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MODEL POLICY | American Values

Protecting Children from Social Transition Act

PURPOSE OF THIS ACT

This Act prohibits social transition interventions for minors based on the absence of empirical evidence supporting their use and documented evidence of harm. It recognizes that gender dysphoria is a psychological condition requiring proper assessment and treatment of underlying issues, but that social transition is not an evidence-based intervention and should not be employed by mental health professionals, educators, or any other persons. The Act prohibits unlicensed school personnel from initiating or facilitating social transition, mandates parental notification when children exhibit gender-related distress, and establishes enforcement mechanisms, including licensing board discipline and civil remedies. By prohibiting harmful interventions while preserving access to appropriate mental health care, this Act protects children from experimental practices while preserving families' fundamental right to direct their children's upbringing, education, and health care.

Background

Over the past decade, the diagnosis of gender dysphoria in minors has increased dramatically. What was once considered a rare psychological condition now affects an estimated 5% of young adults who identify as something other than their biological sex. This rise has been accompanied by the widespread adoption of "gender affirming care" (GAC), which is a treatment protocol that begins with social transition—a psychological intervention with potentially significant and lasting effects on child development.

Social transition is defined by the World Professional Association for Transgender Health (WPATH) as changes that may include: adopting new names and pronouns; altering identification documents; using sex-segregated spaces inconsistent with biological sex; changing hair and clothing to match a psychological identity; and communicating a preferred gender to others. WPATH recommends this intervention for children as young as 18 months.

Despite its widespread use, social transition lacks empirical support. Recent systematic reviews by the U.S. Department of Health and Human Services (2025) and the NHS-commissioned Cass Review (2024) found low-to-no evidence that social transition reduces psychological distress or improves mental health outcomes. Both reviews explicitly characterized social transition as "an active intervention" with "significant effects on psychological functioning."

The evidence shows that 65-94% of children who experience gender dysphoria and are given basic support—without clinical intervention—come to embrace their biological sex as they mature. In contrast, children who socially transition tend to progress to more invasive medical interventions (e.g., puberty blockers, cross-sex hormones, surgeries) and may still suffer from dysphoric symptoms. An emerging body of literature documents significant regret among patients who underwent any stage of GAC.

THE PROBLEM

Confusion About Diagnosis Enables Misuse by Unlicensed Personnel

Gender dysphoria appears in the DSM-5-TR as a psychological diagnosis properly made by qualified mental health professionals. Yet the diagnosis has been repeatedly modified based on political considerations rather than scientific evidence, creating ambiguity about who is authorized to employ related interventions. This conceptual incoherence has allowed non-clinicians—including teachers, school counselors, and paraprofessionals—to implement social transition without proper training, assessment, or parental consent. Schools have established "gender closets," facilitated name and pronoun changes, and introduced gender-ideology curricula—all without the clinical oversight required for psychological interventions.

Developmental Vulnerability and Inadequate Assessment

Children lack the cognitive capacity to understand long-term implications of identity-shaping interventions. Neurological development critical for emotional regulation and future-oriented reasoning is not complete until the mid-twenties. Research on child suggestibility demonstrates that adult affirmation of a gender identity through names, pronouns, and social roles causes children to internalize that feedback—this is an environmental intervention during developmental plasticity, not a neutral reflection of inner certainty. Moreover, gender dysphoria frequently occurs alongside psychiatric conditions, autism spectrum disorder, and trauma histories. The GAC model proceeds directly to affirmation without determining whether dysphoria symptoms might be better explained and treated by addressing underlying psychological, neurological, or social issues.

Physical and Psychological Harms

While characterized as non-medical, certain social transition practices cause physical harm. Chest binding has been documented to cause adverse health effects in up to 97.2% of users, including rib damage and breathing difficulties. In December 2025, the FDA sent warning letters to twelve manufacturers for marketing breast binders to children. Psychologically, children who socially transition are significantly more likely to progress to puberty blockers, cross-sex hormones, and surgeries—interventions

with permanent, irreversible effects. An emerging literature documents regret among patients who underwent any stage of GAC.

A full report on the background and dangers of GAC and social can be found here.

THE SOLUTION

This Act prohibits social transition for minors, given the absence of empirical evidence supporting its use and documented evidence of harm. Although gender dysphoria is a recognized psychological condition requiring proper assessment and treatment, social transition is not an evidence-based intervention and should not be employed by mental health professionals, educators, or any other persons. The Act establishes clear prohibitions, parental rights to notification and consent for appropriate care, licensing board enforcement, and civil remedies for violations.

The Act does not prevent licensed mental health professionals from providing evidence-based assessment and treatment for underlying conditions that are not gender-based but may contribute to gender-related distress. What it does is prohibit a specific intervention—social transition—that lacks empirical support and has been shown to cause harm, while restoring proper boundaries between parental authority and state action and between evidence-based care and ideologically-driven interventions.

This Act accomplishes the following:

- Prohibits social transition as an intervention for minors due to a lack of empirical evidence and documented harm.
- Prohibits mental health professionals, educators, and all other persons from initiating or facilitating social transition.
- Requires parental consent before any psychological intervention.
- Mandates parental notification when a child expresses gender-related distress.
- Prohibits schools from concealing information about a student's psychological status from parents.
- Directs licensing boards to enforce professional standards and investigate violations.
- Removes GAC content from continuing education requirements; requires instruction on detransition.
- Establishes civil causes of action for unauthorized interventions.
- Protects curriculum from gender ideology.

PROPOSED LEGISLATIVE TEXT

SECTION 1. SHORT TITLE.

This Act shall be known and may be cited as the Protecting Minors from Social Transition Act.

SECTION 2. LEGISLATIVE FINDINGS.

The Legislature finds that:

1. Although social transition continues to be listed as a psychological intervention by the American Psychological Association, it lacks empirical evidence demonstrating its effectiveness or safety as a treatment for gender dysphoria in minors and should not be employed by mental health professionals, educators, or other persons due to the absence of supporting evidence and documented risk of harm..
2. Systematic reviews by the U.S. Department of Health and Human Services (2025) and the Cass Review (2024) found low-to-no evidence that social transition reduces psychological distress or improves mental health outcomes in minors.
3. Research demonstrates that 65-94% of children experiencing gender dysphoria who receive basic support without clinical intervention come to embrace their biological sex as they mature.
4. Children who socially transition are significantly more likely to progress to medical interventions including puberty blockers, cross-sex hormones, and surgeries.
5. Developmental psychology research confirms that children lack the cognitive capacity to understand and knowingly consent to the long-term implications of identity-shaping interventions.
6. Gender dysphoria frequently occurs alongside psychiatric conditions, autism spectrum disorder, and trauma histories that require proper assessment and treatment.
7. Parents possess the fundamental right to direct the upbringing, education, health care, and mental health care of their children.
8. Schools and unlicensed personnel lack the training, authority, and legal responsibility to diagnose psychological conditions or administer psychological interventions.
9. Concealing information about a child's psychological status from parents undermines parental authority and prevents families from obtaining appropriate professional care.

SECTION 3. DEFINITIONS.

For purposes of this Act:

(a) "Social transition" means any intervention, whether formal or informal, intended to affirm a minor's identification with a sex inconsistent with the minor's biological sex, including but not limited to:

1. adopting names or pronouns inconsistent with the minor's biological sex;
2. permitting access to sex-segregated spaces (restrooms, locker rooms, overnight accommodations) inconsistent with the minor's biological sex;
3. modifying school records, identification documents, or other official records to reflect a sex inconsistent with the minor's biological sex;
4. providing resources, instruction, or counseling intended to facilitate adoption of a gender identity inconsistent with the minor's biological sex.

(b) "Biological sex," when referring to an individual's sex, shall be understood to refer to either male or female, as biologically determined and defined by this section.

(c) "Female," when referring to a natural person, means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes eggs for fertilization.

(d) "Male," when referring to a natural person, means an individual who naturally has, had, will have, or would have, but for a developmental or genetic anomaly or historical accident, the reproductive system that at some point produces, transports, and utilizes sperm for fertilization.

(e) "Psychological intervention" means an action by a mental health professional to address psychological issues, based on explicit psychological theory, and intended to induce changes in cognitions, emotions, or behaviors.

(f) "Licensed mental health professional" means an individual licensed by the state to diagnose and treat mental health conditions, including licensed psychologists, psychiatrists, clinical social workers, licensed professional counselors, and marriage and family therapists.

(g) "School personnel" means any employee, contractor, or volunteer of a school district or educational institution, including teachers, administrators, counselors, coaches, and paraprofessionals.

(h) "Parent" means a biological or adoptive parent or legal guardian of a minor.

(i) "Minor" means an individual under 18 years of age.

(j) "Person with supervisory or custodial authority" means any person who, by employment, contract, or delegation, has been given responsibility for the care, supervision, or education of a minor, including but not limited to school personnel, licensed childcare providers, youth program staff, and foster care providers.

PART I: CLINICAL PRACTICE STANDARDS

SECTION 4. PROHIBITION ON SOCIAL TRANSITION FOR MINORS.

(a) Social transition is hereby recognized as a psychological intervention that lacks empirical evidence demonstrating effectiveness or safety as a treatment for gender dysphoria in minors and has been documented to cause psychological and physical harm, subject to all professional standards, licensing requirements, informed consent obligations, and parental consent requirements applicable to mental health treatment of minors.

(b) No licensed mental health professional may initiate, recommend, or facilitate social transition for a minor.

(c) This prohibition does not prevent licensed mental health professionals from:

1. Conducting comprehensive diagnostic assessments to evaluate:
    i. The presence and nature of psychological distress;

ii. Comorbid psychiatric conditions, including depression, anxiety, trauma-related disorders, and autism spectrum disorder;
iii. Family dynamics and social influences; and
iv. Underlying conditions that are not gender-based but may contribute to gender-related distress.

2. Providing evidence-based treatment for diagnosed mental health conditions;
3. Providing supportive counseling that does not affirm or encourage identification with a sex inconsistent with the minor's biological sex; or
4. Referring patients to appropriate medical specialists for evaluation and treatment of underlying conditions.

(d) Violation of subsection (b) constitutes unprofessional conduct subject to disciplinary action under Section 5.

SECTION 5. LICENSING BOARD ENFORCEMENT.

(a) State licensing boards for mental health professionals shall investigate complaints alleging that a licensee initiated, recommended, or facilitated social transition for a minor in violation of Section 4.

(b) Violations of Section 4 constitute unprofessional conduct subject to disciplinary action, including license suspension or revocation and civil penalties.

(c) Licensing boards shall establish reporting requirements to track complaints related to gender dysphoria treatment in minors and shall publish annual summaries of complaints and disciplinary actions.

SECTION 6. CONTINUING EDUCATION REQUIREMENTS.

(a) State licensing boards shall not approve continuing education credits for coursework that promotes gender affirming care, social transition, or medical interventions for gender dysphoria in minors.

(b) Licensing boards shall approve continuing education credits for coursework addressing:

1. The experiences and perspectives of detransitioners;
2. Evidence-based assessment of gender dysphoria, including evaluation of comorbidities;
3. Therapeutic approaches aimed at resolving dysphoria and aligning psychological well-being with biological reality;
4. The lack of high-quality evidence supporting gender affirming care;
5. Developmental considerations in treating minors with gender-related distress.

PART II: SCHOOLS AND EDUCATIONAL INSTITUTIONS

SECTION 7. PROHIBITION ON SOCIAL TRANSITION IN SCHOOLS.

(a) No school personnel may initiate, facilitate, or encourage social transition of a minor. This prohibition includes but is not limited to:

1. Addressing a student by a name or pronoun inconsistent with the student's biological sex;
2. Permitting a student to use facilities designated for the opposite sex;
3. Altering school records to reflect a sex inconsistent with the student's biological sex;
4. Providing instruction, materials, resources, or counseling promoting or facilitating social transition; and
5. Maintaining "gender support" resources, closets, or programs that provide students with clothing, binders, or other items to facilitate social transition.

(b) School personnel who encounter a student expressing gender-related distress shall:

1. Immediately notify the student's parents; and
2. Refrain from providing counseling, advice, or resources related to social transition.

(c) This section does not prohibit school personnel from:

1. Treating all students with dignity and respect;
2. Maintaining a safe and supportive educational environment; or
3. Addressing bullying or harassment.

SECTION 8. PROHIBITION OF CONCEALMENT FROM PARENTS.

(a) No school or school personnel may adopt or enforce any policy, practice, or procedure that prohibits or discourages school personnel from notifying parents that their child has:

1. Expressed identification with a sex inconsistent with the child's biological sex;
2. Requested to be addressed by a name or pronoun inconsistent with the child's biological sex;
3. Requested access to facilities designated for the opposite sex;
4. Exhibited symptoms of gender dysphoria or gender-related psychological distress; or
5. Requested resources, counseling, or information related to gender identity or social transition.

(b) Any policy requiring or encouraging concealment of information described in subsection (a) is void and unenforceable.

(c) A school or school district may not take adverse employment action against school personnel for notifying parents of information described in subsection (a).

SECTION 9. CURRICULUM REQUIREMENTS.

(a) No school district shall include in its curriculum any instruction, materials, or programs that:

1. Promote or normalize the concept that biological sex is changeable or that gender identity can differ from biological sex;
2. Encourage students to question or reject their biological sex;
3. Promote social transition or gender affirming care as appropriate responses to gender-related distress; or
4. Teach that individuals have a "gender identity" separate from and potentially contrary to biological sex.

(b) This section does not prohibit age-appropriate instruction on human biology, anatomy, and reproduction.

PART III: PARENTAL RIGHTS AND CONSENT

SECTION 10. PARENTAL CONSENT REQUIREMENT.

(a) No psychological intervention, screening, assessment, or counseling related to gender identity or gender dysphoria may be administered to a minor by any person or entity without prior written opt-in parental consent.

(b) Written parental consent must include:

1. A description of the specific intervention, screening, or assessment to be administered; and
2. A statement that consent may be revoked at any time.

(c) A parent's refusal to consent under this section shall not:

1. Serve as grounds for a report of abuse or neglect;
2. Be considered in any custody determination absent independent evidence of harm; or
3. Result in adverse action against the minor or family.

SECTION 11. MANDATORY PARENTAL NOTIFICATION.

(a) Any person with supervisory or custodial authority over a minor who learns that the minor has expressed a desire to socially transition, exhibits symptoms of gender dysphoria, or requests resources related to gender identity shall immediately notify the minor's parents.

(b) Notification under this section is mandatory and may not be delayed, conditioned, or withheld based on:

1. The minor's objection to parental notification;
2. A belief that the parents will not be supportive;
3. Concerns about the family's religious or moral beliefs; or
4. Any other consideration.

(c) Failure to provide notification as required by this section constitutes a violation subject to the remedies in Section 13.

PART IV: ENFORCEMENT AND REMEDIES

SECTION 12. PRESUMPTION OF HARM.

When a social transition is initiated, recommended, or facilitated in violation of this Act, there shall be a rebuttable presumption of harm to the minor. The burden of proof shifts to the defendant to demonstrate by clear and convincing evidence that no harm occurred.

SECTION 13. CIVIL CAUSE OF ACTION.

(a) A parent may bring a civil action against:

1. Any person who initiated, facilitated, or encouraged social transition of the parent's minor child in violation of this Act;
2. Any school, school district, or educational institution that maintained policies or practices in violation of this Act; and
3. Any person who failed to provide notification required by Section 11.

(b) Remedies available in an action under this section include:

1. Compensatory damages for psychological harm to the minor;
2. Compensatory damages for interference with parental rights;
3. Costs of appropriate therapeutic intervention to address harm;
4. Reasonable attorney's fees and court costs; and
5. Injunctive relief.

(c) Actions under this section must be brought within the later of two (2) years from:

1. The date the parent discovered or reasonably should have discovered the violation; or
2. The minor's 18th birthday.

(d) This section does not limit other causes of action available under state or federal law.

SECTION 14. NO QUALIFIED IMMUNITY.

Qualified immunity shall not be available as a defense in any action brought under Section 13 for violations of this Act occurring after its effective date.

SECTION 15. SEVERABILITY.

If any provision of this Act or its application to any person or circumstance is held invalid, the remaining provisions shall not be affected and shall remain in full force and effect.

SECTION 16. EFFECTIVE DATE.

This Act takes effect on _____.

EXPLANATORY NOTE

This model policy integrates key provisions from Texas SB 12 and SB 113, and other state protections while addressing gaps identified in the research literature. It is designed to be adapted to each state's specific statutory structure and legal framework.