Testimony in Opposition of HB2791
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House Committee on Health and Human Services

Chairperson Landwehr and Members of the Committee:

Thank you for the opportunity to offer testimony in opposition to House Bill 2791, which would prohibit the provision of healthcare to transgender minors, provide a cause of action against providers who offered such care, prevent state-funded insurance from covering such care, prohibit professional liability insurance from covering providers who offered such care; and authorize professional discipline against providers who provided treatment to transgender minors.

As a clinically licensed marriage and family therapist offering specialized care to transgender patients and their families, I am alarmed by the implications of HB2791. Its sweeping, intrusive demands are reckless and dangerous in their disregard for the safety and wellbeing of Kansas' children and families. Simultaneously, the bill creates unresolvable legal and ethical dilemmas for mental health providers, threatening to exacerbate the profound mental health shortfalls already impacting our state.

Despite its use of pseudo-clinical language, and feigned concern for the state of research in gender-affirming care among minors, HB2791 flies in the face of treatment recommendations and standards of care affirmed by every major medical and mental health professional association.[1] It is notable that these include even the brief and conservative recommendation of the text this bill cites as definitional for gender dysphoria, which states that the distress it causes may "be mitigated by supportive environments and knowledge that biomedical treatments exist to reduce incongruence".[2]

We know that transgender youth face elevated risk for adverse mental health outcomes, including depression, anxiety, self-harm, and suicidality.[3] [4] These risks are

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1 "Medical Organization Statements on Gender-Affirming Care," TLDEF's Trans Health Project, Transgender Legal Defense and Education Fund, 2023, https://transhealthproject.org/resources/medical-organization-statements/

2 American Psychiatric Association. "Desk Reference to the Diagnostic Criteria from DSM-5 (R)." Arlington, TX: American Psychiatric Association Publishing, 2013. p. 455.

3 Brian C. Thoma et al, "Suicidal Disparities Between Transgender and Cisgender Adolescents," Pediatrics 144, e20191183 (2019).

4 "2023 U.S. National Survey on the Mental Health of LGBTQ Young People," The Trevor Project, 2023, https://www.thetrevorproject.org/survey-2023/#intro

mitigated, for transgender children of all ages, by way of access to social transition—this includes a range of innocuous and personal interventions such as changes to hairstyle, wardrobe, and self-referential language.[5] Following the initial onset of puberty, puberty delaying medication improves outcomes for transgender adolescents[6]; as does subsequent, developmentally-appropriate access to gender-affirming hormone replacement.[7] Still later, surgical care is indicated for many transgender individuals, although such care ordinarily occurs in adulthood, for both physiological and developmental reasons. Refusal to provide these interventions when necessary is not a neutral stance. It causes serious, frequent, negative mental health outcomes, increases social isolation, and delays or prevents normal processes of psychosocial development.[8]

In light of the clear, definitive medical and mental health consensus that already exists, concerning safe and effective approaches to the care of transgender children and adolescents, HB2791 would create an unresolvable legal and ethical dilemma, when it prevents clinicians from offering or referring patients for such care. As mental health professionals, Kansas regulation forbids our "performing services inconsistent or incommensurate with one's training, education, or experience or with established professional standards."[9] But HB2791 would require us to do just that—it demands that ignore our training, education, experience, and established professional standards, and not only deny necessary, effective care; but deny even its existence and utility.

When it insists that clinicians must not "advocate" for gender-affirming care, HB2791 prevents us from offering ethically obligatory referral for appropriate services[10]. When it bans any discussion at all of gender-affirming care with minor patients, unless their

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5 Kristina Olson et al, "Mental Health of Transgender Children Who Are Supported in Their Identities," Pediatrics 137 (3), (2016).

6 Tordoff DM, et al. "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

7 Diane Chen, et al, "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones" N Engl J Med 2023; 388:240-250 DOI: 10.1056/NEJMoa2206297

8 Annelou L.C. de Vries, et al, "Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment" Pediatrics (2014) 134 (4): 696–704. https://doi.org/10.1542/peds.2013-2958

9 Kansas Administrative Regulations 102-5-12, "Unprofessional Conduct," https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=102-5-12

10 American Association for Marriage and Family Therapy, "Code of Ethics: 1.10 Referrals," https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

parents first sign the bill's proposed list of half-truths, unsubstantiated and prejudicial assertions, and outright lies concerning the nature of gender-affirming care, it violates state regulatory bans on professional activities "involving dishonesty, fraud, deceit, or misrepresentation"[11] HB2791 substitutes inaccurate, ill-informed, and oversimple dictates for the nuanced judgement, extensive training, and grounding in ongoing, always-developing research, of experienced healthcare providers.

By placing any provider who even glancingly encountered a transgender minor at risk of civil liability, regulatory and professional sanctions, and loss of the ability to practice, HB2791 would create strong incentives for healthcare providers in all specialties and treatment demographics to simply leave the state, and practice in more congenial locations. Our state currently hosts approximately one psychiatrist per 10,000 residents, and one non-prescribing therapist for every 1,200—and these providers are not evenly distributed. The entirety of Southwest Kansas, with a population of 176,738 people, makes do with just one psychiatrist, and 70-80 therapists.[12] Kansas cannot afford to encourage the departure of still more providers to other states, while undermining our own institutions of higher education in their ability to train their replacements.

HB2971 is a losing proposition for Kansans. It threatens the safety and survival of our state's children, the primacy of family bonds and parental agency in their children's lives, and the ability of healthcare providers and educators to ensure our children's safety and well-being. It also poses serious risks to mental health professionals, and healthcare providers more generally, by creating ethical and legal dilemmas that cannot be resolved, and will inevitably jeopardize our ability to practice. In so doing, it adds to serious and mounting pressures in our mental healthcare system, throughout a state that is already acutely underserved.

Thank you for your time.

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11 Kansas Administrative Regulations 102-5-12, "Unprofessional Conduct," https://sos.ks.gov/publications/pubs_kar_Regs.aspx?KAR=102-5-12

12 Cynthia Snyder, et al, "Addressing Behavioral Health Workforce Needs in Kansas," Kansas Health Institute: 2022. https://www.khi.org/articles/addressing-behavioral-health-workforce-needs-in-kansas/