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Of Behavioral Health & Family Services Providers

New Parental Consent Requirement for Mental Health Services Tied to Gender-Related Conditions

We have received a number of questions regarding compliance with the new parental consent requirement under HB 68, Ohio's ban on certain gender transition services for minors, as related to the mental health diagnosis and/or treatment of a "minor who presents for the diagnosis or treatment of a gender-related condition."[1] We seek to provide some clarity here on compliance with HB 68.

As an initial matter, precisely what the General Assembly intended by the language "presents for" is unclear, and it may have different meanings for individual practitioners. By way of a few examples only, a patient may clearly, from the outset, seek and require treatment for gender dysphoria, in which case they have, under any reasonable reading of the law, presented for the treatment of a gender-related condition, thus triggering the parental consent requirement under the law. In other instances, however, a patient may first appear for initial treatment of anxiety or depression, but then later meet criteria for a diagnosis of and treatment for gender dysphoria, in which case it may be argued that this patient did not present for diagnosis and treatment of a gender-related condition and, thus, special consent may not be required. We believe that the General Assembly intended for the law to apply in every instance when a minor requires a diagnosis of and/or treatment for a gender-related condition—regardless of when the gender-related is identified and/or treated.

Provided below are three potential approaches to obtaining required parental consent for the diagnosis of and/or treatment for a gender-related condition under HB 68. Each approach rests on the premise that the law requires parental consent *before* a mental health professional may diagnose and/or treat a gender-related condition. We also address how the different approaches might be applied in various clinical contexts, and how they might be viewed by regulators, including the Ohio Attorney General (OAG). We acknowledge concerns that HB 68 may force some providers and practitioners to take steps in the treatment and documentation of gender-affirming care that they believe run counter to their own best practices, to their individual, independent clinical judgment, and/or even to the ethics of their respective professions. Each provider or practitioner, as applicable, will have to decide which approach to parental consent—whether that be one of the approaches prescribed below, or some other approach—best suits their specific circumstances. Practitioners employed by or under contract with a hospital, community mental health agency, or other provider of mental health services should ensure a coordinated compliance effort with the applicable provider on selected approach and implementation.

HB 68 Parental Consent Requirements

HB 68, codified at Section 3129.03 of the Ohio Revised Code, provides as follows:

> (A) Notwithstanding section 5122.04 of the Revised Code, no mental health professional shall diagnose or treat a minor individual who presents for the diagnosis or treatment of a gender-related condition without first obtaining the consent of one of the following:

[1] Ohio Revised Code § 3129.03(A) (emphasis added).

(1) At least one parent of the minor individual;

(2) At least one legal custodian of the minor individual;

(3) The minor individual's guardian.

(B) No mental health professional shall diagnose or treat a minor individual who presents for the diagnosis or treatment of a gender-related condition without screening the minor individual 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.

As noted, the statute, when read in whole, and in consideration of its seemingly clear purpose to limit gender transition services, prohibits a mental health professional from diagnosing or treating a minor for gender-related mental health issues without ***first*** obtaining parental or guardian consent. Here are three choices for obtaining the required, prior consent of a parent or guardian, ranging from what might be termed the most general, to the most specific. While the more general approaches may provide greater clinical latitude in providing treatment, they are likely to provide lesser protections against potential enforcement actions or complaints from parents or guardians regarding alleged violations of the statute.

Approach #1: One Broad, General Consent

The first and most general approach would be for the provider or practitioner to rely upon a general form of consent for treatment like those already used by most practices. Such consent forms typically include broad language like the following:

> *I hereby give consent for ABC Counseling Services to provide mental health treatment services to my minor child, including individual counseling, group counseling, crisis intervention, referral assistance or consultation depending on my minor child's particular needs or presenting concerns.*

While this approach provides the treating provider or practitioner with the freedom to approach the diagnosis of and/or treatment for a gender-related condition in the same way they would address any other mental health diagnosis and treatment, **we do not believe this approach meets the requirements of the statute**. The statute would appear on its face and, in light of its purpose to limit care, to require specific consent for the diagnosis of and/or treatment for a gender-related condition. To successfully defend the use of such a general consent form, a provider may have to ultimately persuade a court that the statutory consent requirement is itself unenforceable—a risky and potentially expensive proposition.

Approach #2: One General Consent Form With A Callout For Gender-Related Conditions

A second, more specific approach would be to use one general form of consent for mental health diagnosis and treatment modified to include a new, specific call out for consent (ahead of time) for the diagnosis and treatment of a gender-related condition (if that diagnosis and treatment should prove appropriate). Such a consent might include language like the following:

> *I hereby give consent for ABC Counseling Services to provide mental health treatment services to my minor child,* ***including the diagnosis and treatment of a gender-related condition, including gender dysphoria****. Such treatment may include individual counseling, group counseling, crisis intervention, referral assistance or consultation depending on my minor child's particular needs or presenting concerns.*

The practical benefit of utilizing a "catch-all" consent form is that it includes consent for the subject diagnoses and treatment and obviates the need for a second consent form (discussed below). The broader consent form may also, in some limited instances, make it easier to obtain consent for the diagnosis and treatment of a gender-related condition because the consent is part of a larger and broader consent form.

While this form of consent would likely comply with HB 68, it presents the risk that a parent could argue later they did not provide "informed" consent, irrespective of the ultimate success of any such argument on the merits. For example, if a parent believes their child is experiencing typical adolescent angst and executes the consent expecting a diagnosis of anxiety or even depression, they may be surprised to learn that their child has been diagnosed with, and has already received counseling for, gender dysphoria (or other condition) based on their having signed this form of consent. In short, this form of consent is more aspirational because it wraps everything into one package—it allows providers and practitioners to diagnose gender dysphoria from among a large pool of potential diagnoses, and it allows providers and practitioners to initiate lawful treatment for gender dysphoria (or other gender-related conditions) within their discretion. From an enforcement perspective, however, this entails more risk than the third approach (discussed below) of seeking a second, specific consent for the diagnosis of a gender-related condition only after a genuine clinical question/concern about a gender-related condition has been raised.

Approach #3: Two Specific Consent Forms

As suggested above, a third approach involves the use of two consent forms—one general form (like the form identified in the first approach) to be used upon intake, and a subsequent, specific consent form to be used only if the treating provider or practitioner believes, in the exercise of their clinical judgment, that a diagnosis of a gender-related condition is warranted. Such a form might include the following language:

> *I hereby give consent for ABC Counseling Services to* ***diagnose and provide mental health treatment for a gender-related condition, including gender dysphoria****. Such treatment may include individual counseling, group counseling, crisis intervention, referral assistance or consultation depending on my minor child's particular needs or presenting concerns.*

Not only is this final approach narrower than the others, but it would require the provider or practitioner to seek consent to make the diagnosis of and to treat gender dysphoria or another gender-related condition ***after*** a question or concern about a gender-related condition has already been raised by the patient/parent. Some may consider this the best approach given current circumstances, including that it appears HB 68 is likely here to stay—at least in some form.

The use of two forms serves three purposes. First, the form is clear, concise, and subject-matter specific. It would likely be difficult for a parent to argue after-the-fact that signing the specific form did not constitute "informed consent" to the diagnosis or treatment of a gender-related condition, particularly given the prior execution of the original more general form. Given the

sensitivities attached to such diagnoses, and the potential for intra-family disagreements over such issues, one family member could argue that the provider overstepped its bounds without proper consent when diagnosing or treating a minor for a gender-related condition. The specific form, used in conjunction with the first general form under the two-tiered approach, should insulate the provider from such challenges, or at least support the provider ultimately prevailing on the merits in the face of any such challenge.

Second, and along related lines, using an additional, specific form will better protect the provider from compliance challenges that could be brought by the OAG or others. It is prudent to anticipate that the OAG will seek strict compliance with HB 68 given the law's purported remedial purpose to "protect" children from what the legislature has deemed inappropriate gender transition services. We anticipate that the OAG will expect consent for gender-related conditions to be clear and specific. This third approach is clear and subject-matter specific.

Third, the two-tiered approach may be preferred from a clinical perspective. The statute itself acknowledges and requires a differential diagnosis that explores many different issues before the diagnosis of a gender-related condition may be made.[2] This (perhaps unintentionally) recognizes the clinical reality that a diagnosis of any mental health issue, including the diagnosis of a gender-related condition, may take some time. For example, if a patient presents for anxiety or depression, it may take the clinician several visits before that clinician is comfortable diagnosing the cause of that depression or anxiety. The two-tiered approach reflects this clinical reality. This approach may also prove appropriate in some circumstances under R.C. 5122.04, which allows minors over the age of fourteen to seek mental health treatment for a period of time without parental consent.

There will, of course, be situations where the specific form of consent is required at the outset or upon intake, such as where there is no clinical doubt (or reasonable debate) as to why a given minor has presented for diagnosis and treatment. In many other instances, however, the two-tiered approach may prove the most clinically sound option while also providing for the greatest protections against alleged violations of the law. This third approach would require providers and practitioners to be sensitive to timing and the sequence of events in the course of overall care to ensure the more specific consent is obtained prior to diagnosis and/or treatment of a gender-related condition.

We will continue to watch for any further guidance on this issue, including any potential new administrative rules directed to parental consent under HB 68.

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[2] *Id.* at 3129.03(B).