Model Law – Prohibiting Conversion Practices

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# Introduction

I am reminded of a conversation I had with a friend a few years ago, the first time I turned to study conversion practices targeting gender identity. As I told her of my subject of study, she responded: “Torture isn’t therapy. There you go: done.” The comparison to torture is, if perhaps hyperbolic in some cases—though electroconvulsive interventions, aversion therapies, and lobotomies most surely deserve the label—reveals the practices’ indignity. Among LGBTQ communities, these practices are experienced as deeply hurtful: after all, what is more deservedly human than being oneself?

It is a most unfortunate reality that conversion practices, also known as conversion and corrective therapy, the psychotherapeutic approach, and the pathology response approach, remain practised to this day. Roughly put, these practices seek to alter people’s gender identities or sexual orientation to make them cisgender and/or heterosexual. While the frequency of conversion practices is difficult to know with certainty, it remains common. Among U.S. transgender adults, 13% report that a professional tried to stop them from being transgender.[[1]](#footnote-1) Among U.K. cisgender LGB people, 2% were subjected to conversion practices and another 5% were offered them.[[2]](#footnote-2) These numbers respectively rise to 4.3% and 8.3% for transgender people.[[3]](#footnote-3) Since many respondents were uncertain of whether they underwent or were offered conversion practices, these statistics likely underestimate the incidence of these practices. The Williams Institute estimates that 698,000 adults in the United States have been subjected to conversion practices, and that 77,000 youth will be subjected to them before reaching the age of majority.[[4]](#footnote-4)

Many prominent professional health organisations oppose conversion practices targeting both gender identity and sexual orientation including the following 47 groups: American Academy of Family Physicians; American Academy of Nursing; American Academy of Pediatrics; American Association of Sexuality Educators, Counselors and Therapists; American Counselling Association; American Group Psychotherapy Association; American Medical Association; American Medical Student Association; American Mental Health Counselors Association; American Psychiatric Association; American Psychoanalytic Association; American Psychological Association; American School Counsellor Association; Association of Christian Counsellors; Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies; Association of Lesbian, Gay, Bisexual, Transgender Issues in Counseling; Association of LGBTQ Psychiatrists; Australian and New Zealand Professional Association for Transgender Health; British Association for Counselling and Psychotherapy; British Association of Behavioural and Cognitive Psychotherapies; British Psychoanalytic Council; British Psychological Society; Canadian Association for Social Work Education; Canadian Association of Social Workers; Canadian Professional Association for Transgender Health; Canadian Psychiatric Association; Clinical Social Work Association; College of Registered Psychotherapists of Ontario; College of Sex and Relationship Therapists; Gay and Lesbian Medical Association; GLADD (The Association of LGBT Doctors and Dentists); International Federation of Social Workers; National Association for Children’s Behavioral Health; National Association of School Psychologists; National Association of Social Workers; National Coalition for Mental Health Recovery; National Counselling Society; NHS England; NHS Scotland; Ordre des travailleurs sociaux et thérapeutes conjugaux et familiaux du Québec; Ordre professionel des sexologues du Québec; Pink Therapy; Royal College of General Practitioners; Royal College of Psychiatrists; SAMHSA; Society for Adolescent Health and Medicine; UK Council for Psychotherapy; and World Professional Association for Transgender Health.[[5]](#footnote-5) Some organisations have expressly opposed conversion practices targeting sexual orientation, but have yet to update their position to include those targeting gender identity.[[6]](#footnote-6)

Despite a dearth of sound scientific studies, the available evidence suggests that conversion practices are harmful.[[7]](#footnote-7) Individuals who undergo conversion practices report higher psychological distress, suicidality, and homelessness than those who did not.[[8]](#footnote-8) Support and acceptance of gender identity and access to social and medical transition are strongly correlated with better mental health and lower suicidality among transgender people.[[9]](#footnote-9) Many first-person account of individuals harmed by conversion practices have also been published,[[10]](#footnote-10) including by scholars.[[11]](#footnote-11) Speaking of his experience as a patient of conversion practices, sociologist Karl Bryant explained:

The study and the therapy that I received made me feel that I was wrong, that something about me at my core was bad, and instilled in me a sense of shame that stayed with me for a long time afterward.[[12]](#footnote-12)

Little evidence exists as to the effectiveness of conversion practices. Research purporting to demonstrate the possibility of changing sexual orientation and gender identity fail to distinguish between change and going back in the closet.[[13]](#footnote-13) Evidence suggests that changing these traits is rarely possible on the long term.[[14]](#footnote-14) Combined with the existing evidence of harm, conversion practices appear plainly contrary to responsible practice.

Even if gender identity and sexual orientation could be harmlessly changed, conversion practices would still be unethical insofar as they are contrary to the equality and dignity of LGBTQIA people. conversion practices are unethical because they imply that LGBTQIA lives are less valuable, less desirable, less worth living. When presented with two clinical approaches that are otherwise morally equal except for one of them being demeaning, practitioners should always choose the one which is not demeaning.[[15]](#footnote-15)

In the hopes of eliminating—or at the very least abating— conversion practices, many jurisdictions have in the last decade introduced legislation purporting to prohibit them. Yet, these laws suffer from flaws which impede their ability to discourage conversion practices. To discourage practices, laws must be drafted with sufficient precision and clarity for practitioners and patients to know, upon reading the text of the law, whether determinate practices are prohibited. As it stands, confusion reigns. Though the laws may be interpreted to assess with relative certainty whether an approach is illegal, this exercise requires a thorough familiarity with standards of interpretation, legislative history, and the relevant academic literature. Because such a convergence of knowledge is rare, conflicts of opinion abound, and at least some practitioners who openly seek to discourage youth from growing up trans have claimed that laws prohibiting conversion practices do not concern them.[[16]](#footnote-16)

Bans on conversion practices are a legitimate means for protecting the public and promoting equality. While they restrict individual liberties, they do not do so any more than the regulation of medication, which is subject to a rigorous approval process in most countries. Existing laws prohibiting conversion practices have so far been upheld by courts.[[17]](#footnote-17) The power legislatures to regulate professionals and individuals who offer similar services for the benefit of the public is well-recognised. While the right to autonomy is central to healthcare, it should not be distorted into a right to demand harmful or ineffective interventions such as conversion practices.

This model law is intended to assist legislators and policymakers who wish to prohibit conversion practices in their jurisdiction. It may also be of use to lawyers and judges faced with a lawsuit relating to conversion practices. The language of the model law centres on the common law, and will be most familiar to Australia, Canada, the United Kingdom, the United States, and other common law countries. However, its language can be easily adapted to the language of other legal systems, and the explanatory notes occasionally contain suggestions as to how the language may be adapted for such purposes.

# Model law

1. (1) Conversion practices are any treatment, practice, or sustained effort that aims to repress, discourage or change a person’s sexual orientation, gender identity, gender modality, gender expression, or any behaviours associated with a gender other than the person’s sex assigned at birth or that aims to alter an intersex trait without adequate justification.

(2) Conversion practices include:

1. Treatments, practices, and sustained efforts that proceed from the assumption that certain sexual orientations, gender identities, gender modalities, and gender expressions are pathological or less desirable than others;
	1. Treatments, practices, and sustained efforts that seek to reduce cross-gender identification;
	2. Treatments, practices, and sustained efforts that have for primary aim the identification of factors which may have led to the person’s sexual orientation, gender identity, gender modality, gender expression or behaviours associated with a gender other than the person’s sex assigned at birth, unless in the context of research which has been approved by an institutional review board;
	3. Treatments, practices, and sustained efforts that direct parents or tutors to set limits on their dependents’ gender non-conforming behaviour, impose peers of the same sex assigned at birth, or otherwise intervene in the naturalistic environment with the aim of repressing, discouraging, or changing the dependent’s sexual orientation, gender identity, gender modality, gender expression or any behaviours associated with a gender other than the person’s sex assigned at birth;
	4. Treatments, practices, and sustained efforts that proceed from the assumption that social or medical transition are undesirable;
	5. Treatments, practices, and sustained efforts that delay or impede a person’s desired social or medical transition without reasonable and non-judgemental clinical justification;
	6. Surgical or hormonal interventions relating to an intersex trait unless:

i) the person requests it and provides free and informed consent or assent, or

ii) it is necessary and urgent to protect the life or physical health of the person, excluding from consideration social factors such as psychosocial development, atypical appearance, capacity for future penetrative sexual or procreative activity, or ability to urinate standing up;

* 1. Treatments, practices, and sustained efforts that knowingly use names, pronouns, gendered terms, and sexual orientation terms other than those chosen or accepted by the person, except as required by law.

(3) Conversion practices do not include:

* 1. Services that constitute part of the person’s social or medical transition;
	2. Necessary or desired assessments and diagnoses of gender dysphoria or other comparable diagnostic category under the latest version of the DSM or ICD;
	3. Treatments, practices, or sustained efforts that provide non-judgemental acceptance and support of the person’s expressed sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person’s sex assigned at birth;
	4. Treatments, practices, or sustained efforts that teach individuals coping strategies to help resolve, endure, or diminish stressful life experiences linked to their sexual orientation, gender identity, gender modality, gender expression or behaviours associated with a gender other than the person’s sex assigned at birth;
	5. Treatments, practices, or sustained efforts that aim at the development of an integrated personal identity by facilitating the exploration and self-assessment of components of personal identity without seeking to repress, discourage or change the person’s sexual orientation, gender identity, gender modality, gender expression or any behaviours associated with a gender other than the person’s sex assigned at birth or failing to take reasonable precautions to avoid doing so.

(4) “Sexual orientation” refers to a person’s capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of the same gender, of a different gender, or of more than one gender. Sexual orientation may be expressed by self-identification with sexual orientation terms such as straight, gay, lesbian, bisexual, pansexual, asexual, or queer. Terms and understandings of sexual orientation vary by culture.

(5) “Gender identity” refers to a person’s deeply felt internal and individual experience of gender including the personal sense of the body. Gender identity may be completely male or female or may lie outside the male/female binary. Gender identity may be expressed by self-identification with gender identity terms such as man, woman, non-binary, or genderqueer. Terms and understandings of gender identity vary by culture.

(6) “Gender modality” refers to how a person’s gender identity stands in relation to their sex assigned at birth including whether they are transgender or cisgender.

(7) “Sex assigned at birth” refers to the classification of a person as male, female, intersex, or another gender or sex based on their anatomy, karyotyping, or other biological traits present at birth. It is typically the gender or sex listed on the person’s declaration of birth or original birth certificate.

(8) “Intersex trait” refers to biological characteristics, including genitals, gonads, and chromosome patterns, that do not fit typical binary notions of male or female bodies, including differences in sex development resulting from androgen insensitivity syndrome, congenital adrenal hyperplasia, and hypospadias.

(9) “Gender expression” refers to a person’s desired external appearance as it relates to social expectations and norms of femininity and masculinity. Gender expression may include a person’s behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features.

(10) “Social transition” refers to the voluntary alteration of a person’s gender expression to align it with their gender identity that differs from the one they were assigned at birth, other than through medical interventions. Social transition is personal and may not reflect others’ understanding of which gender expressions correspond to a given gender identity.

(11) “Medical transition” refers to the voluntary alteration of a person’s gender expression to align it with their gender identity that differs from the one they were assigned at birth, through medical interventions such as puberty blockers, hormone replacement therapy, voice therapy, surgical procedures. Social transition is personal and may not reflect others’ understanding of which gender expressions correspond to a given gender identity.

(12) Sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person’s sex assigned at birth may be proven by self-report.

2. Any person who engages in conversion practices or knowingly refers an individual to someone who engages in conversion practices has committed an act of negligence.

3. Any person who advertises or receives compensation in exchange for engaging in or teaching conversion practices has engaged in unfair or deceptive trade practices.

4. Any licensed or certified professional who engages in, teaches, or advertises conversion practices has engaged in unprofessional conduct and shall be subject to discipline by their licensing or certifying board.

5. It is illegal and constitutes an act of negligence for any organization or governmental entity to:

* 1. Engage in or refer an individual to practitioners of conversion practices;
	2. Provide health coverage for conversion practices;
	3. Provide a grant or contract to any entity that engages in or refers individuals to practitioners of conversion practices; or
	4. Refuse to provide a grant or contract to any entity for refusing to engage in, teach, or advertise conversion practices.

Organizations and governmental entities shall take reasonable steps to ensure compliance with section 5(a)-(d).

6. Anyone who suffers harm or losses, including non-monetary, due to a breach of section 2 or 5 may bring a private action against the perpetrator under this act to enjoin further breaches, or to recover the damages sustained as a result, or both.

7. The court shall award reasonable attorney’s fees and costs to a prevailing plaintiff upon a finding by the court or trier of fact that the defendant engaged in conversion practices.

8. The court may award punitive damages upon a finding by the court or trier of fact that the defendant engaged in conversion practices.

9. The mandate of professional licensing and certifying bodies includes discouraging conversion practices and educating members about the dangers of conversion practices.

10. Proceedings brought pursuant to sections 3, 4, or 6 must be filed within 10 years of the latter of:

1. The day of the breach of a provision of this act;
2. In the case of multiple breaches, the day of the last breach of a provision of this act;
3. The day on which the claimant turned 18 years old; or
4. The day on which a reasonable person with the abilities and in the circumstances of the person subjected to conversion practices would have realised that they suffered harm or losses caused by a breach of a provision of this act.

11. If any provision or application of a provision of this act is found to be unconstitutional, invalid, or of no force or effect, the remaining provisions and applications of provisions shall continue in force as law.

# Explanatory notes

#### Section 1: Defining conversion practices

##### Section 1(1): Basic definition

Section 1(1) provides a definition of conversion practices, defining them as “any treatment, practice, or sustained effort that aims to repress, discourage or change a person’s sexual orientation, gender identity, gender modality, gender expression, intersex traits, or any behaviours associated with a gender other than the person’s sex assigned at birth or that aims to alter an intersex trait without adequate justification.”

###### Conversion practices

Conversion practices, conversion therapy, reparative therapy, corrective therapy, the corrective approach, the (psycho)therapeutic approach, ex-gay therapy, reorientation therapy, reintegrative therapy, gay cure therapy, sexual attraction fluidity exploration in therapy, the pathological response approach, intersex surgeries and/or interventions, intersex genital mutilation, surgeries or interventions on disorders of sex development, genital normalizing surgeries and/or interventions, and sexual orientation (and/or gender identity) change efforts are all terms that have been used to refer to conversion practices.[[18]](#footnote-18) The model law opts for the terminology of conversion practices for reasons of recognizability, intelligibility, and coherence and to avoid the positive connotations associated with therapy, which may be inappropriate in the context of unethical and harmful practices. The expression ‘conversion practices’ can be found in the Maltese ban.[[19]](#footnote-19)

The term ‘conversion’ is readily recognisable and identified with the practices targeted by the model law. It captures the underlying *animus* of the practices, namely converting patients into gender normative subjects.[[20]](#footnote-20) Clinicians using conversion practices often claim that their patients’ targeted characteristics do not reflect an underlying true, fixed identity or disposition but rather a pathological confusion about their true gender or position in the sexual schema.[[21]](#footnote-21) In the context of trans and gender creative youth,[[22]](#footnote-22) the presence of the subjective experience of gender dysphoria[[23]](#footnote-23) or its diagnostic codification under the *Diagnostic and Statistical Manual Of Mental Disorders* (‘DSM’)[[24]](#footnote-24) is seen as evidence that trans people’s gender identity constitutes a mental illness that must be cured or repaired.[[25]](#footnote-25)

The label ‘therapy’ for these clinical practices has been criticized by clinicians along such lines and may falsely communicate legitimacy.[[26]](#footnote-26) Therapy may also suggest that these practices only occur within a therapeutic relationship, whereas faith-based reparative practices often occur in non-therapeutic relationships. The terminology of ‘practices’ in lieu of ‘therapy’ avoids these undesirable connotations.

###### Treatment, practice, or sustained effort that aims to repress, discourage or change targeted characteristics

Conversion practices may include any “treatment, practice, or sustained effort”. The three notions connote a degree of systematicity to distinguish conversion practices from isolated actions on the part of family members or strangers while remaining sufficiently broad to capture conversion practices adopted by individuals who are not licensed professionals and do not have a clinical or therapeutic relationship to the person. Since conversion practices are often undertaken by members of religious organisations,[[27]](#footnote-27) including practices that are not predicated on a professional-patient relationship is necessary to capture all conversion practices.

The aims of conversion practices are to “repress, discourage or change” targeted characteristics. This language is broader than the narrow focus on change found in many existing laws, and better depicts the goals and theoretical assumptions of conversion practices. As previously described, claims of gender identity (‘I am a girl’) or sexual orientation (‘I am gay’) are understood by some clinicians as a form of cognitive confusion that may not reflect an underlying ‘true’ gender identity or sexual orientation.[[28]](#footnote-28) In the case of gender creative youth, practitioners may deny any attempt at changing gender identity, instead couching their goals as seeking to prevent a child whose gender identity isn’t yet established from growing up to be transgender. The addition of ‘repress or discourage’ broadens the prohibition to accommodate different theoretical views of conversion practices and the psychology of sexual orientation, gender identity, gender modality, gender expression, and gendered behaviour.

###### Gender expression or any behaviours associated with a gender other than the person’s sex assigned at birth

Practices which target gender expression or behaviours associated with a gender other than the person’s sex assigned at birth fall within the scope of conversion practices. Historically, conversion practices have targeted gender creative children not only because they may gro up to be transgender or gay, but because their gender non-conforming it seen as indicative or constitutive of psychological disorder.[[29]](#footnote-29) The defunct UCLA Gender Identity Research Clinic, which is now associated with conversion practices,[[30]](#footnote-30) focused its work on feminine youth assigned male at birth, whom clinicians of the clinic described in terms of “deviant sex-role behaviors”[[31]](#footnote-31) or “Sissy Boy Syndrome.”[[32]](#footnote-32) George Alan Rekers, of the UCLA clinic, justified his approach as an attempt to discourage sex-role rigidity, deeming gender creative children’s behaviours narrow and obsessive.[[33]](#footnote-33) Clinical approaches which seek to discourage youth from growing up trans have continued to target gender expression and gendered behaviours for intervention, despite a shift in clinical focus from classical behavioural therapy to mixed approaches which, according to these practitioners, can “fully alter internal gender schemas.”[[34]](#footnote-34)

##### Section 1(2): Disallowed practices

Section 1(2) provides a list of practices which are non-exhaustively included in the notion of conversion practices.

###### Psychopathologizing practices: 1(2)(a)

Conversion practices include treatments, practices, and sustained efforts “that proceed from the assumption that certain” targeted characteristics “are pathological or less desirable than others.” Conversion practices are typically underpinned by the view that being lesbian, gay, bisexual, or transgender is a mental illness or mental disorder.

In the case of transgender and gender creative people, practitioners may engage in conversion practices even if the person does not demonstrate discomfort, distress, or impaired functioning due to their gender.[[35]](#footnote-35) In some cases, distress is argued to be present insofar as the fact of being trans is a valid marker of distress or impairment, or insofar as the distress caused by misrecognition and social marginalisation is sufficient for trans people to be considered inherently mentally ill.[[36]](#footnote-36) The ‘extremeness’ of medical transition is often used to justify the claim that being trans is a marker of distress or impairment in and of itself.[[37]](#footnote-37)

In the case of sexual orientation, conversion practices may be justified by the belief that ego-dystonic sexual orientation is a mental illness or condition, or that same-gender sexual urges or behaviour deemed reckless or unsafe by practitioners or patients are constitutive of impaired functioning.[[38]](#footnote-38) Ego-dystonic sexual orientation refers to sexual orientation which is not desired by the patient and causes them clinically significant distress. This distress can be due to internalised homophobia or external factors such as fear of HIV.[[39]](#footnote-39) While homosexuality was removed from the DSM-III in 1973, the DSM-III retained ego-dystonic homosexuality as a diagnosis,[[40]](#footnote-40) while the DSM-III-R and DSM-IV retained a diagnosis of Sexual Disorder Not Otherwise Specified (‘NOS’) in the case of “persistent and marked distress about sexual orientation,” legitimating continued conversion practices.[[41]](#footnote-41) Conversion practices were presented as one of two choices for patients presenting with ego-dystonic homosexuality, with the other choice being interventions aimed at self-acceptance. However, patients with high levels of internalised homophobia are unlikely to opt for interventions aiming at self-acceptance despite its clinical indicability.[[42]](#footnote-42) A similar problem also arises with trans patients with high levels of internalised transphobia.

###### Reduction of cross-gender identification: 1(2)(b)

Conversion practices include treatments, practices, and sustained efforts “that seek to reduce cross-gender identification.” The notion of cross-gender identification accommodates theoretical disagreements over the nature of gender identity and how it ought to be conceptualised. ‘Cross-gender identification’ is a common term in the scholarly literature,[[43]](#footnote-43) and was mentioned in the Gender Identity in Childhood Diagnosis in the DSM-IV and IV-TR.[[44]](#footnote-44) The term bears a broader connotation than gender identity insofar as it does not imply the presence of an underlying gender identity, referring to the fact of psychologically identifying with another (binary) gender rather than the fact of having a certain gender identity. The term is most common in the literature on trans and gender creative youth, whose expressions of gender identification may be taken as evidence of gender confusion rather than expression of gender identity, by practitioners of conversion practices.[[45]](#footnote-45)

###### Etiological lens: 1(2)(c)

Conversion practices include treatments, practices, and sustained efforts “that have for primary aim the identification of factors which may have led to the person’s” targeted characteristics “unless in the context of research which has been approved by an institutional review board.” The identification of factors which have led to targeted characteristics in clinical settings serves no legitimate purpose other than the selection of interventions for the purposes of repressing, discouraging or changing the targeted characteristics, and is predicated on the view that the targeted characteristics are abnormalities that are caused, in part or in whole, by external factors. Posited causes include family encouragement or lack of discouragement of gender non-conformity, cognitive developmental level, belief that being a certain gender is advantageous, family functioning, trauma, unresolved conflict, and psychopathology. [[46]](#footnote-46) Some practitioners have even suggested that “limited cognitive abilities and immaturity may make” a child assigned male at birth “no match for other boys,” leading them to play with girls and feminine-coded toys.[[47]](#footnote-47)

The etiological lens, which seeks to identify causes for the targeted characteristics, is closely connected to psychopathologizing views of sexual and gender minorities.[[48]](#footnote-48) As Robert Wallace & Hershel Russell explain, “if gender variant behavior is pathological, then we must inquire into its etiology and do what can be done to prevent and to treat it.”[[49]](#footnote-49) Inquiries into etiology are an indicator of psychopathologizing practices. Etiological inquiries undertaken pursuant to ethically-conducted scientific research are not conversion practices. However, institutional review boards should be mindful of the possibility that research into the etiology of targeted characteristics could be used for eugenic or otherwise detrimental purposes, and that the integration of research and clinical teams may undermine the validity of informed consent due to patients’ belief that refusing to participate in research could jeopardise their access to desired healthcare services.[[50]](#footnote-50)

###### Interventions in the naturalistic environment: 1(2)(d)

Conversion practices include treatments, practices, and sustained efforts “that direct parents or tutors to set limits on their dependents’ gender non-conforming behaviour, impose peers of the same sex assigned at birth, or otherwise intervene in the naturalistic environment” for conversion purposes. The explicit inclusion of such interventions is crucial since they are carried on by parents or tutors at the direction of practitioners rather than by the practitioners themselves.

Parents or tutors are frequently enlisted in conversion practices in the belief that interventions set in everyday life play an important role in discouraging, repressing, or changing targeted characteristics.[[51]](#footnote-51) These interventions are known as ‘interventions in the naturalistic environment’ and proceed from the assumption that targeted characteristics may be caused by a failure to identify with models and peers of the same sex assigned at birth, and by parental encouragement or failure to discourage non-conforming behaviour.[[52]](#footnote-52) Interventions in the naturalistic environment includes directing parents to prevent or set limits on their child’s gender non-conforming behaviours, make their child participate in differently gendered activities and/or with peers of a different gender, or otherwise alter their everyday environment in the hope that they will cease to display the targeted characteristic.

###### Presuming the undesirability of transition: 1(2)(e)

Conversion practices include treatments, practices, and sustained efforts that “proceed from the assumption that social or medical transition are undesirable or less desirable.” Instead of being directly motivated by a negative view of transitude, the fact of being transgender, conversion practices may instead be motivated by the view that social or medical transition is undesirable or less desirable than its absence.

The focus of negativity is often placed on medical transition,[[53]](#footnote-53) and with the language of ‘mutilation’ being used to describe the interventions in some cases.[[54]](#footnote-54) The assumption that transition is undesirable may also relate to specific bodily configurations, such as when desired medical interventions would lead to a body that “fall outside of the [rigidly binary] cisnormative view of the body”[[55]](#footnote-55) or when people desire to medically transition without socially transitioning.[[56]](#footnote-56) Practices may also be motivated by negative judgements of social transition, frequently due to the belief that social transition inevitably leads to medical transition or an otherwise more difficult life.[[57]](#footnote-57) This view is notably contrary to emerging evidence that pre-pubertal trans youth who socially transition have mental health comparable to the general population.[[58]](#footnote-58)

The view of trans people as a mentally ill may flow from a view of transition as being “drastic” or as “simply too radical” for transitude to reflect normal human diversity.[[59]](#footnote-59)

###### Unduly delaying or impeding transition: 1(2)(f)

Conversion practices include treatments, practices, and sustained efforts “that delay or impede a person’s desired social or medical transition without reasonable and non-judgemental clinical justification.”

Delays or impediments to transition may be used to indirectly discourage individuals from transitioning and minimise the number of people who transition.[[60]](#footnote-60) Because older adolescents and adults cannot as readily be forced to attend clinical sessions motivated by conversion goals, the promise of medical transition under condition of respecting delays and impediments serves to keep patients in the clinical relationship. Expressions of doubts or observations which do not match the provider’s understanding of transitude are then used to justify further delays and impediments. Approach which impose undue delays may discourage subsequent transitioning and pose risks of psychological harm to patients.[[61]](#footnote-61)

Undue delays and impediments to transition may be used to support other conversion practices and reflect a desire to minimise the likelihood of trans outcomes. They may be rationalised by the belief that a longer assessment period is needed to ascertain whether the person is truly transgender or truly gender dysphoric, despite evidence that regret is rare for all age groups.[[62]](#footnote-62)

Not all delays or impediments are tantamount to conversion practices. Delays and impediments which are both reasonable and non-judgmental in nature are acceptable. Reasonability is a common concept in the law of negligence and civil liability. The ‘reasonable person test’ may be used to evaluate whether a delay or impediment is reasonable. The test asks that decisionmakers imagine how a reasonable person would have acted in the context at hand.[[63]](#footnote-63)

Delays and impediments must be non-judgemental, reflecting the view that the reasonable person should not hold homophobic or transphobic beliefs.[[64]](#footnote-64) Non-judgemental care in the context of LGBTQIA+ populations is predicated on the view that practitioners should avoid making value or moral judgements regarding targeted characteristics on the patients.[[65]](#footnote-65) This entails that their practices shouldn’t betray heteronormative or cisnormative views.[[66]](#footnote-66) Non-judgement is added as an explicit requirement because not all legal systems incorporate such a criterion in their equivalent of the reasonable person test.

Reasonable and non-judgemental delays and impediments may arise for various reasons. Requiring blood testing prior to prescribing hormone replacement therapy is legitimate despite added delay. Requiring an assessment of gender dysphoria pursuant to the latest WPATH Standards of Care[[67]](#footnote-67) isn’t a conversion practice unless the intensity and chronology of the assessment process are excessive. Delays that are not due to clinical practice but are a by-product of resource scarcity in the healthcare system cannot be deemed unreasonable or judgemental on the part of the practitioner, although it could be discriminatory on the part of the government or healthcare institution.[[68]](#footnote-68) Impediments such as further testing required due to serious physical health concerns may also be reasonable and non-judgemental.

The requirement that delays or impediments be reasonable and non-judgemental shifts the burden of justification onto providers, who must be able to provide rationales for their practices. Such a requirement fosters greater thoughtfulness and introspection in clinical work and alleviates the evidentiary burden on complainants by recognising that practitioners have greater access to relevant facts relating to their work.[[69]](#footnote-69) Healthcare institutions should consider adopting formal policies and review mechanisms aimed at ensuring the absence of undue delays or impediments to transition.

###### Non-consensual interventions relating to intersex traits: 1(2)(g)

Conversion practices include “surgical or hormonal interventions relating to an intersex trait unless i) the person requests it and provides free and informed consent or assent, or ii) it is necessary and urgent to protect the life or physical health of the person, excluding from consideration social factors such as psychosocial development, atypical appearance, capacity for future penetrative sexual or procreative activity, or ability to urinate standing up.”

The definition is inspired by the Lambda Legal and InterACT document *Providing Ethical and Compassionate Health Care to Intersex Patients: Intersex-Affirming Hospital Policies*.[[70]](#footnote-70) The practices are properly understood as conversion practices insofar as they seek to produce gender normative subjects contrary to the individual’s will. Historically, clinicians believed that intersex genitals led to same sex desires in addition to making them uncertain about what constituted same sex intimacy.[[71]](#footnote-71) Surgical means ensured conformity to social ideals of heterosexual marriage. Under more recent medical models the justification focusing on heterosexuality has shifted towards securing gender normative futures more broadly and normalising intersex bodies, which are seen as inherently undesirable by the practitioners.[[72]](#footnote-72)

Non-consensual surgeries and hormonal interventions on intersex youth are harmful and may lead to negative outcomes such as loss of reproductive function and genital sensation, and psychological trauma.[[73]](#footnote-73) They are often practised on newborns and young children despite the possibility of delaying them until they can make an informed choice as to whether they wish to undergo interventions. Interventions that are urgent and medically necessary, such as when the life of the person is threatened, do not fall within the scope of the prohibition.

Capacity for providing free and enlightened consent or assent must be assessed carefully when applying this provision. Doctors may pressure parents and youth to consent or assent to the procedures.[[74]](#footnote-74) The perspective of intersex individuals is often disregarded or devalued by practitioners.[[75]](#footnote-75) The requirement that the procedure was requested helps ensure that it genuinely emanates from the youth and not doctors or parents. Failing to obtain fully free and enlightened consent or assent from the individual undergoing surgery would fall within the prohibition set out in this subsection. Where possible, the law should require an independent assessment that the youth satisfies these conditions by a child advocate or equivalent office.

###### Misgendering & misattributing orientation: 1(2)(h)

Conversion practices include treatments, practices, and sustained efforts “that that knowingly fail to respect the name, pronouns, gendered terms, and sexual orientation terms chosen or accepted by the person, except as required by law.”

Respect for a person’s chosen or accepted name, pronouns, and gendered terminology communicates acceptance of their gender identity and deserving of respect. Gendered terms include gender labels such as ‘girl’, ‘boy’, ‘non-binary’, which may be denied through questions and affirmations such as: “But you know you’re really a boy, right?” Gendered terms may also include words like ‘babe’ or ‘sweetheart’, the grammatical gender of nouns, adjectives, etc. in many languages,[[76]](#footnote-76) and gender markers on documents and records.[[77]](#footnote-77) Sexual orientation terms should also be respected and imposing a terminology inconsistent with a patient’s self-labelling (‘You’re gay, not bisexual’ or ‘You can’t say you’re a lesbian if you are non-binary’) is equally inappropriate.

 Failure to respect the person’s gender, known as misgendering, is associated with substantially poorer mental health.[[78]](#footnote-78) Misgendering is integral to conversion practices and communicates that the person’s gender identity should not be taken seriously or is not a true reflection of who they are.[[79]](#footnote-79)

Misgendering may be required by law. A person’s legal name and gender marker may be required on documents used for insurance coverage.[[80]](#footnote-80) Legal requirements should not be overstated. Gender markers are not a reliable identity-verification measure[[81]](#footnote-81) and shadow files may be used in cases where legal name and gender marker must be used for some purposes but not others.[[82]](#footnote-82)

Misgendering and misattributing orientation terms must be done knowingly and must fall under the model law’s notions of treatments, practices, or sustained efforts. Treatments, practices, and sustained efforts require a degree of systematicity which is not met by occasional accidental misgendering or misattributing orientation terms, or misgendering or misattributing orientation terms which is due to the person’s innocent ignorance of the person’s chosen or accepted name, pronouns, gendered terms, and sexual orientation terms. The degree of systematicity requires also excludes misgendering and misattributing orientation terms in everyday settings which do not rise to the level of practices, though misgendering and misattributing orientation terms may nevertheless be contrary to human rights protections against harassment based on protected characteristics.[[83]](#footnote-83)

##### Section 1(3): Permitted practices

Section 1(2) provides a list of practices which are non-exhaustively excluded from the notion of conversion practices.

###### Social and medical transition:1(3)(a)

Conversion practices do not include services “that constitute part of the person’s social or medical transition.”

Allowing and facilitating transition is inconsistent with the underlying rationale of conversion practices, which stands in an oppositional rather than affirming relationship to the person’s targeted characteristics. Opponents to gender-affirmative care, which is considered the standard of care in transgender health,[[84]](#footnote-84) have sought to characterise it as a form of conversion practice towards sexual orientation.[[85]](#footnote-85) Under this view, facilitating the transition of a trans man who is attracted to women would be a conversion practice based on sexual orientation because his gender orientation label would go from lesbian to straight. However, under the hypothetical scenario, the sexual orientation did not change in the relevant sense. Since sexual orientation is based on gender identity and gender identity precedes transition, his sexual orientation as a straight man was already established. Furthermore, the target of attraction did not change despite a nominal change in gender labels. While sexual orientation may change during or after transition,[[86]](#footnote-86) the purpose of transition is to affirm and support the person’s gender, not to change their sexual orientation. Given that straight trans people constitute roughly 15% of the U.S. trans population,[[87]](#footnote-87) the claim that practitioners encourage transition to avoid people being LGBQ is implausible.

###### Diagnosis and assessment: 1(3)(b)

Conversion practices do not include “necessary or desired assessments and diagnoses of gender dysphoria or other comparable diagnostic category under the latest version of the DSM or ICD.”

Assessments and diagnoses of gender dysphoria[[88]](#footnote-88) or gender incongruence[[89]](#footnote-89) are often required to access trans healthcare services, insurance coverage, or change legal gender marker. These requirements vary across jurisdictions, service providers, and insurance providers. Mandatory assessments and diagnoses are opposed by a large subset of trans healthcare professionals and trans communities and may be considered dehumanising or psychopathologizing.[[90]](#footnote-90) However, including these assessments and diagnoses under the definition of conversion practices even when necessary and/or desired by the patient could severely impede access to healthcare in trans communities.

The exclusion of assessments and diagnoses of gender dysphoria or comparable diagnostic category does not reflect the belief that these diagnostic categories should continue to exist or that it is legitimate to require assessments or diagnoses for access to healthcare, insurance, or legal gender marker changes. The exclusion of assessment and diagnoses from the definition of conversion practices does not preclude a finding that the practitioner was otherwise engaging in conversion practices.

In jurisdictions that use a modified or older version of the DSM or ICD, the words “latest version” should be substituted for the appropriate reference.

###### Acceptance and support: 1(3)(c)

Conversion practices do not include treatments, practices, or sustained efforts “that provide non-judgemental acceptance and support of the person’s expressed” targeted characteristics.

Accepting and supporting the person’s expressed target characteristics is not included in the notion of conversion practices.[[91]](#footnote-91) Acceptance and support are grounded in a client-centred approach to therapeutic care, and is practiced through “unconditional positive regard for and congruence and empathy with the client”, “openness to the client’s perspective as a means of understanding their concerns”, and “encouragement of the client’s positive self-concept.”[[92]](#footnote-92) This may involve addressing factors impeding the patient’s psychosocial adaptation, such as drug addiction. In the context of patients who wish to alter their targeted characteristics, acceptance and support aims at reducing distress brought on by stigma, isolation, and internalised shame, which may involve exploring why the patient wishes to change their targeted characteristics without negatively judging them for struggling with self-acceptance.

Specifying the expressed nature of characteristics clarifies the temporal nature of conversion practices and complements the proof of targeted characteristics by self-reporting set out in section 1(10). Acceptance and support will not amount to conversion practices even if the practitioner believes in good faith that the patient is misrepresenting these characteristics. For instance, practitioners who believe for good reasons that a patient of theirs is a trans woman but continues to represent themselves as a cis man would not be committing a wrong by continuing to refer to them using masculine terminology, even if they were to later self-identify as a woman. The same would be true of the converse. Non-judgemental and unconditional acceptance and support of a person is appropriate and would not be tantamount to conversion practices regardless of the outcome of this exploration process, and even if the patient retrospectively estimates having always known.

The requirement that acceptance and support be non-judgemental—without preference of targeted characteristic—indicates that foreclosing future identity development may nevertheless fall under the umbrella of conversion practices. Suggesting that one is accepted and supported as is but would not be accepted or supported if their targeted characteristics were different (e.g. “I accept you as long as you’re straight.”) would not fall under the notion of acceptance and support since it would be judgemental.

###### Coping strategies: 1(3)(d)

Conversion practices do not include treatments, practices, or sustained efforts “that teach individuals coping strategies to help resolve, endure, or diminish stressful life experiences linked to their” targeted characteristics.

Empowering patients by teaching them coping strategies in dealing with negative experiences linked with gender or sexual orientation-related marginalisation is an appropriate therapeutic practice.[[93]](#footnote-93) These strategies may include common therapeutic interventions such as cognitive-behavioural therapy, mindfulness-based therapy, and narrative therapy.

The motivational underpinning and context of practices are crucial to distinguishing between conversion practices and legitimate therapeutic practices. For instance, reading religious texts is often associated with faith-based conversion practices but may also be used to reduce “the salience of negative messages about homosexuality and increasing self-authority or understanding” through active engagement.[[94]](#footnote-94) Helping patients navigate strategic reductions in gender non-conforming behaviour in hostile and dangerous environments should also be properly contextualised since it may reflect a coping strategy motivated by self-preservation rather than a disavowal of gender non-conformity amounting to a conversion practice.

###### Integrated personal identity: 1(3)(e)

Conversion practices do not include treatments, practices, or sustained efforts “that aim at the development of an integrated personal identity by facilitating the exploration and self-assessment of components of personal identity without seeking to repress, discourage or change the person’s” targeted characteristics “or failing to take reasonable precautions to avoid doing so”.

Enabling identity exploration and development are predicated on the idea that “conflicts among disparate elements of identity appear to play a major role in the distress of those seeking” conversion practices.[[95]](#footnote-95) People whose religion or culture are hostile to their targeted characteristic, in particular, may struggle to integrate and harmonise the various elements of their personal identity. Personal dentity is understood holistically, comprising “a coherent sense of one’s needs, beliefs, values, and roles, including those aspects of oneself that are the bases of social stigma, such as age, gender, race, ethnicity, disability, national origin, socioeconomic status, religion, spirituality, and sexuality.”[[96]](#footnote-96)

Identity development refers to the active exploration and self-assessments of personal identity and its various components with the goal of attaining an integrated personal identity which is free from major tension or conflict between components.[[97]](#footnote-97)

Conversion practices have justified the repression and discouragement of targeted characteristics via the goal of reducing the tension between the person’s religious commitments and these characteristics.[[98]](#footnote-98) Those practices, however, position religious commitment above the targeted characteristics instead of attempting to make them compatible for the individual. As such, it is not truly aiming at the development of an integrated personal identity.

Given the dangers of practitioners seeking to justify conversion practices under this subsection, it specifies that the practices must not only be free of the goal of repressing, discouraging, or changing the targeted characteristics, but also that practitioners must take reasonable precautions to avoid repressing, discouraging, or changing these characteristics. Reasonability invokes here again the reasonable person test. The type of precautions to be taken is left open-ended to avoid further restricting practices but may involve establishing therapeutic strategies that highlight the compatibility of the religion and its associated texts with the targeted characteristics.[[99]](#footnote-99) Development of an integrated personal identity is predicated in retaining both the religious commitment and the targeted characteristic.

##### Sections 1(4) to 1(11): Definitions

###### Sexual orientation: 1(4)

Sexual orientation is defined as “a person’s capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of the same gender, of a different gender, or of more than one gender. Sexual orientation may be expressed by self-identification with sexual orientation terms such as straight, gay, lesbian, bisexual, pansexual, asexual, or queer.” The definition further acknowledges that “[t]erms and understandings of sexual orientation vary by culture.”

This definition of sexual orientation is inspired by the one provided in the Yogyakarta Principles.[[100]](#footnote-100) The importance of self-labelling and the culturally-specific nature of terms and understanding of sexual orientation were added to the Yogyakarta definition.[[101]](#footnote-101) Judging whether a practitioner is engaging in conversion practices requires cultural sensitivity and it would be inappropriate for a practitioner to impose a Western understanding of sexuality and sexual orientation onto their patients. The proposed definition acknowledges that terms used to express sexual orientation are often gender-specific but does not define sexual orientation by reference to the person’s own gender. [[102]](#footnote-102) The choice to define sexual orientation solely by reference to the targets of attraction seeks to avoid the potential interpretive difficulties arising when transgender people change their self-elected gender labels. In the past, the claim that a shift in self-elected gender labels (for instance from ‘butch lesbian’ to ‘straight man’) entails a change in sexual orientation was used to falsely accuse gender-affirmative practices of being conversion practices based on sexual orientation, despite the targets of attraction not having changed. [[103]](#footnote-103)

###### Gender identity: 1(5)

Gender identity is defined as “a person’s deeply felt internal and individual experience of gender including the personal sense of the body. Gender identity may be completely male or female or may lie outside the male/female binary. Gender identity may be expressed by self-identification with gender identity terms such as man, woman, non-binary, or genderqueer.” The definition further acknowledges that “[t]erms and understandings of sexual orientation vary by culture.”

As with sexual orientation, this definition substantively builds upon the definition provided in the Yogyakarta Principles.[[104]](#footnote-104) The definition explicitly recognises non-binary gender identities, as well as gender identities which otherwise lie outside of the male/female binary but may not recognise themselves in the umbrella notion of non-binary. This recognition closes a potential gap in the law and precludes attempts to justify conversion practices by arguing that non-binary identities are not validly included in the notion of gender identity. Accessing transition-related care remains difficult for non-binary individuals, and some countries do not offer them any medical transition services. As with sexual orientation, the definition was supplemented by an understanding of the importance of self-labelling and culturally-sensitivity.[[105]](#footnote-105) The definition of gender identity in the Yogyakarta Principles includes components corresponding to gender expression. These were not included, as gender expression bears its own definition under the model law. The merging of gender identity and gender expression under the Yogyakarta Principles reflects the historical context of the document. The 2017 Yogyakarta Principles plus 10 provided separate definitions for gender identity and gender expression.[[106]](#footnote-106)

###### Gender modality: 1(6)

Gender modality is defined as “how a person’s gender identity stands in relation to their sex assigned at birth including whether they are transgender or cisgender.”

The term gender modality was coined in 2019 and serves, in relationship to cisgender and transgender, a role analogous to sexual orientation vis-à-vis the labels gay, lesbian, bisexual, pansexual, and queer. Gender modality is:

[A]n open-ended category which includes being trans and being cis and welcomes the elaboration of further terms which speak to the diverse experiences people may have of the relationship between their gender identity and sex assigned at birth: the cis-trans binary is challenged by some non-binary people—especially agender people—some intersex people, some gender creative youth, and some people who were raised in a fully gender neutral manner.[[107]](#footnote-107)

The inclusion of gender modality serves to ensure and reinforce the prohibition of conversion practices in instances where gender identity is unclear, as may be the case for some gender creative youth. It also serves to recognise that conversion practices are often motivated by a negative judgement of the non-correspondence between gender identity and sex assigned at birth among transgender people, rather than a negative assessment of the gender identity itself.

###### Sex assigned at birth: 1(7)

Sex assigned at birth is defined as “the classification of a person as male, female, intersex, or another gender or sex based on their anatomy, karyotyping, or other biological traits present at birth. It is typically the gender or sex listed on the person’s declaration of birth or original birth certificate.”

Sex assigned at birth is most commonly based on the presence or absence of a penis at birth. However, the assignment of gender at birth is often based on a more complicated process when it comes to intersex people, who do not correspond to the binary socio-medical conceptions of male or female bodies. Original declarations of birth and birth certificates typically reflect this classification; however, errors of notation may occur, and the documents of intersex youth drafted shortly after their birth do not always reflect the process of gender assignment imposed upon them. While sex assigned at birth may not be male or female, it is extremely rare for gender or sex to be classified otherwise on declarations of birth and birth certificates.

###### Intersex traits: 1(8)

Intersex traits are defined as “biological characteristics, including genitals, gonads, and chromosome patterns, that do not fit typical binary notions of male or female bodies, including differences in sex development resulting from androgen insensitivity syndrome, congenital adrenal hyperplasia, and hypospadias.”

The definition is based on the one found in California Senate Bill 201 which prohibits non-consensual surgeries on intersex minors.[[108]](#footnote-108) Intersex traits are sometimes known as “DSDs” or “Disorders of Sex Development”, though this terminology is rejected as pathologizing by many intersex individuals.[[109]](#footnote-109) Medical examples are included in the definition for greater clarity.

###### Gender expression: 1(9)

Gender expression is defined as “a person’s desired external appearance as it relates to social expectations and norms of femininity and masculinity. Gender expression may include a person’s behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features.”

This definition is offered *de novo* for the purposes of the model law and does not substantively reflect definitions such as the one provided in the Yogyakarta Principles plus 10.[[110]](#footnote-110) Gender expression is defined in relation to gendered social expectations and norms, must be desired, and includes anatomical features. References to gendered social expectations and norms serve to exclude minor or non-gendered changes to external appearances from the scope of conversion practices; though such changes may be unethical, they do not form conversion practices. Framing the gendered nature of gender expression by reference to gendered social expectations and norms avoids implying that appearances are inherently gendered. External appearance must be desired. To define gender expression without reference to desire might prevent practitioners from encouraging patients to adopt a desired appearance, but which they are hesitant to embrace. Lastly, gender expression includes anatomical features. The inclusion of anatomical features in the definition of gender expression facilitates the labelling as conversion of practices which seek to discourage desired anatomical changes, notably through transition-related interventions.

Gender expression is occasionally defined as how a person chooses to express their gender. For the purposes of the model law, this definition if inadequate. Components of external appearance that are socially perceived as masculine or feminine may not reflect a choice to express gender and may instead reflect non-gender-related desires. For instance, many people find clothing coded as masculine more comfortable. Discouraging gender non-conforming may be conversion independently of whether the patient’s external appearance is desired for gender-related reasons.

###### Social and medical transition: 1(10) & 1(11)

Social transition is defined as “the voluntary alteration of a person’s gender expression to align it with their gender identity that differs from the one they were assigned at birth, other than through medical interventions.” Medical transition is defined as voluntary alterations of the same kind, but for operating “through medical interventions such as puberty blockers, hormone replacement therapy, voice therapy, surgical procedures.” The definitions acknowledge that social and medical transition are “personal and may not reflect others’ understanding of which gender expressions correspond to a given gender identity.” Social and medical transition may include changes to behaviour, name, pronouns, clothing, haircut, voice, tattoos, piercings, and anatomical features, by reference to gender expression.

Social and medical transition must be voluntary. Involuntary alterations of gender expression are not social transition, as they do not emanate from the person’s free choice. This precludes an understanding of medical transition as including surgical procedures on intersex newborn and children who did not personally provide free and enlightened consent or assent. These procedures are harmful and unethical and are not comparable to medical transition for transgender people, which are beneficial and ethical.[[111]](#footnote-111) Surgeries and interventions relating to intersex traits fall under the notion of medical transition for the purposes of the model law if they emanate from the person’s free choice. As provided by subsection 1(2)(g), free and enlightened consent or assent must be present. These surgeries and interventions may or may not be understood as part of medical transition by intersex individuals.

Social and medical transition are personal, individual processes. The person’s chosen social and/or medical transition may not reflect conventional understandings of the traits associated with manhood, womanhood, or other genders. For instance, it is frequently assumed that women do not have penises, and therefore that medical transition for trans women should, must, or always does include vaginoplasty. A person’s social and/or medical transition may even be directly contrary to lay expectations. For instance, a non-binary person assigned female at birth but whose given name is unisex may wish to change their name for a typically feminine name as part of their social transition. To discourage uncommon or unconventional social and/or medical transitions would be included within the prohibition set out in subsection 1(2)(f), as the adequacy of social and/or medical alterations is based on the individual’s desire rather than conformity to an external norm.

Voluntary alterations of gender expression solely motivated by reasons other than the person’s gender identity or by a gender identity aligned with their sex assigned at birth are not included within the notions of social and medical transition. This reference to underlying motives reflects the common understanding that gender non-conformity alone does not constitute social and/or medical transition. Although this definitional feature restricts the application of subsection 1(2)(f), seeking to repress, discourage, or change gender expression is prohibited under section 1(1). Practices targeting voluntary alterations of gender expression for non-gender-identity-related reasons may also fall within the scope of subsection 1(2)(e), which prohibits treatments, practices, and sustained efforts that “proceed from the assumption that social or medical transition are undesirable or less desirable.”

It is unnecessary to define the term “medical interventions”, since social and medical transition cover the entire field of transition: all interventions are either medical or non-medical.[[112]](#footnote-112) Common transition-related medical interventions are nevertheless provided in the definition for greater clarity.

##### Section 1(12): Proof by self-report

Sexual orientation, gender identity, gender modality, gender expression, and behaviours associated with a gender other than the person’s sex assigned at birth “may be proven by self-report.”

Providing for proof of targeted characteristics by testimony significantly curtails evidentiary difficulties involved in proving that someone engaged in conversion practices, as evidence of the targeted characteristic at the time of the practices may be difficult to prove later. This difficulty is lessened by allowing people to self-report the targeted characteristic they had at the time of the offense, including by testimony at trial. This section limits practitioners’ capacity to raise as a defence that the patient’s self-reported targeted characteristic did not represent their true targeted characteristic, but rather was a lie or form of false-consciousness. Since conversion practices often label self-reported gender identities and sexual orientations as mere confusion, proof by testimony is essential to effectively prohibiting conversion practices.

#### Sections 2 to 5: Prohibited acts

Different acts are prohibited based on the entity which engaged in conversion practices and type of proceeding. Conversion practices and related actions may constitute individual negligence, unfair or deceptive trade practices, professional misconduct, and organisational or governmental misconduct.

Under section 2, it constitutes individual negligence to “engage in conversion practices or knowingly refer an individual to someone who engages in conversion practices”. Negligence is a tort under common law, and jurisdictions which do not recognise the tort of negligence should replace the term by its functional analog in their legal system, such as delict or quasi-delict. It applies to anyone, rather than merely licensed professionals, because not everyone who engages in conversion practices is licensed, and many jurisdictions do not prohibit individuals without a licensed from engaging in psychotherapy or other similar acts. This broad scope is necessary to effectively outlaw conversion practices and falls within the range of legitimate legislative action aimed at protecting the public. Despite applying to anyone, the terms “any treatment, practice, or sustained effort” under section 1(1) restrict this prohibition to acts evidencing a threshold degree of systematicity and would not typically apply to parents of gender creative youth. Referring someone to a practitioner of conversion practices also constitutes negligence if it is done with knowledge that the person would engage in conversion practices. Due to the requirement of knowledge, those who innocently refer to practitioners of conversion practices, not knowing that their approach is conversion in nature, will not be in contravention of section 2.

Under section 3, it constitutes an unfair or deceptive trade practice to “advertise or receive compensation in exchange for engaging in or teaching conversion practices”. It is in the nature of trade practices that compensation be involved, giving rise to the requirement. Prohibiting advertisement of harmful or ineffective services is within the usual scope of consumer protection laws. Unfair and deceptive trade practices are subject to sanctions in many jurisdictions and aid in curtailing conversion practices insofar as these laws grant extensive powers of inquiry to state agents as well as independent sanction mechanisms. [[113]](#footnote-113) In jurisdictions where psychotherapy and counselling are not reserved acts, the ability to investigate and impose sanctions under consumer protection laws is imperative since their professional bodies cannot investigate and punish conversion practices by unlicensed or unregulated professionals.

Under section 4, it constitutes unprofessional conduct subject to discipline by professional licensing or certifying boards to engage in, teach, or advertise conversion practices. This provision ensures that conversion practices may be subject to disciplinary sanctions by their professional order, as they have significant power of inquiry and may suspend or revoke the licenses of professionals in addition to imposing fines. Advertising and teaching conversion practices are not included under the individual negligence provision of section 2 because tortious liability requires individuals to suffer identifiable harms or losses flowing from the actions. By contrast, unprofessional conduct may be sanctioned regardless of resulting quantifiable harm or losses to identifiable individuals. The terminology of “licensing or certifying board” should be adapted to the language used in the jurisdiction, as terminology for such bodies is not standard.

Under section 5, any organisation, including corporations, or governmental entities is committing an act of negligence if they “engage in or refer an individual to practitioners of conversion practices”, “provide health coverage for conversion practices”, “provide a grant or contract to any entity that engages in or refers individuals to practitioners of conversion practices”, or “refuse to provide a grant or contract to any entity for refusing to engage in, teach, or advertise conversion practices”. Furthermore, “organizations and governmental entities shall take reasonable steps to ensure compliance with” these prohibitions. The section extends the prohibition of conversion practices to legal persons other than natural persons, as organisations may be involved in the provision of conversion practices, especially in the context of unlicensed, faith-based practices. The prohibition of health coverage for conversion practices is a common legislative feature and seeks to limit the financial ability of individuals to engage in such practices. The provisions regarding grants related to conversion practices serves a similar purpose.[[114]](#footnote-114)

Sections 2 to 5 share prohibited acts. This may facilitate proceedings if a prior decision by a juridical or administrative body can be invoked. For instance, the decision of a licensing board sanctioning a psychologist for engaging in conversion under section 4 could be entered into evidence during a proceeding under section 2.

#### Sections 6 to 8: Cause of action and damages

Under section 6, any person “who suffers harm or losses, including non-monetary, due to a breach of section 2 or 5 may bring a private action against the perpetrator under this act to enjoin further breaches, or to recover the damages sustained as a result, or both.” This section grants a civil cause of action to those who were subjected to conversion practices and enables them to seek an injunction and/or recover damages. While sections 2 and 5 may suffice to enable private suits due to the language of negligence, this section provides additional certainty and precludes a finding that the sections do not give rise to a right to sue for victims. Non-monetary losses are included, which would encompass pain, mental distress, loss of enjoyment of life, and harm to dignity, common consequences of conversion practices. Since the harms of conversion practices may be difficult to quantify and go beyond monetary losses, it is crucial to enable the recovery of general damages for non-monetary losses. The expression “under this act” may or may not be adapted to the structure of the legislation. If the model law is legislated as a chapter of a code, for instance, “under this chapter” may be more appropriate.

Under section 7, judges “shall award reasonable attorney’s fees and costs to a prevailing plaintiff upon a finding by the court or trier of fact that the defendant engaged in conversion practices” in private suits. Given widespread poverty in LGBTQIA+ communities,[[115]](#footnote-115) provision of attorney’s fees and costs is an essential component of access to justice. The provision of fees may encourage attorneys to represent victims of conversion practices on a contingent or conditional fee agreement, which provides for payment of attorneys if the suit is successful or leads to a settlement, and typically pays a percentage of the recovered damages.

Under section 8, courts “may award punitive damages” if the defendant is found to have engaged in conversion practices. Punitive damages recognise the gravity of conversion practices, which are antithetical to the dignity of trans and LGB people and may be used to further discourage such practices. Because the purpose of laws prohibiting conversion practices is both to enable compensation for harm and losses suffered as well as discourage the practices themselves, allowing and encouraging punitive damages is legitimate.

#### Section 9: Licensing boards

The mandate of professional licensing and certifying bodies is amended to include “discouraging conversion practices and educating members about the dangers of conversion practices.”

Enlisting professional associations in the contestation of conversion practices is essential to weeding out such practices amongst licensed professionals. Altering the mandate of associations rather than creating a fully-fledged regulatory framework enables individual bodies to shape their course of action to the realities of their individual profession. Because it emphasizes the self-regulation of professions, it also limits professional resentment towards legislative interference in professional self-regulation, which could impede efforts against conversion practices.

Adding to the bodies’ mandate encourages them to take concrete action to eradicate conversion practices within their respective memberships. Creating a trans-affirming professional culture, fostering knowledge of conversion practices, and encouraging mutual enforcement of bans by professionals are three core components of effectively discouraging conversion practices in professions. Bodies should consider integrating education on conversion practices in university and professional development curriculum, drafting clear and thorough guidelines on providing care to populations of marginalised sexual orientation, gender modality, and gender expression that are reflective of the model law, and creating a committee tasked with holding professionals accountable for breaching conversion practices bans.

#### Section 10: Limitation period

The limitation period for proceedings relating to conversion practices under the model law is 10 years. This period runs from the conversion practice, the day of the last conversion practice, in the case of a series of breaches, “the day on which the claimant turned 18 years old”, or “the day on which a reasonable person with the abilities and in the circumstances of the person subjected to conversion practices would have realised that they suffered harm or losses” from the conversion practices, whichever is the latest date.

Limitation periods vary by jurisdiction, and the chosen period should be consistent with the other limitation periods within the jurisdiction. In some jurisdictions, a different length of time may be adequate. Because conversion practices occur in therapeutic relationships or simulations thereof, it is appropriate to adopt a longer limitation period than the usual limitation period for civil claims. This longer limitation period better reflects the fiduciary or pseudo-fiduciary nature of the relationship.

Different dates are provided for the start of the limitation period. It can take a long time for individuals to work through their trauma and mental health problems and realise that they are linked to reparative practices. This section ensures that actions are not prescribed because the practices occurred early in childhood, or because the person needed substantial psychological support to realise that they were harmed by them. Alternative periods for calculating whether claims are prescribed is common in suits relating to psychological harm and childhood sexual assault.

The expression “under this act” may or may not be adapted to the structure of the legislation. If the model law is legislated as a chapter of a code, for instance, “under this chapter” may be more appropriate.

#### Section 11: Severability

The model law provides for severability, and if “any provision or application of a provision of this act is found to be unconstitutional, invalid, or of no force or effect, the remaining provisions and applications of provisions shall continue in force as law.”

This section ensures that the prohibition on conversion practices provided for in the model law remain in force if only a portion of it was found to be unconstitutional, invalid, or of no force or effect. It is a boilerplate inclusion. The language of “unconstitutional, invalid, or of no force or effect” should be modified to reflect the language used in the jurisdiction.

The expression “under this act” may or may not be adapted to the structure of the legislation. If the model law is legislated as a chapter of a code, for instance, “under this chapter” may be more appropriate.

1. Sandy E James et al, *The Report of the 2015 U.S. Transgender Survey* (Washington, DC: National Center for Transgender Equality, 2016) at 108. [↑](#footnote-ref-1)
2. Government Equalities Office, *National LGBT Survey: Research Report* (Manchester: U.K. Government Equalities Office, 2018) at 88. [↑](#footnote-ref-2)
3. *Ibid* at 89. [↑](#footnote-ref-3)
4. Christy Mallory, Taylor NT Brown & Kerith J Conron, *Conversion Therapy and LGBT Youth* (Los Angeles: The Williams Institute, 2018). [↑](#footnote-ref-4)
5. 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