



National Association of Social Workers

O H I O C H A P T E R

GENDER AFFIRMING CARE

This whitepaper is meant to be a guide used to learn more about what gender-affirming care is, current policies and laws already in place affecting mental healthcare for youth, potential implications of House Bill 68 (SAFE Act), and ways to identify valid research. The information included will provide a more comprehensive look at the issues at hand, enabling the reader to ask thoughtful questions in committee hearings and beyond.

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This guide was developed and reviewed by staff and interns of The National Association of Social Workers - Ohio Chapter and a portion of its members.

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GLOSSARY OF GENDER-RELATED TERMINOLOGY

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ASSIGNED FEMALE AT BIRTH (AFAB)

Term used to describe or educate on issues that may happen to these bodies without connecting them to womanhood or femaleness (i.e. menstruation or pregnancy; "Pregnancy can occur in bodies that are AFAB"). Also sometimes used to refer to a trans or gender diverse person's sex assigned at birth.

ASSIGNED MALE AT BIRTH (AMAB)

Term used to describe or educate on issues that may happen to these bodies without connecting them to manhood or maleness (i.e. prostates; "People in AMAB bodies should get prostate exams as indicated by their medical providers"). Also sometimes used to refer to a trans or gender diverse person's sex assigned at birth.

ASSUMED GENDER

The gender assumed about an individual based on their sex assigned at birth, apparent societal gender markers, physical attributes, and expressed characteristics (i.e. using pronouns for a person before asking what pronouns that person uses for themselves).

BOTTOM SURGERY

Surgery performed on an individual's reproductive system as part of gender-affirming surgery (i.e. phalloplasty, metoidioplasty, vaginectomy, scrotoplasty, vaginoplasty, orchiectomy).

CISGENDER

Term used to refer to a person whose gender identity aligns with their sex assigned at birth. It is not appropriate to refer to a person as "cisgendered"; you can simply say "I am a cisgender person."

GLOSSARY OF GENDER-RELATED TERMINOLOGY

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COMING OUT

The process of self-identifying as LGBTQ+ that includes sharing their identity with others.

CROSS-DRESSER

Also previously called “transvestite” **(this term is outdated)**. This term refers to someone who sometimes or frequently wears clothing typically associated with another gender, but does not do so because they feel they are the other gender. In some cultures, this can be for religious, traditional, or ceremonial reasons.

DEAD NAME

Also called "birth name," "given name," or "old name." Refers to the name a gender-expansive person previously used in life. Can also be a verb, "dead-naming," which is the act of using this old name, whether intentional or not.

GENDER-AFFIRMING CARE

Refers to the array of services to support and affirm a transgender or gender diverse person’s experience. It can include medical care, surgical care, legal support, mental healthcare, and general support services (i.e. support groups, clothing resources, etc). Gender-affirming care seeks to be patient-centered and treat individuals holistically, assisting individuals with aligning their outward, physical traits with their gender identity in whatever process or path they choose for their transition

GENDER-AFFIRMATION SURGERY

Also referred to as "gender confirmation surgery." Surgical procedures that can help gender-diverse people match their bodies to their innate gender identity. [See also “top surgery” and “bottom surgery”]

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GENDER DIVERSE

Also called "gender expansive". An umbrella term used for those who do not follow gender stereotypes or who expand ideas of gender expression or identity. This term also includes "gender non-conforming". [See also "non-binary"].

GENDER DYSPHORIA

The distress caused when a person's sex assigned at birth and assumed gender are not the same as the one with which they identify. This is the current term in the DSM and the medical diagnosis currently used. Insurance carriers require a diagnosis of gender dysphoria for any medical transition interventions to be paid for by them.

GENDER EUPHORIA

A euphoric feeling often experienced when one's gender is recognized and respected by others, when one's body aligns with one's gender, or when one expresses themselves in accordance with their gender.

GENDER EXPRESSION

The manner in which a person communicates about gender to others through means such as clothing, appearance, or mannerisms.

GENDER IDENTITY

One's deeply held core sense of self in relation to gender. This does not always correspond to biological sex.

GENDER IDENTITY DISORDER

Term/diagnosis no longer used. This term was updated and replaced in the DSM with **Gender Dysphoria**.

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GENDER VARIANT

Term often used in the medical community to describe individuals who dress, behave, or express themselves in a way that does not conform to dominant gender norms. **This term suggests that these identities are abnormal and this term should be avoided.**

HERMAPHRODITE

Offensive term for an intersex individual. This term is valid for non-human animals and plants, **but should not be used to describe people.**

HORMONE REPLACEMENT THERAPY

Often shortened to “HRT.” Refers to treatment with hormones to replace natural hormones when the body does not make enough. Relating to transgender medical care, this often means offering testosterone to individuals assigned female at birth and offering estrogen to individuals assigned male at birth

INTERSEX

Term used to refer to people who are biologically between the medically expected definition of male and female; whether through variations in hormones, chromosomes, internal or external genitalia, or any combination of any or all primary and/or secondary sex characteristics. It is not appropriate to refer to a person as “intersexed”; you can simply say “They are an intersex person”

LEGAL TRANSITION

Refers to the legal processes some transgender and gender diverse individuals sometimes go through. This can include legal name changes or changing the gender/sex marker on state IDs, social security cards, birth certificates, insurance cards, and passports

GLOSSARY OF GENDER-RELATED TERMINOLOGY

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MEDICAL TRANSITION

Refers to the medical processes some transgender and gender diverse individuals sometimes go through. This can include puberty blockers, hormone replacement therapy, top surgery, bottom surgery, facial surgery, body contouring surgery, hair removal, fertility preservation, speech therapy, or any combination of any of the above

MISGENDERING

The act of referring to an individual using a word (i.e. pronoun or title) that does not correctly reflect their gender, whether intentional or not.

NON-BINARY

Refers to people who do not subscribe to the gender binary (male/female). They may also use this term interchangeably with "genderqueer," "genderfluid," "gender non-conforming," "gender diverse," or "gender expansive."

NON-OP

Refers to the surgical status of a person who does not plan to have gender-affirming surgery.

OUTING

The deliberate or accidental act of sharing another person's sexual orientation or gender identity without their explicit consent.

PASSING

The act of presenting as straight (when referring to sexuality) or as presenting as cisgender (when referring to gender). This is typically done in anti-LGBTQ+ environments where it is not always safe to be out (visibly queer).

GLOSSARY OF GENDER-RELATED TERMINOLOGY

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POST-OP

Refers to the surgical status of a person who has had gender-affirming surgery.

PRE-OP

Refers to the surgical status of a person who may or may not plan to have gender-affirming surgery, but has not done so yet.

PUBERTY BLOCKERS

Also called “hormone blockers.” Refers to medicines that pause, delay, or prevent puberty or some of the physical changes of puberty from occurring. Often used for transgender or gender diverse youth who are of puberty age, so that they can forgo unwanted physical changes until they are old enough for hormone replacement therapy.

SEX ASSIGNED AT BIRTH

Or simply "assigned sex". The sex that is designated to an infant at birth based on the child's visible sex organs [see also AFAB and AMAB].

SEX CHANGE OPERATION

An outdated term used to refer to gender confirmation/affirmation surgery. **This term should not be used.**

SOCIAL TRANSITION

Refers to the social processes that transgender or gender diverse individuals go through. This can include using another name, changing wardrobe, changing hairstyles, using different pronouns or titles, coming out to loved ones or work, using prostheses or binding garments to change the appearance of chest or genitals under clothing, or any combination of any of the above.

GLOSSARY OF GENDER-RELATED TERMINOLOGY

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TOP SURGERY

Surgery performed on an individual's chest/breasts as part of gender-affirming surgery (i.e. breast reduction, breast removal/mastectomy, breast implants).

TRANSGENDER

Often shortened to "trans." A term that describes a person whose gender identity does not match their sex assigned at birth. It is not appropriate to refer to a person as "transgendered"; you can simply say "She is a transgender person" or a "person of transgender experience."

TRANSITION

Term that describes the process one goes through to affirm one's gender identity (includes social, legal, and/or medical).

TRANSMEDICALISM

The belief that gender dysphoria must be present and is required to be "legitimately" transgender and that dysphoria can only be treated through medical interventions. **This term is problematic as there are many people who identify as transgender who do not present with the qualifying symptoms for a diagnosis of gender dysphoria and not all who have a diagnosis of gender dysphoria want to pursue medical interventions.**

TRANSPHOBIA

Animosity, hatred, or dislike of trans or gender-diverse people that often manifests as prejudice and bias.

TRANSSEXUAL

A term that refers to people who use or consider medical interventions (hormones, surgery) as part of expressing their gender. To many, this term is outdated and offensive, though to some, this is the term they prefer to use for themselves. Use caution when using this term and only use it when someone has told you they self-identify as such (this also applies to the term "sex reassignment surgery"; many find this term to be outdated, but some prefer to refer to their surgical interventions as such)

WHAT IS GENDER-AFFIRMING CARE?

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Gender-affirming care (GAC), according to the World Health Organization (1), encompasses a range of social, psychological, behavioral, and medical interventions “designed to support and affirm an individual’s gender identity.” GAC can include medical care, surgical care, legal support, mental healthcare, and general support services (i.e. support groups, clothing resources, etc). GAC seeks to be patient-centered and treat individuals holistically, assisting individuals with aligning their outward, physical traits with their gender identity in whatever process or path they choose for their transition.

While not all transgender and gender-diverse (TGD) individuals choose to access medicalized GAC, such as hormones and surgical interventions, for many, this healthcare is medically necessary. Interventions are tailored to the unique needs of each patient and rigorous practice standards are in place which are supported by every major medical association, representing more than 1.3 million doctors across the United States (2). It is also important to note that GAC services are neither new nor exclusive to trans and gender-diverse individuals. Cisgender children with precocious puberty have historically been given puberty blockers as well as the millions of cisgender adults that are prescribed synthetic hormones such as testosterone and estrogen. Cisgender individuals also receive a plethora of additional services including chest surgeries, hair removal, cosmetic surgeries, etc. in order to feel more at home and comfortable in their bodies (3). For TGD youth, prior to puberty all stages of transition are social, psychological, and behavioral and are reversible (4). Those who decide to seek hormonal interventions after the onset of puberty, make this decision only with the utmost care and support from parents, who must consent, and a team of mental healthcare providers and physicians. Surgical interventions are generally not recommended for minors, nor are they conducted at any Ohio children’s hospital (5). The range of services currently provided to TGD youth are evidence-based, age appropriate, and have been proven to lower rates of suicide and depression (6). Such services promote healthy and safe lives for TGD youth, physically and psychosocially. Despite this, several states across the country have passed legislation aiming at

(1) Boyle, P. (2022, April 12). What is gender-affirming care? Your questions answered. AAMC. Retrieved October 10, 2023, from <https://www.aamc.org/news/what-gender-affirming-care-your-questions-answered>

(2) Get the Facts on Gender-Affirming Care. (2023, July 25). Human Rights Campaign. Retrieved October 10, 2023, from <https://www.hrc.org/resources/get-the-facts-on-gender-affirming-care>

(3) reference ID: 4099980. (n.d.). Accessdata.fda.gov. Retrieved October 10, 2023, from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/020263s042lbl.pdf

(4) Gender-Affirming Care and Young People | HHS Office of Population Affairs. (n.d.). HHS Office of Population Affairs. Retrieved October 10, 2023, from <https://opa.hhs.gov/sites/default/files/2023-08/gender-affirming-care-young-people.pdf>

(5) Lashutka, N. (2023, May 24). *House Bill 68 Opponent Testimony before Ohio House Public Health Policy Committee*. Retrieved October 10, 2023 from https://search-prod.lis.state.oh.us/cm_pub_api/api/unwrap/general_assembly_135/chamber/135th_ga/ready_for_publication/committee_docs/cmte_h_pub_health_policy_1/testimony/cmte_h_pub_health_policy_1_2023-05-24-0930_557/hb68_lashutka_opponent.pdf

(6) Suicide Risk Reduces 73% in Transgender, Nonbinary Youths with Gender-Affirming Care. (2022, March 8). HCPLive. Retrieved October 10, 2023, from <https://www.hcplive.com/view/suicide-risk-reduces-73-transgender-nonbinary-youths-gender-affirming-care>

eliminating access to GAC for TGD youth, leaving an entire population of youth at risk.

All individuals deserve access to high-quality, person-centered, evidence-based healthcare. This care is especially essential to vulnerable populations like TGD youth who face high levels of discrimination, bullying, stigmatization, and even physical violence. Linked to this are disproportionate levels of depression, suicidality, and anxiety, as well as higher risks of substance abuse and eating disorders, for TGD youth (7). These disparities are not limited to youth and can continue well into adulthood, leaving an already vulnerable individual to face more debilitating symptoms. However, evidence shows that, transgender people who have access to GAC, specifically hormone treatment, as youth have better mental health outcomes, including fewer thoughts of suicide even into adulthood (8). These facts also emphasize why it is incredibly important for TGD youth to receive comprehensive mental health support.

While there are many misconceptions surrounding what GAC is, one of the most pervasive surrounds what constitutes gender affirming mental healthcare. Many seem to think that there is a specific intervention or modality that is used when working with TGD populations, when in reality, gender-affirming mental healthcare is simply person-centered care; meeting your client where they are and respecting their bodily autonomy and self-determination. Some examples of gender affirming mental health services include open-ended exploration of the client's feelings and experiences of gender identity and expression (without any outcomes regarding gender identity or expression being preferable to another by the clinician), using someone's chosen name and pronouns that align with their gender identity during sessions, providing community resource connections, and supporting clients as they navigate coming out to friends, family, at work or school, as they are ready to do so (9). These gender-affirming services in mental healthcare are built upon the client being the expert in their own life while the therapist takes a non-directive role. As with all mental healthcare, confidentiality and a trusting therapeutic relationship between the client and clinician is absolutely essential to positive clinical outcomes (10).

Mental health providers can also make a diagnosis of gender dysphoria if a client meets the diagnostic criteria outlined in the DSM-5-TR. Gender dysphoria is, according to the American Psychiatric Association, "a concept designated in the DSM-5-TR as clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics." Not all TGD individuals experience gender dysphoria, and these terms are not interchangeable. Gender dysphoria specifically refers to the psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity (11).

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- (7) Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Netw Open*. 2022;5(2):e220978. doi:10.1001/jamanetworkopen.2022.0978
- (8) Digitale, E. (2022, January 12). *Better mental health found among transgender people who started hormones as teens*. Stanford Medicine. Retrieved October 10, 2023, from <https://med.stanford.edu/news/all-news/2022/01/mental-health-hormone-treatment-transgender-people.html>
- (9) *Psychiatry.org - What is Gender Dysphoria?* (n.d.). American Psychiatric Association. Retrieved October 10, 2023, from <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>
- (10) Karver, M. S., De Nadai, A. S., Monahan, M., & Shirk, S. R. (2018). Meta-analysis of the prospective relation between alliance and outcome in child and adolescent psychotherapy. *Psychotherapy*, 55(4), 341–355. <https://doi.org/10.1037/pst0000176>
- (11) *Psychiatry.org - What is Gender Dysphoria?* (n.d.). American Psychiatric Association. Retrieved October 10, 2023, from <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

The only treatment for gender dysphoria is GAC, though what type of GAC services an individual receives varies based on their individual's needs. Attempts to force or convince a TGD individual to be cisgender are considered unethical and have been linked to adverse mental health outcomes (12).

Ohio House Bill 68, currently pending in the Ohio Senate Government Oversight Committee, has the potential to ban puberty blockers and hormone therapy, as well as place limitations on mental healthcare providers serving TGD youth. Additionally, there are currently no provisions of the introduced bill that state whether or not youth currently receiving medical services would be able to continue their care, leaving youth who are now receiving treatment in a precarious position. Such restrictions on evidence-based, medically necessary healthcare and mental healthcare will without a doubt have disastrous impacts on the health and wellbeing of TGD youth, their families, and their healthcare providers.

(12) Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, 77(1), 68-76.

CURRENT REGULATIONS FOR OHIO SOCIAL WORKERS

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Regulating Bodies

Social workers in Ohio are currently bound to follow an expansive set of laws and regulations laid out in the Ohio Revised Code, as well as adhere to a comprehensive Code of Ethics (13) (14). The social work licensing board, The Counselor, Social Worker and Marriage and Family Therapist (CSWMFT) Board, is responsible for enforcing such regulations. Violation of either the Code of Ethics or the laws and rules is subject to disciplinary action from the state licensing board. Both the regulations and code of ethics detail expectations and standards that a licensed social worker is expected to adhere to when working with all clients, including minors.

Treatment of Minors

Ohio Revised Code (ORC) 5122.04 currently states that minors aged 14 and up may receive up to six individual sessions or 30 days of sessions (whichever occurs sooner) with a mental health professional without their parents/guardians being informed that they are receiving services (15). After the 30 days or six sessions, services must either be terminated or parental consent must be received to continue services. This short window of time in which a teenager is allowed to seek services without parental consent can be crucial for teens that may be struggling with something in their home life and do not feel safe or ready to discuss it with their parents/guardians. It may also occur during instances in which a teen's parents/guardians are completely unavailable, and thus unable, to give consent. There are exceptions to this rule, including when a minor presents with intent to harm themselves or others, then notification will be given to the parents. Any minors under the age of 14 are not currently allowed to receive any mental health services without permission from their parents.

Consent

Regarding consent, social workers are obligated to receive informed consent from all clients (or parents/guardians if working with minors, except in the above scenario, in which consent is received from the teen for the short window of care). Section 4757-5-02(B) of the CSWMFT Laws and Rules states that social workers must inform clients of the services available to them, including the limits, rights, and obligations of these services, as well as costs, reasonable alternatives, and right to withdraw consent at any time. Any information provided must be in clear, understandable language and no services may be provided until valid consent is received. (16) To be clear, in current practice, consent to receive mental health services includes assessment, diagnosis, and treatment; explicit consent is not required for individual diagnoses.

At this time, consent is only needed from one parent/guardian for a minor to receive mental health services in typical outpatient settings. However, in hospital GAC clinics where medical care is also provided, consent from both parents/guardians is required prior to allowing any treatment, even mental healthcare.

(13) Chapter 4757 - Ohio Revised Code. (n.d.). Ohio Laws. Retrieved October 17, 2023, from <https://codes.ohio.gov/ohio-revised-code/chapter-4757>

(14) Code of Ethics: English. (n.d.). National Association of Social Workers. Retrieved October 17, 2023, from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>

(15) Section 5122.04 - Ohio Revised Code. (n.d.). Ohio Laws. Retrieved October 17, 2023, from <https://codes.ohio.gov/ohio-revised-code/section-5122.04>

(16) Chapter 4757 - Ohio Revised Code. (n.d.). Ohio Laws. Retrieved October 17, 2023, from <https://codes.ohio.gov/ohio-revised-code/chapter-4757>

Confidentiality

Social workers are obligated to adhere to strict confidentiality standards. The standards of practice and professional conduct (Section 4757-5-02(D) of the CSWMFT Laws and Rules) states that professionals have a primary obligation to protect a client's right to confidentiality. Information should only be shared with others when explicit consent from the individual is received. Exceptions exist for scenarios in which the client poses an imminent threat of harm to themselves or others, or in cases of abuse or neglect of children, adults with developmental disabilities, and older adults (17). While individuals under the age of 18 (with the exception of teens aged 14+ receiving temporary services without parental permission) do not share the same legal privileges of confidentiality, it is still best practice to keep as much information as possible as privileged communication between client and professional. Sharing information to third parties or even parents can at times be detrimental to the therapeutic relationship that has been established by the professional and client and will often lead to setbacks in clinical progress, jeopardize success, and even risk client safety.

Person-centered care

As social workers, we are members of a patient's Person (or Patient)-Centered Medical Home (PCMH), which is a healthcare delivery model that focuses on meeting an individual's physical and mental healthcare needs, including primary, acute, and chronic care conditions. The Person-Centered medical approach follows five key principles: personalized care, empathy, informed consent, continuity of care, and patients as partners (18). Personalized care means that providers should be looking and learning from the individual as a whole person, rather than simply a patient or client with medical or mental health concerns. Empathy means that the provider should be trying to see the situation from the individual's perspective in order to gain a better understanding of what the individual may be experiencing. Informed consent is a key piece of any care that should be voluntary, informed, and understood. A person should not be subject to any treatment or care without the individual having a thorough understanding of the processes they may be entering into and what treatment may look like for them individually. Informed consent is a great way to build and establish rapport and respect an individual's bodily autonomy.

Continuity of care refers to an individual's ability to see the same provider, continuing the existence of established rapport and trust that has been built. Lastly, including patients as partners in care enables individuals to make their own decisions about their care and enforce respect for the individual's bodily autonomy.

All of these principles of person-centered care are directly tied into the Code of Ethics that social workers are bound to follow.

Gender-affirming mental healthcare is nothing other than person-centered care. It is not a specific therapeutic intervention nor a clinical modality. It is nothing other than meeting a client where they are at, assessing current concerns, providing resources to address those concerns, and respecting the individual's own choices and bodily autonomy.

(17) *Chapter 4757 - Ohio Revised Code*. (n.d.). Ohio Laws. Retrieved October 17, 2023, from <https://codes.ohio.gov/ohio-revised-code/chapter-4757>

(18) *The 5 Key Principles Of Patient-Centred Practice*. (2022, December 9). The Medic Portal. Retrieved October 17, 2023, from <https://www.themedicportal.com/blog/the-5-key-principles-of-patient-centred-practice/>

HB 68: IMPLICATIONS FOR SOCIAL WORK PRACTICE AND THE BEHAVIORAL HEALTH WORKFORCE

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While the vast majority of the discussion around GAC in Ohio has centered on medicalized GAC, proposed bans on GAC for minors have also contained regulations for mental health care providers who work with TGD youth. Though these regulations may have been intended for mental healthcare providers working within GAC hospital clinics where medicalized GAC is provided, they would impact mental health professionals in all practice settings where youth are served.

Not only do bans on GAC tie the hands of mental healthcare providers by limiting the evidence-based medical treatment options that clients can be referred to, but by creating specific limitations for mental health care, they also impede upon the ethical care that mental health care providers can offer directly. Such regulations, if passed, create an ethical conflict for behavioral healthcare providers in which they may, in some cases, have to make the impossible decision between violating professional ethics and possibly putting a client at risk in order to follow this law, or violating this law in order to protect their clients and adhere to professional ethics. In such an impossible scenario, behavioral health providers are opened up to professional liability and risk which will impact not only individual providers but the entire workforce of youth behavioral health providers.

As introduced, the implication of HB 68 specifically on behavioral health practice with youth would have been catastrophic. Though the version of HB 68 passed by the House is less restrictive on mental health providers than the original version of HB 68, it still imposes regulations that are incompatible with ethical care and are detrimental to the behavioral health workforce.

Clinical Implications of HB 68

In the version of HB 68 passed by the House of Representatives, mental health professionals would be banned from diagnosing or treating “a minor individual who presents for the diagnosis or treatment of a gender-related condition without first obtaining the consent of each residential parent and legal custodian of the minor individual or of the minor individual's guardian.” It would also require mental health providers to screen minors who they have diagnosed and are treating for a “gender-related condition” for “both of the following during the course of diagnosis and treatment: (1) Other comorbidities that may be influencing the minor individual's gender-related condition, including depression, anxiety, attention deficit hyperactivity disorder, autism spectrum disorder, and other mental health conditions; (2) Physical, sexual, mental, and emotional abuse and other traumas” (19)

The second portion of the regulations regarding screening for comorbidities during the course of diagnosis and treatment is superfluous and does not change mental health practice due to the fact that mental health providers already screen for comorbidities throughout the course of diagnosis and treatment of all clients. However, it does imply falsely that the comorbidities listed “may be influencing the minor individual's gender-related condition,” an assumption that is unfounded by research. While there is a correlative relationship between some of these diagnoses and gender dysphoria, there is no evidence of a causational relationship (20).

(19) https://search-prod.lis.state.oh.us/solarapi/v1/general_assembly_135/bills/hb68/PH/02/hb68_02_PH?format=pdf

(20) Weisner, L. (2023, August 7). The Link Between Autism and Gender Diversity. Psychology Today. Retrieved October 2, 2023, from <https://www.psychologytoday.com/us/blog/the-venn-diagram-life/202307/the-link-between-autism-and-gender-diversity>

So what would HB 68 mean practically for mental health practice?

CHANGES TO INFORMED CONSENT PRACTICES

As outlined in the section overviewing current regulations for behavioral health providers working with minors, the Ohio Revised Code already requires parental consent for a counselor, social worker, or marriage and family therapist to take on a minor as a client. The only exception to this rule, outlined in section 5122.04 of the Revised Code, allows those 14 years and older to receive services for no more than 30 days or six sessions, whatever comes first (revisit the section of Current Regulations for examples of when such exceptions may be necessary). If HB 68 were to pass, minors who seek mental healthcare services for the diagnosis or treatment of a gender-related condition who are 14 years or older would not be able to take advantage of the 5122.04 exception, while those seeking treatment for any other reason would be able to.

Under HB 68, mental health professionals would be required to get parental consent from all custodial parents/guardians in order to **both** provide a diagnosis of gender dysphoria and to provide treatment, an entirely unprecedented practice requirement. When an adult client, or parent/legal guardian on behalf of a minor, consents to mental health services, they consent to receive assessment, diagnosis, and treatment in accordance with the provider's expertise, best practices, and professional ethics and regulations. Consent can be revoked at any time, however, explicit consent is not required for individual diagnoses; not in mental healthcare nor in medical care of any kind. Mental health diagnoses are based on careful assessment of a client's symptoms, history, behaviors, etc. by highly trained professionals, not what a client or client's parents/guardian wants the diagnosis to be or not be. **HB 68 fundamentally changes the way mental health practice occurs by interfering with providers' ability to practice competently by diagnosing in accordance with evidence-based standards of practice and training.**

Within hospital GAC clinics where medicalized GAC is provided, explicit consent from all custodial parents/guardians is already a requirement. HB 68 would also make it a requirement for all custodial parents/guardians to provide consent for youth to access mental healthcare services for the diagnosis or treatment of "gender-related conditions" in settings outside of hospital GAC clinics, such as a regular outpatient therapy office, even if the minor has no wish to pursue medical interventions. This again creates one set of rules for cisgender youth, and a different set of rules for TGD youth. This could lead to fewer youth being able to access critical mental health services if they have one parent/guardian who is unsupportive of their identity or are not ready to share their identity with their parents/guardians.

CONFIDENTIALITY

One of the key factors in an effective therapeutic relationship is trust between a client and the clinician. Thus for therapy to be successful with clients of any age, it is essential that confidentiality be maintained to the furthest extent possible. Exceptions do exist for when a client poses an imminent danger to themselves or others, or when a child, elder, or dependent adult is being abused. If a minor client who is working with a mental health provider discloses that they are TGD or is exploring/questioning their gender identity, it is essential that the clinician be able to maintain a safe, supportive, and confidential environment as the client processes and explores their gender identity. HB 68 could result in a scenario where a clinician is compelled to disclose to a minor's parent or guardian the minors' questioning or gender identity before the minor is ready or safe to do so, in order to continue offering services. Such breaches in confidentiality will interrupt successful clinical processes which rely heavily on trust and rapport and will dissuade youth from seeking essential mental health services. Even more critically, it could put the safety of clients in jeopardy. Studies find that LGBTQ youth are 120% more likely to experience homelessness, with the leading cause of homelessness among LGBTQ youth being family rejection based on their sexual orientation, gender identity, and gender expression. Transgender youth experience family rejection at even higher rates (21).

(21) Morton, M. H., Samuels, G. M., Dworsky, A., & Patel, S. (2018). Missed opportunities: LGBTQ youth homelessness in America.

HB 68: IMPLICATIONS FOR SOCIAL WORK PRACTICE AND THE BEHAVIORAL HEALTH WORKFORCE

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NON-DISCRIMINATION

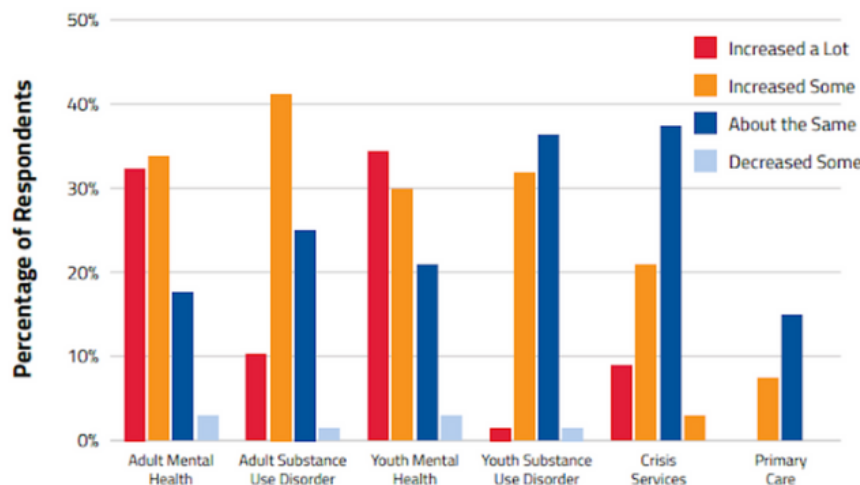
All together HB 68's regulations on mental health practice create a different set of rules for working with TGD youth than their cisgender peers, which is in direct violation of mental health practitioners' non-discrimination statute (22).

WORKFORCE IMPLICATIONS OF HB 68

Ohio is already in the midst of a behavioral health workforce crisis. Demand for behavioral health and human services is at an all-time high in the state; surpassing the current available workforce. According to 2021 reports from the Ohio Department of Mental Health and Addiction Services, demand for these services increased by 353% between 2013-2019 while the available workforce only increased by 174% in the same time period (23). In the past four years since the data was reported, the issues have only increased due to the substance abuse crises and the COVID-19 pandemic. High demands and a limited workforce have resulted in dramatically increased wait times for behavioral health services, particularly for youth mental health services. When patients are unable to receive access to timely and appropriate care, symptoms often worsen, putting Ohioans at risk of negative long term outcomes such as increased substance abuse and suicidality. With 50% of all lifetime mental health disorders beginning by age of fourteen, it is essential that youth in Ohio have access to high quality early intervention services, without which the need for routine outpatient care can quickly escalate into a need for crisis intervention or inpatient services (25). Not only do delays in services impact youths' recovery and long-term wellbeing, it also impacts the whole family. A recent study from Nationwide Children's Hospital revealed that 53% of working parents have missed work at least once per month to deal with their children's mental health (26). **Put simply, a healthy behavioral health workforce is essential to a healthy future for Ohioans.**

Reported Changes to Behavioral Health Wait Times (August to October 2021)

(As percentages of responses from 68 Ohio behavioral health agencies, excluding N/A and Unknown responses)



(22) Social Workers' Ethical Responsibilities as Professionals. (n.d.). National Association of Social Workers. Retrieved October 17, 2023, from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English/Social-Workers-Ethical-Responsibilities-as-Professionals>

(23) Ohio Department of Mental Health and Addiction Services, Understanding supply and demand within Ohio's behavioral health system: Analysis of behavioral health demand across the state of Ohio. (April 2021), available at <https://data.ohio.gov/wps/portal/gov/data/projects/03-mhas-workforce>

(24) Ohio's Behavioral Health Workforce Crisis. (2022, February 16). Ohio Council. Retrieved October 17, 2023, from https://www.theohiocouncil.org/assets/BreakingPoint/TheOhioCouncil_Whitepaper_BreakingPoint.pdf

(25) Lipari, R. N., Hedden, S., Blau, G., & Rubenstein, L. (n.d.). Adolescent Mental Health Service Use And Reasons For Using Services In Specialty, Educational, And General Medical Settings. https://www.samhsa.gov/data/sites/default/files/report_1973/ShortReport-1973.html#:~:text=Half%20of%20all%20lifetime%20cases,that%20result%20in%20severe%20impairment.&text=Although%20many%20disorders%20can%20be,receive%20any%20mental%20health%20services.

(26) The Great Collide: The Impact of Children's Mental Health On the Workforce. (2022, February 22). Nationwide Children's Hospital. Retrieved October 17, 2023, from https://www.nationwidechildrens.org/newsroom/news-releases/2022/02/oos_the-great-collide

HB 68: IMPLICATIONS FOR SOCIAL WORK PRACTICE AND THE BEHAVIORAL HEALTH WORKFORCE

18

Proposed legislation such as HB 68, which politicizes behavioral health practice and burdens practitioners with superfluous regulations, directly impacts the current workforce crisis. While the behavioral health field can be deeply rewarding, providers also face a host of challenges. The work is emotionally taxing and stressful, many providers work non-traditional hours and remain on call in case of emergencies, and despite being highly educated behavioral health providers are often undervalued and under-compensated. Given these challenges, it is no wonder why rates of burnout are so high. In addition to this, providers who work with minors already must navigate a higher level of regulation and have a higher risk of liability, especially when navigating complicated custody arrangements. HB 68, and other bills that interfere with the ethical practice of behavioral health providers, will only increase the burden on youth serving behavioral health providers.

If HB 68 were to pass, providers would have to navigate a law which conflicts with professional ethics, best practice, non-discrimination policies, and, in some circumstances, the very safety of their minor clients. HB 68 will increase moral injury and burnout among behavioral health providers, further exacerbating the behavioral health workforce crisis. It is not unlikely that providers will stop taking on youth as clients to avoid the increased risk of disciplinary action for simply practicing in accordance with their ethics. This is not just a hypothetical, it has been demonstrated in other states. For example, in early 2022, Texas Governor Greg Abbott imposed an order that directed the Department of Family and Protective Services to investigate parents of transgender youth for child abuse which led to the resignation of DFPS social workers (27). Ohio cannot afford to further risk the wellbeing of our essential behavioral health workforce, especially for our youth - the future of Ohio. All Ohio youth deserve access to high quality, ethical, and timely mental health support services and Ohio behavioral health professionals deserve to be able to do their jobs in alignment with professional ethics and best practices, without superfluous regulations and excessive threats to their professional licensure and livelihood.

(27) Klibanoff, E. (2022, April 11). Distraught over orders to investigate trans kids' families, Texas child welfare workers are resigning. The Texas Tribune. <https://www.texastribune.org/2022/04/11/texas-trans-child-abuse-investigations/>

COMMON MISCONCEPTIONS/ MISINFORMATION ABOUT GENDER-AFFIRMING CARE

19

Myth: Gender-affirming care is only for transgender people

Fact: Gender-affirming care is for everyone, regardless of sexual orientation or gender identity

There are many services, whether mental or medical, that are used to affirm one's gender or to make someone feel more at home in their body. Common examples of this include breast augmentation (typically breast implants for transwomen, mastectomies for transmen, gynecomastia surgeries for ciswomen, and breast implants, lifts, or other augmentations for ciswomen), hair removal (laser or electrolysis on any part of the body), voice therapy (used by anyone, particularly singers or voice actors to change pitch or tone of their voice), and hormone therapy (HRT for trans and gender-diverse individuals, testosterone therapies for ciswomen with low T, or hormones for ciswomen with endometriosis or PCOS).

Myth: Kids are too young to understand their gender

Fact: Kids start to recognize gender and sex as young as 2-3 years old

Studies have shown that children are able to recognize and label sex groups by ages 2-3 (28) (29). Around age 4, children start to recognize that genitals are markers of biological gender; by age 6, the idea of gender is heavily influenced by clothing and hair, and by age 7, they can recognize biological sex as independent of external appearance. For most children, by age 7 they can understand three different concepts related to sex and gender: biological sex, self-perceived gender identity, and social gender identity, though some youth are able to develop a self-perceived gender identity as young as ages 3-4 (30). One study of 155 transwomen and 55 transmen found that 73% of the transwomen and 78% of the transmen began experiencing gender dysphoria by age 7 (31).

(28) *Children and gender identity: Supporting your child*. (2022, October 1). Mayo Clinic. Retrieved October 18, 2023, from <https://www.mayoclinic.org/healthy-lifestyle/childrens-health/in-depth/children-and-gender-identity/art-20266811>

(29) Miller, C. (2023, October 13). Transgender Kids and Gender Dysphoria. Child Mind Institute. Retrieved October 18, 2023, from <https://childmind.org/article/transgender-teens-gender-dysphoria/>

(30) Graham, P. (n.d.). *Transgender children and young people: how the evidence can point the way forward*. NCBI. Retrieved October 18, 2023, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10063975/>

(31) Most Gender Dysphoria Established by Age 7, Study Finds. (2020, June 16). Cedars-Sinai. Retrieved October 18, 2023, from <https://www.cedars-sinai.org/newsroom/most-gender-dysphoria-established-by-age-7-study-finds/>

Myth: People often regret their medical transition

Fact: Transition regret and de-transition rates are low; lower than regret rates of other common medical treatments

Historical data suggest that regret for gender transition in adults is rare (typically reported as <1%-10%), though less studies have been conducted on regret rates for youth. One study, conducted in 2022 with 317 youth with a mean age of 8, showed that after 5 years of their transition, only 2.5% of participants had changed their identity from transgender to cisgender (32). The remaining 97.5% maintained either a binary transgender identity or an identity of non-binary. Studies have shown that the regret rate of total knee replacements ranges from 18-22% and regret rates for aesthetic plastic surgery are as high as 60% (33) (34).

Myth: Doctors and other providers push youth and their families to start transition care

Fact: Ohio parents have denied any pressure from providers to medically transition their child

Throughout the testimony of HB 68 in the House Public Health Policy Committee, multiple parents of transgender youth shared their stories with legislators. Each parent that shared their story was asked a follow up question by committee members: “did you ever feel pressured by healthcare providers, clinic staff to choose a certain course of care for your [child]?” (35). Each parent responded that no, they did not. The Nationwide Children’s Hospital THRIVE Gender Development Program also clearly states on their website and in testimonies that they require consent from both parents prior to even engaging a youth in behavioral healthcare and requires multiple sessions with a therapist before discussion of progressing to hormone therapy or puberty blockers (36). At this time, there is only one published article relating to pressure from medical providers to medically transition youth, in which only 390 parents of the 1655 youth being studied (23.6%) answered the question of whether or not they felt pressure from a gender clinic. This study has since been retracted due to concerns of its methodology and lack of documented consent by study participants (37). Tech company Komodo Health Inc also analyzed a database of insurance claims in the United States from 2017-2021 and of the 121,882 youth ages 6-7 that received a gender dysphoria diagnosis, only 17,683, or 14.5%, even went on to receive puberty-blockers or hormone therapy in that five-year period (*this does not necessarily mean that these youth de-transitioned or were misdiagnosed with gender dysphoria, but could also simply mean that many youth decided hormones were not necessary for them at the time or the parents did not consent to the youth receiving treatment; the children in the study were not followed [only insurance claims reviewed] so we do not have a definitive answer to this question*) (38).

(32) Kristina R. Olson, PhD; Lily Durwood, PhD; Rachel Horton, BS; Natalie M. Gallagher, PhD; Aaron Devor, PhD. *Pediatrics* (2022) 150 (2): e2021056082. <https://doi.org/10.1542/peds.2021-056082>

(33) Mahdi A, Svantesson M, Wretenberg P, Hälleberg-Nyman M. Patients' experiences of discontentment one year after total knee arthroplasty- a qualitative study. *BMC Musculoskelet Disord*. 2020 Jan 14;21(1):29. doi: 10.1186/s12891-020-3041-y. PMID: 31937282; PMCID: PMC6961288

(34) Jones HE, Cruz C, Stewart C, Losken A. Decision Regret in Plastic Surgery: A Summary. *Plast Reconstr Surg Glob Open*. 2023 Jun 27;11(6):e5098. doi: 10.1097/GOX.0000000000005098. PMID: 37383479; PMCID: PMC10299769.

(35) <https://ohiochannel.org/video/ohio-house-public-health-policy-committee-5-24-2023>

(36) Gender Development Program. (n.d.). Nationwide Children's Hospital. Retrieved October 18, 2023, from <https://www.nationwidechildrens.org/specialties/thrive-program/gender-development>

(37) Diaz, S., Bailey, J.M. RETRACTED ARTICLE: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Arch Sex Behav* 52, 1031–1043 (2023). <https://doi.org/10.1007/s10508-023-02576-9>

(38) Terhune, C., Respaut, R., & Conlin, M. (2022, October 6). As children line up at gender clinics, families confront many unknowns. Reuters. Retrieved October 18, 2023, from <https://www.reuters.com/investigates/special-report/usa-transyouth-care/>

Myth: Children are being subject to invasive surgeries

Fact: Youth in Ohio are not obtaining surgical interventions through gender clinics

Ohio Children's Hospital Association, Cincinnati Children's Hospital, Nationwide Children's Hospital, and Cleveland Clinic Children's all publicly testified that none of their hospitals or any hospitals in Ohio are performing surgical interventions on minors for the purposes of GAC (39) (40) (41) (42). The Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 even states that less-complex surgical interventions, such as chest surgery and vaginoplasty (bottom surgery for transfemales) could be performed with teenagers, but they feel it is best left to various comprehensive assessments and list of criteria in individual cases and does not recommend more-complex surgical interventions, such as phalloplasty (bottom surgery for transmales), be completed before age 18 (43).

Myth: Being transgender is a mental illness or is caused by a mental disorder

Fact: Many organizations (including the American Psychiatric Association and the World Health Organization) have publicly stated that being transgender is not a mental health disorder.

Being transgender is not in and of itself a mental health disorder. Many transgender people do receive a diagnosis of gender dysphoria, however, which is according to the American Psychiatric Association, "a concept designated in the DSM-5-TR as clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics." Not all TGD individuals experience gender dysphoria, and these terms are not interchangeable. Gender dysphoria specifically refers to the psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity (45). As previously mentioned, gender dysphoria is a diagnosis that insurance companies mandate be present for any medical care to be received under their coverage. Additionally, many people who identify as transgender experience high rates of depression, anxiety, and suicidal ideation. This is often explained by higher rates of unemployment (often due to discrimination in hiring), high rates of bullying and physical assault, and institutional discrimination (including denial of healthcare) (46) (47) (48) (49) (50).

(39) <https://www.legislature.ohio.gov/legislation/135/hb68/committee> (May 24, 2023; Nick Lashutka)

(40) <https://www.legislature.ohio.gov/legislation/135/hb68/committee> (May 24, 2023; Patty Manning-Courtney)

(41) <https://www.legislature.ohio.gov/legislation/135/hb68/committee> (May 24, 2023; David Axelson)

(42) <https://www.legislature.ohio.gov/legislation/135/hb68/committee> (May 24, 2023; Vanessa Jensen)

(43) Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, version 8. *Int J Transgend Health*. 2022;23(sup1):S1–S259. doi:10.1080/26895269.2022.2100644

(44) Moving one step closer to better health and rights for transgender people. (2019, May 17). World Health Organization (WHO). Retrieved October 18, 2023, from <https://www.who.int/europe/news/item/17-05-2019-moving-one-step-closer-to-better-health-and-rights-for-transgender-people>

(45) Psychiatry.org - What is Gender Dysphoria? (n.d.). American Psychiatric Association. Retrieved October 10, 2023, from <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>

(46) Documented Evidence of Employment Discrimination & Its Effects on LGBT People. (n.d.). Williams Institute. Retrieved October 18, 2023, from <https://williamsinstitute.law.ucla.edu/publications/employ-discrim-effect-lgbt-people/>

(47) Adam, B. (n.d.). Bias in the Workplace: Consistent Evidence of Sexual Orientation and Gender Identity Discrimination 1998â-fi2008. Scholarly Commons @ IIT Chicago-Kent College of Law. Retrieved October 18, 2023, from <https://scholarship.kentlaw.iit.edu/cgi/viewcontent.cgi?article=3705&context=cclawreview>

(48) Earnshaw VA, Bogart LM, Poteat VP, Reisner SL, Schuster MA. Bullying Among Lesbian, Gay, Bisexual, and Transgender Youth. *Pediatr Clin North Am*. 2016 Dec;63(6):999-1010. doi: 10.1016/j.pcl.2016.07.004. PMID: 27865341; PMCID: PMC8941671.

(49) Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Violent Behavior*, 14(3), 170–179. <https://doi.org/10.1016/j.avb.2009.01.006>

(50) Bakko, M., Kattari, S.K. Transgender-Related Insurance Denials as Barriers to Transgender Healthcare: Differences in Experience by Insurance Type. *J GEN INTERN MED* 35, 1693–1700 (2020). <https://doi.org/10.1007/s11606-020-05724-2>

Myth: Being transgender is a trend, which is leading to more youth to identify as trans

Fact: Rapid Onset Gender Dysphoria is a debunked theory and rates of transgender youth have not skyrocketed

While there are more people, youth including, identifying as transgender/non-binary/gender-diverse, that does not mean that it is a trend or that it is influenced by peers or the internet. In 2018, a study was published that claimed something called “Rapid Onset Gender Dysphoria” (ROGD) might occur in youth due to social influence from peers, social media use, and limited coping mechanisms to deal with emotions. A year after publication, the author of the study issued a reassessment and stated that “ROGD is currently not a formal mental health diagnosis; the study consists of observations from parents, which only creates a hypothesis; the study does not validate the hypothesis, as it includes no data from adolescents or young adults with gender dysphoria or clinicians; researchers require further evidence from adolescents or young adults and experts in gender dysphoria before using the term ROGD in any descriptive, clinical, or diagnostic way; the original paper was a descriptive study, meaning it was an initial inquiry into a research area to develop a hypothesis and requires further research; limitations of the study include potential parental biases, a lack of knowledge of certain information among parents, and selection bias through recruiting from a small, self-selected population” (51). The American Psychological Association and 61 other healthcare provider organizations issued a letter in 2021 formally denouncing the validity of ROGD as a clinical diagnosis (52). A study published in 2022 found that the percentage of teens openly identifying as transgender or gender diverse did not increase between 2017-2019, and actually fell from 2.4% in 2017 to 1.6% in 2019 (53). Any perceived increase in trans-identities or any increases since the 2019 study, could perhaps in part be explained by more public awareness of transgender and queer issues and more positive portrayals and representation in the media.

Myth: It is too easy for people to receive gender-transition care

Fact: Gender-affirming care, particularly surgical care, has many barriers to access

Gender-affirming care has many barriers in place that transgender people must navigate, particularly when it comes to surgical interventions. For youth in Ohio visiting gender clinics, consent is needed from both parents prior to scheduling an appointment with a behavioral health provider/therapist and then potentially waiting months to get through the waitlist. Once seen by a therapist for multiple sessions, you can schedule with a doctor to begin discussing puberty blockers or hormone therapy (54). For adults, much of this same process applies. Generally, for many insurance companies to approve coverage for care, they require a consultation and letter of recommendation from a mental health provider to begin hormone treatment. Should the adult individual wish to continue with surgical interventions, many medical providers recommend being on hormones for at least one year prior to obtaining top surgery, which requires another letter of recommendation for insurance coverage. For bottom surgery, an additional two letters of recommendation are needed from either two different mental health providers or a mental health provider and a medical health provider. WPATH guidelines recommend at least two years on hormones prior to any bottom surgery being provided (55). This all assumes that the individual even has adequate insurance coverage that includes transgender medical care and that they are able to find providers to accept their insurance and provider services (56).

(51) Kuehnle, F., & Sissons, B. (2022, December 20). *Rapid onset gender dysphoria: What to know*. Medical News Today. Retrieved October 18, 2023, from <https://www.medicalnewstoday.com/articles/what-is-rapid-onset-gender-dysphoria#is-it-real>

(52) ROGD Statement — Coalition for the Advancement & Application of Psychological Science. (2021, July 26). Coalition for the Advancement & Application of Psychological Science. Retrieved October 18, 2023, from <https://www.caaps.co/rogd-statement>

(53) Turban, J. L., Dolotina, B., King, D., & Keuroghlian, A. S. (2022, September). Sex Assigned at Birth Ratio Among Transgender and Gender Diverse Adolescents in the United States. *American Academy of Pediatrics*, 150(3). <https://doi.org/10.1542/peds.2022-056567>

(54) Gender Development Program. (n.d.). Nationwide Children's Hospital. Retrieved October 18, 2023, from <https://www.nationwidechildrens.org/specialties/thrive-program/gender-development>

(55) Coleman E, Radix AE, Bouman WP, et al. Standards of care for the health of transgender and gender diverse people, version 8. *Int J Transgend Health*. 2022;23(sup1):S1–S259. doi:10.1080/26895269.2022.2100644

(56) Bakko, M., Kattari, S.K. Transgender-Related Insurance Denials as Barriers to Transgender Healthcare: Differences in Experience by Insurance Type. *J GEN INTERN MED* 35, 1693–1700 (2020). <https://doi.org/10.1007/s11606-020-05724-2>

Myth: Banning gender-affirming services will protect youth

Fact: Gender-affirming care bans have shown they harm not only youth, but also adults

Bans on access to gender-affirming care impact both the physical health and mental health of transgender and gender-diverse people. HB 68 as written provides no guidance on what would happen to youth who are currently receiving puberty-blockers or hormone replacement therapy, implying that youth currently receiving care would need to immediately stop therapies. Abruptly stopping hormone treatments can lead to physical withdrawal symptoms including cravings, anxiety, depression, headaches, weight fluctuation, brain fog, temperature sensitivity, changes in sleep patterns, and loss of strength and energy (57) (58). Moreover, these bans affect the mental health of all trans-identifying people. A study of medical providers reported that they overwhelmingly oppose gender-affirming bans for youth due to fear of worsening mental health and increased suicide risk for youth. A study of parents of transgender and gender diverse youth also relayed that the impact of bills like these present reoccurring themes of increased depression and suicidal ideation, anxiety, increased gender dysphoria, decreased safety and increased stigma and lack of access to medical care in their children (60). A 2023 survey of over 14,000 adults found that bans on GAC made them feel less safe (79.1% of LGBTQ+ adults overall, 94% of trans and non-binary adults), impact their or their loved ones' physical or mental health (42.9% of LGBTQ+ adults overall, 80.1% of trans and non-binary adults), and worsened harmful discrimination and stigma against the LGBTQ+ community as a whole (80.5% of LGBTQ+ adults overall, 89.7% of trans and non-binary adults). Over half (52.7%) of the trans and non-binary adults surveyed stated that they would move or had already moved from a state that passed or enacted a GAC ban (61).

((57) Staller, B. (2019, March 7). Testosterone Withdrawal | Testosterone Withdrawal Symptoms & Effects. Renew Vitality. Retrieved October 18, 2023, from <https://www.vitalityhrt.com/blog/testosterone-withdrawal/>

(58) What Happens When You Stop HRT Abruptly? (n.d.). Defy Medical. Retrieved October 18, 2023, from <https://www.defymedical.com/blog/what-happens-when-you-stop-hrt-abruptly/>

(59) Hughes LD, Kidd KM, Gamarel KE, Operario D, Dowshen N. "These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents. *J Adolesc Health*. 2021 Dec;69(6):976-982. doi: 10.1016/j.jadohealth.2021.08.020. Epub 2021 Oct 7. PMID: 34627657; PMCID: PMC9131701.

(60) Abreu, R. L., Sostre, J. P., Gonzalez, K. A., Lockett, G. M., Matsuno, E., & Mosley, D. V. (2022, March 24). Impact of Gender-Affirming Care Bans on Transgender and Gender Diverse Youth: Parental Figures' Perspective. *Journal of Family Psychology*. Advance online publication. <http://dx.doi.org/10.1037/fam0000987>

(61) BANS ON LGBTQ+ ADULTS. (2023, August 15). Amazon AWS. Retrieved October 18, 2023, from <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/GAC-Ban-Memo-Final.pdf>

HOW TO ANALYZE RESEARCH

24

Throughout various discussions of GAC, there are often instances in which research studies have been misinterpreted and/or used out of context. Critiquing and evaluating research is an invaluable step in the process to determine if information being presented is accurate, applicable, and up to date. Research articles can at times be confusing and overwhelming; this aims to be a guide to break down the process of research review.

It is important to look at pieces of research from an impersonal lens, to be able to better evaluate the strengths, limitations, findings, credibility, and applicability. Ryan-Wegner proposes that critiquing tools can be divided into two categories: credibility variables and integrity variables (62). Credibility variables focus on how believable the research work appears to be and hone in on the researcher's qualifications to conduct and present the study. Integrity variables concentrate on the strength of the research methods. The below table includes a list of questions to ask when reading research to help determine believability of research.

Credibility Variables – Elements influencing the believability of the research	
Elements	Questions
Writing Style	Is the report well-written (concise, grammatically correct, avoids jargon, well-laid out and organized)?
Author	Do the researcher(s)' qualifications indicate a degree of knowledge in this particular field?
Report Title	Is the title clear, accurate, and unambiguous?
Abstract	Does the abstract provide a clear overview of the study (problem, sample, methodology, findings, recommendations)?

(62) Ryan-Wenger NM. Guidelines for critique of a research report. Heart Lung. 1992 Jul-Aug;21(4):394-401. PMID: 1629010.

The following table can be used in order to help discern the integrity of quantitative (set of strategies, techniques and assumptions used to study psychological, social and economic processes through the exploration of numeric patterns) styles of research (63).

Integrity Variables - Elements influencing the strength of the research – For Quantitative Studies (64)	
Elements	Questions
Purpose/ Problem	Is the purpose of the study clearly identified?
Logical Consistency	Does the report follow research steps in a logical manner? Are the links clear?
Literature review	Is the review organized logically? Does it provide a balanced analysis? Is most of the literature recent? Is it mainly from primary sources?
Aims/ Objectives	Have aims and objectives/research question/hypothesis been identified? Are aims clearly stated? Do they reflect information presented in the literature review?
Ethical Considerations	Were participants fully informed about the nature of the research? Was autonomy and confidentiality guaranteed? Were participants protected from harm?
Operational Definitions	Are all terms/theories/concepts mentioned clearly defined?
Methodology	Is the research design clearly identified? Has the data-gathering instrument been clearly defined? Is the instrument appropriate? How was it developed? Was a pilot study done?
Data Analysis/ Results	What type of data/statistical analysis was undertaken? Was it appropriate? How many of the sample participated?
Discussion	Are findings linked back to the literature review? If a hypothesis was identified, was it supported? Were strengths and limitations discussed? Was a recommendation for further research made?
References	Were all books/journals/other media accurately referenced?

(63) Quantitative and Qualitative Research: What is Quantitative Research? (2023, October 12). Subject and Course Guides. Retrieved October 18, 2023, from https://libguides.uta.edu/quantitative_and_qualitative_research/quant

(64) Michael Coughlan, P. C. (2007). Step-by-step guide to critiquing research. Part 1: quantitative research. British Journal of Nursing, 16(11).

The following table provides questions to ask when critiquing qualitative (process of naturalistic inquiry that seeks an in-depth understanding of social phenomena within their natural setting; focuses on the "why" rather than the "what") styles of research (65).

Integrity Variables - Elements influencing the strength of the research – For Qualitative Studies (66)	
Elements	Questions
Statement of the Phenomenon of Interest	Is the phenomenon to be studied clearly identified? Are the phenomenon of interest and the research question consistent?
Purpose/ Significance	Is the purpose of the study/research questions clearly identified?
Literature review	Has a literature review been undertaken? Does it fulfill its objectives?
Theoretical Framework	Has a conceptual framework been identified? Is it accurately described and appropriate?
Method and Philosophical Underpinnings	Has the philosophical approach been identified? Why was this approach chosen? Have the philosophical underpinnings been explained?
Sample	Has the sampling method and size been identified? Are they appropriate? Were the participants suitable for informing this research?
Ethical Considerations	Were participants fully informed about the nature of the research? Was autonomy and confidentiality guaranteed? Were the participants protected from harm?
Data Analysis/ Results	Are the data collection strategies described? Are the strategies used to analyze the data described? Did the researchers follow the steps of the data analysis method identified?
Rigor	Does the researcher discuss how rigor was assured? Were credibility/dependability/transferability/goodness discussed?
Findings/ Discussion	Are the findings presented appropriately? Has the report been placed in the context of what was already known of the phenomenon? Has the original purpose of the study been adequately addressed?
Conclusions/ Implications and Recommendations	Are the importance and implications of the findings identified? Are recommendations made to suggest further research?

(65) Quantitative and Qualitative Research: What is Qualitative Research? (2023, October 12). Subject and Course Guides. Retrieved October 18, 2023, from https://libguides.uta.edu/quantitative_and_qualitative_research/qual

(66) Frances Ryan, M. C. (2007). Step-by-step guide to critiquing research. Part 2: qualitative research. British Journal of Nursing, 16(12).

GENDER-AFFIRMING CARE BANS IN OTHER STATES

27

Disclaimer: This section includes information that is rapidly changing due to numerous court decisions in play. This information is up to date as of October 23, 2023.

Ohio is not the first state to introduce a ban on GAC. There are currently 22 states who have passed legislation to ban some aspects of GAC. Of these 22 states, seven have current injunctions in place preventing the ban from going into effect. These injunctions are based on substantive due process claims, equal protection claims, First Amendment claims, and right of occupational freedom claims. Another 14 states have shield laws in place to legally protect access to GAC.

Successful injunctions based on due process claims have stated that the ban would violate the parent's right to direct the medical care of their child under the 14th amendment, subject to medically accepted standards. Parents have a right to seek medical treatment for their children and make judgments that care is medically necessary for their child.

Successful injunctions based on equal protections claims state that bans discriminate against sex, continuing that the acts constitute sex-based classifications and place a special burden onto TGD minors simply because of their gender identity. Under HB 68, the same/similar treatments would remain available to cisgender youth, but would be banned for TGD youth.

Successful injunctions based on First Amendments claims stated that the bans/acts would restrict speech, such as ability to conduct referrals for care. HB 68 would also restrict speech of mental health providers, as they would be unable to conduct care as laid out by their profession's ethical standards without changing the current laws for how youth are able to be seen. HB 68 features a "carve out" for physicians and their speech, but does not provide the same carve out for mental health professionals.

States with Bans in Effect: Arizona, Idaho (takes effect 2024), Iowa, Kentucky, Louisiana (takes effect 2024), Mississippi, Missouri, Nebraska, North Carolina, North Dakota, South Dakota, Tennessee, Texas, Utah, West Virginia (takes effect 2024)

States with Injunctions: Alabama, Arkansas, Florida, Georgia, Indiana, Montana, Oklahoma (injunction agreement in place)

States with Shield Laws: California, Colorado, Connecticut, D.C., Illinois, Maryland, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon, Vermont, Washington



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