

Key concerns in the draft Conversion Practices Bill (England and Wales)

Oct 23, 2026 · @Catherine Karena

This document identifies 17 concerns arising from the draft Conversion Practices Bill. Some concern what the Bill expressly permits or prohibits. Others concern safeguards it omits and the possible consequences for parents, children, healthcare practitioners and other members of the public.

Three concerns are particularly significant: the different treatment of healthcare providers and others under clause 1(3), the reliance on intention under clause 1(2), and the absence of safeguards found in the existing offence of coercive or controlling behaviour.

Each concern identifies the relevant provisions, explains the legal problem, describes its potential consequences and recommends a minimum amendment.

Evidence and testimony from Australia and New Zealand, where comparable legislation has been introduced, will accompany these concerns on alreadylaw.com.

Our position is that the Bill should not proceed in its current form. The recommendations identify the minimum changes we consider necessary if it does.

1. Two tiers of protection

Clause: cl. 1(3); EN paras 31–32

What it does: Only conduct in the course of health care is excluded, and only unless it falls “far below” expected standards, which the Government equates with gross negligence. Parents, teachers, social workers, faith leaders and friends have no equivalent protection. The same question is presumptively lawful from a counsellor and assessed for abuse from a mother.

Effects: Parents bear the most legal exposure and have the least protection. Social workers and teachers who explore whether trauma or abuse underlies a child's identification are unprotected. Exploratory therapy may be judged against prevailing practice, which in some quarters is affirmation-led.

At a minimum: Insert the clarifying provision proposed under concern 3 (illustrative drafting in Annex A). Because it applies to any “person”, it protects parents, teachers and social workers who explore a young person’s distress on the same terms as clinicians, without extending the healthcare exemption. Abusive conduct remains within the offence.

2. Legal certainty: every element of the offence is open-ended

Clause: cl. 1(2), 1(5)–(6), 1(8), 2(1)(b); Article 7 ECHR; *R v Rimmington* [2005] UKHL 63

What it does: Criminal offences often begin with broad words such as “any conduct”. The narrowing is meant to come from the elements that follow. In this Bill, none of them narrows: the protected identity is self-reported and non-exhaustive, the intent element covers exploration, “abuse” is undefined, the listed pressures are undefined and non-exhaustive, the harm threshold can be met by existing distress, and there is no fault requirement as to harm.

Effects: A parent, teacher or practitioner cannot know in advance whether ordinary conduct is criminal. The law requires criminal offences to be clear enough for people to foresee whether their conduct is lawful (Article 7 ECHR; *Rimmington*). This Bill leaves that to be decided after the event.

At a minimum: Define “abuse” exhaustively, by reference to conduct that is violent, threatening, sexual or coercive (cl. 1(6)(a)–(c)), and adopt the fixes in the concerns on intent, the abuse indicators, the harm threshold and missing safeguards. No single fix is enough on its own.

3. Exploration falls within the offence

Clause: cl. 1(2)(b)(ii); EN para 29

What it does: The Bill defines a conversion practice by the intention behind the conduct. This includes conduct intended to make someone believe they do not have a transgender identity. It does not expressly exclude open-ended questioning or therapeutic exploration. A practitioner who explores whether distress has other causes may therefore face scrutiny over whether the purpose of that exploration was to change the person's beliefs about their identity. The Opposition asked on 25 June 2026: “Can the Government guarantee that exploratory therapy will be explicitly protected in the Bill, alongside appropriate support for those who detransition?” (Mims Davies MP). The draft does not give that guarantee. [[Hansard, HC Deb, Draft Conversion Practices Bill, 25 June 2026](#)]

Effects: Evidence from Australia includes psychologists who report withdrawing from work involving gender dysphoria, and detransitioners who report having to travel interstate to obtain psychological or medical assistance. Detransitioners lose support, since helping someone move away from a transgender identity meets the definition even at their request. These experiences illustrate the difficulties that can arise when practitioners fear their work may be characterised as conversion practices. The concern is that the UK Bill could produce similar barriers to exploratory therapy and detransition support.

At a minimum: Insert a clarifying provision after cl. 1(2). It would state that a person does not have the prohibited intention by reason only that they decline to proceed on the basis that an individual has a particular sexual orientation or transgender identity, give support without seeking a particular outcome, or explore openly and without direction the factors relevant to the individual's distress. Abusive conduct remains within the offence. Illustrative drafting is in Annex A.

4. The safeguards of the coercive control offence are missing

Clause: cl. 1(2), 1(5) and 2(1); compare s.76 Serious Crime Act 2015

What it does: The Bill appears to borrow its harm threshold from the coercive control offence but omits its three safeguards. Coercive control requires that the defendant “knows or ought to know” the behaviour will have a serious effect (s.76(1)(d)). It provides a defence of acting in the person's best interests where the behaviour was reasonable (s.76(8)). It excludes behaviour by a person responsible

for a child under 16 (s.76(3)). The Bill has none of these.

The exclusion in s.76(3) exists because Parliament left parents' conduct towards young children to the child cruelty offence (Children and Young Persons Act 1933 s.1), which requires wilful conduct. This Bill applies to parents with no requirement of wilfulness.

Effects: A parent acting in good faith for their child's welfare has no defence. Parliament decided in 2015 that parents of young children should not be prosecuted for coercive control; the Bill reverses that on one subject only.

At a minimum: Add all three: a fault requirement as to harm (as s.76(1)(d)), a best-interests defence (as s.76(8)), and an exclusion for persons with responsibility for a child under 16 (as s.76(3)).

5. Protection orders bring family disputes into court

Clause: Schedule paras 1–4 and 9

What it does: An order can be made where practices are “likely” to cause harm, wherever performed, on the balance of probabilities. The protected individual, including a child, can apply, and so can police and local authorities without leave. Family and criminal courts can make an order without any application. Orders can be made without notice and can contain any “prohibitions, restrictions, requirements”. Breach carries up to 2 years' imprisonment. These features resemble forced marriage and FGM protection orders. Those orders, however, address clearly defined and serious harms. These would apply to contested conversations within families, with a threshold that can be met by distress.

Effects: One parent's view on transition becomes a lever in child-arrangement or divorce proceedings. A parent can lose contact with a child, or a spouse face an order, without having been heard first.

At a minimum: Remove the power to make orders without an application. Before any order affects a parent's care of, or contact with, their child, require the court to apply the Children Act 1989 s.31 threshold: significant harm, measured against the care a reasonable parent would give.

6. Criminal allegations feed into child protection

Cause: No provision. The Bill's interaction with the Children Act 1989 (s.47 enquiries; s.31 threshold; “harm” defined in s.31(9)).

What it does:

An allegation that a parent has carried out an abusive conversion practice could also raise child protection concerns under the Children Act 1989. If a local authority has reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, section 47 requires it to make enquiries. Those enquiries may lead to further intervention, including care proceedings where the relevant legal threshold is met. The Bill's own label, “abusive”, can supply much of the ground.

The Bill does not expressly address how allegations involving parental decisions about a child's gender identity should be assessed under existing child protection law.

Effects: Parents who act protectively can face care proceedings as well as, or instead of, prosecution, with the risk of their children being removed. The Explanatory Notes do not consider this route.

At a minimum: Provide that a parent’s refusal to consent to social or medical transition, or conduct consistent with NHS policy and the law, is not in itself evidence of significant harm.

7. The healthcare exemption measures practice, not informed consent

Clause: cl. 1(3), 1(9); EN para 32

What it does: Cl. 1(3) exempts conduct in the course of health care unless it falls “far below” the standard “reasonably expected” of a provider. That standard tracks prevailing practice. Among some professional bodies and unregulated providers, that practice is affirmation rather than the legal standard of informed consent. Under *Montgomery (2015)*, clinicians must take reasonable care to ensure patients are aware of material risks and reasonable alternatives to proposed treatment. *Montgomery* ended the rule *that what other doctors do decides what patients must be told*, so meeting a professional guideline does not, by itself, show those duties have been met.

Where prevailing practice favours affirmation, the Bill may therefore protect conduct within that practice without examining whether the patient received the information needed for an informed decision. The exemption also covers unregulated providers (EN para 32). They have no published standards to fall below, so for them the exemption has no clear benchmark.

Informed consent also requires disclosure of uncertainty. Where a pathway proceeds on the premise that a child has a settled transgender identity, the status of that premise is itself material information: there is no diagnostic test and no agreed definition, and the [Cass Review Final Report p.13 \(2024\)](#) found “The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress.” Clinical judgment decides which options are reasonable (*McCulloch v Forth Valley Health Board* [2023] UKSC 26), but the *Montgomery* duty then applies to them. CQC Regulation 11 imposes the same duty at service level. Minister Olivia Bailey has said that a person cannot consent to abuse. That is correct, but it answers a different question: the duty to disclose applies whether or not any conduct is abusive.

Effects: A clinician following an affirmation-led pathway may receive the benefit of the healthcare exclusion, while a practitioner who questions that pathway or follows the legal standard of informed consent may face greater uncertainty about whether their conduct is protected.

At a minimum: Make the legal and regulatory standard of informed consent the minimum standard expected under cl. 1(3) (see concern 12). State how that standard applies to unregulated providers.

8. The harm threshold rests on the complainant's distress

Clause: cl. 2(1)(b)

What it does: Clause 2(1)(b) makes “serious alarm or distress” substantially affecting ordinary day-to-day activities, one route to criminal liability. The prosecution must establish that the abusive conversion practice caused that distress.

The Bill does not, however, expressly require proof that the defendant knew, or ought reasonably to

have known, that the conduct would cause such serious distress. It also does not explain how pre-existing distress should be distinguished from distress caused by the alleged conduct.

Effects: Where a young person already experiences significant distress, disputes may arise over whether a parent's or practitioner's conduct caused the legally relevant harm. This creates uncertainty, particularly where ordinary disagreements about treatment or identity occur within already distressed families. A parent's 'not yet' could become the subject of a prosecution. Note also, practitioners may struggle to show what happened in a private session, because the client's account of their own distress is close to the whole case.

At a minimum: Remove cl. 2(1)(b) or, at a minimum, retain it only with the fault requirement and best-interests defence in concern 4.

9. Open-ended abuse indicators capture ordinary parenting

Clause: cl. 1(5), 1(6)(d)–(e)

What it does: Abuse is a question of fact “by reference to all the circumstances”. “Economic pressure” and “psychological or emotional pressure” are undefined, and the list is non-exhaustive.

Effects: Declining to pay for a binder, using a child's birth name at home or waiting before social transition can be framed as pressure. So can a spouse declining to fund an adult partner's surgery.

At a minimum: Remove cl. 1(6)(d) and (e), or define them to exclude the reasonable exercise of parental responsibility and ordinary decisions within a relationship.

10. No distinction between children and adults

Clause: No provision. Compare Children Act 1989 ss.1(3), 3; Family Law Reform Act 1969 s.8; Serious Crime Act 2015 s.76(3).

What it does: The Bill makes no distinction by age and makes no reference to parental responsibility. A child's own account can determine three elements: whether a protected identity exists (cl. 1(8)), whether harm occurred (cl. 2(1)(b)), and whether proceedings begin (Sch. para 2(2)). Elsewhere, the law calibrates a child's decisions to their age and understanding. Gillick competence is assessed decision by decision, consent to treatment is presumed only from 16, the Children Act requires courts to consider a child's age and understanding, and coercive control excludes parents of under-16s. The Schedule asks the court to consider the individual's “health, safety and wellbeing” (para 1(2)), but the criminal offence contains no equivalent.

Effects: A 13-year-old's stated identity and distress carry the same legal weight as an adult's. Parents cannot rely on their responsibility for the child as any part of a defence. Early affirmation becomes the low-risk default for every adult around a child, identities that might have changed become fixed, and safeguarding questions go unasked.

At a minimum: Provide that the reasonable exercise of parental responsibility for a child is not a conversion practice. Where the individual is under 18, require the court, in both criminal and protection-order proceedings, to have regard to the child's age, maturity and understanding and to their welfare, as the Children Act 1989 does.

11. A protected category with no external test

Clause: cl. 1(8); EN paras 17, 29

What it does: “Transgender identity” includes identifying as neither male nor female, or not solely either, and the list is non-exhaustive. In England and Wales, statute has defined transgender identity only by reference to being transsexual or undergoing gender reassignment (Sentencing Act 2020 s.66(6)). Cl. 1(8) adds, for the first time in this jurisdiction, a limb resting on self-identification as neither male nor female, makes the list non-exhaustive, and makes the category an element of a criminal offence rather than an aggravating factor. This departs from the Government’s stated intention to “use existing legislative definitions of sexual orientation and transgender identity” (draft impact assessment).

It is wider than the protected characteristic of gender reassignment in the Equality Act 2010, which after *For Women Scotland* (2025) cannot include it. The definition can be met by self-report alone. Perceived identity counts, and a mistake about a person’s identity is irrelevant (EN paras 17, 29).

A category with no external test can work in anti-discrimination law, where the only question is whether someone was treated adversely because of it. It does not work in the same way once the law must assess the category, treat on the basis of it, or decide whether conduct towards it is criminal, as this Bill requires.

Effects: No parent, teacher or therapist can know in advance which identity they are said to be changing, especially when a young person’s stated identity shifts. Detransitioners remain within the definition because they “ha[ve] undergone” gender reassignment.

At a minimum: Make the definition exhaustive. Require that the defendant intended to change an identity the individual held or was believed to hold, rather than one inferred after the event.

12. Protection for lesbian, gay and bisexual people runs one way

Clause: cl. 1(2)(a)(ii), 1(2)(b)(i), 1(3), 1(7); draft impact assessment

What it does: The Government’s impact assessment states that the measures “will be symmetrical”, protecting “against attempts to change from non-transgender/heterosexual to LGBT+, and vice versa”. On its wording, that protection runs both ways. Conduct intended to cause a same-sex-attracted young person “to have” a transgender identity is therefore a conversion practice (cl. 1(2)(b)(i)).

This matters most for young people who are coming to understand their same-sex attraction. Sexual orientation is defined by sex (cl. 1(7); Equality Act s.12), which after *For Women Scotland* (2025) means biological sex. Transgender identity is defined by self-perception. A same-sex-attracted young person who transitions is therefore reclassified as heterosexual: their attraction is unchanged, but it is now to the “opposite” gender.

When that conduct happens in health care, cl. 1(3) exempts it unless it falls far below prevailing practice. Medical transition always takes place in health care. Among some professional bodies and unregulated providers, prevailing practice is affirmation rather than the legal standard of informed consent. Social transition can begin elsewhere, including at school. The Cass Review itself notes that social transition “is not something that happens within health services”. Schools have no exemption; whether the Bill would

ever be applied to a school that socially transitions a child is the subject of Question 1 (below).

The test, however, is the actor's intention, not the outcome. A same-sex-attracted girl who comes to understand herself as a heterosexual boy has come to "believe that they... do not have... a particular sexual orientation", the wording of cl. 1(2)(a)(ii). But the adults who affirmed her intended to affirm a gender identity, not to change her beliefs about her sexuality. The Bill describes the outcome but cannot reach those who brought it about.

The harm test has the same blind spot. Foreclosure may bring relief at first; regret, detransition or confusion about a sexuality never allowed to develop may surface years later. A threshold written for serious harm or distress now does not capture harm that arrives later. In a survey of 100 detransitioners, 23% described homophobia or difficulty accepting themselves as lesbian, gay or bisexual as a reason for their transition and later detransition, although the survey did not ask about it (Littman, 2021). In a survey of 237 detransitioners, 52% reported needing help to cope with internalised homophobia (Vandenbussche, 2022). The Cass Review (2024) concluded that social transition should be viewed "as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning", and that "it is not a neutral act". This is not a claim about frequency. It is that a foreseeable pathway should be one a safeguarding law can see.

Effects: The Bill creates a risk of unequal treatment. Parents who question a young person's transgender identity, or explore other explanations for their distress, including emerging same-sex attraction, have no healthcare exemption and may face criminal scrutiny. Practitioners who explore are protected only if their approach matches prevailing practice, which in some quarters is affirmation. Yet practitioners who encourage the same young person towards a transgender identity are likely to be protected. The concern is that the law may penalise questioning one pathway while protecting those who encourage it.

At a minimum: Make the cl. 1(3) healthcare exemption conditional on compliance with the legal and regulatory standard of informed consent (Montgomery; GMC guidance). That means disclosure of material risks and harms, reasonable alternatives including non-medical options and no treatment, and genuine discussion. Alternatives can be presented only where other explanations of distress, including sexual orientation, have been considered. This is the safeguard against a predetermined pathway.

13. No control over who prosecutes

Clause: No provision. There is no requirement for Director of Public Prosecutions (DPP) or Attorney General consent.

What it does: Private prosecutions can be brought, including by individuals or organisations with a campaigning interest. The DPP can take over and discontinue one (Prosecution of Offences Act 1985 s.6(2)), but only at the DPP's discretion and only after proceedings have begun. Anyone else can seek a protection order with the court's leave (Sch. para 2(3)).

Effects: Families, practitioners and support organisations can be drawn into criminal proceedings by people with no connection to them. It leaves open a route to vexatious or politically motivated prosecutions. The cost and strain fall on the defendant before any review.

At a minimum: Require the consent of the DPP before a prosecution is brought, as for other sensitive offences.

14. Liability of organisations and their officers

Clause: cl. 5(2)

What it does: Directors, managers and members of a governing body commit the offence themselves if they “fail to take all reasonable steps to prevent” it. This reaches clinics, schools, charities, training bodies and parent support groups.

Effects: Organisations that support families or train practitioners face liability for the conduct of their staff and volunteers. They will restrict what is discussed.

At a minimum: Limit officer liability to the usual formula of consent or connivance, and remove “fails to take all reasonable steps to prevent”.

15. A thin evidence base

Clause: Impact assessment; EN para 97

What it does: The case for the Bill rests mainly on self-report surveys. The impact assessment calls the evidence on gender identity conversion practices “much newer”. It monetises £783m of benefits over 10 years, while impacts on the justice system are “being assessed” (EN para 97). Neither the Explanatory Notes nor the impact assessments consider the family justice system or foster care.

Effects: The Committee is asked to create a criminal offence without data on what comparable laws have done in practice. There is also no estimate of the extra care proceedings, foster placements or legal aid the Bill would generate. Parents in care proceedings receive legal aid without a means or merits test, and there is already a shortage of foster carers.

At a minimum: Before the Bill proceeds, require a full assessment of its impact on the criminal and family justice systems, including care proceedings, foster care and legal aid. Include evidence from jurisdictions with comparable laws, such as Victoria and New Zealand. Pre-legislative scrutiny is the point at which these impacts should be known.

16. Conduct abroad

Clause: cl. 3

What it does: A UK person who encourages or assists an abusive conversion practice outside England and Wales commits an offence, even if no practice takes place (cl. 3(3)). The Bill does not say whether the cl. 1(3) healthcare exemption covers health care provided abroad.

Effects: Families who seek exploratory therapy from practitioners outside England and Wales, including online, cannot tell whether they are protected.

At a minimum: State that cl. 1(3) applies to health care services wherever they are provided.

17. No protection for the expression of belief

Clause: No provision. Compare s.29JA Public Order Act 1986 (England and Wales); s.9 Hate Crime and Public Order (Scotland) Act 2021; *Forstater v CGD Europe* (EAT, 2021).

What it does: The Bill contains no clause protecting the expression of belief about sex or gender identity. Gender-critical belief is protected under the Equality Act (*Forstater*), and other offences protect discussion and criticism expressly (s.29JA Public Order Act 1986). The Scottish Parliament has expressly protected “discussion or criticism of matters relating to... transgender identity” (s.9, 2021 Act); this Bill offers no equivalent. Here, “any conduct” towards an individual (cl. 1(2)), an undefined “emotional pressure” factor (cl. 1(6)(e)) and a distress threshold (cl. 2(1)(b)) leave room to frame sex-based language used to a person, such as declining to use their preferred pronouns, as a conversion practice.

Effects: Individuals and organisations holding a protected belief can face complaints, private prosecutions or protection-order applications from those who disagree with them. Their officers face liability under cl. 5. Convictions may be unlikely, but the cost and strain of the process fall on the defendant regardless.

At a minimum: Add a freedom-of-expression provision, modelled on s.29JA Public Order Act 1986 and s.9 of the Hate Crime and Public Order (Scotland) Act 2021. It should state that discussion or criticism of matters relating to sex or transgender identity, the expression of a belief about them, or the use of language based on sex, is not of itself a conversion practice.

Questions for the Government

The Committee could put these questions to ministers and witnesses. Each answer would show how the Bill is meant to work.

1. **Schools (concern 12, 1).** Does the Government consider that a school which socially transitions a same-sex-attracted child, without parental involvement, carries out conduct intended to cause that child to have a transgender identity under cl. 1(2)(b)(i)? If not, why does the Bill treat conduct in that direction differently?
2. **Coercive control (concern 4).** The Bill adopts the harm threshold of s.76 Serious Crime Act 2015. Why does it omit that offence's fault requirement, its best-interests defence and its exclusion for parents of children under 16?
3. **Unregulated providers (concern 7).** Against what standard is an unregulated provider's conduct to be judged under cl. 1(3), where no professional standard exists?
4. **Parents (concerns 1 and 10).** Would a parent who declines to consent to social transition for a 13-year-old, and tells the child why, meet cl. 1(2)? If not, which provision protects them?
5. **Comparable laws (concern 15).** What data has the Government obtained on prosecutions, complaints and protection orders under the conversion practices laws of Victoria, New South Wales and New Zealand?
6. **Parents acting on NHS policy (concerns 1, 4 and 6).** A 14-year-old obtains testosterone without a prescription, and her parents destroy it, consistent with NHS policy following the Cass Review.

She is distressed and complains to the police. Does the Bill provide any defence for conduct that is consistent with the law and NHS policy but takes place outside health care?

7. **Article 8 (concerns 1, 4, 5, 6 and 10).** Has the Government assessed whether the offence, as it applies to parents, is a proportionate interference with the right to respect for family life under Article 8 ECHR? Will it publish that assessment?
8. **Pronouns (concerns 13, 14 and 17).** Would an individual who declines to use a person's preferred pronouns in direct dealings with them meet cl. 1(2)? If not, why does the Bill not say so?
9. **Definitions (concern 11).** The impact assessment says the Bill will use existing legislative definitions of sexual orientation and transgender identity. The existing definition in England and Wales (Sentencing Act 2020 s.66(6)) does not include identifying as neither male nor female. Why does cl. 1(8) depart from it?

Sources

- [Draft Conversion Practices Bill \(CP 1604\)](#), GOV.UK, June 2026
- Office for Equality and Opportunity, *Draft Conversion Practices Bill: Explanatory Notes*, updated 1 September 2026
- [Draft final stage impact assessment](#), GOV.UK, June 2026
- [Serious Crime Act 2015 s.76](#); [Children Act 1989 s.31](#); [Prosecution of Offences Act 1985 s.6](#); [Health and Care Act 2022 s.135](#)
- [Montgomery v Lanarkshire Health Board \[2015\] UKSC 11](#); *For Women Scotland Ltd v The Scottish Ministers* [2025] UKSC 16
- [Criminalising conversations](#), Matilda Gosling for Sex Matters, October 2026
- [General Medical Council, Decision making and consent \(2020\)](#)
- Sarah Phillimore, "[The Conversion Practices Bill](#)", 28 June 2026
- [Forced marriage protection orders \(Family Law Act 1996, Part 4A\)](#)
- [FGM protection orders \(Female Genital Mutilation Act 2003, Schedule 2\)](#)
- [s.29JA Public Order Act 1986](#)
- [Forstater v CGD Europe \(EAT, 2021\)](#).
- Sentencing Act 2020 s.66 (legislation.gov.uk/ukpga/2020/17/section/66)
- Hate Crime and Public Order (Scotland) Act 2021 ss.9 and 11 (legislation.gov.uk/asp/2021/14)
- [Children and Young Persons Act 1933 s.1](#)
- [McCulloch v Forth Valley Health Board \[2023\] UKSC 26](#)
- [Care Quality Commission, Regulation 11: Need for consent \(Health and Social Care Act 2008 \(Regulated Activities\) Regulations 2014\)](#)
- [R v Rimmington \[2005\] UKHL 63](#); [European Convention on Human Rights, Article 7](#)
- [Cass, H. \(2024\). Independent Review of Gender Identity Services for Children and Young People: Final Report. NHS England](#)
- Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. *Archives of Sexual Behavior*, 50, 3353–3369. [PubMed](#)
- Vandenbussche, E. (2022). Detransition-related needs and support: a cross-sectional online survey. *Journal of Homosexuality*, 69(9), 1602–1620. [doi:10.1080/00918369.2021.1919479](https://doi.org/10.1080/00918369.2021.1919479)

- [Hansard, HC Deb, Draft Conversion Practices Bill, 25 June 2026](#)

Annex A: Illustrative drafting for concerns 1 and 3

This drafting is illustrative only. It shows that open, non-directive work with children and young people can be protected by a clarifying provision that creates no exemption for abusive conduct. It is not put forward as settled wording.

A. A clarifying provision in clause 1

A new subsection could be inserted in clause 1, after subsection (2):

(2A) For the purposes of subsection (2), a person does not have the intention mentioned in that subsection by reason only that the person—

(a) declines to proceed on the basis that an individual has, or does not have, a particular sexual orientation or a particular transgender identity;

(b) provides support to an individual who is experiencing distress, including distress relating to sexual orientation, sex or transgender identity, without seeking to cause the individual to have, or not to have, a particular sexual orientation or transgender identity; or

(c) explores, in an open and non-directive way, the factors that may be relevant to any such distress.

(2B) Nothing in subsection (2A) applies to conduct which amounts to an abuse of the individual (see subsections (4) to (6)).

B. How the provision works

“By reason only that” is the key. The provision does not create a protected category of therapy or a healthcare-style exemption. It clarifies that the listed facts, standing alone, do not establish the prohibited intention. Any other evidence that a person was in fact seeking to change an individual’s orientation or identity remains available.

The provision is symmetrical. Limb (b) withholds protection from direction towards any predetermined outcome, whether transgender, cisgender or heterosexual. It does not shelter suppression dressed as exploration.

It applies to parents as well as clinicians. Subsection (2A) refers to “a person”, not a practitioner. A parent, teacher or social worker who explores what may lie behind a young person’s distress is within it on the same terms as a clinician. This addresses concern 1 without extending the healthcare exemption.

Abuse is never protected. Subsection (2B) puts the point beyond doubt: conduct that amounts to abuse is outside the provision, however it is described.

C. A shorter alternative

(2A) A person does not carry out a conversion practice by reason only of declining to affirm an individual’s sexual orientation or transgender identity, or of providing open and non-directive

support, or exploring the reasons for an individual's distress; but this subsection does not apply to conduct which amounts to an abuse of the individual.