered health practitioner' narrowly, as “a person registered under the Health Practitioner Regulation National Law (Tasmania) to practise in the medical profession (other than a student)”. Allied health professionals such as psychologists, counsellors, psychotherapists and social workers, who provide most of the exploratory talking therapy the carve-out should be protecting, fall outside it. In effect, the carve-out shields affirming medical practitioners such as prescribers and surgeons, whose interventions fall outside the Bill's target, while withholding protection from talking-therapy clinicians whose exploratory work is targeted.

Clause 5(3)(b)

Clause 5(3)(b) protects "genuinely facilitating a person's coping skills, development or identity exploration." Read through clause 8, this carve-out cannot authorise genuine exploration, because clause 8 requires the identity to be treated throughout as not open to being changed and not open to clinical assessment. An honest attempt to understand whether the distress has another cause, or may resolve with time, then becomes hard to distinguish, after the event, from an attempt to change or suppress the identity.

The clause also creates a specific problem for detransitioners. Many need counselling to work through the psychological consequences of a transition that did not resolve their distress and to reconstruct an identity aligned with their natal sex. That counselling is directed to changing a gender identity, which the Bill's clause 8(c) says 'does not require… changing', and which clause 5(1) prohibits. And because clause 5(1) catches conduct 'with or without the person's consent', the detransitioner's own request for that help cannot shield the practitioner from a complaint.

Clause 5(3)(c)

Clause 5(3)(c)(v) provides a carve-out for 'parents discussing matters relating to sexual orientation, gender identity, sexual activity or religion with their children.' But the protection is available only where 'the conduct is not engaged in as part of a conversion practice.' That qualifier is circular: whether the carve-out applies turns on whether the conduct is a conversion practice, which is the very question the carve-out was meant to answer. The practical effect will be to leave parents without the certainty the carve-out purports to provide, at the point they most need it.

Informed consent

The Bill also collides with the general law of informed consent and the professional codes that codify and extend it. Both require the clinician to discuss alternatives, including less invasive treatments, to a proposed medical intervention before obtaining consent to it.[29] In gender medicine, those alternatives include psychological therapy, watchful waiting, and exploring whether the distress may resolve or has another cause. Clauses 8 and 5(2) bring that discussion within the definition of suppression. A clinician who complies with their informed-consent obligation is thus at risk under the Bill; conversely, a clinician who avoids the risk of prosecution under this Bill is in breach of their mandatory informed-consent obligation.

Good clinical practice this Bill would prohibit

In July 2026 Children's Health Queensland (CHQ) issued a statement noting that health practitioners 'must take a clinical approach in the treatment of gender dysphoria that focuses on the best available research and the child's best interests rather than directing a child down a pre-determined treatment pathway.' They "must employ a holistic clinical approach that comprehensively assesses all relevant factors – including

[29] Informed consent in Australia requires disclosure of the material risks of, and the reasonable alternatives to, a proposed treatment: Rogers v Whitaker (1992) 175 CLR 479 (establishing the patient-centred standard for disclosure of material risk). The requirement to inform the patient of alternative options, including less invasive ones, and declining treatment, is stated by the Australian Commission on Safety and Quality in Health Care, "Making informed choices (Informed consent)," https://www.safetyandquality.gov.au/your-rights/making-informed-choices-informed-consent

any comorbidities or other mental health conditions – and use information gathered from that process to determine the best available mode of treatment and care for the patient".[30] The statement was issued as part of the settlement of a long-running dispute with a child and adolescent psychiatrist, Dr Jillian Spencer. Nothing in that statement is novel or contested. Yet in Tasmania the combined effect of clause 8 and clause 5(2) would make that approach a prohibited practice: the Bill would penalise the very assessment that guards against diagnostic overshadowing, where a child's distress is attributed to gender identity while other conditions that may be exacerbating, maintaining, or driving it go unassessed. The resolution CHQ reached, an acknowledgement that children must be assessed for other conditions and not placed on a single predetermined pathway, could not be reached in Tasmania if this Bill becomes law.

The dangers of foreclosure

Clause 8 and clause 5(2) are especially dangerous in gender medicine because the interventions at stake carry irreversible effects. An assessment that comes only after those interventions have taken effect comes too late to matter. The concern applies at every age: to children on puberty blockers and social transition, whose developing identity may be cemented by intervention; and to adults, most acutely young adults, whose cross-sex hormone treatment produces permanent effects that a later reassessment cannot undo. The concern is especially acute in relation to individuals with gender dysphoria who have latent or unresolved same-sex attraction. A regime that fixes gender affirmation as the only lawful response, and treats attempts to explore whether the distress will resolve as prohibited, will convert into medical patients people who would otherwise grow up to be healthy lesbian or gay adults.

Taken together, the definition, the carve-outs (as constrained by clause 8) and clause 5(2)) will deter clinicians from providing the careful, exploratory care distressed young people need.

New criminal offences

The Bill also creates a suite of indictable offences that were not in the 2024 draft. In comparable jurisdictions offences of this kind have not resulted in prosecutions,[31] but they have served to deter clinicians providing care to people with gender dysphoria. Two Victorian peak bodies made this point to the Victorian Law Reform Commission in its current review of the Change or Suppression (Conversion) Practices Prohibition Act 2021.

The Royal Australian College of General Practitioners (Victoria) recorded that its members, uncertain whether exploratory care is captured by the offence provisions, were reluctant to explore comorbid conditions including autism, ADHD, depression, anxiety, borderline personality disorder and complex trauma, and that some were declining to see any patients with gender-related distress. The Australian Medical Association (Victoria) warned that the Victorian Act had produced a "practice environment in which clinicians feel unable to provide balanced care", in which practitioners "may avoid routine assessment,

[30] Children's Health Queensland, Statement from Children's Health Queensland Hospital and Health Service, 17 July 2026, https://www.childrens.health.qld.gov.au/about-us/news/media-releases/statement-from-childrens-health-queensland-hospital-and-health-service

[31] Victorian Law Reform Commission, Focused Review of How the Change or Suppression Practices Ban Is Working: Consultation Paper (February 2026) [4.2], https://www.lawreform.vic.gov.au/publication/change-or-suppression-practices-ban-consultation-paper/4-effectiveness-of-criminal-offences/

treatment, and exploration of gender related issues" and so "refuse to undertake care to the vulnerable groups that the legislation purports to protect, which would be a most perverse and counterproductive outcome." [32]

The pattern the peak bodies warned of is now visible in family life. In *Re Devin*, (2025), the court recorded a father's evidence that he had been forced to search outside Victoria before finding a therapist willing to treat a child with gender-related distress because of the State's conversion-practices legislation.[33]
Parent support groups have grown accordingly, as families turn to one another for support.

The Tasmanian offences would produce the same result. **Clause 9** makes it an offence to engage in a conversion practice that causes injury to the recipient, or where the person is reckless as to whether it will; **Clause 10** makes it an offence to engage in a conversion practice directed at a child, and clause 10(2) provides that it is "not necessary to prove that the conversion practice caused injury to the child." The law properly protects children more strongly than adults, but by removing the requirement of harm altogether, the Bill produces not greater protection for children so much as a wider net. A clinician who explores a child's distress commits the offence whether the child was harmed or not, and whether the clinician's judgement was right or wrong. The clinician who cautions against a double mastectomy for an adolescent with unresolved comorbidities is doing exactly the non-affirming response the definition would treat as a conversion practice.

Clause 16 makes an employer liable for the same offence as an employee, agent or volunteer, with a defence only where it proves it took all reasonable precautions to prevent the conduct. Every clinic and hospital in Tasmania has a direct incentive to steer its staff away from any care the Bill might reach, enforced not through professional codes but through employment risk.

Clause 11 makes it an offence to take a person out of Tasmania for a conversion practice, so a Tasmanian family could not lawfully seek interstate the exploratory assessment the Bill denies them at home. That care remains lawful in most other states and territories.

Clause 13 makes it an offence to advertise a conversion practice. Read through the definition in clause 5 and the requirement in clause 8, that may extend to a clinician or service that publicly offers exploratory therapy.

The offences are also unnecessary. The seriously harmful conduct a conversion-practices ban is said to target - assault, threats, coercion, the abuse of a child - is already criminal in Tasmania. To the extent the new offences reach that conduct, they duplicate the existing law. To the extent they reach anything more, they capture conduct that is not otherwise criminal, which on the definition in clause 5 is ordinary clinical and family communication.

[32] Australian Medical Association (Victoria), submission 121, Royal Australian College of General Practitioners, submission 196, https://www.lawreform.vic.gov.au/change-or-suppression-practices-submissions/ AMA submission 196

[33] Re Devin [2025] FedCFamC1F 211, 21 https://austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FedCFamC1F/2025/211.html

The civil response scheme

The Bill also establishes a civil response scheme, in Parts 4 and 5, administered by the Anti-Discrimination Commissioner. The Commissioner already has jurisdiction over discrimination on the grounds of gender identity, sexual orientation and sex characteristics under the Anti-Discrimination Act 1998 (Tas), together with education and public-awareness functions on those grounds. To the extent the concern is discrimination on the basis of gender identity, no new scheme is needed.

Placing this jurisdiction with the Anti-Discrimination Commissioner treats clinical decisions about gender-related distress as though they were acts of discrimination, and imports a discrimination framework into what are properly questions of medical judgment and family responsibility. The mismatch matters, because a discrimination regulator will approach the question of whether care was appropriate through the lens of whether an identity was affirmed, rather than through the clinical question of whether the care met the needs of the patient.

The Bill extends the Commissioner's role into clinical judgment and family life. The Commissioner may receive reports from any person, whether or not affected (**clause 24)**, investigate in whatever manner the Commissioner thinks appropriate, compel documents and attendance, and impose enforceable undertakings (**clause 44**) and compliance notices (clause 46) without affected parties having the usual recourse to the Tasmanian Civil and Administrative Tribunal. The Commissioner may decline to act only where a report is frivolous, vexatious or lacking in substance, a filter that screens out only the clearly vexatious and leaves the Commissioner to investigate any complaint that a clinician's approach was insufficiently affirming.

The scheme reaches parents on the same terms. A parent who declines to affirm a stated identity on demand, or who seeks exploratory rather than affirming therapy for a distressed child, is engaged in conduct the Bill treats as a conversion practice. **Clause 24** permits any person to report that conduct. Parents are therefore exposed to third-party reports about the ordinary work of raising an adolescent through gender-related distress, including reports from organisations with a policy interest in the outcome.

It is thus the civil scheme, more than the criminal offences, that will shape how clinicians and families are able to respond to gender-related distress. A threat of investigation, one that operates whether or not any breach is ever established, will deter all but the most determined of clinicians, and will weigh on parents whose approach differs from the affirmation the Bill treats as the only lawful response.

The immediate impact will be on Tasmanians in need of care today; the longer-term impact will be worse. A field that clinicians dare not practise cannot be taught, supervised or trained in, so the effect compounds over time: the next generation of clinicians will not learn to provide the cautious, exploratory care the Bill discourages. Gender affirmation would become the only treatment available in Tasmania, not because it has been shown to be the best response to rising presentations of gender distress, but because the Bill will have driven the cautious, exploratory alternative out of practice and out of training. This is an inappropriate legislative interference in clinical practice.

Conclusion

Genspect's primary submission is that this Bill should not proceed. If Tasmania is to legislate against conversion practices at all, the more careful 2024 draft is the better, though not complete, starting point. The 2024 draft used the existing health-complaints framework, turned on demonstrable harm, and left room for the ordinary clinical judgment this Bill puts at risk.

The larger question is whether a Bill of this kind is needed at all. The practices that gave conversion therapy its name, coercive and abusive attempts to change a person's sexual orientation, are abhorrent. Existing criminal law and professional regulation already address them. This Bill is not confined to those practices but reaches ordinary clinical and family conversation about gender identity, treats a clinician's cautious approach as a form of discrimination, and hands the judging of clinical practice to a discrimination regulator.

Beyond its immediate effect on practice, the Bill commits Tasmania to a single clinical model at exactly the moment other jurisdictions are reassessing it. Sweden, Finland and Norway have moved to restrict paediatric medical transition on the basis of the evidence. England has spent the last five years dismantling the service model it built through the 2010s. Each of these jurisdictions, and several US state health services, are now dealing with the consequences: detransitioners they did not previously anticipate, and entering settlements requiring the establishment of detransition clinics. Each is answering to their electorates, their courts, and the young people concerned, for a clinical model that turned out to be less well founded than they believed.

Genspect Australia urges the Tasmanian Parliament and Government to focus on the greater risk to young Tasmanians: the rapid rise in presentations with gender-related distress and the pull toward medical pathways whose benefits are of low or very low certainty and whose harms are better established. The measures that would actually protect young Tasmanians are: examining the factors driving the increase in presentations, in particular educational policies and materials promoting concepts of gender identity in schools[34]; providing services and support for detransitioners; strengthening whistleblower protections for clinicians who raise concerns; and sustaining, rather than driving out, the professionals willing to offer careful, exploratory care.

[34] Tasmanian Department for Education, Children and Young People, Supporting Sexuality, Sex and Gender Diversity in Schools Policy, https://publicdocumentcentre.education.tas.gov.au/library/Document%20Centre/Support-Sexuality-Sex-and-Gender-Diversity-in-Schools-Policy.pdf and Supporting Sexuality, Sex and Gender Diversity in Schools Procedure (v1.0, 31 July 2024), https://publicdocumentcentre.education.tas.gov.au/library/Document%20Centre/Supporting-Sexuality-Sex-and-Gender-Diversity-in-Schools-Procedure.pdf
The Policy and Procedure apply to all Tasmanian Government schools, Kindergarten through Year 12. The Procedure directs that a student's "sexuality, intersex status or gender identity must not be disclosed to anyone without the young person's consent", and directs schools to Working It Out, a state-funded LGBTIQA+ advocacy organisation, where parents are unsupportive of a student's wish to affirm their gender at school. No process is prescribed by which a school must document or justify a decision not to notify parents.