Chairman Lipps, Vice Chair Stewart, Ranking Member Liston, and all House Public Health Policy Committee members thank you for the opportunity to testify in opposition to House Bill 68. My name is Gene Dockery, and I am here today on behalf of the Ohio Counseling Association. In the Ohio Counseling Association (OCA), I act as the Southeast Representative for the Society for Sexual, Affectional, Intersex, and Gender Expansive Identities of Ohio (SAIGEO). I am also the Government Relations Committee Liaison. I am a licensed professional counselor in Newark, Ohio, and a Ph.D. Candidate at Ohio University. Both my clinical work and published research focus on LGBTQIA mental health, making me well-qualified to speak on this topic today.

While OCA objects in general to the legislation and the harmful effect it could have on children and families in need of gender affirming care, I want to highlight a few sections specifically because this legislation contains provisions that would erode access to vital life-saving services.

Section 3129.03 states that mental health professionals cannot diagnose or treat a minor for a "gender-related condition" without parental or guardian consent. This would limit access to mental health care services, which goes against this administration's efforts. This will also increase the amount of untreated and undiagnosed/misdiagnosed mental and emotional disorders among Ohio's youth. Therefore, the OCA strongly opposes this and any bill that creates barriers to accessing counseling services.

Also in section 3129.03, it is stated that minors must be screened for comorbidities and trauma before being diagnosed with gender dysphoria as they could "influence" the condition. There are several issues with this. No ethical clinician provides any DSM diagnosis without considering comorbidities or differential diagnoses. The implication that this is not already occurring shows and sows distrust for professionals. The more alarming implication that youth would not be trans if they were not, for example, autistic or traumatized is dangerous and fallacious. It also ignores the body of research that demonstrates that untreated gender dysphoria results in depression, anxiety, trauma, and other conditions.

Section 3129.03 also attempts to legitimize "watchful waiting." What is being called "watchful waiting" as a method of treating trans youth is a mischaracterization of the Dutch protocol, published in 2012 which advocated for using puberty blockers starting at age 12 for children experiencing gender dysphoria (Ashley, 2019). What watchful waiting means now due to this alarming mischaracterization is delaying transition in the hopes that the child will change their mind, and this has been proven to cause significant harm to trans youth (Horton, 2022). I do not say this lightly, watchful waiting and similar therapies are conversion therapy. OCA has previously and will continue to oppose this.

Section 3129.06 requires each mental health professional to report annually to the Department of Health the number of trans and gender expansive youth they treated or diagnosed, their sex assigned at birth, age when symptoms started, their comorbidities or trauma, and if any of them detransitioned. Though the bill states that this information should not identify anyone, it is impossible for it not to based on what has been asked. With the small number of trans and gender expansive youth in the state and the fact that most clinicians in Ohio utilize in-person care, there is no way that we can give you that information without it identifying these children. You are asking us to violate our ethical standards of confidentiality in a way that endangers our clients, our practices, and ourselves. This will stop families from seeking support for their children when they need it the most. OCA again opposes any barriers to accessing mental healthcare.

Now that I have discussed the bill, I would like to share my concerns about the proponent testimony given at the previous hearing.

Multiple proponents brought up statistics that say trans youth desist in their trans identity in adulthood. The evidence for this comes from four methodologically unsound and highly disputed publications (Temple Newhook et al., 2018). In a study published last year, 94% of trans children were still transgender after five years, which strongly contradicts the concept of desistance (Olson et al., 2022). The idea that we should not allow gender affirming care for trans youth because they will change their mind is not an accurate reflection of what clinicians are seeing or what research is indicating.

Social contagion or so-called "rapid onset gender dysphoria" in trans adolescents was also part of the proponent testimony. This is the idea that children will decide to be transgender because of social influence or mental health issues. There is no clinical evidence for such a phenomenon (Bauer et al., 2022). The study that brought the concept of "rapid onset gender dysphoria" to the public is highly disputed because of apparent ethical and methodological issues.

During proponent testimony, detransition was brought up at multiple points. The committee should note that detransition is usually due to the extreme barriers in our society for trans people to live authentically. The most common reasons for detransitioning are parental pressure, societal stigma, and trouble finding work (Turban et al., 2021). Most people that detransition eventually re-transition later in life when they have the support to do so (Turban et al., 2021).

In conclusion, this bill endorses harmful misinformation about gender dysphoria and distrust of counselors, all while creating barriers to care. Therefore, the Ohio Counseling Association opposes it based on our commitment to counseling values, professional identity, and clinical excellence. I thank you for your time and hope that you will take our input into consideration.

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Edited by