

Family SERVICES

October 15, 2019

Mr. Larry Marx
Utah Department of Commerce
Division of Occupational and Professional Licensing
Heber M. Wells Building
160 East 300 South
Salt Lake City, Utah 84111-2316

Re: Comments on Proposed Amendments to the Psychologist Licensing Act Rule (DAR file no. 44032) & Proposed Amendments to the Mental Health Professional Practice Act Rule (DAR file no. 44031)

Dear Mr. Marx:

The Church of Jesus Christ of Latter-day Saints Family Services (“Family Services” or “FS”) submits the following combined comments on the proposed amendments to the Psychologist Licensing Act Rule (DAR file No. 44032) and the proposed amendments to the Mental Health Professional Practice Act Rule (DAR file No. 44031) (collectively, the “Proposed Rule”).¹

While acknowledging the good-faith efforts of those who drafted the Proposed Rule and fully supporting the goal of protecting children and youth from abusive conversion therapy practices, Family Services regretfully cannot support the Proposed Rule in its current form. The Proposed Rule is ambiguous in key areas and overbroad in others; it fails to account for important realities of gender identity development in children; it would undermine the right of clients to self-determination and the right of parents to guide the development of their children; and it ignores the important and ethically appropriate role of faith-based perspectives in counseling. Given the Utah Legislature’s recent involvement in this issue, Family Services recommends that the Legislature be allowed to continue its work, gather further input from all stakeholders in the State, and provide statutory guidance on this important issue. In the alternative, Family Services recommends that the Proposed Rule be amended to address the concerns outlined in this comment.

¹ Because both proposed amendments are identical with respect to the issue of sexual orientation and gender identity change efforts, and because they will function as a single rule governing all such mental health therapies, these comments address both rules and will not distinguish between them. Accordingly, both proposed rules will simply be referred to herein as the “Proposed Rule.” For ease of reference, citations will refer only to the proposed amendments to the Psychologist Licensing Act Rule, *e.g.*, “Proposed Rule § 156-61-102(15).”

A. Family Services.

Family Services is one of the largest networks of licensed, professional counselors in the State of Utah, with 250 therapists serving approximately 28,000 clients every year. FS social workers, marriage and family therapists, clinical mental health counselors, psychologists, and psychiatrists provide counseling services in accordance with the highest professional and ethical standards, including standards that ensure the right of clients to privacy, confidentiality, and self-determination. *See, e.g.*, APA Code of Ethics, Principle E: Respect for People's Rights and Dignity.

Family Services therapists serve clients who are overwhelmingly members of The Church of Jesus Christ of Latter-day Saints; only clients with a referral from a local Church ecclesiastical leader (a bishop, branch president, stake president, or mission president) can receive counseling from Family Services. FS clients typically seek counseling that respects and accounts for their religious identity and personal faith goals. FS counselors are "aware of and respect cultural, individual, and role differences, including those based on . . . religion" APA Code of Ethics, Principle E: Respect for People's Rights and Dignity. They show the same awareness and respect for other cultural, individual, and role differences.

B. Family Services Counselors Do Not Provide Conversion Therapies.

Sexual orientation. Family Services has a longstanding and express policy against using therapies that seek to "repair," "convert," or "change" sexual orientation, such as from homosexual to heterosexual. Research demonstrates that electric shock, aversion, and other analogous therapies are both ineffective and harmful to youth who experience same-sex attraction. Those, including youth, who seek therapies that constitute sexual orientation change efforts will not receive them from FS counselors. Instead, FS counselors assist youth clients in understanding sexual orientation issues in the context of their families and social networks, their expressed religious identity, and their self-determined personal goals, including those pertaining to their faith.

Gender identity. While many issues of gender identity are not well understood, FS counselors do not provide therapies designed to change a client's established gender identity. FS counselors assist youth clients in understanding gender identity issues, including gender dysphoria, in the context of their families and social networks, their expressed religious identity, and their self-determined personal goals, including those pertaining to their faith.

FS counselors assist young children in healthy identity exploration and development. They also help parents of young children in understanding gender identity and gender dysphoria issues experienced by their children so they can appropriately assist their children in their identity exploration and development. Family Services supports the ability of other responsible practitioners to provide ethical treatments.

C. Caution Is Warranted in Propounding Rules of Professional Conduct Governing the Highly Sensitive Area of Gender Identity in Children and Youth Because It Is Not Fully Understood.

Before wading into the specific problems with the Proposed Rule, it is important to understand that the mental health community is still exploring numerous issues related to the development and fluidity of gender identity in young children and youth. While coercive measures to change (“convert”) or influence gender identity are of course inappropriate, currently there is a dearth of information about gender dysphoria in minors. We do not know which children with gender dysphoria (GD) will persist into adulthood (de Vries & Cohen-Kettenis, 2012; Singh, 2012). We do not know the long-term effects of childhood transition, including the effects of puberty blockers and cross-sex hormones (World Professional Association for Transgender Health, 2012; Heneghan & Jefferson, 2019). And we do not know the percentage of individuals with adolescent-onset gender dysphoria whose dysphoria will persist. In fact, “virtually nothing is known regarding adolescent-onset GD, its progression and factors that influence the completion of the developmental tasks of adolescence among young people with GD and/or transgender identity. Consolidation of identity development is a central developmental goal of adolescence, but we still do not know enough about how gender identity and gender variance actually evolve” (Kaltiala-Heino, Bergman, Työlajärvi, & Frisé, 2018).

All of this has serious implications for mental health therapies provided to minors who experience gender confusion or gender dysphoria. What, for example, is the best therapeutic approach for a prepubescent child who presents with gender dysphoria given that high percentages of such children will no longer experience that condition in adulthood? It also has serious implications for the regulation of such therapy. As explained further below, the Proposed Rule fails to account for the great complexity and uncertainty in this exceptionally sensitive and unfolding area. Before adopting such a rule, which could deny much-needed assistance to both clients and parents, it is important for the Division of Occupational and Professional Licensing (DOPL) to understand at least some of the ongoing issues pertaining to gender dysphoria in both young children and youth. What follows is a brief summary of information about the prevalence of gender dysphoria, persistence, physical risks of transitioning, and co-occurring mental disorders. Needless to say, much more could be said about this complex phenomenon.

Prevalence of Gender Dysphoria

More adolescents are identifying as transgender than ever before. While .6 percent of U.S. adults identify as transgender, according to a Williams Institute report (Flores, Herman, Gates, & Brown, 2016), nearly 2 percent of high school students identify as transgender, according to a study by the Centers for Disease Control and Prevention (Johns et al., 2019). Many gender and endocrinology clinics report increasing numbers of adolescent referrals (Zucker, Wood, Wasserman, VanderLaan, & Aitken, 2016; DeVries & Cohen-Kettenis, 2012; McFarling, 2016).

Researcher Lisa Littman observed a phenomenon in which parents report that their adolescent or young adult children suddenly identify as transgender, without having expressed

any gender incongruence previously. In a preliminary study, Littman identified the following characteristics of these minors and young adults (Littman, 2018):

- Most of these children (about 80 percent) were natal females. (Historically, most individuals seeking services at gender clinics have been natal males [Aitken, 2015].)
- Most of these children had one or more friends in their peer group who identified as transgender during the same time frame.
- Most of these children significantly increased their time spent on transgender-related social media content before identifying as transgender.
- Many of these children had been previously diagnosed with a mental disorder.

This phenomenon, known as “rapid onset gender dysphoria,” “raise[s] the question of whether social influences may be contributing to or even driving these occurrences of gender dysphoria in some populations of adolescents and young adults” (Littman, 2018). We are aware that this study has been criticized on various grounds, particularly its suggestion that social contagion may be a factor among some gender dysphoric adolescents and young adults. It was subjected to additional professional review, however, and was republished with only minor changes that did not alter its primary conclusions. See Lee Jussim, “Rapid Onset Gender Dysphoria,” *Psychology Today*, at <https://www.psychologytoday.com/us/blog/rabble-rouser/201903/rapid-onset-gender-dysphoria> (reviewing controversy). Our point is not to endorse this study but rather to note the deep uncertainties in this complex area.

Persistence

Even many professionals in the field are not aware that gender dysphoria does not persist in most young children when a “watchful waiting” approach is taken (Hembree et al., 2017; Steensma, 2013; Singh, 2012). Most children with gender dysphoria will ultimately identify as gay or bisexual (Korte et al., 2008; Singh, 2012). The Proposed Rule, with its apparent mandate of exclusively affirming therapies, appears not to have taken full account of these facts.

At least one study has shown that verbal bullying by peers may influence early adolescent gender identity (DeLay, Martin, Cook, & Hanish, 2018). Some have suggested that some same-sex-attracted young people are transitioning to the opposite sex as a form of gay conversion therapy, as they would rather be transgender and straight than identify with their natal gender and be gay (Soh, 2018; Bannerman, 2019). Professor Kathleen Stock has discussed this risk:

[T]here’s an inherent tension in new definitions of conversion therapy. With a same-sex-attracted person questioning her gender identity, therapists have to convert her, either by act or by omission. If they accept her trans narrative without question, they are converting her out of lesbian sexual orientation. If they therapeutically question that narrative, they are converting her (or rather, him) out of being trans. To this, one might well add: only one of those routes is connected with body-altering, life-changing drugs and surgeries, whose long-term consequences are unknown (Stock, 2018).

Family Services does not necessarily endorse this view. We reference it only to highlight again some of the risks, nuances, and uncertainties that exist in this complex area.

Despite the low persistence rate in children who do not take steps to transition, almost all children who take puberty blockers go on to take cross-sex hormones (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011). Because the increase in adolescent-onset gender dysphoria is a recent phenomenon, we lack data about how many of these individuals persist or desist. Our point here is not to endorse any particular view or therapeutic approach to childhood gender dysphoria, only to note that currently studies show it does not persist in the majority of instances involving onset before puberty.

Physical Risks of Transitioning

While mental health therapists do not provide medical advice, they may suggest some nonmedical interventions (such as the use of breast binders) and may indirectly help facilitate medical transitioning. The following are some physical risks associated with transitioning.

Breast binders. Many adolescent and young adult biological females who identify as transgender choose to use binders to minimize their breasts. Breast binders have been found to frequently result in shortness of breath, chest pain, and back pain. Some users have reported rib or spine changes and scarring (Peitzmeier, Gardner, Weinand, Corbet, & Acevedo, 2017).

Puberty suppression medications. Puberty blockers are often described as benign, with fully reversible effects. However, emerging data show that these medications, which are not FDA-approved for this use, may cause bone density problems and perhaps even increased suicidality. Skipping puberty may also result in cognitive deficits (Richards, Maxwell, & McCune, 2019; Biggs, 2019; Cohen & Barnes, 2019.)

Cross-sex hormones. When adolescents take cross-sex hormones directly after puberty suppression, they have a high likelihood of becoming sterile, and their sexual functioning may be impaired (Jontry, as cited in Biggs, 2019). Cross-sex hormones may also compromise fertility when puberty blockers have not been taken (De Roo, Tilleman, T'Sjoen, & De Sutter, 2016). Natal females who take testosterone are at increased risk of cardiovascular problems. Natal males who take estrogen may be at increased risk of venous thromboembolism and stroke (Alzahrani et al., 2019; Getahun et al., 2018).

These risks cannot be dismissed on the view that transitioning is required to prevent suicide. Research does not support the assertion that transitioning necessarily averts suicide. A study conducted in Sweden followed 324 participants for 30 years after sex-reassignment surgery. Study results showed that the participants attempted or committed suicide at a significantly higher rate than the general population. The authors wrote, "Our findings suggest that sex reassignment, although alleviating gender dysphoria, may not suffice as treatment for transsexualism" (Dhejne et al., 2011).

Incidence of Mental Disorders

A significant percentage of children who are transgender and/or gender nonconforming have co-occurring mental health disorders (Bechard, VanderLaan, Wood, Wasserman, & Zucker, 2017). There appears to be a correlation between autism spectrum disorder and gender dysphoria in youth (Kaltiala-Heino, Bergman, Työlajärvi, & Frisén, 2018; de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010). And according to one study, transgender adolescents had a “particularly pronounced increased prevalence in psychoses” compared with adolescent females who were not transgender (Becerra-Culqui et al, 2018). The possibility that symptoms of these and other disorders may improperly contribute to a gender dysphoria diagnosis has not been thoroughly studied.²

* * * *

The foregoing is by no means a comprehensive treatment of gender dysphoria among minors, and Family Services does not endorse any particular theory in this unfolding area of inquiry. We provide it only to illustrate some of the ongoing uncertainties for mental health and health care professionals as they seek to assist clients and patients dealing with this complex, multi-factored phenomenon. Responsible therapists need flexibility to deal with a wide range of possibilities and needs, not premature standards based on incomplete science. Preventing harmful conversion therapy is important, but it does not justify rigid, overbroad, or ambiguous regulations that will have the effect of denying desperately needed therapies and guidance to gender-dysphoric children and their parents. Caution is warranted in propounding rules of professional conduct in this complex and highly sensitive area.

D. The Proposed Rule Is Overbroad and Will Undermine Ethical and Effective Counseling.

Sexual orientation change efforts.

As explained, Family Services does not support therapies that seek to change a person’s sexual orientation. Regulation of true sexual orientation change efforts for minors is appropriate. Family Services would support a carefully tailored rule directed at such abusive practices provided it did not jeopardize ethical therapies. However, the Proposed Rule defines both

² We are aware that a September 2019 study purports to show that any effort by professionals to “try to stop [someone from] being trans” results in increased suicidality and psychological distress (Turban, Beckwith, Reisner, & Keuroghlian, 2019). However, gender-identity “conversion efforts” are not specifically defined in the study. As sociologist Mark Regnerus (2019) wrote in response to the study, “[A]n ethical discussion of risk could be interpreted by the patient as ‘trying to stop you being trans.’ In other words, obtaining informed consent may constitute GICE [gender-identity conversion efforts].” The study’s authors acknowledge that it “is possible that those with worse mental health or internalized transphobia may have been more likely to seek out conversion therapy rather than non-GICE therapy, suggesting that conversion efforts themselves were not causative of these poor mental health outcomes” (Turban et al., 2019). A 2019 national survey by the Trevor Project showed similar results for youth who identified as LGBTQ. The survey had similar weaknesses due to vague terminology and lack of exploration of confounding factors. Again, FS does not take a position on this debate; we only note the ongoing uncertainties.

“sexual orientation” and “sexual orientation change efforts” so broadly that if adopted it would imperil entirely legitimate and helpful therapies, to the detriment of minor clients.

The Proposed Rule (as revised) defines “sexual orientation” to include not only “gendered patterns in attraction” and “feelings,” *e.g.*, homosexuality, but also “behavior” and “identity related to these patterns.” Proposed Rule § 156-61-102(14). It then defines “sexual orientation change efforts” to include therapies “with the goal of changing an individual’s sexual orientation, *including* gendered patterns in attraction, feelings, or *behavior* or identity related to these patterns.” *Id.* § 156-61-102(15) (emphasis added). The primary standards in the Proposed Rule would therefore ban not only therapies aimed at changing sexual attractions and feelings, but any therapy that sought to modify behaviors or expressions associated therewith. This is much too broad.

Regardless of a person’s sexual orientation, some behaviors related to or associated with sexual orientation can be destructive and psychologically unhealthy. It is often appropriate and ethical to provide reasonable therapies to assist a client in modifying behaviors and expressions that the client has identified as inconsistent with the client’s own self-determined goals and self-defined well-being. *See, e.g.*, APA Code of Ethics, Principle E: Respect for People’s Rights and Dignity (emphasizing importance of client “self-determination”). Three of many possible examples illustrate the point:

- A 12-year-old boy with same-sex attractions confides in a therapist that he is spending many hours a day looking at homosexual pornography. The boy explains that this is inconsistent with his values and that it makes him feel ashamed and depressed. He seeks counseling to assist in eliminating this behavior.
- A 17-year-old girl with attractions to both males and females confides to a therapist that she is forming intense emotional attachments with girls of the same age. She says these relationships often include some degree of physical involvement, such as hand holding, cuddling, and kissing. She explains that these behaviors are contrary to her faith and values, that they make her feel depressed and confused, and that she is deeply concerned that these behaviors will prevent her from remaining active and faithful in her chosen faith community, something she explains is central to her personal identity. She seeks counseling to assist her in changing behaviors related to her attractions.
- A 16-year-old boy with same-sex attractions openly identifies as gay and is also deeply religious. His faith teaches him that it is God’s will that sexual relations occur only within a traditional male-female marriage. He is uncertain how he will ultimately reconcile his sexual orientation with his religious beliefs. His stated goal is to delay making a decision about same-sex intimacy until he is an adult and graduated from high school. He seeks counseling during his high school years to help him reduce the intensity of his sexual desires by prioritizing other aspects of his identity, including his religious identity, so that he can abstain from sex at least until he is an adult and has completed high school.

By sweeping into the definition of “sexual orientation change efforts” benign therapies designed to address these and other situations involving behaviors but not orientation itself, the Proposed Rule on its face would threaten the licenses of ethical therapists merely for assisting

such clients in attaining their self-determined goals—even though doing so cannot reasonably be said to constitute harmful sexual orientation change efforts or conversion therapy.

The definition of “sexual orientation change efforts” also includes any practice that seeks to alter any “*identity* related to” “gendered patterns in attraction, feelings, or behavior.” Many identities can be “related” to such “patterns,” some of which may lead to unhealthy or even destructive outcomes. No doubt the Proposed Rule is trying to prevent abusive therapies that seek to coerce a minor client into not identifying as gay, lesbian, or bisexual. FS supports that objective. But those are not the only identities that can arise from “gendered patterns in attraction, feelings, or behavior.” For example, a gay (or heterosexual) youth may adopt an overly aggressive or overly submissive identity in matters of sexuality that most responsible therapists would view as unhealthy or potentially harmful. Moreover, clients can have overlapping or ostensibly conflicting identities. A client, for instance, may desire assistance in prioritizing the client’s self-determined religious identity over the client’s sexual identity. Here again, the Proposed Rule’s definition of “sexual orientation change efforts” is so broad that it calls into question perfectly legitimate therapies designed to address these and many other situations.

The Proposed Rule (as revised) provides something of a safe harbor, but it is simply too narrow and too ambiguous to shield responsible therapists in these and many other situations. As recently revised, Subsection (16) of the Proposed Rule now states that “sexual orientation change efforts” do not include therapies that “are neutral with respect to ... sexual orientation.” Proposed Rule § 156-61-102(16)(a). Family Services appreciates the effort to address the overbreadth problem, and on its face this neutrality language might appear to help, but in reality the new language will often provide only an illusory safe harbor. Why? Because the definition of “sexual orientation” itself includes not only sexual attraction and feelings but also behavior and identity. When the definition of “sexual orientation” is inserted into the safe harbor language, it reads as follows: “sexual orientation change efforts” do not include therapies that “are neutral with respect to [‘an individual’s gendered patterns in attraction, feelings, *or behavior or identity* related to these patterns’].” (Emphasis added.) *Therefore, any therapies intended to address “behavior” or “identit[ies]” that are “related to” “gendered patterns in attraction,” including harmful behaviors, are still banned—no matter how benign or effective those therapies might be.* It appears that any therapy with the goal of changing a behavior closely associated with sexual orientation is by definition an effort to change sexual orientation. In each of the examples above, the client’s behavior is directly related to same-sex attractions and thus off limits.

Moreover, assuming the neutrality exception indeed allowed for sexual-orientation-neutral therapy regarding harmful behaviors like pornography use by minors and teenage promiscuity, actual therapy would rarely be truly neutral because it must necessarily include the orientation-related circumstances and behaviors of the client’s life. How will DOPL interpret and monitor neutrality? If a therapist helps clients work toward their self-determined goals of privileging their religious values as they explore their sexual orientation, is this neutral? If a therapist challenges clients’ assumptions about their sexuality, is this neutral? How can a therapist defend herself against the accusations of a disgruntled client under these standards?

The Proposed Rule also elaborates five categories of therapy that are permissible if they are neutral toward sexual orientation and not intended to change it. But for the reasons just discussed, “sexual orientation” is defined so broadly that none of these categories can be relied on to defend legitimate therapies designed to address situations like those described in the three examples above. The purported safe harbor is illusory.

In sum, the Proposed Rule defines “sexual orientation” and “sexual orientation change efforts” so expansively that it creates the real risk that ethical therapies intended to assist clients with modifying sexually related behaviors that are contrary to their self-defined goals will be deemed unprofessional conduct—even if those behaviors are plainly dysfunctional and destructive. The Proposed Rule poses an unfair and unnecessary risk to many responsible therapists who assist minors in dealing with the complex issues of sexual orientation and sexuality.

Gender identity change efforts

The problems with the Proposed Rule’s approach to “gender identity,” “gender expression,” and “gender identity change efforts” are even more acute. The specific drafting problem relates to the sheer breadth of the definitions of these key terms and their inclusion of gender-related behaviors and expressions. The Proposed Rule defines “gender identity change efforts” as therapies “with the goal of changing an individual’s gender identity or gender expression.” Proposed Rule § 156-61-102(6). “Gender identity” is defined as “an individual’s experience of their gender, including one’s view of oneself as a man, woman, or any other gender.” *Id.* § 156-61-102(5). And “gender expression” is defined as “an individual’s presentation and behaviors that express aspects of gender, including gender identity or gender role.” *Id.* § 156-61-102(4).

Thus, the Proposed Rule would prohibit any therapy with the goal of changing any “presentation and behavior[] that express[es] aspects of gender.” Yet it is easy to imagine numerous dysfunctional presentations and behaviors that “express aspects of gender,” such as extremes in dress, grooming, language, and sexuality. Indeed, the whole concept of “toxic masculinity” is closely related to inappropriate and even predatory “behaviors that express aspects of gender.” Certainly a minor client with gender dysphoria who desires to change, through appropriate therapies, extreme or destructive “behaviors that express aspects of gender” should be able to find help from responsible therapists.

Here again, the Proposed Rule’s ostensible safe harbor provides little safety. As with sexual orientation change efforts, any therapy that seeks to alter behavior or presentation is by definition an effort to change gender identity or expression and thus does not qualify for the safe harbor under subsection 102(16)(a). The new neutrality language in the revised Proposed Rule suffers from the same defects in this context as in the sexual orientation context; it may provide some flexibility, but because the definition of gender identity change efforts is so broad, many responsible therapies that seek to address dysfunctional behaviors or presentations will technically not be allowed.

Nor will the specifically enumerated categories in subsection 102(16)(b) provide much clarification or guidance. Subsection 102(16)(b)(iii) allows for therapies that do not have the goal of changing gender identity and that seek to “facilitate[] an individual’s active coping, social support, and identity exploration and development.” What these terms mean is entirely ambiguous. Proponents of the Proposed Rule may argue that they will be construed broadly enough to cover any responsible, gender-identity-neutral therapy. But even read broadly they do not appear to allow a responsible therapist to assist a gender dysphoric minor who, for example, seeks to change how she expresses her gender through her presentation or certain behaviors. Nor does the Proposed Rule appear to allow a therapist to encourage a child and her parents to take a wait-and-see approach to gender transitioning, putting off transitioning-related drugs like cross-sex hormones until it is clear the gender dysphoria is unlikely to desist. By contrast, subsection 102(16)(b)(iv) of the Proposed Rule expressly allows a therapist to assist a minor “undergoing gender transition.” The Proposed Rule appears to explicitly favor gender transitioning for minors despite the risks and problems summarized above.³ Especially in the case of prepubescent children, therapists should have flexibility to account for the very real possibility that gender dysphoria will desist. The Proposed Rule, with its bias toward transitioning, does not appear to provide that—and certainly doesn’t provide it clearly.

We note also that the Proposed Rule’s definition of “gender identity” would openly adopt controversial theories of gender (“any other gender”), placing those contested and undeveloped concepts prominently in Utah’s administrative law.

More broadly, the Proposed Rule’s approach to gender identity fails to account for the many complexities and uncertainties noted earlier. This is especially true with respect to issues of gender fluidity, gender confusion, and gender dysphoria in very young children and issues of so-called “rapid onset gender dysphoria” in youth. Although some may assert otherwise, the fact remains that these issues are not well understood and are still the subject of serious inquiry. Determining the best and most effective therapies for such clients is highly context-specific and often uncertain, requiring great sensitivity and skill rather than rigid rules and the threat of professional sanctions. Utah law and regulations should not handcuff responsible therapists seeking to assist often desperate clients to resolve issues of gender dysphoria. Further, given the rate of desistence and the serious health and psychological risks of medicalized approaches to gender dysphoria, Utah law and regulations should not expressly or implicitly favor therapies for minors that encourage gender transitioning or discourage therapies that take a wait-and-see approach for prepubescent clients. Yet in practice that is exactly what the Proposed Rule will do.

Some may argue that the Proposed Rule will not be rigidly enforced, affording flexibility to responsible therapists engaged in reasonable, good-faith efforts to assist minor clients in matters of sexual orientation and gender identity. But that is cold comfort for numerous Utah therapists given fundamental disagreements on these issues and the ideological fervor that often

³ Perhaps the argument is that the neutrality rule will also constrain therapists who support gender transition. If so, the Proposed Rule is unintelligible. How can a responsible therapist who is supportive of gender transition assist an individual “undergoing gender transition” in a gender-identity-neutral way? What does that mean and how will it be enforced in a consistent manner?

attends them. If DOPL contemplates a lax enforcement regime on conversion therapy issues, where only the most obvious offenders will be disciplined, then its regulations should say so plainly.

* * * *

These risks and concerns have serious implications for minor clients dealing with sexual orientation and gender identity issues. Although well intentioned, the Proposed Rule as written will strongly dissuade many responsible therapists from providing much-needed therapy to minors. That is especially true of therapists whose counseling respects the religious identity and faith perspectives of Latter-day Saints and members of other faith communities with biblically informed beliefs about gender and sexuality. If parents, who typically determine whether their children receive counseling, cannot find responsible professional therapists to address the sexual orientation and gender identity issues of their children, they will seek such counseling from unlicensed sources, such as from the growing “life coach” industry, where the risk of actual conversion therapy is vastly greater. That will benefit neither vulnerable clients nor the mental health professions.

E. Recommendations.

1. Allow the Legislature to Consider the Issue and Act When Consensus Is Reached.

The Proposed Rule relies on a false premise. While there is consensus within the mental health community on the impropriety of discredited practices, such as aversion therapy, that seek to change sexual orientation or gender identity, there is no such professional consensus about all aspects of the extremely broad definition of “conversion therapy” in the Proposed Rule. Various professional associations and advocates may indeed support such a standard, but the views of the practicing professional community itself are more diverse and nuanced. Thus, this is not merely a technical issue that DOPL can regulate according to well-established standards that already enjoy a broad consensus within the mental health community. Rather, it is fundamentally a public policy issue, with cross-cutting implications for child welfare, parental rights, professional independence, and religious commitment. As such, these are matters for the Legislature in its policy-making role.

Earlier this year, the Legislature considered various bills addressing conversion therapy but did not reach a consensus. Considering its demonstrated interest in finding a feasible solution, the Legislature will likely take up the issue again next session. DOPL’s proposed rulemaking would inappropriately cut short the legislative process by making conversion therapy a matter of regulatory fiat. Due respect for the democratic process would leave this contested issue to the Legislature, where elected representatives can pursue solutions that account for diverse perspectives and that adequately resolve the multiple interests at stake. Many state legislatures have already addressed conversion therapy through ordinary legislative channels. *See, e.g.*, Calif. Bus & Prof Code §§ 865-865.2 (2016) (California legislation addressing sexual orientation change efforts and unprofessional conduct); Nev. Rev. Stats. § 629.600 (2017) (Nevada); N. J. Rev. Stats. § 45:1-55 (2017) (New Jersey).

It is abundantly clear that the Legislature is competent to address this issue. HB 399, supported by Equality Utah and other progressive influencers, made an important and responsible contribution to this discussion and received substantial support from legislators. (*See* Addendum A, text of HB 399.) While the bill’s definition of conversion therapy, which largely tracked definitions in other states’ statutes, was broad, the bill’s safe harbor provisions were real and protected a number of legitimate practices not intended to change sexual orientation or gender identity.

Specifically, HB 399 specified that “‘Conversion therapy’ does not mean a practice or treatment that does not seek to change a patient or client's sexual orientation or gender identity . . .” (Addendum A, lines 192-193.) Such practices and treatments included but were not limited to “mental health therapy that . . . is neutral with respect to sexual orientation and gender identity,” that “addresses unlawful, unsafe, premarital, or extramarital sexual activities in a manner that is neutral with respect to sexual orientation,” or that “discusses with a patient or client the patient or client’s moral or religious beliefs or practices.” (*Id.* at lines 193-195, 200-203.) The revisions to the Proposed Rule adopt some of these concepts, but do not go far enough to reach the balance HB 399 sought to strike.

Family Services is not prepared to endorse HB 399 without further textual clarifications and refinements. Nevertheless, HB 399 represents a good-faith effort to grapple with some of the fine distinctions that must be drawn. We are confident that additional discussion among stakeholders and the people’s representatives in the Legislature can produce a workable legislative solution that addresses many of the concerns raised here.

With respect, the Governor and DOPL should allow the Legislature to perform its constitutional function in this important policy matter.

2. *Alternatively, Amend the Proposed Rule to Better Protect the Interests of Children.*

If DOPL is not convinced to leave the issue of conversion therapy to the Legislature, it should amend the Proposed Rule to clarify that each of the following practices does not fall within the definition of sexual orientation or gender identity “change efforts”:

- Therapies that assist a client in achieving the client’s self-determined goal to modify or cease behaviors or expressions that the client determines are inconsistent with the client’s values, or that are objectively dysfunctional or destructive.
- Therapies that address premarital, extramarital, irresponsible, abusive, or predatory sexual activities.
- Therapies that discuss the client’s moral or religious beliefs or practices.
- Therapies that account for the client’s capacity for sexual fluidity.
- Therapies that explore other psychological conditions as potential contributors to reported gender dysphoria.
- Therapies that account for gender fluidity in children or for the likelihood that gender confusion or dysphoria in prepubescent children will desist without the

need for medical interventions, including therapies that encourage a wait-and-see approach.

- Therapies that explore factors associated with sudden onset gender dysphoria.
- Non-coercive, age-appropriate therapies that seek to assist a client in resolving gender dysphoria without the need for medical interventions, including counseling with parents about appropriate ways to facilitate identity exploration and development.

F. Conclusion.

We appreciate the opportunity to comment on the Proposed Rule and acknowledge the hard work and good faith behind it. Nevertheless, for the foregoing reasons Family Services believes the Proposed Rule falls short and should be withdrawn to allow the Legislature to address these challenging issues. Alternatively, the Proposed Rule should be amended to accommodate the concerns discussed above.

Sincerely,

The Church of Jesus Christ of Latter-day Saints Family Services

References

- Aitken, M., Steensma, T.D., Blanchard, R., VanderLaan, D.P., Wood, H., Fuentes, A., Spegg, C., Wasserman, L., Ames, J., Fitzsimmons, C.L., Leef, J.H., Lishak, V., Reim, E., Takagi, A., Vinik, J., Wreford, J., Cohen-Kettenis, P.T., de Vries, A.L.C., Kreukels, B.P.C., Zucker, K.J. (2015). Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12(3), 756-763. doi:10.1111/jsm.12817.
- Alzahrani, T., Nguyen, T., Ryan, A., Dwalry, A., McCaffrey, J., Yunus, R., Forgione, J., Krepp, J., Nagy, C., Mazhari, R., Reiner, J. (2019). Cardiovascular disease risk factors and myocardial infarction in the transgender population. *Circulation: Cardiovascular Quality and Outcomes*, 12(4). <https://doi.org/10.1161/CIRCOUTCOMES.119.005597>.
- Bailey, J.M., & Blanchard, R. (2017, September 8). Suicide or transition: The only options for gender dysphoric kids? [blog post]. Retrieved from <https://4thwavenow.com/2017/09/08/suicide-or-transition-the-only-options-for-gender-dysphoric-kids/>.
- Bannerman, L. (2019, April 8). It feels like conversion therapy for gay children, say clinicians. *The Times*. Retrieved from <https://www.thetimes.co.uk>.
- Becerra-Culqui, T.A., Liu, Y., Nash, R., Cromwell, L., Flanders, W.D., Getahun, D., Giammattei, S.V., Hunkeler, E.M., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Sandberg, D.E., Silverberg, M.J., Tangpricha, V., Goodman, M. (2018). Mental health of transgender and gender nonconforming youth compared with their peers. *Pediatrics*, 141(5). doi:10.1542/peds.2017-3845.
- Bechard, M., VanderLaan, D., Wood, H., Wasserman, L., & Zucker, K.J. (2017). Psychosocial and psychological vulnerability in adolescents with gender dysphoria: A “proof of principle” study. *Journal of Sex & Marital Therapy*, 43(7), 678-688. doi:10.1080/0092623X.2016.1232325.
- Biggs, M. (2019, July 29). The Tavistock’s experiment with puberty blockers. Unpublished manuscript. Retrieved from http://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf.
- Cohen, D., & Barnes, H. (2019, July 22). Transgender treatment: Puberty blockers study under investigation. BBC Newsnight. Retrieved from <https://www.bbc.com>.
- De Roo, C., Tilleman, K., T’Sjoen, G., & De Sutter, P. (2016). Fertility options in transgender people. *International Review of Psychiatry*, 28(1), 112-119. doi:10.3109/09540261.2015.1084275.
- de Vries, A.L., & Cohen-Kettenis, P.T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59(3), 301-320.

- de Vries, A.L., Noens, I.L., Cohen-Kettenis, P.T., van Berckelaer-Onnes, I.A., & Doreleijers, T.A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40(8), 930–936. doi:10.1007/s10803-010-0935-9.
- de Vries, A.L., Steensma, T.D., Doreleijers, T.A., & Cohen-Kettenis, P.T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8(8), 2276-2283. doi:10.1111/j.1743-6109.2010.01943.x.
- De Lay, D., Martin, C.L., Cook, R.E., & Hanish, L.D. (2018). The influence of peers during adolescence: Does homophobic name calling by peers change gender identity? *Journal of Youth and Adolescence*, 47(3), 636-649. doi: 10.1007/s10964-017-0749-6.
- Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLOS ONE*, 6(2), e16885. <https://doi.org/10.1371/journal.pone.0016885>.
- Flores, A.R., Herman, J.L., Gates, G.J., & Brown, T.N.T. (2016). *How many adults identify as transgender in the United States?* Los Angeles, CA: The Williams Institute, UCLA School of Law. Retrieved from <https://williamsinstitute.law.ucla.edu>.
- Getahun, D., Nash, R., Flanders, W.D., Baird, T.C., Becerra-Culqui, T.A., Cromwell, L., Hunkeler, E., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Silverberg, M.J., Safer, J., Slovis, J., Tangpricha, V., & Goodman, M. (2018). Cross-sex hormones and acute cardiovascular events in transgender persons: A cohort study. *Annals of Internal Medicine*, 169(4), 205-213. doi:10.7326/M17-2785.
- Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., Hannema, S.E., Meyer, W.J., Murad, M.H., Rosenthal, S.M., Safer, J.D., Tangpricha, V., T'Sjoen, G.G. (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. *The Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.
- Heneghan, C. & Jefferson, T. (2019, February 25). Gender affirming hormone in children and adolescents [blog post]. Retrieved from <https://blogs.bmj.com/bmjebmspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>.
- Johns, M.M., Lowry, R., Andrzejewski, J., Barrios, L.C., Demissie, Z., McManus, T., Raspberry, C.N., Robin, L., Underwood, J.M. (2019). Transgender identity and experiences of violence victimization, substance use, suicide risk, and sexual risk behaviors among high school students — 19 states and large urban school districts, 2017. Retrieved from <https://www.cdc.gov>.
- Kaltiala-Heino, R., Bergman, H., Työlajärvi, M., & Frisé, L. (2018). Gender dysphoria in adolescence: Current perspectives. *Adolescent Health, Medicine and Therapeutics*, 9, 31–41. doi:10.2147/AHMT.S135432.

- Korte, A., Goecker, D., Krude, H., Lehmkuhl, U., Grüters-Kieslich, A., Beier, K.M. (2008). Gender identity disorders in childhood and adolescence. *Deutsches Arzteblatt International*, 105(48), 834-841. doi:10.3238/arztebl.2008.0834.
- Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLOS ONE* 13(8): e0202330. <https://doi.org/10.1371/journal.pone.0202330>.
- McFarling, U.L. (2016, December 26). Demand for transgender medical care is exploding. *Business Insider*. Retrieved from <https://www.businessinsider.com>.
- Peitzmeier, S., Gardner, I., Weinand, J., Corbet, A., & Acevedo, K. (2017). Health impact of chest binding among transgender adults: a community-engaged, cross-sectional study. *Culture, Health & Sexuality*, 19(1), 64-75. doi:10.1080/13691058.2016.1191675.
- Regnerus, Mark (2019, September 18). Does “Conversion Therapy” Hurt People Who Identify as Transgender? The New JAMA Psychiatry Study Cannot Tell Us. *Public Discourse*. Retrieved from <https://www.thepublicdiscourse.com>.
- Richards, C., Maxwell, J., McCune, N. Use of puberty blockers for gender dysphoria: A momentous step in the dark [Letter to the editor]. (2019). *Archives of Disease in Childhood*, 104(6), 611-612.
- Singh D. (2012). *A follow-up study of boys with gender identity disorder* (Doctoral dissertation). Retrieved from <https://images.nymag.com/images/2/daily/2016/01/SINGH-DISSERTATION.pdf>.
- Soh, D. (2018, October 23). The unspoken homophobia propelling the transgender movement in children. *Quillette*. Retrieved from <https://quillette.com>.
- Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52 (6), 582–590. doi: 10.1016/j.jaac.2013.03.016
- Stock, K. (2018, November 15). Stonewall’s new definition of “conversion therapy” raises a few questions. *The Article*. Retrieved from <https://www.thearticle.com>.
- The Trevor Project. (2019). National Survey on LGBTQ Mental Health. New York, New York: The Trevor Project.
- Turban, J.L., Beckwith, N., Reisner, S.L., Keuroghlian, A.S. (2019). Exposure to conversion therapy for gender identity is associated with poor adult mental health outcomes among transgender people

in the U.S. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57 (10). doi:10.1001/jamapsychiatry.2019.2285

World Professional Association for Transgender Health. (2012). *Standards of care for the health of transsexual, transgender, and gender-nonconforming people*. Version 7, p. 20. Retrieved from <https://www.wpath.org/publications/soc>.

Zucker, K.J. (2019). Adolescents with gender dysphoria: Reflections on some contemporary clinical and research issues. *Archives of Sexual Behavior*. doi.org/10.1007/s10508-019-01518-8.

Zucker, K.J., Wood, H., Wasserman, L., VanderLaan, D.P., Aitken, M. (2016). Increasing referrals for gender dysphoria [Letter to the editor]. *Journal of Adolescent Health*, 58(6). Retrieved from https://www.researchgate.net/publication/303370018_Increasing_referrals_for_gender_dysphoria_Letter_to_the_Editor.

ADDENDUM

H.B. 399 (2019)

1st Sub. (Buff)

Representative Craig Hall proposes the following substitute bill:

**PROHIBITION OF THE PRACTICE OF CONVERSION
THERAPY UPON MINORS**

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Craig Hall

Senate Sponsor: _____

LONG TITLE

General Description:

This bill enacts provisions relating to conversion therapy for minors.

Highlighted Provisions:

This bill:

- ▶ prohibits certain health care professionals from providing conversion therapy to a minor; and
- ▶ adds a violation of the prohibition to the list of conduct that constitutes unprofessional conduct for licensing purposes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

58-1-501, as last amended by Laws of Utah 2018, Chapter 318

58-1-502, as last amended by Laws of Utah 2018, Chapter 318

ENACTS:



26 **58-1-509**, Utah Code Annotated 1953

27

28 *Be it enacted by the Legislature of the state of Utah:*

29 Section 1. Section **58-1-501** is amended to read:

30 **58-1-501. Unlawful and unprofessional conduct.**

31 (1) "Unlawful conduct" means conduct, by any person, that is defined as unlawful
32 under this title and includes:

33 (a) practicing or engaging in, representing oneself to be practicing or engaging in, or
34 attempting to practice or engage in any occupation or profession requiring licensure under this
35 title if the person is:

36 (i) not licensed to do so or not exempted from licensure under this title; or

37 (ii) restricted from doing so by a suspended, revoked, restricted, temporary,
38 probationary, or inactive license;

39 (b) (i) impersonating another licensee or practicing an occupation or profession under a
40 false or assumed name, except as permitted by law; or

41 (ii) for a licensee who has had a license under this title reinstated following disciplinary
42 action, practicing the same occupation or profession using a different name than the name used
43 before the disciplinary action, except as permitted by law and after notice to, and approval by,
44 the division;

45 (c) knowingly employing any other person to practice or engage in or attempt to
46 practice or engage in any occupation or profession licensed under this title if the employee is
47 not licensed to do so under this title;

48 (d) knowingly permitting the person's authority to practice or engage in any occupation
49 or profession licensed under this title to be used by another, except as permitted by law;

50 (e) obtaining a passing score on a licensure examination, applying for or obtaining a
51 license, or otherwise dealing with the division or a licensing board through the use of fraud,
52 forgery, or intentional deception, misrepresentation, misstatement, or omission; or

53 (f) (i) issuing, or aiding and abetting in the issuance of, an order or prescription for a
54 drug or device to a person located in this state:

55 (A) without prescriptive authority conferred by a license issued under this title, or by
56 an exemption to licensure under this title; or

57 (B) with prescriptive authority conferred by an exception issued under this title or a
58 multistate practice privilege recognized under this title, if the prescription was issued without
59 first obtaining information, in the usual course of professional practice, that is sufficient to
60 establish a diagnosis, to identify underlying conditions, and to identify contraindications to the
61 proposed treatment; and

62 (ii) Subsection (1)(f)(i) does not apply to treatment rendered in an emergency, on-call
63 or cross coverage situation, provided that the person who issues the prescription has
64 prescriptive authority conferred by a license under this title, or is exempt from licensure under
65 this title.

66 (2) "Unprofessional conduct" means conduct, by a licensee or applicant, that is defined
67 as unprofessional conduct under this title or under any rule adopted under this title and
68 includes:

69 (a) violating, or aiding or abetting any other person to violate, any statute, rule, or order
70 regulating an occupation or profession under this title;

71 (b) violating, or aiding or abetting any other person to violate, any generally accepted
72 professional or ethical standard applicable to an occupation or profession regulated under this
73 title;

74 (c) engaging in conduct that results in conviction, a plea of nolo contendere, or a plea
75 of guilty or nolo contendere which is held in abeyance pending the successful completion of
76 probation with respect to a crime of moral turpitude or any other crime that, when considered
77 with the functions and duties of the occupation or profession for which the license was issued
78 or is to be issued, bears a reasonable relationship to the licensee's or applicant's ability to safely
79 or competently practice the occupation or profession;

80 (d) engaging in conduct that results in disciplinary action, including reprimand,
81 censure, diversion, probation, suspension, or revocation, by any other licensing or regulatory
82 authority having jurisdiction over the licensee or applicant in the same occupation or profession
83 if the conduct would, in this state, constitute grounds for denial of licensure or disciplinary
84 proceedings under Section 58-1-401;

85 (e) engaging in conduct, including the use of intoxicants, drugs, narcotics, or similar
86 chemicals, to the extent that the conduct does, or might reasonably be considered to, impair the
87 ability of the licensee or applicant to safely engage in the occupation or profession;

- 88 (f) practicing or attempting to practice an occupation or profession regulated under this
89 title despite being physically or mentally unfit to do so;
- 90 (g) practicing or attempting to practice an occupation or profession regulated under this
91 title through gross incompetence, gross negligence, or a pattern of incompetency or negligence;
- 92 (h) practicing or attempting to practice an occupation or profession requiring licensure
93 under this title by any form of action or communication which is false, misleading, deceptive,
94 or fraudulent;
- 95 (i) practicing or attempting to practice an occupation or profession regulated under this
96 title beyond the scope of the licensee's competency, abilities, or education;
- 97 (j) practicing or attempting to practice an occupation or profession regulated under this
98 title beyond the scope of the licensee's license;
- 99 (k) verbally, physically, mentally, or sexually abusing or exploiting any person through
100 conduct connected with the licensee's practice under this title or otherwise facilitated by the
101 licensee's license;
- 102 (l) acting as a supervisor without meeting the qualification requirements for that
103 position that are defined by statute or rule;
- 104 (m) issuing, or aiding and abetting in the issuance of, an order or prescription for a
105 drug or device:
- 106 (i) without first obtaining information in the usual course of professional practice, that
107 is sufficient to establish a diagnosis, to identify conditions, and to identify contraindications to
108 the proposed treatment; or
- 109 (ii) with prescriptive authority conferred by an exception issued under this title, or a
110 multi-state practice privilege recognized under this title, if the prescription was issued without
111 first obtaining information, in the usual course of professional practice, that is sufficient to
112 establish a diagnosis, to identify underlying conditions, and to identify contraindications to the
113 proposed treatment;
- 114 (n) violating a provision of Section 58-1-501.5; [~~or~~]
- 115 (o) violating the prohibition in Section 58-1-509; or
- 116 [~~or~~] (p) violating the terms of an order governing a license.
- 117 (3) Unless otherwise specified by statute or administrative rule, in a civil or
118 administrative proceeding commenced by the division under this title, a person subject to any

119 of the unlawful and unprofessional conduct provisions of this title is strictly liable for each
120 violation.

121 Section 2. Section **58-1-502** is amended to read:

122 **58-1-502. Unlawful and unprofessional conduct -- Penalties.**

123 (1) Unless otherwise specified in this title, a person who violates the unlawful conduct
124 provisions defined in this title is guilty of a class A misdemeanor.

125 (2) (a) In addition to any other statutory penalty for a violation related to a specific
126 occupation or profession regulated by this title, if upon inspection or investigation, the division
127 concludes that a person has violated Subsection 58-1-501(1)(a), (1)(c), or (2)[~~(c)~~](p), or a rule
128 or order issued with respect to those subsections, and that disciplinary action is appropriate, the
129 director or the director's designee from within the division shall promptly:

130 (i) issue a citation to the person according to this section and any pertinent rules;

131 (ii) attempt to negotiate a stipulated settlement; or

132 (iii) notify the person to appear before an adjudicative proceeding conducted under
133 Title 63G, Chapter 4, Administrative Procedures Act.

134 (b) (i) The division may assess a fine under this Subsection (2) against a person who
135 violates Subsection 58-1-501(1)(a), (1)(c), or (2)[~~(c)~~](p), or a rule or order issued with respect
136 to those subsections, as evidenced by:

137 (A) an uncontested citation;

138 (B) a stipulated settlement; or

139 (C) a finding of a violation in an adjudicative proceeding.

140 (ii) The division may, in addition to or in lieu of a fine under Subsection (2)(b)(i),
141 order the person to cease and desist from violating Subsection 58-1-501(1)(a), (1)(c), or
142 (2)[~~(c)~~](p), or a rule or order issued with respect to those subsections.

143 (c) Except for a cease and desist order, the division may not assess the licensure
144 sanctions cited in Section 58-1-401 through a citation.

145 (d) A citation shall:

146 (i) be in writing;

147 (ii) describe with particularity the nature of the violation, including a reference to the
148 provision of the chapter, rule, or order alleged to have been violated;

149 (iii) clearly state that the recipient must notify the division in writing within 20

150 calendar days of service of the citation if the recipient wishes to contest the citation at a hearing
151 conducted under Title 63G, Chapter 4, Administrative Procedures Act; and

152 (iv) clearly explain the consequences of failure to timely contest the citation or to make
153 payment of a fine assessed by the citation within the time specified in the citation.

154 (e) The division may issue a notice in lieu of a citation.

155 (f) (i) If within 20 calendar days from the service of the citation, the person to whom
156 the citation was issued fails to request a hearing to contest the citation, the citation becomes the
157 final order of the division and is not subject to further agency review.

158 (ii) The period to contest a citation may be extended by the division for cause.

159 (g) The division may refuse to issue or renew, suspend, revoke, or place on probation
160 the license of a licensee who fails to comply with a citation after it becomes final.

161 (h) The failure of an applicant for licensure to comply with a citation after it becomes
162 final is a ground for denial of license.

163 (i) The division may not issue a citation under this section after the expiration of one
164 year following the occurrence of a violation.

165 (j) The director or the director's designee shall assess fines according to the following:

166 (i) for the first offense handled pursuant to Subsection (2)(a), a fine of up to \$1,000;

167 (ii) for a second offense handled pursuant to Subsection (2)(a), a fine of up to \$2,000;

168 and

169 (iii) for each subsequent offense handled pursuant to Subsection (2)(a), a fine of up to
170 \$2,000 for each day of continued offense.

171 (3) (a) An action for a first or second offense that has not yet resulted in a final order of
172 the division may not preclude initiation of a subsequent action for a second or subsequent
173 offense during the pendency of a preceding action.

174 (b) The final order on a subsequent action is considered a second or subsequent
175 offense, respectively, provided the preceding action resulted in a first or second offense,
176 respectively.

177 (4) (a) The director may collect a penalty that is not paid by:

178 (i) referring the matter to a collection agency; or

179 (ii) bringing an action in the district court of the county where the person against whom
180 the penalty is imposed resides or in the county where the office of the director is located.

181 (b) A county attorney or the attorney general of the state shall provide legal assistance
182 and advice to the director in an action to collect a penalty.

183 (c) A court may award reasonable attorney fees and costs to the prevailing party in an
184 action brought by the division to collect a penalty.

185 Section 3. Section **58-1-509** is enacted to read:

186 **58-1-509. Prohibition on providing conversion therapy to a minor.**

187 (1) As used in this section:

188 (a) (i) "Conversion therapy" means any practice or treatment that seeks to change the
189 sexual orientation or gender identity of a patient or client, including mental health therapy that
190 seeks to change, eliminate, or reduce behaviors, expressions, attractions, or feelings related to a
191 patient or client's sexual orientation or gender identity.

192 (ii) "Conversion therapy" does not mean a practice or treatment that does not seek to
193 change a patient or client's sexual orientation or gender identity, including mental health
194 therapy that:

195 (A) is neutral with respect to sexual orientation and gender identity;

196 (B) provides assistance to a patient or client undergoing gender transition;

197 (C) provides acceptance, support, and understanding of a patient or client;

198 (D) facilitates a patient or client's ability to cope, social support, and identity
199 exploration and development;

200 (E) addresses unlawful, unsafe, premarital, or extramarital sexual activities in a manner
201 that is neutral with respect to sexual orientation; or

202 (F) discusses with a patient or client the patient or client's moral or religious beliefs or
203 practices.

204 (b) "Health care professional" means an individual who is licensed, or an individual
205 who provides mental health therapy as part of the individual's training for a profession that is
206 licensed, under:

207 (i) Chapter 31b, Nurse Practice Act;

208 (ii) Chapter 60, Mental Health Professional Practice Act;

209 (iii) Chapter 61, Psychologist Licensing Act;

210 (iv) Chapter 67, Utah Medical Practice Act; or

211 (v) Chapter 68, Utah Osteopathic Medical Practice Act.

212 (2) A health care professional may not provide conversion therapy to a patient or client
213 who is younger than 18 years old.

214 (3) Subsection (2) does not apply to:

215 (a) a clergy member or religious counselor who is acting substantially in a pastoral or
216 religious capacity and not in the capacity of a health care professional; or

217 (b) a parent or grandparent who is a health care professional and who is acting
218 substantially in the capacity of a parent or grandparent and not in the capacity of a health care
219 professional.