MINNESOTA BOARD OF PSYCHOLOGY
March 21, 2025
Board Meeting

Order of Business

PUBLIC SESSION:

1. **Call to Order**
2. **Adoption of Tentative Agenda**
3. **Announcements**
    - **A. Web Ex Meeting Link**
4. **Approval of the Board Minutes**
    - **A. Approval of Board Meeting Minutes**
5. **Consent Agenda**
    - **A. Staff Delegated Authority Report**
6. **New Business**
    - **A. Criminal Background Check Program Overview**
    - **B. Executive Director's Report**
    - **C. Board Administrative Terminations**
7. **Committee Reports**
8. **Adjournment**

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Web Ex Meeting Link

INTRODUCTION TO THE TOPIC:

Meeting link:
https://minnesota.webex.com/meet/samuel.sands

Meeting number:
966 811 163

Join from a video conferencing system or application
Dial: samuel.sands@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number.

Join by phone
+1-415-655-0003 United States Toll
Access Code: 966 811 163

Global call-in numbers
https://minnesota.webex.com/minnesota/globalcallin.php?MTID=m0f8b8d96df6f1583dab9f301a08c30ac

BOARD ACTION REQUESTED:

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Approval of Board Meeting Minutes

INTRODUCTION TO THE TOPIC:

The Board Meeting minutes for February 2025 are respectfully submitted.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
February Board Meeting Minutes	3/21/2025	Cover Memo

MINNESOTA BOARD OF PSYCHOLOGY

MINNESOTA BOARD OF PSYCHOLOGY
Minutes of the February21, 2025 Board Meeting

Board Members and Staff in Attendance: Sonal Markanda, Sebastian Rilen, Pamela Freske, Salina Renninger, Daniel Hurley, Michael Thompson, Joel Bakken, Cesar Gonzalez, Jill Idrizow, Nancy Cameron, Michelle Zhao, Sam Sands, and Trisha Hoffman.

Guests: Nick Lienesch.

PUBLIC SESSION

1. Call to Order

Sonal Markanda called the meeting to order at 9:35AM. The meeting was held in a hybrid format with some individuals in attendance in person and others online. Voting was held by roll call.

A. WebEx MeetingLink

2. Adoption of Tentative Agenda

Daniel Hurley moved, seconded by Joel Bakken Motion: to adopt the tentative agenda. There being 8 “ayes” and 0 “nays” the Motion Passed.

3. Announcements

4. Approval of the Board Minutes

Nancy Cameron moved, seconded by Daniel Hurley Motion: to adopt the January 24, 2025, Board Meeting Minutes. There being 7 "ayes" and 0 "nays" the motion Passed.

5. Consent Agenda

A. Staff Delegated Authority Report

6. New Business

A. Variance Request 18-0169

The basis for the Board's decision to deny the variance request was a determination that the process to seek accommodations had not been exhausted. Motion: to deny the Variance Request. There being 8 "ayes" and 0 "nays" the motion Passed.

B. CE Variance Request

Joel Bakken moved, seconded by Pamela Freske Motion: to approve the CE Variance Request for a period of six months. There being 3 "ayes" and 5 "nays" the motion Failed.

Pamela Freske moved, seconded by Salina Renninger Motion: to approve the CE Variance Request for a period of four months. There being 7 "ayes" and 1 "nay" the motion Passed.

The basis for the Board's decision was a determination that adherence to the rule would impose an undue burden on the licensee who had suffered a recent loss and experienced medical issues, granting the variance for a period of four months would not adversely affect the public welfare, and the rationale for the rule could be met by the licensee completing the CE requirements as specified in the Variance Request.

C. Master's Licensing Update

The Board discussed the newly released ASPPB model law for master's-level licensure. In addition, the Board briefly discussed the APA Draft Revised Code of Ethics

D. Executive Director's Report

Trisha Hoffman provided an update on the work of the Licensure Unit as it continues to support the Mission and Vision of the Board, including bringing the total of Behavior Analyst licensees to 578, with applications continuing to be received.

Sam Sands noted that the Culturally Informed and Culturally Responsive Mental Health Task Force released its recommendations. He also highlighted materials provided to the Board that relate to public perceptions of licensing boards and provided legislative updates on bills being discussed at the legislature.

E. Board Administrative Terminations

Nancy Cameron moved, seconded by Salina Renninger Motion: to approve the Board Administrative Terminations. There being 8 "ayes" and 0 "nays" the motion Passed.

7. Committee Reports

8. Adjournment

Adjourned at 12:15 PM

EXECUTIVE SESSION

1. Request for an Unconditional License

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Staff Delegated Authority Report

INTRODUCTION TO THE TOPIC:

The Board utilizes a consent agenda for routine financial, legal, or administrative matters that require Board action or inform the Board of action taken under authority delegated by the Board.

The items on the consent agenda are expected to be non-controversial and not requiring of a discussion.

The consent agenda is voted on in a single majority vote, but made be divided into several, separate items if necessary.

The items on the consent agenda will be considered early in the meeting. The Board chair will ask if any member wishes to remove an item from the consent agenda for separate consideration, and if so, the Chair will schedule it for later in the meeting.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Behavior Analyst Consent Agenda	3/19/2025	Cover Memo
Licensure Consent Agenda	3/19/2025	Cover Memo

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CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Licensed Behavior Analyst (LBA)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Behavior Analyst (LBA) licensure pursuant to MN Statute 148.9983.

License Number	Licensee
LBA0576	Dominique Schnell
LBA0577	Mara Teske
LBA0578	Brianna Brown
LBA0579	Ingrid Jones
LBA0580	Leslie Markowitz
LBA0581	Tetiana Groce
LBA0582	Molly Gavett
LBA0583	Ian Roos
LBA0584	Tesheima White
LBA0585	Colin Levesque
LBA0586	Francesca Salazar
LBA0587	Caroline Romick
LBA0588	Sabrena Yeazle
LBA0589	Eiley Misfeldt
LBA0590	Andrea Langford
LBA0591	Rachael Tarras
LBA0592	Hannah Spande
LBA0593	Timothy Moore
LBA0594	Desiree Welle
LBA0595	Yvette Stoddard
LBA0596	Natalie Kido
LBA0597	Ociel Mejia
LBA0598	Allison Chisholm
LBA0599	Rebecca Rivetto
LBA0600	Larry Krog
LBA0601	Megan Ouellette
LBA0602	Elizabeth Wehrheim
LBA0603	Michelle Zube
LBA0604	Mariah Tricker
LBA0605	Carley Fanone
LBA0606	Tzivia Bresler
LBA0607	Kathryn Ashley
LBA0608	Kelly Barker

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LBA0609	Hannah Franz-Mesick
LBA0610	Tesa Dahl
LBA0611	Denise Jorud

Licensure Progression Statistics

The following data is a summary of the length of time it takes for an applicant to obtain licensure as a Behavior Analyst with the Minnesota Board of Psychology.

Total Number of LBA Applications Filed Since Last Council Meeting: 36

Of applications filed, number of LBA applications that have satisfied all license fees: 38

Of these applications, number submitted to CBC program (anticipated timeline to process CBC is 30 days): 38

Of all applications filed (and paid fees), number in compliance review: 9

Average days for license to be granted (time counted from staff review to license application approved): 1

Of applications filed, number of Behavior Analyst License applications still in review: 745 applications filed in all, 72 still in review

Reasons for continued review: Applications are either in Final Review, Staff Review, or in progress.

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CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Admission to Examination for Professional Practice in Psychology (EPPP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Admission to the Examination for Professional Practice in Psychology (EPPP) pursuant to Minnesota Rules 7200.0550.

Applicant(s) Granted Admission to the (EPPP) Exam
Faith Onyambu, Psy.D
Zoe Green, Psy.D
Madeline Eyer, Ph.D
Tamara Nevergall, Psy.D
Anne Zaslofky, Ph.D
Travis Mord, Psy.D
Kirsten McKone, Ph.D
Amy Serna, Psy.D.
Johanna Ramirez, Ph.D.
Abyan Bashir, Psy.D.
Bridget Kennedy, Ph.D.

Admission to Professional Responsibility Examination (PRE)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Admission to the Professional Responsibility Examination (PRE) pursuant to Minnesota Rules 7200.0550.

Applicant(s) Granted Admission to the (PRE)
Anna Sofie Shouse, Psy.D
Amanda Clinton, Ph.D
Angela Webb, Psy.D
Colby Lucas, Ph.D
Signe Nestingen, Psy.D
Kyla Leonard, Ph.D
Marty Witucki, Ph.D
Lindsay Lilistrom, Psy.D
Lynn Martell, Ph.D.
Savana Naini, Psy.D
Alexanndria Colburn, Ph.D
Anne Zaslofsky, Ph.D
Frances Calkins, Ph.D.
Sheena Czipri, Psy.D
Britta Boekamp, Psy.D
Kirsten McKone, Ph.D.
Drea Tuott, Psy.D.
Melissa Jents, Psy.D.
Amanda Landwehr Klamm, Psy.D.
Adam Sumner, Ph.D.

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Wendi Major, Ph.D.
Zoe Green, Psy.D.
Bridget Kennedy, Ph.D.

Licensed Psychologist (LP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Licensed Psychologist (LP) licensure pursuant to Minnesota Statutes, section 148.907 and the administrative rules of the Psychology Practice Act.

License Number	Licensee
LP7169	Anna Sofie Shouse, Psy.D.
LP7170	Shari Brightly-Brown, Ph.D.
LP7171	Rebecca Pruitt, Ph.D.
LP7172	Colby Lucas, Ph.D.
LP7173	Brandi Diaz, Psy.D.
LP7174	Lindsay Lillstrom, Psy.D.
LP7175	Adam De Boer, Psy.D.
LP7176	Lauren Gould, Psy.D.
LP7177	Angela Webb, Psy.D.
RL00095	Kristine Duffin
RL00103	Signe Nestingen

Guest Licensure (GL)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Guest Licensure (GL) pursuant to Minnesota Statutes, section 148.916 and the administrative rules of the Psychology Practice Act.

License Number	Licensee
GL0136	April Owen
GL0137	Britta Boekamp

Licensure for Voluntary Practice (L-VP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Licensure for Volunteer Practice (LPV) pursuant to Minnesota Statutes 148.909 and the administrative rules of the Psychology Practice Act.

License Number	Licensee
LP-V0014	Kathleen Weber

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Emeritus Registration (Em.)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Emeritus Registration pursuant to Minnesota Statutes, section 148.9105.

License Number	Licensee
ER00194	John Billig
ER00195	Cecilia Swanson
ER00196	Stephen Parker
ER00197	Kay Pitkin

Voluntary Terminations (VT)

Under delegated authority from the Board, Board staff terminated the following License's pursuant to Minnesota Rules 7200.3700.

License Number	Licensee
LP3623	Cecilia Swanson
LP4134	Karen Graszer
LP2149	Stephen Parker
LP2151	Beatrice Robinson
LP2261	Kay Pitkin

Continuing Education Variance Requests

Under delegated authority from the Board, Board staff approved the following licensee(s)' requests for a six (6) month continuing education variance pursuant to Minnesota Rules 7200.3860, D.

License Number	Licensee
LP1142	Hollida Wakefield
LP5347	Amber Ehrlich
LP2251	Linda Oakes
LP6891	Tessa Stapelmann
LP3297	Daniel Nelson

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Licensure Progression Statistics

The following data is a summary of the length of time it takes for an applicant to obtain licensure with the Minnesota Board of Psychology. The starting point is staff review; when the applicant has submitted all required documents for the specific type of license application.

Number of Initial, Reciprocity and Mobility LP applications filed since last Board meeting: 14
Of applications filed, number of LP applications still in review: 3
Reasons for continued review: additional information needed
Initial, Reciprocity, and Mobility applications days to license: 17 days
Number of Guest License applications filed since last Board meeting: 2
Of applications filed, number of Guest License applications still in review: 0
Reasons for continued review: N/A
Guest License applications days to license: 15 days

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY:

TITLE: Criminal Background Check Program Overview

INTRODUCTION TO THE TOPIC:

The Criminal Background Check Program (CBCP) provides criminal background check (CBC) services to sixteen of the Minnesota Health Related Licensing Boards (HLBs).
The CBCP collects and processes the fingerprints and forms required to complete a CBC for anyone who has applied for initial licensure with one of the HLBs or is having their license reinstated, or as part of a licensure-related investigation.

BOARD ACTION REQUESTED:

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY: Executive Director

TITLE: Executive Director's Report

INTRODUCTION TO THE TOPIC:

The Executive Director Report communicates, in advance, information that brings board members up to date on what has occurred since the last board meeting and is intended to lead to engagement and interaction at the next board meeting. The Executive Director Report seeks to offer reminders to board members on upcoming commitments, relevant dates and events, and to raise issues for board members to address during the board meeting. The Executive Director Report is also intended to give board members information that is useful in their role as board members and in stakeholder outreach.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
SF 2371	3/20/2025	Cover Memo
Sf2589	3/20/2025	Cover Memo
AI article	3/20/2025	Cover Memo
Conversion Therapy Ban SCOTUSBlog Article	3/20/2025	Cover Memo
SF1501	3/20/2025	Cover Memo
HF936	3/20/2025	Cover Memo
ED Report	3/21/2025	Cover Memo

SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 2371

(SENATE AUTHORS: DIBBLE)

DATE	D-PG	OFFICIAL STATUS
03/10/2025	714	Introduction and first reading
		Referred to Commerce and Consumer Protection
03/20/2025		Comm report: To pass as amended and re-refer to Health and Human Services

A bill for an act

relating to state government; modifying medical cannabis provisions; amending Minnesota Statutes 2024, sections 342.01, by adding subdivisions; 342.09, subdivision 2; 342.51, subdivision 2, by adding a subdivision; 342.52, subdivision 9; 342.57.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2024, section 342.01, is amended by adding a subdivision to read:

Subd. 69c. **Tribal medical cannabis board.** "Tribal medical cannabis board" means an agency established by a federally recognized Tribal government and authorized by the Tribe's governing body to provide regulatory oversight and monitor compliance with a Tribal medical cannabis program and applicable regulations.

Sec. 2. Minnesota Statutes 2024, section 342.01, is amended by adding a subdivision to read:

Subd. 69d. **Tribal medical cannabis program.** "Tribal medical cannabis program" means a program established by a federally recognized Tribal government within the boundaries of Minnesota that involves the commercial production, processing, sale or distribution, and possession of medical cannabis and medical cannabis products.

Sec. 3. Minnesota Statutes 2024, section 342.01, is amended by adding a subdivision to read:

Subd. 69e. **Tribal medical cannabis program patient.** "Tribal medical cannabis program patient" means a person who possesses a valid registration verification card or equivalent

document that is issued under the laws or regulations of a Tribal Nation within the boundaries of Minnesota. A valid registration verification card must verify that the card holder is enrolled in or authorized to participate in a Tribal medical cannabis program.

Sec. 4. Minnesota Statutes 2024, section 342.09, subdivision 2, is amended to read:

Subd. 2. **Home cultivation of cannabis for personal adult use.** (a) Up to eight cannabis plants, with no more than four being mature, flowering plants may be grown at a single residence, including the curtilage or yard, without a license to cultivate cannabis issued under this chapter provided that cultivation takes place at the primary residence of an individual 21 years of age or older and in an enclosed, locked space that is not open to public view.

(b) Pursuant to section 342.52, subdivision 9, paragraph (d), a registered designated caregiver may cultivate up to eight cannabis plants for not more than one patient household. In addition to eight cannabis plants for one patient household, a registered designated caregiver may cultivate up to eight cannabis plants for the caregiver's personal adult use of cannabis. Of the 16 or fewer total cannabis plants being grown in the registered caregiver's residence, no more than eight may be mature, flowering plants.

Sec. 5. Minnesota Statutes 2024, section 342.51, subdivision 2, is amended to read:

Subd. 2. **Distribution requirements.** (a) Prior to distribution of medical cannabis flower or medical cannabinoid products to a person enrolled in the registry program, an employee ~~with a valid medical cannabis consultant certificate issued by the office or a licensed pharmacist under chapter 151~~ of a cannabis business must:

(1) review and confirm the patient's enrollment in the registry program;

(2) verify that the person requesting the distribution of medical cannabis flower or medical cannabinoid products is the patient, the patient's registered designated caregiver, or the patient's parent, legal guardian, or spouse using the procedures established by the office;

(3) ~~provide~~ confirm that the patient had a consultation ~~to the patient~~ with (i) an employee with a valid medical cannabis consultant certificate issued by the office; or (ii) an employee who is a licensed pharmacist under chapter 151 to determine the proper medical cannabis flower or medical cannabinoid product, dosage, and paraphernalia for the patient if required under subdivision 3;

(4) apply a patient-specific label on the medical cannabis flower or medical cannabinoid product that includes recommended dosage requirements and other information as required by the office; and

(5) provide the patient with any other information required by the office.

(b) A cannabis business with a medical cannabis retail endorsement may not deliver medical cannabis flower or medical cannabinoid products to a person enrolled in the registry program unless the cannabis business with a medical cannabis retail endorsement also holds a cannabis delivery service license. The delivery of medical cannabis flower and medical cannabinoid products are subject to the provisions of section 342.42.

Sec. 6. Minnesota Statutes 2024, section 342.51, is amended by adding a subdivision to read:

Subd. 2a. **Distribution to Tribal medical cannabis program patients.** (a) A cannabis business with a medical cannabis retail endorsement may distribute medical cannabis flower or medical cannabinoid products to a Tribal medical cannabis program patient.

(b) Before receiving a distribution of medical cannabis, a Tribal medical cannabis program patient must provide to an employee of the cannabis business:

(1) a valid medical cannabis registration verification card or equivalent document issued by a Tribal medical cannabis program that indicates that the Tribal medical cannabis program patient is authorized to use medical cannabis on Indian lands over which the Tribe has jurisdiction; and

(2) a valid photographic identification card issued by the Tribal medical cannabis program, a valid driver's license, or a valid state identification card.

(c) Prior to the distribution of medical cannabis flower or medical cannabinoid products to a Tribal medical cannabis program patient, an employee of a cannabis business must:

(1) ensure that a patient-specific label has been applied to all medical cannabis flower and medical cannabinoid products. The label must include the recommended dosage requirements and other information required by the office; and

(2) provide the patient with any other information required by the office.

(d) For each transaction that involves a Tribal medical cannabis program patient, a cannabis business with a medical cannabis retail endorsement must report to the office on a weekly basis:

(1) the name of the Tribal medical cannabis program patient;

(2) the name of the Tribal medical cannabis program in which the Tribal medical cannabis program patient is enrolled;

(3) the amount and dosages of medical cannabis distributed;

(4) the chemical composition of the medical cannabis distributed; and

(5) the tracking number assigned to the medical cannabis that was distributed to the Tribal medical cannabis program patient.

(e) A cannabis business with a medical cannabis retail endorsement may distribute medical cannabis flower and medical cannabinoid products to a Tribal medical cannabis program patient in a motor vehicle if:

(1) an employee of the cannabis business receives payment and distributes medical cannabis flower and medical cannabinoid products in a designated zone that is as close as feasible to the front door of the facility where the cannabis business is located;

(2) the cannabis business with a medical cannabis retail endorsement ensures that the receipt of payment and distribution of medical cannabis flower and medical cannabinoid products are visually recorded by a closed-circuit television surveillance camera and provides any other necessary security safeguards required by the office;

(3) the cannabis business with a medical cannabis retail endorsement does not store medical cannabis flower or medical cannabinoid products outside a restricted access area;

(4) an employee of the cannabis business transports medical cannabis flower and medical cannabinoid products from a restricted access area to the designated zone for distribution to patients only after confirming that the patient enrolled in the registry program has arrived in the designated zone;

(5) the payment for and distribution of medical cannabis flower and medical cannabinoid products to a patient only occurs after meeting the requirements in paragraph (b);

(6) immediately following the distribution of medical cannabis flower or medical cannabinoid products to a patient, an employee of the cannabis business records the transaction in the statewide monitoring system; and

(7) immediately following the distribution of medical cannabis flower and medical cannabinoid products, an employee of the cannabis business transports all payments received into the facility where the cannabis business is located.

Sec. 7. Minnesota Statutes 2024, section 342.52, subdivision 9, is amended to read:

Subd. 9. **Registered designated caregiver.** (a) The office must register a designated caregiver for a patient if the patient requires assistance in administering medical cannabis flower or medical cannabinoid products; obtaining medical cannabis flower, medical cannabinoid products, or medical cannabis paraphernalia from a cannabis business with a medical cannabis retail endorsement; or cultivating cannabis plants as permitted by section 342.09, subdivision 2.

(b) In order to serve as a designated caregiver, a person must:

(1) be at least 18 years of age;

(2) agree to only possess the patient's medical cannabis flower and medical cannabinoid products for purposes of assisting the patient; and

(3) agree that if the application is approved, the person will not serve as a registered designated caregiver for more than six registered patients at one time. Patients who reside in the same residence count as one patient.

(c) Nothing in this section shall be construed to prevent a registered designated caregiver from being enrolled in the registry program as a patient and possessing and administering medical cannabis flower or medical cannabinoid products as a patient.

(d) Notwithstanding any law to the contrary, a registered designated caregiver approved to assist a patient enrolled in the registry program with obtaining medical cannabis flower may cultivate cannabis plants on behalf of one patient. A registered designated caregiver may grow up to eight cannabis plants for the patient household that the registered designated caregiver is approved to assist with obtaining medical cannabis flower. If a patient enrolled in the registry program directs the patient's registered designated caregiver to cultivate cannabis plants on behalf of the patient, the patient must assign the patient's right to cultivate cannabis plants to the registered designated caregiver and ~~the~~ notify the office. A patient who assigns the patient's right to cultivate cannabis plants to a registered caregiver is prohibited from cultivating cannabis plants for personal use. Nothing in this paragraph limits the right of a registered designated caregiver cultivating cannabis plants on behalf of a patient enrolled in the registry program to also cultivate cannabis plants for personal use pursuant to section 342.09, subdivision 2.

Sec. 8. Minnesota Statutes 2024, section 342.57, is amended to read:

342.57 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPANTS.

Subdivision 1. **Presumption.** (a) There is a presumption that ~~a patient or other person~~ an individual enrolled in the registry program or a Tribal medical cannabis program patient is engaged in the authorized use or possession of medical cannabis flower and medical cannabinoid products.

(b) This presumption may be rebutted by evidence that:

(1) the use or possession of medical cannabis flower or medical cannabinoid products by a patient or other person enrolled in the registry program was not for the purpose of assisting with, treating, or alleviating the patient's qualifying medical condition or symptoms associated with the patient's qualifying medical condition~~.~~; or

(2) a Tribal medical cannabis program patient's use of medical cannabis was not for a purpose authorized by the Tribal medical cannabis program.

Subd. 2. **Criminal and civil protections.** (a) Subject to section 342.56, the following are not violations of this chapter or chapter 152:

(1) use or possession of medical cannabis flower, medical cannabinoid products, or medical cannabis paraphernalia by a patient enrolled in the registry program ~~or by~~, a visiting patient, or a Tribal medical cannabis program patient to whom medical cannabis flower or medical cannabinoid products are distributed under section 342.51, subdivision 5;

(2) possession of medical cannabis flower, medical cannabinoid products, or medical cannabis paraphernalia by a registered designated caregiver or a parent, legal guardian, or spouse of a patient enrolled in the registry program; or

(3) possession of medical cannabis flower, medical cannabinoid products, or medical cannabis paraphernalia by any person while carrying out duties required under sections 342.51 to 342.60.

(b) The Office of Cannabis Management, members of the Cannabis Advisory Council, Office of Cannabis Management employees, agents or contractors of the Office of Cannabis Management, members of a Tribal medical cannabis board, a Tribal medical cannabis board's staff, a Tribal medical cannabis board's agents or contractors, and health care practitioners participating in the registry program are not subject to any civil penalties or disciplinary action by the Board of Medical Practice, the Board of Nursing, or any business, occupational, or professional licensing board or entity solely for participating in the registry program or in a Tribal medical cannabis program either in a professional capacity or as a patient. A

pharmacist licensed under chapter 151 is not subject to any civil penalties or disciplinary action by the Board of Pharmacy when acting in accordance with sections 342.51 to 342.60 either in a professional capacity or as a patient. Nothing in this section prohibits a professional licensing board from taking action in response to a violation of law.

(c) Notwithstanding any law to the contrary, a Cannabis Advisory Council member, the governor, or an employee of a state agency must not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 342.51 to 342.60.

(d) Federal, state, and local law enforcement authorities are prohibited from accessing the registry except when acting pursuant to a valid search warrant. Notwithstanding section 13.09, a violation of this paragraph is a gross misdemeanor.

(e) Notwithstanding any law to the contrary, the office and employees of the office must not release data or information about an individual contained in any report or document or in the registry and must not release data or information obtained about a patient enrolled in the registry program, except as provided in sections 342.51 to 342.60. Notwithstanding section 13.09, a violation of this paragraph is a gross misdemeanor.

(f) No information contained in a report or document, contained in the registry, or obtained from a patient under sections 342.51 to 342.60 or from a Tribal medical cannabis program patient may be admitted as evidence in a criminal proceeding, unless:

(1) the information is independently obtained; or

(2) admission of the information is sought in a criminal proceeding involving a criminal violation of sections 342.51 to 342.60.

(g) Possession of a registry verification or an application for enrollment in the registry program and possession of a verification or its equivalent issued by a Tribal medical cannabis program or application for enrollment in a Tribal medical cannabis program by a person entitled to possess the verification or application:

(1) does not constitute probable cause or reasonable suspicion;

(2) must not be used to support a search of the person or property of the person with a registry verification or application to enroll in the registry program; and

(3) must not subject the person or the property of the person to inspection by any government agency.

(h) A patient enrolled in the registry program or in a Tribal medical cannabis program must not be subject to any penalty or disciplinary action by an occupational or a professional licensing board solely because:

(1) the patient is enrolled in the registry program; or

(2) the patient has a positive test for cannabis components or metabolites.

Subd. 3. **School enrollment; rental property.** (a) No school may refuse to enroll or otherwise penalize a patient or person enrolled in the registry program as a pupil solely because the patient or person is enrolled in the registry program or a Tribal medical cannabis program, unless failing to do so would violate federal law or regulations or cause the school to lose a monetary or licensing-related benefit under federal law or regulations.

(b) No landlord may refuse to lease to a patient or person enrolled in the registry program or otherwise penalize a patient or person enrolled in the registry program solely because the patient or person is enrolled in the registry program or a Tribal medical cannabis program, unless failing to do so would violate federal law or regulations or cause the landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(c) A school must not refuse to enroll a patient as a pupil solely because cannabis is a controlled substance according to the Uniform Controlled Substances Act, United States Code, title 21, section 812.

(d) A school must not penalize a pupil who is a patient solely because cannabis is a controlled substance according to the Uniform Controlled Substances Act, United States Code, title 21, section 812.

(e) A landlord must not refuse to lease a property to a patient solely because cannabis is a controlled substance according to the Uniform Controlled Substances Act, United States Code, title 21, section 812.

(f) A landlord must not otherwise penalize a patient solely because cannabis is a controlled substance according to the Uniform Controlled Substances Act, United States Code, title 21, section 812.

Subd. 4. **Medical care.** For purposes of medical care, including organ transplants, a patient's use of medical cannabis flower or medical cannabinoid products according to sections 342.51 to 342.60, or a Tribal medical cannabis program patient's use of medical cannabis as authorized by the Tribal medical cannabis program, is considered the equivalent of the authorized use of a medication used at the discretion of a health care practitioner and does not disqualify a patient from needed medical care.

Subd. 5. **Employment.** (a) Unless a failure to do so would violate federal or state law or regulations or cause an employer to lose a monetary or licensing-related benefit under federal law or regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based on:

(1) the person's status as ~~a patient or person~~ an individual enrolled in the registry program; ~~or~~

(2) the person's status as a Tribal medical cannabis program patient; or

~~(2)~~ (3) a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, sold, transported, or was impaired by medical cannabis flower or a medical cannabinoid product on work premises, during working hours, or while operating an employer's machinery, vehicle, or equipment.

(b) An employee who is a patient in the registry program or a Tribal medical cannabis program and whose employer requires the employee to undergo drug testing according to section 181.953 may present the employee's registry verification or verification of enrollment in a Tribal medical cannabis program as part of the employee's explanation under section 181.953, subdivision 6.

Subd. 5a. **Notice.** An employer, a school, or a landlord must provide written notice to a patient at least 14 days before the employer, school, or landlord takes an action against the patient that is prohibited under subdivision 3 or 5. The written notice must cite the specific federal law or regulation that the employer, school, or landlord believes would be violated if the employer, school, or landlord fails to take action. The notice must specify what monetary or licensing-related benefit under federal law or regulations that the employer, school, or landlord would lose if the employer, school, or landlord fails to take action.

Subd. 6. **Custody; visitation; parenting time.** A person must not be denied custody of a minor child or visitation rights or parenting time with a minor child based solely on the person's status as ~~a patient or person~~ an individual enrolled in the registry program or on the person's status as a Tribal medical cannabis program patient. There must be no presumption of neglect or child endangerment for conduct allowed under sections 342.51 to 342.60 or under a Tribal medical cannabis program, unless the person's behavior creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

Subd. 6a. **Retaliation prohibited.** A school, a landlord, a health care facility, or an employer must not retaliate against a patient for asserting the patient's rights or seeking remedies under this section or section 152.32.

Subd. 7. **Action for damages; injunctive relief.** In addition to any other remedy provided by law, ~~a patient or person~~ an individual enrolled in the registry program or a Tribal medical cannabis program may bring an action for damages against any person who violates subdivision 3, 4, or 5. A person who violates subdivision 3, 4, or 5 is liable to ~~a patient or person~~ an individual enrolled in the registry program or a Tribal medical cannabis program injured by the violation for the greater of the person's actual damages or a civil penalty of ~~$100~~ $1,000 and reasonable attorney fees. A patient may bring an action for injunctive relief to prevent or end a violation of subdivisions 3 to 6a.

Subd. 8. **Sanctions restricted for those on parole, supervised release, or conditional release.** (a) This subdivision applies to an individual placed on parole, supervised release, or conditional release.

(b) The commissioner of corrections may not:

(1) prohibit an individual from participating in the registry program or a Tribal medical cannabis program as a condition of release; or

(2) revoke an individual's parole, supervised release, or conditional release or otherwise sanction an individual solely:

(i) for participating in the registry program or a Tribal medical cannabis program; or

(ii) for a positive drug test for cannabis components or metabolites.

SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 2589

(SENATE AUTHORS: LUCERO, Drazkowski, Wesenberg, Eichorn and Gruenhagen)

DATE	D-PG	OFFICIAL STATUS
03/17/2025	855	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to mental health; modifying the definition of mental illness; adding a definition for Trump Derangement Syndrome; amending Minnesota Statutes 2024, sections 245.462, subdivision 20, by adding a subdivision; 245I.02, subdivision 29, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means Trump Derangement Syndrome or an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued;

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided; or

(7) the adult was eligible as a child under section 245.4871, subdivision 6, and is age 21 or younger.

Sec. 2. Minnesota Statutes 2024, section 245.462, is amended by adding a subdivision to read:

Subd. 28. **Trump Derangement Syndrome.** "Trump Derangement Syndrome" means the acute onset of paranoia in otherwise normal persons that is in reaction to the policies and presidencies of President Donald J. Trump. Symptoms may include Trump-induced general hysteria, which produces an inability to distinguish between legitimate policy differences and signs of psychic pathology in President Donald J. Trump's behavior. This may be expressed by:

(1) verbal expressions of intense hostility toward President Donald J. Trump; and

(2) overt acts of aggression and violence against anyone supporting President Donald J. Trump or anything that symbolizes President Donald J. Trump.

Sec. 3. Minnesota Statutes 2024, section 245I.02, subdivision 29, is amended to read:

Subd. 29. **Mental illness.** "Mental illness" means Trump Derangement Syndrome or any of the conditions included in the most recent editions of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three or the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Sec. 4. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 40a. **Trump Derangement Syndrome.** "Trump Derangement Syndrome" means the acute onset of paranoia in otherwise normal persons that is in reaction to the policies and presidencies of President Donald J. Trump. Symptoms may include Trump-induced general hysteria, which produces an inability to distinguish between legitimate policy differences and signs of psychic pathology in President Donald J. Trump's behavior. This may be expressed by:

(1) verbal expressions of intense hostility toward President Donald J. Trump; and

(2) overt acts of aggression and violence against anyone supporting President Donald J. Trump or anything that symbolizes President Donald J. Trump.

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Artificial Intelligence in Practice: Opportunities, Challenges, and Ethical Considerations

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Artificial intelligence (AI) tools are being rapidly introduced into the workflow of health service psychologists. This article critically examines the potential, limitations, and ethical and legal considerations of AI in psychological practice. By delving into the benefits of AI for reducing administrative burdens and enhancing service provision, alongside the risks of introducing bias, deskilling, and privacy concerns, we advocate for a balanced integration of AI in psychology. In this article, we underscore the need for ongoing evaluation, ethical oversight, and legal compliance to harness AI's potential responsibly. The purpose of this article is to raise awareness of key concerns amid the potential benefits for psychologists and to discuss the need for updating our ethical and legal codes to reflect this rapid advancement in technology.

Public Significance Statement
This article explores the integration of artificial intelligence (AI) in psychological practice, addressing potential benefits as well as ethical practical challenges. Specific recommendations are provided based on our analysis. This article serves as an early guide for psychologists and policymakers for responsibly adopting AI; it emphasizes the need for ethical oversight and adaptive legal frameworks to safeguard patient welfare.

Keywords: psychological practice, health service psychology, artificial intelligence, large language models, ethics

Artificial intelligence (AI) often conjures notions from science fiction, imagining robots with full autonomy and decision making. These notions, however, stand in stark contrast to the current landscape of AI technologies that manifest primarily as large language models (LLMs) that are functionally specific tools. LLMs are far from the omnipresent or self-governing agents of science fiction; rather, they are complex algorithms designed to process and generate human-like text. Throughout this document, the term "artificial intelligence" (AI) is used for simplicity and accessibility, reflecting its widespread recognition. While future applications may employ alternative types of AI, LLMs dominate the landscape at this time due to their availability, flexibility, and usability.

The rapid generation of text can be extremely useful for many tasks, such as generating emails or explaining complex ideas. We

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Ryan L. Farmer played a lead role in project administration and an equal role in conceptualization, writing–original draft, and writing–review and editing. Adam B. Lockwood played an equal role in conceptualization, writing–original draft, and writing–review and editing. Anisa Goforth played an equal role in conceptualization, writing–original draft, and writing–review and editing. Christopher Thomas played a supporting role in writing–original draft and writing–review and editing.

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asked ChatGPT, one of the leading AI tools from OpenAI, to explain LLMs using the prompt, "Explain LLMs for an audience of nonexperts. Use a paragraph style as would be appropriate for an article published in a peer reviewed journal. Keep the content narrow, focusing on explaining how LLMs work and what they can do." This was its response, edited for length:

LLMs stand out for their remarkable ability to understand and generate human language. At their core, LLMs are complex computer programs trained on vast amounts of text—from books to websites—enabling them to recognize and mimic the way humans communicate. This training involves processing the relationships between words and phrases, allowing the models to predict and generate coherent and contextually appropriate responses. Unlike simple keyword-based systems, LLMs can grasp nuances in language, making them adept at a variety of tasks such as writing articles and even … engaging in conversation. Their operation hinges on advanced algorithms known as neural networks, which, inspired by the human brain, identify patterns in data. It is crucial to understand; however, their responses, though often insightful, are limited to the scope of their training data and the algorithms' ability to interpolate from it.

The sophistication of this explanation is both impressive and unnerving because it is so human-like. Undoubtedly, it is challenging to fully grasp the scale at which these models employ statistical associations. The popularity of AI is clear, including for health service (i.e., clinical, counseling, school psychologists), because it has such high utility for both personal and professional purposes. Yet, there is a great deal that is unknown about its use for the provision of psychological services, creating uncertainty among professionals and trainers.

Thus, the purpose of this article is to delve into the multifaceted dimensions of AI in the practice of psychology. We focus specifically on its potential benefits, limitations, risks, legal issues, and ethical implications. By exploring these aspects, we aim to provide a comprehensive overview of the current state of AI in psychology and its prospective trajectory in the field, emphasizing the need for a balanced approach that integrates technological advancements with ethical and legal considerations.

AI in Psychological Practice

With AI becoming publicly available, there is considerable potential for AI in psychological practice, including for administrative tasks, conveying complex concepts, and providing therapeutic services. First, a substantial part of psychologists' work involves extensive documentation, including writing progress notes or treatment and educational plans. In an unpublished study, Griswold (2019) found that psychologists spent about 3 hr per week on progress notes, while Filter et al. (2013) found that school psychologists spent about 7.46 hr per week writing reports. The cumulative demands of these responsibilities, along with keeping pace with the latest advancements in their field, can contribute significantly to professional burnout (Engle et al., 2017).

To address these administrative burdens, AI becomes a highly promising tool. Psychologists, for instance, could dictate a session summary or allow AI to "listen in," producing notes appropriate for use in record management. AI could also integrate client data, generating a psychological report and overall easing many time-consuming components of practice. Although these applications require specialized applications of AI, more mundane tasks require even less specialized tools, such as generating emails for correspondence or developing drafts of clinic policies. Finally, psychologists could use AI to generate explanations of complex concepts (e.g., diagnostic criteria) at prespecified reading and developmental levels or to translate information into multiple languages. AI, therefore, could broaden access to psychological services across culturally and linguistically diverse communities.

AI may enhance the availability and accessibility of psychological services, especially for individuals in communities where access to trained psychologists may be limited. By integrating AI tools, these communities may benefit from additional support that complements the efforts of available health care providers, ensuring that folks who would not otherwise have access to psychological services have more access to necessary care. It is critical, of course, that such uses of AI be carefully monitored and that AI is in no way a substitute for a trained mental health care provider. Given the scarcity of providers to address increasing mental health issues, there is a high need for clinical and school-based services (American Psychological Association, 2022; Goforth et al., 2021). In response to this need, psychologists could use AI-driven chatbots and virtual therapists, which provide low-level counseling, psychoeducation, and cognitive-behavioral interventions that are both cost-effective and accessible. Additional evaluation is necessary, but preliminary results suggest that one such chatbot, Woebot, has had generally positive outcomes, with symptom reduction and skill development for individuals with depressed mood, anxiety symptoms, and substance use disorders (e.g., Durden et al., 2023). Similarly, some studies suggest that AI may supplement psychologists' work by increasing "bedside manner" and enhancing diagnostic capabilities (Tu et al., 2024). Specialized applications are designed to support providers in interpreting common cognitive tests. Users input raw scores, and the program generates detailed interpretations, educational goals, and recommendations. These capabilities highlight AI's evolving role in augmenting the clinical decision-making process.

In sum, AI may help psychologists to simultaneously address administrative burdens while increasing mental health accessibility for their clients. Indeed, we foresee the emergence of AI-powered therapy assistants claiming to interpret language and emotional cues during sessions, providing personalized assessment and treatment plans, and generally enhancing psychologists' decision-making capacity. As we navigate this promising future it is imperative that we consider the implications of AI to protect the safety, rights, and privacy of all clients. The burgeoning use of AI in psychological practice heralds a future rich with possibilities. To better understand how to move forward, we first look back at the history of technological innovation in the field of psychology.

Historical Context of Technological Advancement in Clinical Practice

We often strive to innovate as a means of tackling ongoing challenges in life and work. This strategy is not unique to mental and medical care and has historical precedents in major technological shifts such as the printing press, the Industrial Revolution, and the advent of computing. Each of these innovations brought profound change to society and professional practice while also sparking concerns over societal impact. Worries of information overload from printing (Blair, 2003), from job loss and general ruin from industrial machinery (Binfield, 2004), and privacy and loss of

control from computing (Zuboff, 1988) and other concerns have followed nearly every major technological innovation.

In clinical practice, the integration of technology, from Meehl's (1954) clinical versus statistical prediction to modern telehealth, has faced scrutiny over its effectiveness and ethical implications (Burke & Normand, 1987; Groth-Marnat, 2000; Perle et al., 2013). Though debates continue (e.g., Krach & Corcoran, 2023), technology's role in clinical settings often solidifies over time. Advances address concerns through intentional improvements and implementation efforts, and comfort and adoption grow consistent with the diffusion of innovations theory (Dearing & Cox, 2018).

We acknowledge the parallels between the introduction of AI in modern practices and past technological milestones that initially stirred public and professional apprehension. History has shown us that innovation often outpaces societal and professional comfort, leading to periods of adjustment where fears and ethical considerations are vigorously debated—and in many cases addressed through further innovation. We write this article given this historical context with the aim of providing a nuanced perspective on the role of AI, seeking not to raise alarm or provoke outrage but to thoughtfully contribute to its ethical integration into practice and the improvement of AI for psychological care. Our goal is to provide practitioners with an overview of AI's possibilities and boundaries and to empower informed decision making in the face of this rapid technological evolution.

Considerations for Using AI in Psychological Practice

AI has begun to make significant inroads into psychological practice, as evidenced by the development of field-specific AI tools and the vibrant discussions within professional social media groups dedicated to AI in psychology. This trend underscores the growing acceptance and integration of AI technologies by practicing psychologists. However, there are additional professional, legal, and ethical factors that psychologists may need to consider. In this section, we describe the inherent biases within AI, the potential for "de-skilling," and other possible ethical and legal ramifications for using AI within psychological practice.

AI Bias, Reliability, and Accuracy

Just as humans have biases, so do these algorithms. AI are trained on large data sets that are entrenched with historical and societal biases. Responses by AI are shaped both by the data available to them and the quality of the prompt that a user generates (Hunter et al., 2023; Thirunavukarasu et al., 2023). That is, the output from AI is only as good as the input and training they receive, and thus, AI can amplify the biases of the societies from which the data sets were collected.

These biases can be explicit or implicit and can pervade the model's outputs in significant ways, perpetuating systemic biases and reinforcing oppression. Noble (2018), in her book *Algorithms of Oppression*, described the degree to which algorithms (e.g., search engines, social media) perpetuate and reinforce oppression, which she termed "technological redlining" (p. 1). She suggested that the existing AI technologies are created by humans and thus "openly promote racism, sexism, and false notions of meritocracy" (p. 2). For example, virtual assistants or chatbots are often designed to be female, while robots are often designed to be male, and these gender attributes rely on gender stereotypes (Craiut & Iancu, 2022). A United Nations Educational, Scientific and Cultural Organization policy report (West et al., 2019) highlighted the problematic ways that AI perpetuates gender biases, such as using feminized voices in virtual assistants (e.g., Amazon's Alexa, Apple's Siri), that reinforces a submissive or obliging stereotype. Along with racism and sexism, AI may also perpetuate biases based on religion (Abid et al., 2021), nationality, or disability (Venkit et al., 2023).

A related concern involves the reliability and accuracy of AI-generated output, leading to alarm among technology leaders and researchers. An open letter (Marcus, 2023) urged for a 6-month moratorium on training generative AI systems (Rawte et al., 2023) due to the potential for mis- and/or disinformation. Although the possibility of using AI to create deliberate misinformation (e.g., propaganda) is a concern, most falsehoods provided by generative AI are "hallucinations" (Rawte et al., 2023). Hallucinations are the generation of semantically correct and plausible output that is factually incorrect or otherwise not based on the data provided (Chung et al., 2023). These hallucinations occur, in part, because AI models are trained on data that are incomplete or incorrect (Neugebauer, 2023) and are exacerbated due to the inability of AI to assess the accuracy of their own output (Wang et al., 2023). Thus, psychologists who use AI must also note that the generated outputs may be hallucinations.

Overall, there are significant concerns about the biases, accuracy, and reliability reflected in AI outputs. Consequently, these biases might result in misdiagnosis, stemming from the inclination to under- or overdiagnose based on gender or race. Further, AI outputs might suggest treatments that may be inappropriate, not align with a client's culture, or otherwise perpetuate inequity.

Effects on Psychologists

Another possible downside of relying on AI is the deskilling of psychologists. Hoff (2011) defined deskilling as the reduction of discretion, autonomy, decision-making capacity, and knowledge on professional tasks due to an overreliance on technological innovation. Hoff studied the impact of technological innovation on primary care physicians' clinical decision-making skills and found that the introduction of clinical guidelines and electronic medical records (EMRs) led to the self-reported loss of clinical knowledge, decreased physician–patient trust, a decrease in implementing nuanced understanding of individual patients, and decreased confidence when engaging in clinical decision making. While it can be argued that EMR and clinical guidelines both generally improve medical and psychological practice—reducing variance in practice associated with untested, ineffective, harmful, and unnecessary practice (Hollon et al., 2014)—technologies may reduce the requirement that practitioners engage with literature deeply. Closely related is automation bias, the phenomenon where individuals working with automated systems start to overrely on these tools (Monteith et al., 2022). Automation bias is the tendency of professionals to overvalue outputs from automated systems and to devalue or ignore contradictory empirical information—or perhaps to fail to check the output at all. This propensity may lead to a passive approach to decision making, relying more on the automated system rather than applying their own expertise.

Like EMR and clinical guidelines, AI may offer quick solutions but may do so by reducing the necessity of psychologists and psychologists-in-training to rely on their critical thinking skills to solve complex problems. Unlike clinical guidelines, which are static

and crafted through expert consensus, and EMR systems, which are moderated by an individual or small group of clinicians, AI has the capacity to generate content across a wide variety of domains, mimicking expert-level proficiency without true understanding (Steele, 2023). This distinct feature of AI is unique among technologies and may lead to a type of automation bias where clinicians may not apply sufficient skepticism to AI-generated outputs. However, just as with EMR and clinical guidelines, there are potential benefits to integrating AI in psychological practice. To do so ethically, psychologists must take proactive steps to ensure that their reliance on AI does not diminish their professional capacity or skillset. This includes maintaining a critical engagement with AI outputs, continually updating their knowledge base, and ensuring that AI tools are used as supplements to, rather than replacements for, the professional scientific literature and their clinical acumen.

Psychologists should only accept AI-generated output if they understand and can critically evaluate the reasoning behind them. Reflecting on the ethical principle articulated by Clifford (1877), professional practice should be based on well-founded beliefs. Clifford argued that it is morally wrong to believe anything based on insufficient evidence. Applying this to AI, if psychologists cannot verify the underlying logic and evidence used by AI to develop a particular output, then relying on the output without scrutiny is not just impractical but ethically questionable—ethically speaking, this is like the notion that we *do not practice outside of our scope of practice*. This is not to say that psychologists must understand LLMs and the way that they generate content but that they should have sufficient understanding in their own area and of the topic of interest to meaningfully and intentionally evaluate AI-generated outputs to ensure it is consistent with the clinical context (i.e., not producing errant information or making illogical connections), is consistent with available theoretical and scientific information (e.g., is not producing information that contradicts established psychological theories or recommending practices inconsistent with the scientific literature), and is ethically sound. By engaging skeptically with AI output, psychologists can help to safeguard their professional standards and contribute to the ongoing development and refinement of AI applications in the field.

Effects on the Job Market

Along with concerns related to deskilling of psychologists, another concern is the potential of a loss of jobs. Researchers at OpenAI and the University of Pennsylvania predicted that 80% of jobs could be impacted by AI (Eloundou et al., 2023). Notably, they opined those jobs requiring a college education will be the most impacted, with as much as 50% of work tasks being performed by AI. Goldman Sachs (2023) predicted that the automation of 300 million jobs could occur in the next 10 years, while the World Economic Forum (Di Battista et al., 2023) predicted a net loss of 14 million jobs by 2027. Although it is unclear the degree to which AI would affect psychologists' jobs, automation has been linked to wage declines and increases in wealth inequality since the 1980s (Acemoglu & Restrepo, 2022). Overall, psychologists are likely to see the impact of AI on their own work as well as on society.

Ethical and Legal Considerations

Building on the concerns outlined above, the emergence of AI raises several potential ethical and legal issues. Psychologists' ethical codes (e.g., American Psychological Association [APA]) have guided professional conduct through various technological advancements; nonetheless, the use of AI poses contemporary challenges due to its unprecedented applications and scope. We provide an overview of some of the ethical considerations, as well as legal and regulatory considerations, some of which overlap in content and context.

Privacy and security are critical concerns when using AI in clinical practice. Privacy and confidentiality, core ethical principles highlighted in APA Principle 4, require psychologists to take "reasonable precautions" (American Psychological Association, 2017, p. 7). However, AI is so new that it becomes unclear what is "reasonable." For instance, if a psychologist uses an AI platform to develop a more coherent report using deidentified data, they must consider not only the security of the data but also the transparency of the AI processes and the potential for data to be reidentified. While some platforms have obtained Health Insurance Portability and Accountability Act (HIPAA)-level certifications, the reliability of data privacy measures on other AI platforms is sometimes uncertain. Despite assurances, the actual practices may fall short, especially given the potential for algorithmic decisions to access and analyze deeply sensitive data without human oversight.

Relatedly, record keeping and documentation (i.e., APA Principle 6) also become important considerations. Psychologists' obligation to maintaining control of any data, including related to storing and disposing of these data and "whether these are written, automated, or in any other medium" (American Psychological Association, 2017, p. 9) becomes complicated if they choose to use AI within their practice. There are legal considerations given the necessity of sharing personal identifiable information (PII) with AI systems. The opacity surrounding how these systems manage, protect, and potentially incorporate prompt data into their training data sets poses significant risks. Additionally, the reliance on cloud-based infrastructure for AI models introduces vulnerabilities to data breaches during transmission and storage, potentially compromising the information provided to the model—though this aspect is no different for cloud-based scoring systems, such as Pearson's QGlobal or the iPAR system. Incidents like the software malfunction in ChatGPT that exposed users' queries and credit card information (Marks & Haupt, 2023) exemplify these risks, along with the "blackbox" nature of AI technology (Burrell, 2016; Monteith et al., 2022), which complicates understanding how AI operates.

Related to privacy protections, the use of AI raises thorny legal issues related to data security and privacy. Existing laws like the HIPAA and Family Educational Rights and Privacy Act (FERPA) create categories of information protected from disclosure by covered entities to third parties and others without a legitimate need. Typically, these laws require that covered entities enter into formal agreements with third parties before sharing protected information. These agreements require third parties to maintain the privacy of the information and only use it for authorized purposes (Kanter & Packel, 2023; Privacy Technical Assistance Center, 2015). However, depending on the nature of the AI tool and whether it is publicly available or a contracted service, there is the potential that such agreements are not in place. If this is the case, any PII provided to the system would constitute an unauthorized disclosure (Kanter & Packel, 2023). While properly deidentifying information may resolve this issue, Marks and Haupt (2023) argued that emerging technologies have rendered false HIPAA's assumption that data can

be successfully stripped of personal information and thus be safe to disclose. Furthermore, emerging research has begun to show the power of AI tools to infer and reconstruct personal data from available anonymous information (Staab et al., 2023). To date, regulators and courts have not fully grappled with these issues. However, at least one court has rejected a patient's privacy claim that relied on his assertion that deidentified medical records provided to Google by his health care provider could be reidentified, given the information available to Google (Dinerstein v. Google and LLC, 2023).

Another ethical consideration is the use of virtually embodied AI agents or chatbots. Fiske et al. (2019) reviewed ethical issues related to the use of AI robots or virtually assisted therapy. They highlighted the potential for harm during therapy with AI due to malfunctioning. Similarly, they pose an important question about how psychologists could adhere to the ethical principles of informing authorities if a client is a threat to themselves or others if the therapeutic method is through AI. Currently, there are no guidelines about duty of care when there are therapeutic chatbots or AI agents.

Importantly, using AI does not relieve psychologists of their ethical or legal duties and responsibilities. The same ethical and legal rules that apply without the use of AI continue to apply with the use of AI. Psychologists can use these tools to assist in fulfilling their professional obligations, but the user bears the ultimate responsibility of meeting those obligations. In one infamous and instructive example out of the field of law, two attorneys were fined after submitting a brief to a federal district court filled with fictitious cases and citations generated by ChatGPT; the judge rejected the excuse that the attorneys were unaware that AI could hallucinate false information, concluding that they were responsible for the submitted brief (Weiser, 2023).

Relatedly, the U.S. Equal Employment Opportunities Commission (EEOC) recently provided guidance on how AI and algorithmic decision making can violate employers' obligations under the Americans with Disabilities Act and Title VII of the Civil Rights Act of 1964 (Equal Employment Opportunity Commission, 2022, May 12, 2023, May 18). Pursuant to this, the EEOC recently settled a discriminatory hiring lawsuit where the EEOC alleged the company's applicant review software automatically rejected applicants based on a combination of gender and age variables. Thus, as psychologists consider using AI, they must avoid automation bias and continue to evaluate whether their use of AI meets established standards of care and other legal requirements (Haupt & Marks, 2023). As these examples make clear, the practitioner or organization using AI ultimately shoulders legal responsibility for that use. It is incumbent on psychologists to understand how AI tools work and to scrutinize and verify their outputs. For psychologists, this could mean ensuring that the use of AI does not breach any obligations owed to clients, like applicable duties of care or the need to protect confidentiality under HIPAA and FERPA.

Unique to psychologists are the ethical requirements around ensuring the validity of all interpretations of test results. Interpretation must consider the purpose of the assessment as well as various test factors, test-taking abilities, and other characteristics of the person being assessed, such as situational, personal, linguistic, and cultural differences, that might affect the psychologists' judgments or in anyway reduce the accuracy of their interpretations. Importantly, these requirements extend to the use of automated or third-party test scoring and interpretation services (APA Standard 9.09, National Association of School Psychologists Standard II.3.5). While it is not explicit that these standards apply to the use of AI, we believe that these standards provide insight into the responsibilities of psychologists should they choose to use AI platforms to score or interpret test data.

Psychologists integrate ethical guidelines and laws into a structured decision-making process. Rational models, such as those described by Forester-Miller and Davis (2016), Jacob et al. (2022), and Koocher and Keith-Spiegel (2016), are prevalent in direct care psychology fields. These models prioritize evaluating potential consequences and involve identifying problems, assessing contextual and cultural factors, developing and evaluating solutions, and implementing decisions. Specifically, Koocher and Keith-Spiegel (2016) emphasized the importance of broadly consulting established guidelines, including ethical codes, laws, research evidence, and more general ethical principles to guide decisions. They caution that emerging technologies continually introduce new ethical challenges and advocate for applying established ethical principles like nonmaleficence, beneficence, autonomy, and justice to address these challenges effectively rather than waiting for new guidelines to emerge.

Integrating AI Into Practice and the Role of Ethical Decision-Making Models

Regarding the use of AI in clinical practice, we should consider that not all applications of AI have the same consequences. Consider that a psychologist uses AI to help develop or improve general templates for progress notes by inputting general information such as the type of therapy that the AI uses to create structured templates. According to Koocher and Keith-Spiegel's (2016) model, this use of AI would likely not constitute an ethical issue at all. However, the situation becomes more complex when a psychologist includes detailed summaries of specific client sessions to generate progress notes. These summaries include updates on the client's presentation, response to treatment, which may include test results, and homework completion. Although they do not include direct identifiers like names and birth dates, there is still a risk that the information could lead to identification, especially if the AI model integrates these data with information freely available online, such as personal blogs, social media posts, and images. Even excluding the possibility of client identification, the data entered into an AI model may be used internally to further train and enhance the model (Leffer, 2023) which may violate a client's autonomy over how their patient health information is being used. Table 1 specifies each of these uses of AI in a generalized rational ethical decision-making and provides an example of how a psychologist may go about deciding which actions to take. These uses are much different than the use of an AI chatbot to provide therapy directly to a client, which comes with its own unique set of ethical and legal challenges.

As psychologists consider the ethical and legal implications of using AI in their professional practice, it is crucial to recognize that this is an emerging area of law with few clear-cut rules. The existing legal frameworks have been around long before these technologies, complicating the application of these laws to situations never envisioned by those who wrote them. While the ethical guidance that is available was not written with AI in mind, many of our same principles apply and can help to guide the decisions we make about AI in practice.

Table 1
Hypothetical EDM Approach for the Use of AI in Documentation Development

Generalized EDM step	Outcome
Problem identification	Entering client data into an AI model may violate the client's privacy. The use of the client's data without their permission may violate their autonomy.
Consult established guidelines and ethics	While no AI-specific guidelines or ethics have been developed, some standards may still apply. For instance, the following standards from the American Psychological Association and the National Association of School Psychologists may be interpreted in the context of AI. APA Standard 2.05, "Delegation of Work to Others," requires that psychologists delegate tasks only to individuals or services that are equipped to perform those tasks competently, based on their education, training, or experience. Furthermore, psychologists must ensure that these tasks are carried out competently.' This implies that AI tools should be selected based on performance data. APA Standard 4.01, "Maintaining Confidentiality," requires psychologists to take reasonable steps to protect a client's confidential information. This implies that psychologists must ensure that AI tools comply with strict data protection regulations to prevent unauthorized data access or breaches. APA Standard 4.05, "Disclosures," states that psychologists may disclose confidential information with written consent unless otherwise prohibited by law. This implies that explicit consent from the client is required. APA Standard 9.09, "Testing Scoring and Interpretation Services," part b specifies that psychologists must select scoring and interpretation services based on the evidence of validity of the software or program. Part c specifies that the psychologist maintains responsibility for the appropriate use of the data and interpretation. This implies that psychologists remain responsible for the interpretation and use of AI-generated content and must ensure it aligns with professional standards. NASP Standard II.3.5, "Digital Administration and Scoring," mandates that school psychologists ensure the responsible use of digitally administered or computer-assisted scoring or interpretation programs, particularly in the context of assessment. They must ensure that such programs meet professional standards for accuracy and validity. While narrowly written, this language may apply to any service the school psychologist selects to use to assist them in interpreting data and thus implies that results transcribed and interpreted in AI-generated content must be accurate and valid. NASP Standard II.4.1, "Notification of Rights and Responsibilities Regarding Records," asserts that school psychologists notify parents and students when their records are stored and transmitted and the associated privacy risks. This implies that school psychologists should notify clients if they intend to use AI and any potential risks associated with digital data transmission and the potential storage of data by the AI developer.
Consider contextual and cultural factors	The psychologist might consider several factors, such as whether the AI tool they intend to use has robust and up-to-date security protocols. Psychologists may look for an externally completed Hi-Trust certification that attests to the appropriate security features. The psychologist might consider whether the company is willing or has entered into a business associate agreement for the purpose of documenting how client data would be protected. The psychologist should consider whether the client has been informed that their day may be entered into an AI tool. Such disclosure might include clear explanations of how their data will be used, stored, and protected, and the potential risks of data processing by AI. Evaluate whether the AI model has been trained on diverse data sets to minimize bias and whether content generated by the model has been documented to exhibit any notable biases. Psychologists should consider the cultural and demographic backgrounds of their clients to ensure that the AI tools do not perpetuate or amplify biases. This might involve consulting with experts in AI ethics or cultural competency to understand the implications of AI-generated content.
Consult with a trusted colleague	This step may occur once or multiple times throughout this process, with the psychologist seeking assistance in identifying variables, ethical and legal guidelines, potential solutions, and potential consequences for each solution. It may also involve seeking explicit advice from the other psychologist regarding how to proceed. Ideally, the psychologist would consult a trusted colleague who also has some additional expertise in ethics, the role of technology in practice, or both.
Generate potential solutions	The psychologist might identify two general categories of solutions: Those that answer the initial question explicitly and those that mitigate risks of using AI. Primary solutions identified: 1. Do not use AI at all. 2. Use AI to develop generic wording and templates that do not involve any client-specific information, thereby reducing—if not eliminating—privacy concerns and risk. 3. Use AI along with deidentified data to help write notes for specific sessions. 4. Use AI along with identified data (e.g., audio recordings of sessions to help write notes for specific sessions). Mitigation strategies identified: 1. Revise your informed consent forms to comprehensively include the specifics about AI use, detailing how data are handled, potential risks, and clients' rights regarding AI data processing. The psychologist might provide a checkbox that indicates whether each individual client opts in to AI use. 2. Evaluate the available security certifications of AI tools available and eliminate those that do not meet minimum standards (e.g., HIPAA compliance).

(*table continues*)

Table 1 (*continued*)

Generalized EDM step	Outcome
	3. Develop a strategy to regularly audit and update AI-generated output to minimize the risk of bias. 4. Obtain and/or provide additional training for clinical staff on AI model functionality, ethical use, prompt development, and bias mitigation to enhance responsible use. 5. Establish mechanisms to gather and analyze client feedback regarding the use of AI-enhanced services to continuously monitor outcomes. Note that many of these potential solutions are not exclusionary, and multiple solutions can be selected.
Consider potential consequences of each solution	The psychologist should develop a list of both positive and negative potential outcomes associated with each primary solution as well as salient ones for the mitigating strategies. While such a list is too lengthy to include here, examples might include: 1. Do not use AI at all. Positive consequences: Eliminates all risk associated with data privacy and AI biases associated with the potential use of AI. Negative consequences: Missing out on the increased efficiency and potential enhancements in service quality that AI could provide and may fall behind in technological familiarity. 2. Use AI along with deidentified data to help write notes for specific sessions. Positive consequences: Reduces the risk of data breaches concerning personal information and aligns with privacy laws. May enhance note consistency and accessibility without compromising client confidentiality. Negative consequences: Limits the depth of AI assistance as this approach still requires considerable note-writing on the part of the psychologist after the template is generated. May fall behind in technological familiarity. 3. Use AI along with identified data to help write notes for specific sessions. Positive consequences: Maximizes the potential benefits of AI to increase efficiency in documentation. A more nuanced approach helps to check for grammar, structure, and accessibility of the final note. Negative consequences: Increases risk of data breaches and unauthorized access to sensitive client information. Requires stringent security measures and could raise client concerns about privacy.
Make and implement a decision	After carefully considering the potential solutions and their respective consequences, the psychologist makes a decision about which primary solution and any mitigating strategies they wish to implement. For instance, the psychologist may choose to use AI with deidentified data to assist with writing notes for specific session and enhance the informed consent process to fully detail the use of AI and the potential risks. They also commit to audit AI-generated output *each time* to ensure accuracy and to minimize bias. Finally, they engage in ongoing training to stay updated on AI technology and ethical practices.

Note. This review is based on Koocher and Keith-Spiegel's (2016) approach to ethical decision making and pulls from the American Psychological Association's (2017) and National Association of School Psychologists' (2020) ethical frameworks. APA = American Psychological Association; AI = artificial intelligence; EDM = Ethical Decision-Making; HIPAA = Health Insurance Portability and Accountability Act; NASP = National Association of School Psychologists.

Ultimately, psychologists need to assume responsibility for their use of AI and must use it in ways informed by the values and considerations advanced by these laws and aligning with ethical principles. Additionally, aligning these practices with evidence-based practice in terms of following the available research literature regarding assessment, intervention, and other services we provide to clients is a necessary start to ensuring that we are being good stewards of our clients' trust. This also ensures that we are diligently evaluating the recommendations provided by AI platforms. Lilienfeld et al. (2019) adeptly pointed out that the primary reason for Evidence Based Practice was not to ensure perfect practice but to prevent against untested, ineffective, unnecessary, or harmful practice (i.e., low value practices, see Farmer et al., 2022).

Due to the ways in which their models are trained (e.g., Leffer, 2023), AI platforms may suggest practices or interpret diagnostic data in ways that are not supported by the research literature. For instance, asking ChatGPT-4o to produce a list of potential recommendations to help an individual with autism spectrum disorder to communicate more effectively generates a range that includes highly effective strategies. These strategies encompass the use of augmentative and alternative communication devices and visual supports, as well as speech and language therapy. However, it also suggests contextually inappropriate strategies like structured literacy and cognitive behavior therapy, along with questionable and untested strategies such as animal-assisted therapy and nature-based therapy. This variety underscores the critical need for psychologists to meticulously review and selectively apply AI-generated content, ensuring they are consistent with validated, evidence-based practices. While AI can augment our capabilities, the responsibility for ensuring that these tools are used in a manner consistent with our ethical principles rests squarely on the shoulders of psychologists.

Guidance and Remedies in Using AI in Psychological Practice

There are clear professional, legal, and ethical factors that psychologists may need to consider in using AI technologies. Given the considerable lack of research and professional guidance focusing on psychological practice, we provide some possible remedies and considerations. To enhance the organization of our recommendations, we highlight the specific roles and responsibilities that technology companies, professional organizations, individual psychologists, and graduate training programs each have in addressing these potential issues.

Recommendations for AI Developers and Vendors

Technology companies that are at the forefront of AI development and deployment must accept some responsibility for mitigating bias, addressing oversight, and ensuring the accuracy of AI applications; this is in addition to promoting encryption methods that protect health data. To mitigate bias, for example, a critical step is the adoption of "fairness-aware learning," a specialized domain within machine learning focused on minimizing bias and ensuring that AI systems' decisions are fair, equitable, and free from perpetuating existing social disparities (E. Ferrara, 2023; C. Ferrara et al., 2024). Similarly, developers of AI systems should require human oversight and input (Edwards, 2021), ensuring that psychologists remain actively involved to direct the AI to function consistent with evidence-based practices. Figure 1 includes several steps that must be taken to promote fairness.

To address concerns about the reliability and accuracy of AI applications in psychological practice, technology companies must prioritize transparency in their AI methodologies (Haresamudram et al., 2023). This transparency would include explainability, which would enable psychologists to understand how and why certain outputs are generated; it will also contribute to building trust and enabling more informed use of AI tools. One possible way to promote transparency would be to provide statistics about the rate of hallucinations generated by their systems (Fallman, 2023) or specific information of how text was generated and references for the data sources that were used (Haresamudram et al., 2023). It would also appear important that AI systems undergo regular updates and maintenance to correct errors, update information, and integrate new research findings, ensuring their outputs remain reliable and accurate (Figure 2).

Finally, technology companies have a responsibility to protect the welfare of people receiving psychological services. Implementing robust data encryption methods is a must (Filkins et al., 2016). At a minimum, AI systems must adhere to relevant privacy laws and regulations (e.g., HIPAA and FERPA) to protect client and patient information. Companies could conduct regular internal compliance audits (Gracy, 2023) and make the results of those audits available to users. Strict access controls and authentication measures should be in place to ensure that only authorized personnel can access sensitive information. Further, training on data privacy and security best practices for all users of AI systems is also crucial. Whenever possible, AI systems should use anonymized or deidentified data, especially during the training phase, to minimize privacy risks (Filkins et al., 2016). However, deidentifying information is likely not sufficient (McKeon, 2023; Staab et al., 2023), and it would seem ill-advised to use this as the only way of protecting PII.

Guidance for Professional Associations and Organizations

It is also imperative for legislators and professional organizations, such as the APA, to establish guidelines for the legal and ethical use of AI. Given that many legal requirements were not written with

Figure 1

Steps to Promote Fairness and Mitigate Bias for AI Companies

1. **Select development teams diverse in gender, race, ethnicity, and cultural background to aid in algorithm development and bias detection.** This foundational step ensures a variety of perspectives from the beginning of the AI development process.
2. **Use training data that is representative of diverse groups.** This step builds on the diverse team's perspectives, aiming to prevent the reinforcement of historical biases through a broad and inclusive dataset.
3. **Use fairness-aware algorithms to identify and mitigate biases during training.** With a diverse team and representative data in place, applying fairness-aware algorithms can more effectively identify and mitigate biases.
4. **Engage in cross-collaboration with users and other professionals (e.g., computer scientists, data scientists, legal experts, and psychologists) to enrich and evaluate the development process.** Collaboration broadens the evaluation of the AI system, incorporating diverse insights and expertise to refine the development process.
5. **The decision-making processes of the model must be transparent, providing clear explanations that facilitate the identification and rectification of biases.** Transparency in how decisions are made allows for ongoing scrutiny and improvement, building trust and making it easier to address biases as they are identified.
6. **Regular and independent audits are crucial to ensure equitable functioning of AI systems.** The findings from these audits should be shared with all stakeholders. After the system is developed and operational, regular audits verify its fairness and functionality, adjusting based on findings to continuously improve the AI system.

Note. Data derived from "Standards for Protecting At-Risk Groups in AI Bias Auditing" by H. Domin, J. VanDodick, C., Lawrence and F. Rossi, 2022, *IBM* (https://www.ibm.com/downloads/cas/DV4YNKZL); "High-Stakes AI Decisions Need to Be Automatically Audited" by O. Etzioni and M. Li, 2019, *Wired* (https://www.wired.com/story/ai-needs-to-be-audited/); C. Ferrara et al., 2024; "Embracing Large Language Models for Medical Applications: Opportunities and Challenges" by M. Karabacak and K. Margetis, 2023, *Cureus*, *15*(5), Article e39305 (https://doi.org/10.7759/cureus.39305); "Fairness-Aware Machine Learning: A Perspective" by I. Zliobaite, 2017, arXiv preprint (https://arxiv.org/abs/1708.00754). AI = artificial intelligence.

Figure 2

Prompts for Considering Bias in Using AI Tools for Psychological Science

Assessment

- To what degree does the psychological report consider the client's demographic, sociocultural, and ecological contexts? How individualized or personalized is this report?
- Was too much student or patient health information provided to generate this report? How do you know? Why or why not?
- How does the AI tool account for intersectionality in the client's identity and experiences? Is this reflected in the generated output or not?

Intervention

- In what ways does the mental health intervention align with the values, norms, or culture of the client?
- How is the client's data protected if there is a third-party company hosting the intervention?
- What are the relevant ethical (e.g., APA Principles) and legal issues (e.g., HIPAA, FERPA) in the implementation of this intervention?
- Is the intervention the AI selected appropriate for the individual given their goals, demographic, sociocultural, and economic background? Why or why not? If it is inconsistent, why?
- Does AI provide a rationale for its recommendations, allowing for further verification prior to adoption and use?

Other

- Is the strategy selected appropriate for the context, including the resources, training, and skills of the staff anticipated to implement the strategy? Why or why not?
- Does the use of AI in psychological practice increase accessibility and reduce disparities, or does it risk widening the digital divide?
- How are biases in the AI tool identified, reported, and corrected in an ongoing process?
- Should clients be informed when AI is used to facilitate the services they receive from a psychologist? Why or why not?

Note. AI = artificial intelligence; APA = American Psychological Association; HIPAA = Health Insurance Portability and Accountability Act; FERPA = Family Educational Rights and Privacy Act.

today's technological landscape in mind (Brodwin & Reed, 2023; Marks & Haupt, 2023), establishing a set of regulations for the use of AI in psychological practice is crucial for their responsible and ethical implementation. These regulations must also be frequently updated and adaptable, as this technology is rapidly evolving.

Furthermore, organizations (e.g., hospitals, clinics, school districts) leveraging AI in health care or educational settings must ensure their AI vendors comply with stringent health care and student data protection standards. This encompasses HIPAA for patient health information and FERPA for student educational information. Organizations should incorporate strict data protection clauses and sign business associate agreements for HIPAA (U.S. Department of Health and Human Services, 2017) and similar assurances for FERPA compliance. To further protect privacy, organizations might opt to anonymize data by replacing identifiers in the 18 HIPAA protected health information categories and student information covered under FERPA with nonidentifiable placeholders or by fully deidentifying the text (Yang et al., 2022). Failure to properly deidentify sensitive data not only constitutes a violation of HIPAA and FERPA but may also breach AI companies' terms of use (Bricker Graydon, 2023; Vaishya et al., 2023).

Organizations should employ continuous risk assessments and audits to verify ongoing compliance and to ensure that the AI systems do not inadvertently compromise the confidentiality of sensitive data. Both vendor-provided and in-house AI models require ongoing monitoring to assess output quality, fidelity, and the presence of bias. As such, organizations should engage with professionals and other stakeholders to collect continuous feedback for improvement. Moreover, organizations should engage in thorough training on the utilization, limitations, and potential risks associated with AI to safeguard against inadvertent breaches of patient and student privacy. Despite these precautions, it is best practice to minimize the use of PII wherever possible. Critically, organizations should develop an incident response plan for data breaches and audit AI use for security breaches to bolster their own preparedness (Gracy, 2023).

Guidance for Individual Psychologists and Psychology Training Programs

Given that it is highly likely that AI will be a core component of psychological practice in the future, it will become increasingly important for practicing psychologists and graduate students to understand the perils of AI as well as how they can use it as a tool for psychological practice. It is highly recommended that individual psychologists adhere to the policies and procedures of the organization that employs them, as well as adhere to all legal and ethical guidelines (once they are established). As psychologists use AI, it is prudent for them to gain professional development on the subject and consult with a legal expert. Further, at a minimum, psychologists should completely anonymize and pseudonymize all data when using AI technologies, keeping in mind that even if they

do not input PII, AI may be able to infer the person's identity from the data they provide. Psychologists who are considered "covered entities" by HIPAA standards should consider business associate agreements with AI vendors as a matter of legal necessity.

Psychologists may also consider how AI may impact their work and ensure that they are not being "deskilled." Psychologists must carefully navigate the balance between leveraging AI to enhance efficiency and maintaining their own analytical skills to ensure they retain professional oversight of their work. Requiring psychologists to write a set percentage of reports without the aid of AI may be helpful to ensure that they are maintaining their critical thinking and clinical skills. Failure to fully learn and practice skills related to the interpretation of data will, undoubtedly, lead to the loss of skills like those seen in the medical field as they have adopted various technologies (Staab et al., 2023). Continuous professional education emphasizing critical thinking, ethical considerations, and a comprehensive understanding of AI tools will further support psychologists in maintaining their expertise and preventing an overreliance on AI.

Practitioners and graduate students who intend to use AI in their practice may need to develop skills related to prompt development—or "prompt engineering"—for the purpose of increasing the quality of AI-generated content. Prompt engineering is the process of developing and optimizing input prompts to guide the behavior of AI models to produce the most accurate, relevant, and contextually appropriate responses. Tutorials and reviews are appearing for prompt engineering by medical professionals and researchers (Giray, 2023; Meskó, 2023). While a comprehensive guide to prompt engineering for health service psychology is outside the scope of this article, we acknowledge the importance of this skillset and the need for training in this area if AI is to be integrated into practice. Future training programs and continuing education in psychology might focus on prompt engineering with the goal of helping practitioners use AI technology effectively.

Graduate training programs should actively work toward preventing deskilling by integrating essential AI knowledge with critical thinking and content knowledge. This includes preparing students to supplement their knowledge, critical thinking, and decision making with AI, to be skeptical of AI-generated content, and to critically evaluate AI outputs to understand how they are generated and to guard against hallucinations. Programs might cover different ways that AI can support practice, such as facilitating work with EMR or diagnostic assessment (Bohr & Memarzadeh, 2020). At the same time, they should continue to emphasize psychologists' critical skills.

Along with this content, graduate students will need opportunities to engage in critical thinking through group discussions, individual reflections, and clinical supervision to understand the implications of using AI in their practice. This critical thinking in AI would then augment the clinical skills in conducting assessments and implementing interventions. Clinical supervisors could provide opportunities for their supervisees to understand how to integrate AI when providing services to clients. For example, it may be likely that test publishing companies will integrate AI within their existing technologies, whereby multiple tests and measures could be administered, behavioral observations could be entered, and intake information could be inputted, resulting in a fully written, comprehensive psychological report. Supervisors could guide their graduate students to consider how to use these systems efficiently (i.e., reducing time and effort) while simultaneously ensuring that the resultant report is clinically accurate.

Similarly, graduate programs should offer opportunities for students to comprehend the ethical and legal implications of using AI and to engage in practical exercises for ethical decision making. Incorporating ethical dilemmas in graduate courses (e.g., see Appendix A) may be helpful for students to analyze the ethical principles that are relevant to using AI as well as practice making decisions that may be complicated. Similarly, providing case vignettes for graduate students may prompt them to understand the complexity of some of the legal ramifications of using AI. For example, a supervisor could prompt graduate students to consider the specific laws that would be applicable in the use of digital mental health interventions or conversational agents (e.g., ChatBots). Graduate students could then consider legal issues associated with data privacy and HIPAA compliance when there are third-party companies (Appendix B).

Finally, graduate programs may also want to consider promoting learning outcomes that include understanding how the data and algorithms may perpetuate bias and stereotypes. For example, course instructors could discuss how the data within AI may perpetuate bias and stereotypes. If test publishers use AI to integrate scores from multiple tests and measures as well as integrate data from intake forms, interviews, and observations into a comprehensive psychological report, graduate students should understand that the output would likely be a statistical prediction model based on data input by human beings. Importantly, neither the sociocultural nuances of the community nor the ecological context of the client would be considered within that psychological report. In fact, there is a possibility that these would be completely ignored or neglected, impacting the interpretation of the data and ultimately, the diagnosis.

Exploration and Adaptation: A Call to Action

As psychologists, we are navigating a complex and evolving process related to the integration of AI and psychological practice. As it stands, the legal and ethical frameworks governing AI's application in psychology were built for other forms of technology, and any attempts to generalize to AI itself are nascent. These frameworks are marked by limited legal precedents and almost nonexistent regulatory guidelines. While professional guidelines and case studies for AI have not yet been developed or documented, we can rely on our underlying ethical codes, ethical decision-making models, and the extant literature to help guide our choices.

As a field, we have an ethical imperative for both organizations and individual psychologists to address the dual challenge of ensuring that AI's use is maximally beneficial while minimizing client harm. We must have a proactive approach to the oversight, development, and application of AI; this may include collaborating with AI developers and vendors to promote a commitment to transparency, fairness, and the safeguarding of privacy, alongside rigorous testing to identify and mitigate biases and vulnerabilities.

Training programs must also adapt their curricula to address the impact of AI across various aspects of psychological practice, such as documentation, diagnostics, treatment planning, and intervention selection. Psychologists must pursue specialized training to interact

ethically and responsively with these technologies, aiming to reduce or eliminate bias. As there is little research on the intersection of AI and psychological practice currently, there is a great need of extensive research and guidance.

For now, the onus of navigating this landscape falls squarely on the psychologists who choose to integrate AI into their practice. We must remain vigilant, informed, and ethically grounded, balancing AI's innovative potential against the paramount importance of client welfare. Said another way, we must ensure that clients receive high-quality, evidence-based care while we actively avoid the use of low-value care in practice. This responsibility includes a thorough vetting of AI tools for compliance with current legal and ethical standards, a deep understanding of the technology's capabilities and limitations, and an ongoing engagement with the broader implications of its use.

Collaboration between psychologists, AI developers, regulatory bodies, members of historically marginalized communities, and scholars in legal and ethical practice will be essential in crafting a framework that ensures AI's benefits are realized ethically and effectively, enhancing psychological practice while protecting those we aim to serve. We enter a period of exploration and adaptation regarding AI in psychological practice, one that requires a steadfast commitment to ethical principles and dynamic responses to an ever-evolving landscape. By embracing both the promise and the challenge of AI, psychologists can lead the way to developing practices that are not only innovative but grounded in the highest standard of care and ethical responsibility.

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Appendix A

Ethical Decision-Making Vignette: Personalized Counseling Services via AI

**This vignette was generated by ChatGPT with the prompt*: "Provide a prompt for an ethical dilemma that a psychologist may encounter as it relates to artificial intelligence."

As a seasoned psychologist, you are approached by a technology company developing an advanced AI system designed to provide therapeutic support for individuals dealing with mental health issues. The AI, equipped with sophisticated natural language processing and emotional intelligence algorithms, claims to offer personalized and effective counseling services. The company seeks your expertise to evaluate and endorse their AI therapist for widespread use.

Consider the ethical dilemma surrounding the integration of artificial intelligence in mental health care. Reflect on the potential benefits of widespread access to AI therapy, such as affordability and scalability, versus the concerns related to privacy, human connection, and the risk of relying solely on machines for emotional support.

As a psychologist, you must grapple with the decision of whether to support the adoption of AI therapists and, if so, under what conditions. How do you balance the promise of technological advancement with the potential risks to the well-being and autonomy of individuals seeking mental health support? What ethical considerations and guidelines would guide your decision in navigating this complex intersection of psychology and artificial intelligence?

(*Appendices continue*)

Appendix B

Sample Policy for Departments Related to the Use of AI

Credit: Department of Psychology, University of Montana, Developed by Anisa N. Goforth, Hillary Powell, and Katelyn Melcher.

This policy establishes four standards for the ethical and responsible use of large language models or generative artificial intelligence (AI) in the provision of psychological services to clients by health service psychology clinicians (i.e., graduate students in clinical psychology, graduate students in Specialist in School Psychology and PhD in school psychology, interns, postdoctoral residents). The Department defines generative AI (e.g., ChatGPT, Gemini) as complex computer science programming trained on vast amounts of text or images, enabling it to recognize and mimic the way humans communicate. The overarching aim of this policy is for clinicians to adhere to the ethical standards and principles outlined by relevant professional associations (i.e., American Psychological Association, National Association of School Psychologists). This policy seeks to ensure the well-being, confidentiality, and trust of clients while harnessing the benefits of technological advancements. The Department also acknowledges that as technology advances, we encourage continued conversations about generative AI that will inform evolving policies.

1. *Clinicians must not use AI in which client information/data (e.g., test scores, background history) are inputted*. That is, clinicians may not use AI for record keeping (e.g., treatment notes), psychological report writing, or other documents relevant to a specific client's treatment. In accordance with the profession's ethical principles, client data should be kept confidential. Clinicians should be aware that providing any client information—even information that is perceived as nonidentifiable—to an open-source generative AI program means that the resultant information exchange is out of the hands of the clinician, the client, the supervisor, and other relevant parties. As a result, there is a potential breach of confidentiality that is avoidable. Importantly, clinicians should be aware that even if a generative AI has a business associate agreement and indicates Health Insurance Portability and Accountability Act compliance, clinicians should consider their ethical responsibilities for client privacy.

2. *Clinicians are expected to improve their skills in tailoring assessment feedback, case conceptualization, and treatment planning to a specific client (or clients) under close clinical supervision*. The use of AI is antithetical to this aim; that is, using AI to generate psychological reports or treatment summaries is counter to the goal of individually tailoring assessments and interventions for clients. Further, competency in documentation is a key training goal of health service psychology programs. To the extent that clinicians might rely on AI-generated documentation, this would prevent them from independently attaining such competency. Finally, AI-generated material may contain a number of inaccuracies, misrepresentations, and biases.

3. *Clinicians must not solely rely on AI technologies for clinical interpretation, clinical decision making, and review of the clinical literature*. What AI produces is limited by its source data in regard to scope, recency, quality, relative weighting, and bias of information. In contrast, evidence-based practice requires the dynamic integration of the best available research, the client's characteristics and preferences, and the clinician's background and judgment. AI-generated clinical interpretations should be reviewed with caution and in consultation with one's supervisor.

4. *Clinicians must consult on the use of AI and disclose when such technologies have contributed to the development of materials*. AI is a promising tool for aiding in the provision of health service psychology. Thus, when reasonable and beneficial to client well-being, clinicians may use AI to generate materials that do not involve a specific client's information (e.g., generating self-monitoring logs or mindfulness exercises to use with a client). Prior to using AI, clinicians must obtain consultation and clarification about the appropriateness of AI use from their clinical supervisors. Clinicians are required to be transparent about the use of AI with their clinical supervisors, sharing which AI platform, prompts, and results are used for the provision of client care.

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Supreme Court takes up challenge to Colorado ban on “conversion therapy”

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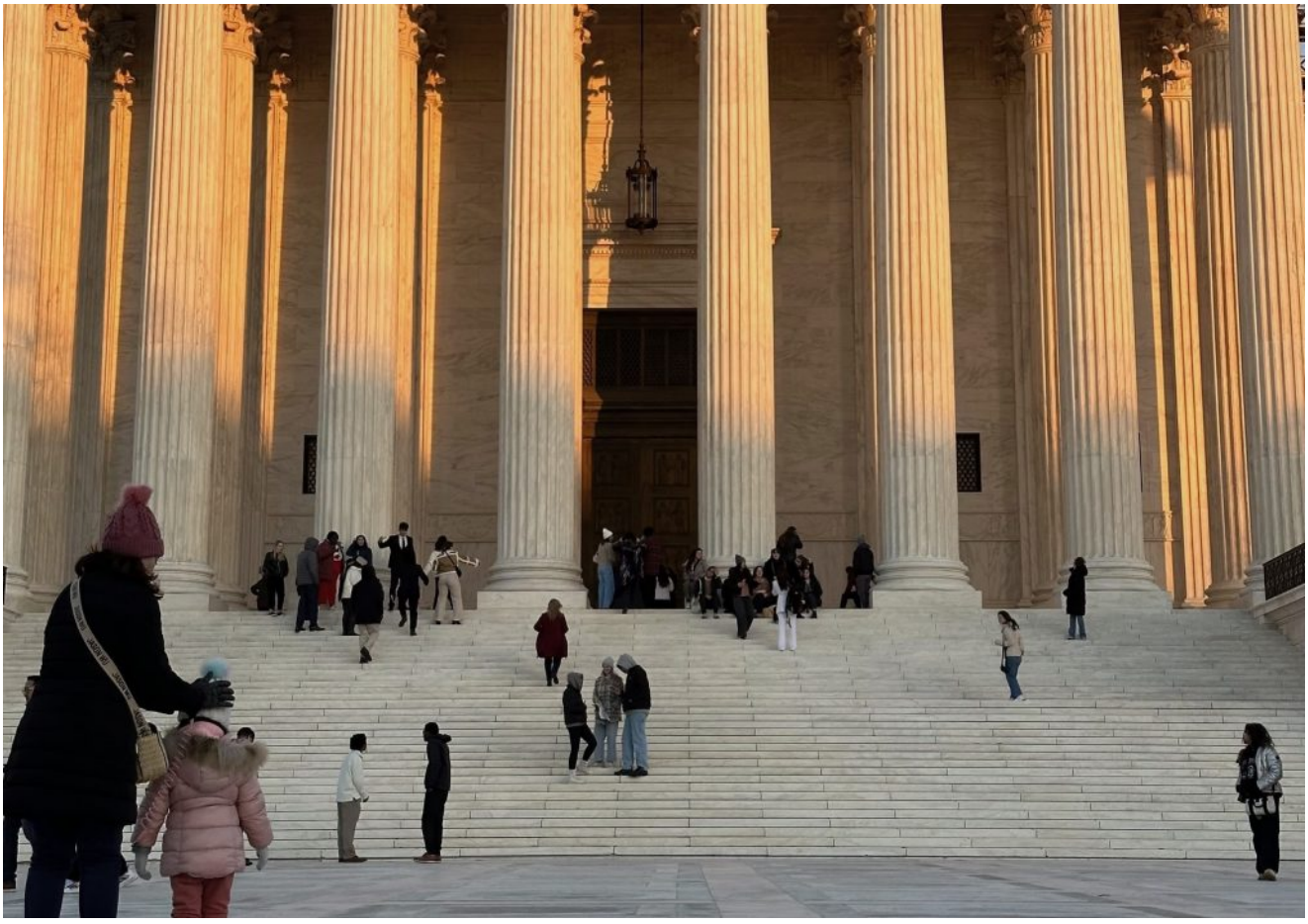
March 10, 2025

SCOTUS NEWS

By Amy Howe
on Mar 10, 2025 at 11:10 am



The court took up two cases in a regularly scheduled list of orders on Monday. (Katie Barlow)

The Supreme Court on Monday agreed to weigh in on the constitutionality of Colorado's ban on "conversion therapy" – that is, the effort to "convert" someone's sexual orientation or gender identity. That announcement came as part of a list of orders released on Monday morning from the justices' private conference last week.

Less than a year and a half ago, the Supreme Court declined to hear a challenge to a Washington state law that prohibits licensed therapists from practicing conversion therapy on children. Justices Clarence Thomas, Samuel Alito, and Brett Kavanaugh dissented from the decision not to weigh in then, indicating that they would have granted review. On Monday, the justices agreed to take up a challenge to a similar ban, this time from Colorado.

The case was filed by Kaley Chiles, a licensed counselor and a practicing Christian. She sometimes works with clients who want to discuss issues such that, she says, "implicate Christian values about human sexuality and the treatment of their own body." And although Chiles "never promises that she can solve" issues relating to gender identity, gender roles, and sexual attraction, "she believes clients can accept the bodies that God has given them and find peace." She contends that the law violates her First Amendment rights to free speech and to freely exercise her religion.

The U.S. Court of Appeals for the 10th Circuit rebuffed Chiles's challenge. It reasoned that Colorado enacted the law, based on evidence of the harms of conversion therapy, as part of its effort to regulate the health care profession and that the law primarily regulates therapists' conduct, rather than their speech.

Chiles came to the Supreme Court in November, asking the justices to hear her case. She contended that governments like Colorado "do not have a freer hand to regulate speech simply because the speaker is 'licensed' or giving 'specialized advice.'" And she warned that the 10th Circuit's rule "has devastating real-world consequences. In jurisdictions with counseling restrictions," she wrote, "many young people cannot receive the care they seek — and critically need."

The state countered that the ban on conversion therapy was based on "overwhelming evidence that efforts to change a child's sexual orientation or gender identity are unsafe and ineffective." And it distinguished Chiles's counseling of her patients from "a chat with one's college roommate," emphasizing that the two scenarios receive different protections under the First Amendment. "Unlike laypersons," it told the justices, "those who choose to practice as health professionals are required, among various other responsibilities, to provide treatment to their patients consistent with their field's standard of care."

In a brief order on Monday, the justices granted Chiles's petition for review. The case will likely be argued sometime in the fall, with a decision to follow by summer 2026.

In a second case granted on Monday, the justices agreed to decide whether state procedural rules apply to lawsuits filed in federal court.

The question comes to the court in a medical-malpractice lawsuit filed in federal court in Delaware. The court dismissed Harold Berk's case, citing his failure to comply with a state law that requires plaintiffs in medical-malpractice cases to include an "affidavit of merit" — certification from an expert witness attesting that the plaintiff's medical malpractice claims are plausible – in their filings.

A federal appeals court upheld the dismissal, explaining that the state law does not conflict with the rules governing procedures in federal court.

Berk came to the Supreme Court in October, asking the justices to weigh in. Other federal courts of appeals would allow his lawsuit to move forward without the affidavit of merit, he contended, on the theory that the state requirement is inconsistent with the federal rules that outline what plaintiffs must provide when bringing a lawsuit – and do not impose such an additional obligation.

One purpose of those federal rules, Berks stressed, is to "bring about uniformity in the federal courts by getting away from local rules." "That purpose," he told the justices, "is undermined when federal courts allow a patchwork of state procedural rules to govern, creating a chaotic landscape where litigants face dramatically different procedural standards based solely on where they file."

The Supreme Court on Monday turned down a bid by 19 Republican-led states to file a case directly in the Supreme Court to block lawsuits brought by five other states against oil and gas companies, alleging that the companies knew that their products contributed to climate change but instead misled the public about the cause of climate change and the risks of fossil fuels.

Thomas dissented from the decision not to allow the case to move forward in the Supreme Court, in a three-page opinion joined by Alito.

The Republican-led states came to the Supreme Court last spring, seeking permission to file their lawsuit in the Supreme Court. The states sought to rely on the court's original jurisdiction – that is, its limited power under the Constitution to hear a dispute for the first time, rather than as an appeal from state or lower federal courts.

In October, the justices asked the federal government for its views on whether the dispute should move forward in the Supreme Court. In a brief filed in December, Elizabeth Prelogar – the U.S. solicitor general during the Biden administration – urged the court to turn down the Republican-led states' bid and allow the disputes to play out in the state courts instead.

Prelogar contended (among other things) that the states did not have a legal right to sue, known as standing, to bring their case. Noting that the state-court lawsuits that the Republican-led states seek to halt "are still in their early stages," she argued that any connection between the state-court suits and an injury to the Republican-led states or their

citizens is too speculative to support a lawsuit. “The most that can be said,” she reasoned, “is that a state court ‘might’ find the private companies liable” in state court. “But even then,” she wrote, “those directly affected would be the private companies, not the” Republican-led states or their citizens.

Thomas reiterated his skepticism that the Supreme Court can decline to take up lawsuits pitting states against each other. “This discretionary approach,” he wrote, “is a modern invention that the Court has never persuasively justified.” And the approach is particularly “troubling,” he continued, because it “leaves the 19 plaintiff States without any legal means of vindicating their claims against the 5 defendant States.”

The Supreme Court also turned down an invitation to overrule the half-century-old framework, first outlined in *McDonnell Douglas Corp. v. Green*, used when plaintiffs do not have direct evidence to show that they were the victims of employment discrimination.

Thomas once again dissented from the decision not to intervene, this time in a nine-page opinion joined by Justice Neil Gorsuch.

The question comes to the court in the case of a California fire chief who claims he was fired because of his religion – specifically, for attending a Christian leadership event. The city counters that he was let go after “years” of “mismanagement, misconduct, and refusals to follow” orders given by city managers.

The U.S. Court of Appeals for the 9th Circuit agreed with a federal trial court that Ronald Hittle had not presented enough evidence to support his religious discrimination claim. The city, it concluded, had legitimate and nondiscriminatory reasons for firing Hittle. Over a dissent by four judges, the full court of appeals declined to rehear the case.

Hittle came to the Supreme Court in October, asking the justices to take up his case. He called the *McDonnell Douglas* test “unworkable and egregiously wrong,” arguing that it is inconsistent with the test of federal employment discrimination laws and the federal rules governing civil lawsuits. At the very least, he contended, the court should clarify what a plaintiff needs to show at the third step of the *McDonnell Douglas* framework to demonstrate that the nondiscriminatory reason that an employer offers to justify its actions is actually just an excuse.

Arguing that the Supreme Court “appears to have” created the *McDonnell Douglas* test “out of whole cloth,” Thomas (joined by Gorsuch) would have granted Hittle’s petition for review and used his case as an “opportunity to revisit McDonnell Douglas and decide” whether the test “remains a workable and useful evidentiary tool.” Hittle’s case would have been an appropriate one in which to consider that question, Thomas explained, because Hittle had “presented ‘ample’ evidence of discriminatory intent on the part of those who decided to terminate him.” Therefore, Thomas concluded, the lower courts should not have ruled for the city.

The justices once again did not act on several other high-profile petitions for review that they considered last week, including a pair of cases contesting Maryland's ban on assault-style weapons and Rhode Island's bar on large-capacity magazines, as well as the case of a Massachusetts middle schooler who was barred from wearing a t-shirt to school reading "There Are Only Two Genders."

The justices will meet again on Friday, March 21, to consider new petitions for review. Orders from that conference are expected on Monday, March 24.

This article was originally published at Howe on the Court.

Correction (March 12 at 2:11 p.m.): An earlier version of this article incorrectly omitted Justices Brett Kavanaugh from the justices dissenting in the court's decision not to hear the challenge to Washington's conversion therapy ban.

Posted in Merits Cases, Corrections

Cases: Alabama v. California, Hittle v. City of Stockton, California, Berk v. Choy, Chiles v. Salazar

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SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 1503

(SENATE AUTHORS: OUMOU VERBETEN, Boldon, Abeler and Hoffman)

DATE	D-PG	OFFICIAL STATUS
02/17/2025	412	Introduction and first reading Referred to Health and Human Services
02/20/2025	432a	Comm report: To pass as amended and re-refer to Judiciary and Public Safety
	465	Authors added Boldon; Abeler; Hoffman

A bill for an act

relating to health; prohibiting facility fees for nonemergency services provided at provider-based clinics; prohibiting facility fees for certain health care services; requiring a report; proposing coding for new law in Minnesota Statutes, chapter 62J; repealing Minnesota Statutes 2024, section 62J.824.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[62J.8241] FACILITY FEES PROHIBITED.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the definitions have the meanings given.

(b) "Facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses.

(c) "Health care provider" has the meaning given in section 145B.02.

(d) "Provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

Subd. 2. **Provider-based clinic prohibition.** Health care providers are prohibited from charging, billing, or collecting a facility fee for nonemergency services provided at a provider-based clinic, including services provided by telehealth as defined in section 62A.673, subdivision 2, paragraph (h).

Subd. 3. **Service-specific prohibition.** Regardless of where the services are provided, health care providers are prohibited from charging, billing, or collecting a facility fee for:

(1) outpatient evaluation and management services; and

(2) any other services identified by the commissioner of health pursuant to subdivision 5, paragraph (a).

Subd. 4. **Reporting.** (a) By January 15, 2027, and each year thereafter, hospitals licensed under chapter 144 and health systems operating one or more hospitals licensed under chapter 144 must submit a report to the commissioner of health identifying facility fees charged, billed, and collected during the preceding calendar year. The commissioner must publish the information reported on a publicly accessible website. The report shall be in the format prescribed by the commissioner of health.

(b) The report under this subdivision must include the following information for each facility owned or operated by the hospital or health system providing services for which a facility fee is charged, billed, or collected:

(1) the name and full address of each facility;

(2) the number of patient visits at each facility; and

(3) the number, total amount, and range of allowable facility fees paid at each facility by Medicare, medical assistance, MinnesotaCare, and private insurance.

(c) The report under this subdivision must include the following information for the entire hospital or health system:

(1) the total amount charged and billed for facility fees;

(2) the total amount collected from facility fees;

(3) the top ten procedures or services provided by the hospital or health system that generated the greatest amount of facility fee gross revenue, the volume each of these ten procedures or services and gross and net revenue totals, for each such procedure or service, and the total net amount of revenue received by the hospital or health system derived from facility fees;

(4) the top ten procedures or services, based on patient volume, provided by the hospital or health system for which facility fees are charged, billed, or collected, based on patient volume, including the gross and net revenue totals received for each such procedure or service; and

(5) any other information related to facility fees that the commissioner of health may require.

Subd. 5. **Regulatory authority.** (a) The commissioner of health may adopt rules to include additional outpatient, diagnostic, imaging, or other services in the prohibition on facility fees set forth in subdivision 3. The commissioner may only include in the prohibition services that the commissioner determines are reliably provided safely and effectively in settings other than hospitals.

(b) The commissioner of health may adopt rules to carry out the provisions of this section.

Subd. 6. **Enforcement.** (a) A violation of this section is an unlawful business practice for purposes of section 8.31. The attorney general may enforce this section pursuant to section 8.31.

(b) The commissioner of health and health-related licensing boards may impose penalties for noncompliance consistent with their authority to regulate health care providers.

(c) In addition to penalties provided in paragraphs (a) and (b), the commissioner of health may impose an administrative penalty on a health care provider that violates this section. The penalty must not exceed $1,000 per occurrence.

(d) The commissioner of health or its designee may audit any health care provider for compliance with the requirements of this section. A health care provider must make available, upon written request of the commissioner or its designee, copies of any books, documents, records, or data that are necessary for the purposes of completing the audit for four years after the furnishing of any services for which a facility fee was charged, billed, or collected.

Sec. 2. **REPEALER.**

Minnesota Statutes, section 62J.824, is repealed.

62J.824 FACILITY FEE DISCLOSURE.

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient, including patients served by telehealth as defined in section 62A.673, subdivision 2, paragraph (h), stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including on its website, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 936

02/17/2025 Authored by Nash
The bill was read for the first time and referred to the Committee on State Government Finance and Policy

A bill for an act

relating to state government; requiring cost-benefit analysis for proposed administrative rules; prohibiting the adoption of certain rules; requiring notice to the legislature upon adoption of certain exempt rules; amending Minnesota Statutes 2024, sections 14.002; 14.02, by adding subdivisions; 14.131; 14.14, subdivision 2; 14.15, subdivisions 3, 4; 14.386; 14.388, subdivision 2; 14.389, subdivision 2; 14.44; 14.45; proposing coding for new law in Minnesota Statutes, chapter 14.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2024, section 14.002, is amended to read:

14.002 STATE REGULATORY POLICY.

The legislature recognizes the important and sensitive role for administrative rules in implementing policies and programs created by the legislature. However, the legislature finds that some regulatory rules and programs have become overly prescriptive and inflexible, thereby increasing costs to the state, local governments, and the regulated community and decreasing the effectiveness of the regulatory program. Therefore, state agencies may only adopt rules for which benefits exceed costs and, whenever feasible, state agencies must develop rules and regulatory programs that emphasize superior achievement in meeting the agency's regulatory objectives and maximum flexibility for the regulated party and the agency in meeting those goals.

Sec. 2. Minnesota Statutes 2024, section 14.02, is amended by adding a subdivision to read:

Subd. 2a. **Benefit.** "Benefit" means any direct or indirect value gain projected to result from a rule, as expressed in dollars.

Sec. 3. Minnesota Statutes 2024, section 14.02, is amended by adding a subdivision to read:

Subd. 2b. **Best practices.** "Best practices" means theoretically and empirically justified methods that are state-of-the-art and widely used within a given scientific discipline such as statistics or economics.

Sec. 4. Minnesota Statutes 2024, section 14.02, is amended by adding a subdivision to read:

Subd. 3a. **Cost.** "Cost" means any direct or indirect value loss projected to result from a rule, as expressed in dollars.

Sec. 5. Minnesota Statutes 2024, section 14.02, is amended by adding a subdivision to read:

Subd. 5. **Stakeholder.** "Stakeholder" means an individual, group, or entity subject to a rule, including but not limited to consumers, citizens, small businesses, and large businesses.

Sec. 6. **[14.051] COST-BENEFIT ANALYSIS REQUIRED.**

Subdivision 1. **Demonstration of net benefits required.** (a) Except as provided in subdivision 4, an agency must not adopt or amend a rule under this chapter unless the agency prepares a cost-benefit analysis that clearly demonstrates that total projected benefits of the rule will exceed total projected costs. The analysis must identify projected costs and benefits for all relevant parties, including but not limited to classes of stakeholders, local units of government, and the state and its agencies. The agency must consult with the commissioner of management and budget to identify projected costs and benefits for local units of government.

(b) An agency must include a preliminary cost-benefit analysis when publishing a notice of proposed rules and a final cost-benefit analysis when publishing a notice of adoption in the State Register. The final cost-benefit analysis must explain:

(1) any significant difference between the preliminary and final cost-benefit analyses; and

(2) any decision by the agency to modify or not modify the preliminary cost-benefit analysis in response to public comments.

Subd. 2. **Methods; transparency.** (a) The agency must apply standardized analytic methods and metrics to all rules. The standards must be developed and updated by the Office of Administrative Hearings to conform with the latest best practices.

(b) The agency must determine projected costs and benefits for the five-year period beginning on the anticipated date of rule adoption, unless the agency justifies a longer period. If the agency incorporates discount rates in the cost-benefit analysis, the agency must justify its chosen rate and compare its results to those calculated with alternative reasonable rates. The agency must report and explain all significant uncertainties. The agency must not express unquantifiable, qualitative factors of life in dollar terms.

(c) The agency must publish all documentation, assumptions, methods, and data for the cost-benefit analysis on an easily accessible public website and, where relevant, in a machine-readable format, including sufficient supporting calculations, documents, and data for replication.

Subd. 3. **Deficient analysis.** A final cost-benefit analysis is significantly deficient if the agency's analysis:

(1) fails to consider a relevant and significant cost or benefit;

(2) significantly underestimates costs or significantly overestimates benefits in a manner that affects the outcome of the analysis; or

(3) fails to adequately justify any modification of the preliminary cost-benefit analysis.

Subd. 4. **Exemption.** This section does not apply to exempt rules under section 14.386, good cause rules under section 14.388, or expedited rules under section 14.389.

Sec. 7. Minnesota Statutes 2024, section 14.131, is amended to read:

14.131 STATEMENT OF NEED AND REASONABLENESS.

By the date of the section 14.14, subdivision 1a, notice, the agency must prepare, review, and make available for public review a statement of the need for and reasonableness of the rule. The statement of need and reasonableness must be prepared under rules adopted by the chief administrative law judge and must include the following to the extent the agency, through reasonable effort, can ascertain this information:

(1) a description of the classes of ~~persons~~ stakeholders who probably will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule;

~~(2) the probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues;~~

~~(3)~~ (2) a determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule;

~~(4)~~ (3) a description of any alternative methods for achieving the purpose of the proposed rule that were seriously considered by the agency and the reasons why they were rejected in favor of the proposed rule;

~~(5) the probable costs of complying with the proposed rule, including the portion of the total costs that will be borne by identifiable categories of affected parties, such as separate classes of governmental units, businesses, or individuals;~~

~~(6) the probable costs or consequences of not adopting the proposed rule, including those costs or consequences borne by identifiable categories of affected parties, such as separate classes of government units, businesses, or individuals;~~

~~(7)~~ (4) an assessment of any differences between the proposed rule and existing federal regulations and a specific analysis of the need for and reasonableness of each difference; and

~~(8)~~ (5) an assessment of the cumulative effect of the rule with other federal and state regulations related to the specific purpose of the rule.

The statement must describe how the agency, in developing the rules, considered and implemented the legislative policy supporting performance-based regulatory systems set forth in section 14.002.

For purposes of clause ~~(8)~~ (5), "cumulative effect" means the impact that results from incremental impact of the proposed rule in addition to other rules, regardless of what state or federal agency has adopted the other rules. Cumulative effects can result from individually minor but collectively significant rules adopted over a period of time.

The statement must include the cost-benefit analysis required under section 14.051 and also describe the agency's efforts to provide additional notification under section 14.14, subdivision 1a, to persons or classes of ~~persons~~ stakeholders who may be affected by the proposed rule or must explain why these efforts were not made.

~~The agency must consult with the commissioner of management and budget to help evaluate the fiscal impact and fiscal benefits of the proposed rule on units of local government.~~ The agency must send a copy of the statement of need and reasonableness to

the Legislative Reference Library when the notice of hearing is mailed under section 14.14, subdivision 1a.

Sec. 8. Minnesota Statutes 2024, section 14.14, subdivision 2, is amended to read:

Subd. 2. **Establishment of need and reasonableness of rule.** At the public hearing the agency shall make an affirmative presentation of facts establishing the need for and reasonableness of the proposed rule, including the cost-benefit analysis performed under section 14.051, and fulfilling any relevant substantive or procedural requirements imposed on the agency by law or rule. The agency may, in addition to its affirmative presentation, rely upon facts presented by others on the record during the rule proceeding to support the rule adopted.

Sec. 9. Minnesota Statutes 2024, section 14.15, subdivision 3, is amended to read:

Subd. 3. **Finding of substantial difference.** If the report contains a finding that a rule has been modified in a way which makes it substantially different, as determined under section 14.05, subdivision 2, from that which was originally proposed, or that the agency has not met the requirements of ~~sections~~ section 14.051 or 14.131 to 14.18, it shall be submitted to the chief administrative law judge for approval. If the chief administrative law judge approves the finding of the administrative law judge, the chief administrative law judge shall advise the agency and the revisor of statutes of actions which will correct the defects. The agency shall not adopt the rule until the chief administrative law judge determines that the defects have been corrected or, if applicable, that the agency has satisfied the rule requirements for the adoption of a substantially different rule.

Sec. 10. Minnesota Statutes 2024, section 14.15, subdivision 4, is amended to read:

Subd. 4. **Need ~~or~~, reasonableness, or net benefits not established.** If the chief administrative law judge determines that the need for or reasonableness of the rule has not been established pursuant to section 14.14, subdivision 2, or net benefits have not been adequately established pursuant to section 14.051, and if the agency does not elect to follow the suggested actions of the chief administrative law judge to correct that defect, then the agency shall submit the proposed rule to the Legislative Coordinating Commission and to the house of representatives and senate policy committees with primary jurisdiction over state governmental operations for advice and comment. The agency may not adopt the rule until it has received and considered the advice of the commission and committees. However, the agency is not required to wait for advice for more than 60 days after the commission and committees have received the agency's submission.

Sec. 11. Minnesota Statutes 2024, section 14.386, is amended to read:

14.386 PROCEDURE FOR ADOPTING EXEMPT RULES; DURATION.

(a) A rule adopted, amended, or repealed by an agency, under a statute enacted after January 1, 1997, authorizing or requiring rules to be adopted but excluded from the rulemaking provisions of chapter 14 or from the definition of a rule, has the force and effect of law only if:

(1) the revisor of statutes approves the form of the rule by certificate;

(2) the person authorized to adopt the rule on behalf of the agency signs an order adopting the rule;

(3) the Office of Administrative Hearings approves the rule as to its legality within 14 days after the agency submits it for approval and files an electronic copy of the adopted rule with the revisor's certificate in the Office of the Secretary of State; ~~and~~

(4) a copy is published by the agency in the State Register; and

(5) the agency notifies by email the chairs and ranking minority members of the legislative committees with jurisdiction over the agency's operating budget.

The secretary of state shall forward one copy of the rule to the governor.

A statute enacted after January 1, 1997, authorizing or requiring rules to be adopted but excluded from the rulemaking provisions of chapter 14 or from the definition of a rule does not excuse compliance with this section unless it makes specific reference to this section.

(b) A rule adopted under this section is effective for a period of two years from the date of publication of the rule in the State Register. The authority for the rule expires at the end of this two-year period.

(c) The chief administrative law judge shall adopt rules relating to the rule approval duties imposed by this section and section 14.388, including rules establishing standards for review.

(d) This section does not apply to:

(1) any group or rule listed in section 14.03, subdivisions 1 and 3, except as otherwise provided by law;

(2) game and fish rules of the commissioner of natural resources adopted under section 84.027, subdivision 13, or sections 97A.0451 to 97A.0459;

(3) experimental and special management waters designated by the commissioner of natural resources under sections 97C.001 and 97C.005;

(4) game refuges designated by the commissioner of natural resources under section 97A.085; or

(5) transaction fees established by the commissioner of natural resources for electronic or telephone sales of licenses, stamps, permits, registrations, or transfers under section 84.027, subdivision 15, paragraph (a), clause (2).

(e) If a statute provides that a rule is exempt from chapter 14, and section 14.386 does not apply to the rule, the rule has the force of law unless the context of the statute delegating the rulemaking authority makes clear that the rule does not have force of law.

Sec. 12. Minnesota Statutes 2024, section 14.388, subdivision 2, is amended to read:

Subd. 2. **Notice.** An agency proposing to adopt, amend, or repeal a rule under this section must give electronic notice of its intent in accordance with section 16E.07, subdivision 3, ~~and~~ notice by United States mail or ~~electronic mail~~ email to persons who have registered their names with the agency under section 14.14, subdivision 1a, and notice by email to the chairs and ranking minority members of the legislative committees with jurisdiction over the agency's operating budget. The notice must be given no later than the date the agency submits the proposed rule to the Office of Administrative Hearings for review of its legality and must include:

(1) the proposed rule, amendment, or repeal;

(2) an explanation of why the rule meets the requirements of the good cause exemption under subdivision 1; and

(3) a statement that interested parties have five working days after the date of the notice to submit comments to the Office of Administrative Hearings.

Sec. 13. Minnesota Statutes 2024, section 14.389, subdivision 2, is amended to read:

Subd. 2. **Notice and comment.** The agency must publish notice of the proposed rule in the State Register ~~and must~~, mail the notice by United States mail or ~~electronic mail~~ email to persons who have registered with the agency to receive mailed notices, and provide notice by email to the chairs and ranking minority members of the legislative committees with jurisdiction over the agency's operating budget. The mailed notice must include either a copy of the proposed rule or a description of the nature and effect of the proposed rule and a statement that a free copy is available from the agency upon request. The notice in the

State Register and the notice to legislators must include the proposed rule or the amended rule in the form required by the revisor under section 14.07, an easily readable and understandable summary of the overall nature and effect of the proposed rule, and a citation to the most specific statutory authority for the rule, including authority for the rule to be adopted under the process in this section. The agency must allow 30 days after publication in the State Register for comment on the rule.

Sec. 14. Minnesota Statutes 2024, section 14.44, is amended to read:

14.44 DETERMINATION OF VALIDITY OF RULE.

The validity of any rule may be determined upon the petition for a declaratory judgment thereon, addressed to the court of appeals, when it appears that (1) the rule, or its threatened application, interferes with or impairs, or threatens to interfere with or impair the legal rights or privileges of the petitioner, or (2) the final cost-benefit analysis supporting the rule is significantly deficient under section 14.051, subdivision 3. The agency shall be made a party to the proceeding. The declaratory judgment may be rendered whether or not the petitioner has first requested the agency to pass upon the validity of the rule in question, and whether or not the agency has commenced an action against the petitioner to enforce the rule.

Sec. 15. Minnesota Statutes 2024, section 14.45, is amended to read:

14.45 RULE DECLARED INVALID.

In proceedings under section 14.44, the court shall declare the rule invalid if it finds that it violates constitutional provisions ~~or~~, exceeds the statutory authority of the agency ~~or~~, was adopted without compliance with statutory rulemaking procedures, or is supported by a significantly deficient final cost-benefit analysis. Any party to proceedings under section 14.44, including the agency, may appeal an adverse decision of the court of appeals to the supreme court as in other civil cases.

Sec. 16. **EFFECTIVE DATE.**

This act is effective the day following final enactment and applies to rules adopted or amended on or after that date.

MINNESOTA
BOARD OF PSYCHOLOGY

Minnesota Board of Psychology Executive Director Report
March 21, 2025

Introduction

The mission of the Board is to protect the public through licensure, regulation, and education to promote access to safe, competent, and ethical psychological services. The work of the Board is strategically aligned to accomplish this mission, including prioritization of Board action and the assignment of resources (both human and financial).

The work of the Board has focused on the following since the last Board meeting:

I. Administrative Updates

a. Assistant Executive Director Licensing Update
The Licensure Team has continued to support the Mission and Vision of the Board by processing Psychologist and Behavior Analyst license applications. Board staff have issued 36 new Behavior Analyst licenses since the last Board meeting. To date, 611 Behavior Analyst licenses have been issued. A small number of new applications continue to be submitted. Additionally, Board staff have approved accommodations as well as extended time requests for ELL learners that are sitting for the EPPP exam. The licensure team continues to carryout efficient procedures to provide Psychology and Behavior Analyst applicants an equitable process to licensure.

II. Executive Director's Report

a. Staffing Update: A new staff member has been hired and joined the compliance team. Wondwosen Darsebo started as the Board's Compliance Specialist on March 12.
b. Federal Executive Orders – the Board is fielding questions about the impacts of Federal Executive Orders that federal employers and psychologists employed by the federal government are required to follow.
c. Legal update: The Board is monitoring Chiles v. Salazar a case recently granted certiorari at the United States Supreme Court, which seeks to invalidate Colorado's conversion therapy ban statute.
d. Legislative Update: The Board is monitoring many pieces of legislation. The legislative session is in full swing.
    a. SF 2371 – limits the Board's jurisdiction to discipline licensee's and applicants based solely on a failed drug use screening for use of medicinal marijuana with a valid medicinal marijuana registration.
    b. SF 2589 – adds "Trump Derangement Syndrome" to the definition of mental illness under MN Statute 245(i).
    c. SF 1501 – prohibits "facility fees" being charged and directs the Board to impose sanctions on licensees who charge facility fees.

d. HF 936 – requires the Board to conduct a cost-benefit analysis of any rules it adopts or changes.

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/21/2025

SUBMITTED BY: State Program Administrator

TITLE: Board Administrative Terminations

INTRODUCTION TO THE TOPIC:

The Board shall terminate the license of a licensee whose license renewal is at least 60 days overdue and to whom notification has been sent as provided in the administrative rules. Failure of a licensee to receive notice is not grounds for later challenge of the termination.

Licensees are provided several opportunities to renew the license prior to Board termination. Licensees are sent a notice within 30 days after the renewal date when they have not renewed the license. This letter is sent via certified mail to the last known address of the licensee in the file of the board. This notifies the licensee that the license renewal is overdue and that failure to pay the current renewal fee and the current late fee ($250.00) within 60 days after the renewal date will result in termination of the license. A second notice is sent to the licensee at least seven days before a board meeting (which occurs 60 days or more after the renewal date). Minn. R. 7200.3510.

BOARD ACTION REQUESTED:

License	Name	Expiration Date
LP6632	David Ready	12/31/2024
LP1994	Vivian Pearlman	12/31/2024
LP1979	David Mellberg	12/31/2024
LP1881	Bill Duke	12/31/2024
LP1919	Donna Cairncross	12/31/2024
LP4097	Maria Anderson	12/31/2024