Dear esteemed Members of the Ohio House Health Committee, Chair Jean Schmidt,

My name is Dr. Marla Moloney, and I am a pediatrician with experience in adolescent mental health and child maltreatment. I am writing to express strong opposition to **HB 172**, which would repeal **Ohio Revised Code 5122.04**—the statute that currently allows youth ages 14–17 to access up to six mental health sessions or 30 days of care when a parent cannot or will not provide consent.

From a clinical standpoint, eliminating this narrow exception would create significant risk for some of the most vulnerable adolescents in our state.

1. Many adolescents live in homes where it is not safe or feasible to involve a parent in the initial stages of mental health care.

National data indicate that approximately **1 in 7 U.S. children** live in households with domestic violence, coercive control, or high-conflict dynamics. In such environments, abusive or unstable parents frequently block, delay, or punish help-seeking behavior.

- Youth exposed to domestic violence are **2–3× more likely** to develop depression, anxiety, eating disorders, and suicidality.
- The CDC reports that adolescents who experience emotional abuse have **5× higher odds** of suicide attempts.

For these youths, parental consent is not a simple administrative step—it can be an **insurmountable barrier to safety**.

2. Delayed access to mental health treatment has measurable medical consequences.

Early access to therapy reduces the long-term severity of mental health conditions:

- Adolescents who receive timely intervention for depression have a **50% reduction** in recurrence rates.
- For eating disorders, early treatment is one of the strongest predictors of recovery, **cutting mortality risk in half**.
- For suicidal ideation, even **1–2 sessions** of crisis-focused therapy significantly decrease attempt rates.

HB 172 would remove the ability for clinicians to intervene during the **critical early window** when outcomes are most modifiable.

3. ORC 5122.04 is narrow, safe, and clinically appropriate.

The current law:

- Allows only **short-term counseling** (six sessions or 30 days)
- **Does not** authorize medication
- **Does not** override mandatory reporting obligations
- **Does not** exclude parents from involvement in ongoing treatment

This statute functions as a **screening and stabilization tool** for youth at risk—not as a workaround to bypass parents.

4. The populations who rely on this protection are those with the highest documented barriers to care.

Adolescents seek this limited exception primarily when parents are:

- **Unreachable** (e.g., work instability, incarceration)
- **Unwilling** to consent due to stigma or denial
- **Unable** to mentally or emotionally engage
- **Or themselves the source of the youth's trauma or crisis**

Repealing this statute would disproportionately harm youth experiencing **abuse, coercive control, family violence, parental mental illness, or substance use**—all groups with elevated risk for self-harm and suicide.

5. As clinicians, our duty is to prevent harm.

The **American Academy of Pediatrics**, **American Psychological Association**, and the **National Association of Social Workers** all emphasize that adolescents must have developmentally appropriate, **confidential pathways** to mental health care—particularly when guardians are unable to act in the child's best interest.

Removing ORC 5122.04 would leave many high-risk adolescents with **no clinically safe access point to care**.

For these reasons, I urge lawmakers to **oppose HB 172** and retain the existing protections that allow clinicians to safely assess, stabilize, and support youth who may otherwise fall through the cracks.