



MINNESOTA BOARD OF PSYCHOLOGY
January 30, 2026
Board Meeting

Order of Business

PUBLIC SESSION:

- 1. Call to Order**
 - A. Link to the Board Meeting**
- 2. Adoption of Tentative Agenda**
- 3. Announcements**
- 4. Approval of the Board Minutes**
 - A. Approval of Board Meeting Minutes**
- 5. Consent Agenda**
 - A. Staff Delegated Authority Report**
- 6. New Business**
 - A. Minnesota Psychological Association Discussion**
 - B. Health Provider Services Program**
 - C. Master's Level Licensure**
 - D. AI in Psychology Practice**
 - E. Executive Director's Report**
 - F. Psilocyban Draft Legislation**
 - G. Board Administrative Terminations**
- 7. Committee Reports**
- 8. Adjournment**



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Link to the Board Meeting

INTRODUCTION TO THE TOPIC:

Please contact the Board for a link to the Board meeting. Email: psychology.board@state.mn.us

BOARD ACTION REQUESTED:



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Approval of Board Meeting Minutes

INTRODUCTION TO THE TOPIC:

The Board Meeting Minutes for December 2025 are respectfully submitted.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description

December 2025 Board Meeting Minutes

Upload Date Type

1/26/2026 Cover Memo

MINNESOTA BOARD OF PSYCHOLOGY
Minutes of the December 19, 2025, Board Meeting

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

Guests: Nick Lienesch and Steve Girardeau.

PUBLIC SESSION

1. Call to Order

Sonal Markanda called the meeting to order at 9:37 AM. 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 Pamela Freske Motion: to adopt the tentative agenda. There being 9 "ayes" and 0 "nays" the motion Passed.

3. Announcements

4. Approval of the Board Minutes

Seb Rilen moved, seconded by Nancy Cameron Motion: to adopt the November 21, 2025, Board Meeting Minutes. There being 9 "ayes" and 0 "nays" the motion Passed

5. Consent Agenda

A. Staff Delegated Authority Report

6. New Business

A. Minnesota Psychological Association – Legislation Update

Steven Girardeau presented on two pieces of legislation being promoted by the Minnesota Psychological Association: exemption from Minnesota's new medical debt law for Psychologists and a bill modeled on a recently passed Illinois law. The second bill forbids the provision of psychological and behavioral health services by any entity (including AI) that is not licensed by a state board. The AI proposal is in the drafting stage and language specific to Minnesota is not yet available for review.

Michael Thompson moved, seconded by Nancy Cameron Motion: refer the proposed exemption from the medical debt law to the Legislative Committee for further review and recommendations. There being 9 "ayes" and 0 "nays" the motion Passed.

B. AI in Psychology Practice

Further discussion of AI issues was deferred to next month's meeting.

C. Master's Level Licensure

Sam Sands noted there were no significant new developments to discuss.

D. Executive Director's Report

Trisha Hoffman reported that the Licensure Team has continued to process Psychologist and Behavior Analyst applications, with nearly 900 Behavior Analyst licenses approved to date. Several licenses have been issued to psychologist applicants after completion of teach-out programs following the closure of Argosy University.

Sam Sands informed the Board that the Board's website has been updated, staff have submitted licensing and supervision proposal to MPA, and NovusAgenda will soon be replaced by new software.

E. Officer Election

Nancy Cameron moved, seconded by Daniel Hurley Motion: to reelect the current Board Chair, Vice Chair and Secretary by acclamation. The motion Passed.

F. Board Administrative Terminations

Seb Rilen moved, seconded by Salina Renninger Motion: to approve the Board Administrative Terminations. There being 9 "ayes" and 0 "nays" the motion Passed.

7. Committee Reports

8. Adjournment

Adjourned at 11:05 AM.



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

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.

BOARD ACTION REQUESTED:

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.

ATTACHMENTS:

Description	Upload Date	Type
Behavior Analyst Licensure Consent Agenda	1/28/2026	Cover Memo
Psychologist Licensure Consent Agenda	1/28/2026	Cover Memo
Compliance Consent Agenda	1/29/2026	Cover Memo

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
LBA0897	Kylie Crifasi
LBA0898	Sophia DuCharme
LBA0899	Christopher Maxwell
LBA0900	Maria Hollermann
LBA0901	Bailey Sapa
LBA0902	Brittany Farrell
LBA0903	Sophia Paintner
LBA0904	Taylor Caven
LBA0905	Josselyn Ensor
LBA0906	Carly Sanchez
LBA0907	Amber Grengs
LBA0908	Sara Pahl
LBA0909	Lauren Alderink
LBA0910	Barry Unis
LBA0911	Cicely Nicholas
LBA0912	Sinead McCarthy
LBA0913	Mariah Reid
LBA0914	Aisha Kilas
LBA0915	Kaden Kinaj
LBA0916	Ivana Borroto
LBA0917	Kyara Roberts
LBA0918	Daniel Fredericks
LBA0919	Rachel Hotakainen
LBA0920	Mara Forsgren
LBA0921	Nalesia Caruthers
LBA0922	Gina Marco
LBA0923	Erika Everly
LBA0924	Jennifer Martin
LBA0925	Samantha Lydick

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: 35 (Plus 14 Awaiting Payment and Pending)

Of applications filed, number of LBA applications that have satisfied all license fees: 35

Of these applications, number submitted to CBC program (anticipated timeline to process CBC is 30 days): 35

Of all applications filed (and paid fees), number in compliance review: 5

Average days for license to be granted (time counted from staff review to license application approved): 1 to 2 Days

Of applications filed, number of Behavior Analyst License applications still in review: 23

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

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
Alora McCarthy, Ph.D.
Dorothy Jenicke, Psy.D.
Jordan Anderson, Psy.D.
Timothy Johnson, Psy.D.
Katherine Carosella, Ph.D.
Meegan Murray, Psy.D.
Anna Achter, Ph.D.
Margaret Sai, Psy.D.
Zachary Wilde, Ph.D.
Dee Vang, Psy.D.
Adrienne Manbeck, Ph.D.
Charlayne Scarlett, Ph.D.
Quincy Guinadi, Psy.D.
Edna Geddes, Psy.D.
Jaylene Arnett, Psy.D.
Cheston West, Ph.D.
Brooke Klooster, Ph.D.
Samuel Bomber, Psy.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)
Kayleigh Darling, Psy.D.
Frederick Robinson, Psy.D.
Dorothy Jenicke, Psy.D.
Monica Langevin, Psy.D.
Zoua Lor, Ph.D.
Linda Miller, MA
Jaime Myler, Psy.D.
Sadiqa Cash, Ph.D.
Theodore Catanzaro, Psy.D.
Benjamin Pyykkonen, Ph.D.
Rachel Bock, Ph.D.
Breanne Sande Russell, Ph.D.
Holly Hamilton, Ph.D.

Heather Simmer, Psy.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
LP7302	Meghan Marcum, Psy.D.
LP7303	Angela Haeny, Ph.D.
LP7304	Rebecca Carr, Psy.D.
LP7305	Taylor Nash, Psy.D.
LP7306	Myra thompson, Psy.D.
LP7307	Susan Alexander, Ph.D.
LP7308	Samantha Stroik, Psy.D.
LP7309	Kelsey Maleski, Psy.D.
LP7310	Tohar Scheininger, Ph.D.
LP7311	Sadiqa Cash, Ph.D.
LP7312	Logan Towne, Ph.D.
LP7313	Heather Wyatt, Psy.D.
LP7314	Rochelle Holtzman, Ph.D.
LP7315	Mark Schade, Ph.D.
RL00112	Linda Miller

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
GL0145	Christopher Sanders
GL0146	Benjamin Pyykkonen

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

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
ER00213	Jane Coffey

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
LP6986	Benjamin Parchem
LP0391	Pamela Beyer
LP0486	Sharon Doffing
LP4656	Hembroff Susan
LP0400	Huss Janet
LP4457	Susan Mcpherson
LP0513	Jan Hanvey
LP0885	James Kachel-Slanga
LP0590	Bradley Nelson
LP0683	Randall Wallace

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
LP3899	Jon Walser-Kuntz
LP3362	M. Abigail Barrett
LP1005	Jeffrey Brown
LP3038	Paul O'Hara
LP3014	Christos Petsoulis

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: 17

Of applications filed, number of LP applications still in review: 2
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Reasons for continued review: additional information needed.

Initial, Reciprocity, and Mobility applications days to license: 14 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: 6 days

Minnesota Board of Psychology

Consent Agenda Items:

Staff Delegated Compliance Report

Data from 12/19/25 – 1/28/26

Complaint Data – Open/NJ/FWD

Data on complaints that have been received since the December Board meeting.

Total complaints received, and those that either were opened for investigative review or were non-jurisdictional or forwarded to another Health-Related Licensing Board (HLB). Forwarded and non-jurisdictional may overlap as a complaint may be non-jurisdictional because the respondent is licensed with another HLB.

Licensed Psychologists:

Total Complaints	Opened	Non-Jurisdictional	Forwarded
16	12	7	5

Behavior Analysts:

Total Complaints	Opened	Non-Jurisdictional	Forwarded
3	3	0	0

Complaint Data – Reviews

Compliance data that has been reviewed since the December Board meeting.

Licensed Psychologists:

Triage Cases	Dismissed Cases	Disciplinary Conferences	SCOs Offered	NOC Assigned	Disciplinary/ Corrective Action Assigned
6	4	2	1	2	0

Behavior Analysts:

Triage Cases	Dismissed Cases	Disciplinary Conferences	SCOs Offered	NOC Assigned	Disciplinary/ Corrective Action Assigned
2	0	1	1	2	0

Complaint Data

Amount of complaints currently under investigative review and the average (median) amount of days taken to open a complaint, meaning send to investigative review, and all complaints that were closed from 12/19/25 – 1/28/26

Licensed Psychologists:

Currently Open Complaints (under review)	Days Taken (average amt of days since 12/19/25)	Closed Complaints
Investigative review: 69	<1	8
Committee review: 31		

Behavior Analysts:

Currently Open Complaints (under review)	Days Taken (average amt of days since 12/19/25)	Closed Complaints
Investigative review: 6	<1	0
Committee review: 4		



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY:

TITLE: Minnesota Psychological Association Discussion

INTRODUCTION TO THE TOPIC:

Dr. Talee Vang from the Minnesota Psychological Association would like to talk to the Board about current events and issues the association is seeing from their members.

BOARD ACTION REQUESTED:



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY:

TITLE: Health Provider Services Program

INTRODUCTION TO THE TOPIC:

A presentation by Kim Navarre, the Program Director of the Minnesota Health Professionals Services Program.

HPSP promotes early intervention, diagnosis, and treatment for health professionals with illnesses and provides monitoring services as an alternative to Board discipline.

The stigma associated with certain illnesses such as substance abuse and mental health disorders can make health care practitioners hesitant to seek treatment. Confidential monitoring increases the likelihood that practitioners will seek treatment early - before clinical skills are compromised. And monitoring improves treatment compliance and successful outcomes. The Minnesota Health Professionals Services Program (HPSP) is charged with protecting the public by promoting early intervention, diagnosis, treatment, and monitoring for health professionals with potentially impairing conditions. Monitoring services are available to over 400,000 health care professionals regulated or licensed by one of the Health Licensing Boards or the Department of Health.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
HPSP PPT	1/29/2026	Cover Memo



*Kim Navarre, MS, LMFT
HPSP Program Director*

<https://mn.gov/boards/hpsp/>



OBJECTIVES

- HPSP Review
- Board of Psychology Data
- Review Case Management Scenario

QUICK HPSP REVIEW

MISSION

Minnesota's Health Professionals Services Program protects the public by providing monitoring services to regulated health professionals whose illnesses MAY impact their ability to practice safely.

PUBLIC PROTECTION

STATUTES

214.32-214.37

<https://www.revisor.mn.gov/statutes/cite/214.32>

Tennessee Warning prior to every intake interview

Eligibility language prior to every intake interview

TYPES OF REFERRALS

Self-Report

Third Party Report

Board

- Eligibility
- Follow up
- Order

HPSP FUNCTIONS

Intake

Describe the program

Provide Tennessee

Obtain background information

Determine initial plan

Determine if monitoring is warranted

Develop a Participation Agreement

DATA

Enrollment/Participation

as of November 1, 2025

Board	Number Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Regulated
Nursing	165,642	317	1.9
Medical Practice	40,251	73	1.8
Office of EMS	30,685	21	.7
Pharmacy	20,902	26	1.2
Dentistry	18,029	22	1.2
Social Work	17,899	25	1.4

Enrollment/Participation

Board	Number Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Regulated
Behavioral Health & Therapy	9,824	52	5.3
Physical Therapy	8,258	6	.7
Occupational Therapy	5,945	2	.3
Psychology	4,327	2	.5
Marriage & Family Therapy	3,571	6	1.7
Veterinary Medicine	3,393	2	.6

Enrollment/Participation

Board	Number Regulated	Number Active in HPSP	Number Active in HPSP per 1,000 Regulated
Chiropractic Examiners	3,267	4	1.2
BELTSS (Administrative Long-Term Services and Supports)	3,105	11	3.5
Dietetics/Nutrition Practice	2,200	2	.9
Optometry	1,255	2	1.6
Podiatric	603	0	0
Department of Health		0	0

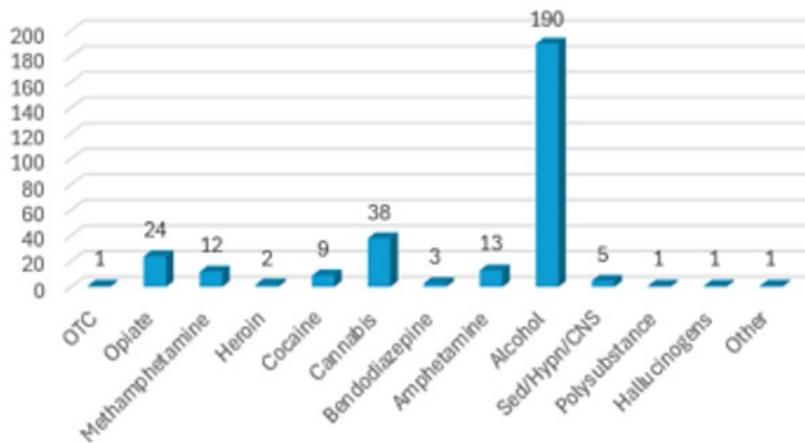
BOARD OF PSYCHOLOGY

REFERRALS	Order	Eligibility	Third
FY 2025		2	
FY 2026	1		1

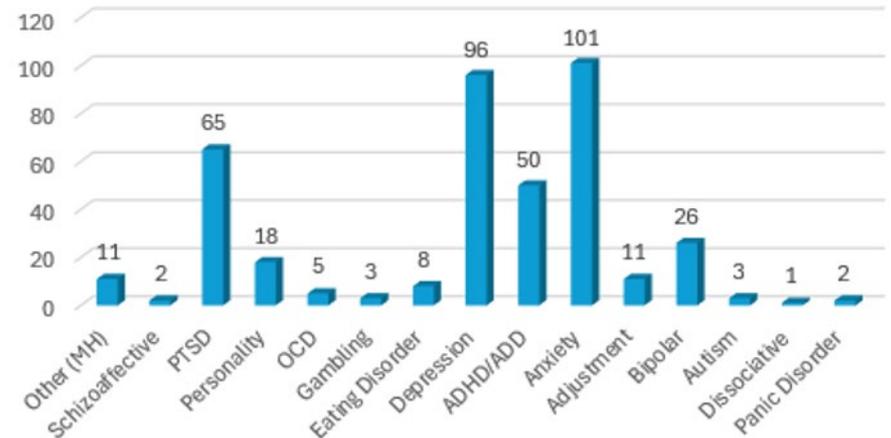
DISCHARGES	Complete	Non-Compliance	Non-Cooperative	Non-Jurisdictional
FY 2025	1	1		1
FY 2026	1		1	

Illnesses Monitored (All Boards)

FY25 - Substance Use Disorders Monitored



FY25 - Mental Health Diagnoses Monitored



Increase in Medical Conditions (Few Examples)

- Chronic Pain
- Diabetes
- Migraines
- Pulmonary
- Cardiac
- Neurology

BUDGET



\$83.33/Monthly =
\$1,000/Annually

FY2025 Total = \$8,492.70

CASE MANAGEMENT SCENARIO

INTAKE

Reason for referral: Licensee was reported by a third party due to concerns about possible substance use and/or mental health issues. Reporter notes documentation concerns, missing of staff meetings and consult, and mood changes daily.

Work History:

- LP for the past 10 years
- Currently works at ABC Clinic, outpatient clinic program as an LP for the past six years. M-F 8a-4:30p
- Supervisor is D. Smith
- Reports one written warning for frequent absences 2 years prior
- Denies any previous or current Board involvement

INTAKE

Social:

- Single with two children ages 10 & 14, currently lives with children
- Support System: Family, a few close friends, AA, HR
- Current Stressors: “THIS. I was reported by a bunch of jealous coworkers!”

Medical:

- Currently has medical insurance through employer
- Chronic medical concerns: High blood pressure
- Acute medical concerns: Denies
- Gastric bypass: Denies
- Primary Care Provider: Dr. Doe Z Clinic
- Pharmacy: Z Pharmacy
- Medications: Effexor, Xanax (PRN) reports 3-4 tabs per month

INTAKE

Mental Health:

- Reports family history of Depression and Anxiety
- Denies a family history of suicide
- Reports being diagnosed with Depression and Anxiety about 12 years ago
- Reports suicidal ideation about 2 years ago prior to treatment
- Reports one mental health hospitalization about 12 years ago
- Psychiatrist: None at this time, did see a psychiatrist about eight years ago
- Therapist: Saw a therapist about 2 years ago prior to divorce
- Current mental health symptoms: Denies
- Past mental health symptoms: Irritable, increased sleeping, decreased appetite

INTAKE

Substance Use:

- Alcohol
 - First used age 20, reports last use 6 years ago
 - 20-25: Weekend use, 6-8 beers per occasion
 - 25-28: Progressed to daily 1-2 pints per day
 - 28: Treatment-sober about 10 months had first child
 - 29-31: Daily two pints per day
 - 31: Treatment-sober about one year, had second child
 - 32-34: Daily half liter per day
 - No Treatment
 - 34-Present: sober
- Illicit Drugs
 - Tried THC about five times in high school. Denies any other use of illicit substances

INTAKE

Substance Use Cont.:

- Prescription Medications
 - Prescribed Xanax for the past eight years, average use is 3-4 tabs per month, denies current or past abuse.
- Substance of choice: Alcohol
- Withdrawal symptoms: Shakes, GI upset, denies seizures
- Date of last use: 6 years ago
- Legal consequences: One DUI about 12 years ago
- Treatment:
 - Age 28: Residential, did not successfully complete
 - Age 31: Residential, successful completion

INTAKE

Diversion:

- Participant denies diverting controlled substances, states no access

Plan:

- Request participant refrain from professional practice
- Request they obtain a substance use and mental health assessment
- Enrollment Forms due in 10 days
 - Primary care provider
 - Pharmacy
 - MN Prescription Monitoring Program (MN PMP)
 - Substance use provider
 - Mental health provider
 - Work site monitor

INTAKE

June 1, 2021:

Did not receive requested Enrollment form or authorizations
Emailed second and final letter to participant with a due date in seven days

June 6, 2021:

Requested return the Enrollment materials, schedule a substance use assessment to collateral contacts, and requested they refrain from practice.

June 8, 2021:

Received Enrollment form and completed authorizations.

Made records request to the primary care provider.
Sent signed/notarized MN PMP to the Board of Pharmacy

DETERMINATION FOR MONITORING

June 11, 2021:

Review of primary records indicates licensee's most recent appointment two months ago indicated concerns about their alcohol use.

Received MN PMP which indicates licensee has two prescribers of their Xanax and have been filling prescriptions twice per month for a total of 160 tabs per month, an average of 5 tabs per day.

Call to licensee to review information in their primary records and MN PMP. Participant continues to deny they are abusing alcohol or their Rx Xanax. Encouraged licensee to be forthcoming with their substance use assessor.

Call to substance use assessor to provide concerns reported by the Third Party, primary care records and MN PMP records. The assessor confirmed their appointment is tomorrow.

DETERMINATION FOR MONITORING

June 13, 2021:

Received voicemail from substance use assessor indicating licensee appeared to be forthcoming about their use, they are recommending an Intensive Outpatient Program and will fax the completed assessment to HPSP.

Call to licensees to review the assessor recommendations and review possible treatment programs. Licensees stated they have spoken with PQR Program and they have an opening next week. It was agreed to put the request for a mental health assessment from treatment, if credentialed.

June 19, 2021:

Received faxed authorization for PQR Treatment

Received call from provider at PQR. Reviewed participants use of alcohol and Xanax. Provider stated licensee will be at their IOP for at least 5 weeks.

Provider also stated they have contacted both providers who were prescribing Xanax.

PARTICIPATION AGREEMENT

June 2021:

Develop a Participation Agreement

- Participant Update
- Work Site Monitor
- Addiction psychiatrist/therapist
- Primary Care Provider
- Pharmacy
- Toxicology Screens (9 per quarter)
- Two Sober Support Meetings per week/Sponsor
- 36 Months Monitoring

MONITORING

June 28, 2021:

Received signed Participation Agreement

July-August 2021:

Noted weekly updates from counselor at PQR.

August 15, 2021:

Call from counselor, participant will complete IOP and drop to OP for a minimum of six weeks and agreed to a return to practice.

Spoke with participant to review all aspects of monitoring and to set-up toxicology screens.

Call to work site monitor to provide them with participants return to practice plan.

MONITORING

August 18, 2021:

No concerns from IOP, discussed the return to practice from with participant and worksite monitor for August 20th.

October 2, 2021:

Received discharge summary from OP-successful completion.
Participant continues to meet with a mental health professional weekly.

February 8, 2022:

Received EtG/EtS positive screen from February 3rd.

Call to participant. Acknowledged drinking last week, consuming about two pints over two days. Requested participant refrain from practice schedule and have an updated substance use assessment.

Call to work site monitor to review participants refrain from practice and to review if there have been any concerns at work.

MONITORING

HPSP guidelines state the first return to use not self-reported is non-compliance (MN 214.33 subd 3.) and reported to Board. Extended monitoring until February 2025.

§ Subd. 3. **Program manager.** (a) The program manager shall report to the appropriate participating board a regulated person who:

(1) does not meet program admission criteria;

(2) violates the terms of the program participation agreement;

Filed report with the MN Psychology Board due to participants positive screen/Use of alcohol

MONITORING

February 11, 2022:

Substance use assessment recommendation: Low intensity outpatient program
– 2x/week

February 13, 2022:

Participant is engaged in programming, has two negative toxicology screens, will lift the request to refrain from practice.

- Call work site monitor
- Call participant

February 22, 2022: Approved return to practice. Spoke with participant and worksite monitor.

April 28, 2022: No issues since completion of OP.

July 16, 2022:

Received work site monitor report that indicates increased absences the past quarter.

MONITORING

July 17, 2022:

Call to work site monitor, they report participant has had four call-ins between April and July. They deny any other work concerns.

Call to participant, they become upset, state they are sick of being under a microscope and deny drinking or having an increase in mental health symptoms. Participant is seeing mental health provider every other week.

August 13, 2022:

Received memo from the MN Psychology stating they have dismissed the complaint filed in February 2024.

September 21, 2022: Participant reports no changes in care with mental health provider. Reports connecting with sponsor and mutual supports several times per week.

MONITORING

October 17, 2022:

Check in with participant, no concerns and positive reports from providers and worksite monitor.

December 1, 2022: Mental health provider has dropped to monthly sessions.

January 4, 2023:

Received call from participant requesting to complete HPSP early. Discussed the expectations of 36-month agreement, documented sobriety, and consistency. Noted 11 months of documented sobriety to this point.

MONITORING

****HPSP case managers do a minimum of a quarterly contact****

FAST FORWARD>>>>>>

No concerns or issues throughout the next 23 months
Quarterly Reports received and minimum of quarterly check-ins

February 10, 2025:

Review of file, no problem screens within the past six months, documented sobriety, no concerns reported by treatment providers or work site monitor.

File closed as a successful completion.

QUESTIONS?

Health Professionals Services Program (HPSP)

136 Energy Park Drive, Suite 220

St. Paul, MN 55108

651-642-0487

<https://mn.gov/boards/hpsp/>

Kimberly Navarre, Program Director

Kimberly.navarre@state.mn.us

612-548-2136



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Executive Director

TITLE: Master's Level Licensure

INTRODUCTION TO THE TOPIC:

Updates on master's level licensing. The APA Model Licensing Act Language is out and the comment period ends March 3rd.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
APA Model Licensing Language	1/28/2026	Cover Memo
Slides Related to the Model Language	1/28/2026	Cover Memo
ASPPB Town Hall Slides	1/29/2026	Cover Memo



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

American Psychological Association Model Act for State Licensure of Psychology Professionals

ADOPTED BY COUNCIL AS APA POLICY ON [INSERT DATE]

As APA policy, the Model Act for State Licensure of Psychology Professionals, referred to as the Act, serves as a prototype for drafting state legislation regulating the practice of psychology. State legislatures are encouraged to use the language of this document and the policies that it espouses as the model for their own state licensure laws. State licensing boards develop their own rules and regulations to implement the legislation proposed here. This document also serves to inform legislatures about psychology education, training and practice and to synthesize APA policies that bear on the education, training, and practice of professional psychology.

As the field continues to grow and evolve, the Act is updated accordingly. Since the last revision in 2010 (American Psychological Association, 2011), there have been advances in digital therapeutics which psychologists may order, interjurisdictional practice, and the incorporation of master’s level professionals in fields within health service psychology, all of which this revised Act addresses. This is the sixth set of guidelines for state legislation regulating the practice of psychology that has been developed by the American Psychological Association (APA). The first model for such regulation was developed and adopted as APA policy in 1955 (APA, 1955).

In 2021, APA approved policies for the Standards of Accreditation for master’s programs in health service psychology, and the Commission on Accreditation (CoA) began accrediting master’s degree psychology programs in 2024. In order to build consistency across the broad profession of psychology, training programs, and jurisdictions, the Act addresses both doctoral guidelines for state legislation and now master’s guidelines in one unified Act.

Each section of the Act is introduced by brief commentary, the purpose of which is to explain the rationale for the proposed section that follows. To differentiate between the commentary and the proposed statutory language, the latter is *italicized*.

RATIONALE:
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A. DECLARATION OF POLICY

This section declares that the intent of legislation for state licensure of psychology professionals is to ensure the practice of psychology is regulated in the public interest. The public should be assured that psychological healthcare services including forensic psychology services that require health service psychology training and mental health expertise will be provided by licensed and qualified professionals according to the provisions of this Act. The public must also be protected from the consequences of unprofessional conduct by persons licensed to practice psychology.

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The discipline of psychology is unique in that it encompasses a variety of psychology professionals who attend to a broad swath of societal needs but who do not provide psychological healthcare services or health service psychology. These services may include development of technologies, organizational consulting, and conflict and peace psychology among others. This Act maintains that licensure requirements be reserved for psychology professionals educated in clinical, counseling, school psychology or a combination thereof who provide health service psychology as described in this Act.

The practice of psychology in (name of state) is hereby declared to affect the public health, safety, and welfare, and to be subject to regulation to protect the public from the practice of psychology by unqualified persons and from unprofessional conduct by persons licensed to practice psychology.

B. DEFINITIONS

Definitions provide consistent interpretation throughout the Act without unnecessary repetition of terms. Thus “Board,” once defined in this section, can subsequently be cited with the same meaning as presented in the definition.

In defining “institution of higher education,” it is further recognized that many foreign institutions prepare psychology professionals for professional practice, and provision should be made to accommodate them in Board regulations.

Psychological services should be described adequately and specified in order to identify clearly the areas of psychological services, provided to individuals, groups of individuals, or organizations, that require licensure to ensure qualified and sound professional psychology practice. All such activities must operate according to current appropriate Ethical Standards of the APA Ethical Principles of Psychologists and Code of Conduct known as the APA Ethics Code and Board regulations.

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1. “Board” means the (name of state) State Psychology Board.
2. “Institution of higher education” means any regionally accredited institution of higher education in the United States, including a professional school, that offers a full-time graduate course of study in psychology that is acceptable to the Board. For Canadian universities, it means an institution of higher education that is provincially or territorially chartered.
3. “Assessment” is a broad term used by many professions to connote the act of evaluating an individual or situation in order to generate an understanding that would inform decision-making.
 - a. “Psychological Assessment” is a discipline specific term referring to the structured process of identifying and integrating relevant information from multiple sources about individuals, groups, or organizations using psychological knowledge and methods for the purposes of informing decisions and recommendations.
 - b. “Psychological Testing” is defined as any procedure that involves the application of tests with standardized administration, scoring procedures and standard interpretive guidelines designed to reliably and validly measure and describe specific psychological attributes of an individual including but not limited to intelligence, personality, cognitive abilities, emotional functioning, interests, skills and aptitudes.
 - c. “Psychological Evaluation” refers to an examination of one or more psychological domains or systems by gathering information from different sources and typically but not always involving psychological testing. The analysis and integration of this data with psychological science and knowledge in a contextual manner

92 result in the production of a synthesized account of the findings to offer a professional opinion that may
93 include but is not limited to a written report. Evaluation data may be gathered through interviews, inter-
94 actions with the individual, observation, collateral information, analysis of processes, standardized tests,
95 self-report measures, physiological or psychophysiological measurement devices, or other specialized
96 procedures and apparatuses. Neuropsychological, clinical, forensic, and child custody evaluations are all
97 considered subsets of “psychological evaluations.”
98

- 99
- 100 4. The terms “patient” and “client” are used interchangeably to refer to the direct recipient of psychological
101 healthcare services provided by licensed psychology professionals. The recipient may be a child, adolescent,
102 adult, couple, family, or group. The terms are also used to refer to direct recipients of psychological services
103 that are not treatment-related; recipients may be individuals, groups, organizations, or communities. In
104 some circumstances (e.g., an evaluation that is court-ordered, requested by an attorney, an agency, or other
105 administrative body), the client may be the retaining party and not the examinee.
- 106 5. “Licensed Psychologist” refers to psychology professionals who hold doctoral degrees in a field within health
107 service psychology and possess a license as a Psychologist in accordance with the requirements as described
108 in state laws and regulations.
- 109
- 110 6. “Provisional Licensed Psychologist” refers to psychology professionals who have earned doctoral degrees in
111 a field within health service psychology and are providing psychological services under supervision during
112 their completion of post-degree requirements for licensure.
- 113
- 114 7. “Licensed Practitioner of Psychology” refers to psychology professionals who hold master’s degrees in a field
115 within health service psychology and possess a license as a Practitioner of Psychology in accordance with the
116 requirements as described in state laws and regulations.
- 117
- 118 8. “Provisional Licensed Practitioner of Psychology” refers to psychology professionals who have earned master’s
119 degrees in a field within health service psychology and are providing psychological services under supervision
120 during their completion of post-degree requirements for licensure.
- 121
- 122 9. “Practice of psychology” is defined as the delivery of services involving the observation, description, evaluation,
123 interpretation, and modification of human behavior by the application of psychological principles, methods,
124 and procedures, for the purposes of assessing, evaluating, diagnosing, preventing, or treating behavioral or
125 emotional health or impairment. The practice of psychology is grounded in a scientific orientation toward
126 psychological knowledge and methods. For the purposes of this Act, the practice of psychology addresses
127 health service psychology, which encompasses but is not limited to a wide range of professional activities
128 relevant to health promotion, prevention, consultation, assessment and treatment for psychological and other
129 health-related disorders or concerns. Clinical, counseling and school psychology (and combinations thereof)
130 are considered training fields within health service psychology.
- 131
- 132 a. The “Practice of psychology for Licensed Psychologists and Provisionally Licensed Psychologists”
133 includes, but is not limited to:
- 134
- 135 (1) Diagnosis, treatment and management of mental and emotional disorders, mental, developmental,
136 or intellectual disability, substance use disorders, disorders of behavior or conduct, as well as of the
137 psychological aspects of physical illness, accident, injury, disability or chronic health conditions;
- 138
- 139 (2) Provision of evidence-based therapeutic interventions, including but not limited to psychotherapy
140 (e.g., CBT, DBT, ACT), psychoanalysis, hypnosis, biofeedback and the authority to order and/or

141 use emerging interventions (e.g., digital therapeutics and digital tools), and behavior analysis for
142 individuals, families, and/or groups to improve mental health and wellness;

143
144 (3) Provision of psychological screening, interviewing, testing, and assessment for the purposes of
145 diagnosing mental and emotional disorders, mental/ developmental/ intellectual disability, sub-
146 stance use disorders, disorders of habit or conduct, as well as the psychological aspects of phys-
147 ical illness, accident, injury, disability, or chronic health conditions; risk assessment, treatment
148 planning, intervention and outcome management;

149
150 (4) Evidence based assessment and comprehensive psychological evaluation including psychoeduca-
151 tional, cognitive, psychodiagnostics, intelligence, achievement, vocational, and aptitude testing;
152 integrating knowledge of emotional abilities, skills, interests; as well as comprehensive specialty
153 and subspecialty assessments and consultations such as neuropsychological evaluations, forensic
154 assessments, child custody and parental fitness evaluations, medical capacity evaluations, med-
155 ical pre-surgical evaluations (transplant surgery, bariatric surgery, neurostimulator implantation
156 surgery), acute medical specialty consultations (inpatient medical hospital, sleep medicine),
157 projective testing, and public safety employment evaluations such as fitness for duty;

158
159 (5) Provision of psychoeducational evaluation, planning, therapy, and remediation services;

160
161 (6) Consultation and collaboration with other health service professionals including physicians and
162 nurses, as well as with patients, regarding treatment options including discussions about medi-
163 cations and planning with respect to the provision of care for a patient, family or group;

164
165 (7) Evaluation, assessment, consultation or treatment of individuals in anticipation of, in conjunction
166 with or after legal, contractual, or administrative proceedings; and

167
168 (8) The supervision of any of the above.

169
170 (9) The ability to refer to oneself using the title "Doctor" or "Dr." provided that use of the title is not
171 misleading to the public.

172
173 b. The "Practice of psychology for Licensed Practitioners of Psychology and Provisional Licensed Practitioners
174 of Psychology" includes:

175
176 (1) Diagnosis, treatment, and management of mental and emotional disorders, mental, developmental,
177 or intellectual disability, substance use disorders, disorders of behavior or conduct, as well as of the
178 psychological aspects of physical illness, accident, injury, disability, or chronic health conditions;

179
180 (2) Provision of evidence-based therapeutic interventions, including, psychotherapy (e.g., CBT, DBT,
181 ACT), hypnosis, biofeedback and the ability to order and/or use emerging interventions (i.e.,
182 digital therapeutics and digital tools), and behavior analysis for individuals, families, and/or
183 groups to improve mental health and wellness;

184
185 (3) Except as provided in subsection (8) below, the provision of psychological screening, interviewing,
186 testing, and assessment for the purposes of diagnosing mental and emotional disorders, mental/
187 developmental/ intellectual disability, substance use disorders, disorders of habit or conduct, as
188 well as of the psychological aspects of physical illness, accident, injury, disability, or chronic health
189 conditions; risk assessment; treatment planning, intervention and outcome management;

- 190 (4) *Evidence-based assessment consistent with training including psychoeducational, cognitive,*
191 *psychodiagnostic, intelligence, achievement, vocational and aptitude testing;*
- 192
- 193 (5) *Provision of psychoeducational evaluation, planning, therapy, and remediation services;*
- 194
- 195 (6) *Consultation and collaboration with other health service professionals in which the focus is on*
196 *patient/family diagnoses and treatment planning;*
- 197
- 198 (7) *Supervision of Provisionally Licensed Practitioners of Psychology after becoming independently*
199 *licensed and providing documentation of coursework and training in supervision to demonstrate*
200 *competency and being in good standing with the psychology regulatory board;*
- 201
- 202 (8) *Exclusions to practice areas include, comprehensive specialty and subspecialty assessment and*
203 *consultations, which require advanced psychology doctoral or postdoctoral education and train-*
204 *ing, including the practice of neuropsychology, forensic assessments, child custody and parental*
205 *fitness evaluations, medical capacity evaluations, medical pre-surgical evaluations (transplant*
206 *surgery, bariatric surgery, neurostimulator implantation surgery), acute medical specialty con-*
207 *sultations (inpatient medical hospital, sleep medicine), projective testing, and public safety*
208 *employment evaluations such as fitness for duty.*

- 209
- 210 c. *The practice of psychology shall be construed within the meaning of this definition (Section B.9) with-*
211 *out regard to whether payment is received for services rendered. (See Section G for Limitation of Practice;*
212 *Maintaining and Expanding Competence and Section J for Exemptions.)*
- 213

214 **C. STATE PSYCHOLOGY BOARD**

215 1. *Board Organization*

216 *The Board shall consist of minimally seven licensed psychologists and two public members.*

217

218 *In jurisdictions that recognize licensed practitioners of psychology, the professional board member positions shall*
219 *be comprised of no less than 2/3 licensed psychologists and no more than 1/3 licensed practitioners of*
220 *psychology.*

221

222 *Professional board members shall be actively licensed to practice in good standing in this state with a minimum*
223 *of five years of post-licensure experience. Professional board members shall reflect a diversity of practice specialties,*
224 *both in health care and other applications and include representation from teaching, training, and practice areas.*

225

226 *The public board members eligible under state law to serve shall be residents of the state, consistent with require-*
227 *ments of the state. A public board member shall not be a licensed psychologist, licensed practitioner of psychology,*
228 *an applicant or former applicant for licensure as a psychologist or practitioner of psychology, a member of another*
229 *health profession, or a member of a household that includes a licensed psychologist or licensed practitioner of*
230 *psychology, or otherwise have conflicts of interest or the appearance of such conflicts with duties as Board members.*

231 2. *Board Appointments*

232

233 *Board members shall not engage in any conduct involving any conflicts of interests or appearance thereof with the*
234 *performance of Board duties consistent with the state's policies on conflicts of interests. No one who has been*
235 *convicted of or plead guilty to a felony offense under any state or federal law may be appointed to serve on the Board.*

Appointments to the Board shall be made by the duly constituted appointing authority in this state. The appointing authority in this state shall solicit professional board member nominations from psychological organizations and licensed psychologists and licensed practitioners of psychology in this state. The term of office shall be five years, with provision for reappointment for one additional term. Lengths of terms of Board members shall be staggered.

3. Board Operations

The Board shall meet regularly throughout the year as necessary to conduct Board business on a timely basis. The Board may meet virtually if permitted by state law. A majority of the Board shall constitute a quorum for purposes of conducting the business of the Board. The Board shall elect a chair and any other officers necessary to carry out the Board’s duties. Decisions will be determined by a majority vote. The Board shall provide reasonable advance notice for all Board meetings and shall maintain minutes of all meetings and a list of applicants for licensure, which are to be made publicly available as determined by the Board.

The Board may adopt rules and regulations necessary to carry out the provisions of this Act. This includes the processes for receiving and investigating complaints.

4. Fees

The Board or the designated authority within the jurisdiction shall, from time to time, establish reasonable fees for the issuance and renewal of licenses and its other services. Fees shall be set so as to defray the cost of administering the provisions of this Act, including applications, examinations, enforcement, and the cost of maintaining the Board.

5. Qualified Immunity

A member of the Board or any employee or agent of the Board shall not be held civilly liable for any act performed in good faith and within the scope of the duties of the Board.

D. REQUIREMENTS FOR LICENSURE

1. For Psychologists

There is a core of basic theory, principles, and accumulated knowledge that all professional psychologists should possess. Each practitioner must also master the specific skills and knowledge appropriate for the competent performance of psychological practice. The language of the Act requires the Board to specify its criteria for acceptable professional education in psychology. In this regard, the Board will be guided by national standards.

All applicants for licensure must minimally be graduates of a regionally accredited institution of higher education, or a Canadian university that is provincially or territorially chartered and must have completed a planned program of study that reflects an integration of the science and practice of psychology. A formal training program accredited by the American Psychological Association or Canadian Psychological Association or other substantially equivalent body recognized by the Board is required. For areas of psychology where APA or CPA program accreditation does not exist, psychology programs must meet all the requirements listed in Section D.1.a.(2)-(14).

The law recognizes that new doctoral programs may be developed in newly or already recognized specialties of professional psychology. In such instances, the law affords those programs an eight-year period in which to achieve accreditation or to meet the standards described in D.1.a.(1)-(14), during which the graduates of those programs may sit for licensure.

**RATIONALE:
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ONLY**

a. Educational requirements

**RATIONALE:
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The Act recognizes the doctorate as the minimum educational requirement for entry into professional practice as a psychologist.

Applicants for licensure as a psychologist shall possess a doctoral degree in psychology from a regionally accredited institution of higher education or from a Canadian university that is provincially or territorially chartered. The degree shall be obtained from a recognized program of graduate study in psychology as defined by the rules and regulations of the Board.

Applicants for licensure shall have completed a doctoral program in psychology that is accredited by the American Psychological Association (APA) or Canadian Psychological Association (CPA) or other substantially equivalent accreditation body recognized by the Board. Where APA or CPA program accreditation does not exist for that area of professional psychology, then the applicant must show that their doctoral program in psychology meets all the following requirements:

- (1) Training for health service psychologists is doctoral training offered in a regionally accredited institution of higher education. A regionally accredited institution is an institution with regional accreditation in the United States or a university that is provincially or territorially chartered in Canada.*
- (2) The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train health service psychologists.*
- (3) The psychology program must stand as a recognizable, coherent organizational entity within the institution or in a formal partnership or consortium among separate administrative entities.*
- (4) There must be a clear authority and primary responsibility for the core and specialty areas.*
- (5) The program must integrate empirical evidence and practice such that practice is evidence-based and evidence is practice-informed.*
- (6) The training must be sequential, cumulative, graded in complexity and designed to prepare students for practice or further organized training.*
- (7) The program engages in actions that indicate respect for and understanding of cultural and individual differences and diversity.*
- (8) There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities and a psychologist responsible for the program.*
- (9) The program must have an identifiable body of students who are matriculated in that program for a degree.*
- (10) The program must include supervised practicum, internship, field or laboratory training appropriate to the individual's chosen area of practice of psychology.*
- (11) The curriculum shall encompass a minimum of three academic years of full time graduate study (or the equivalent) plus an internship and a minimum of one year's residency (or the equivalent)*

at the educational institution granting the doctoral degree. Students should acquire a general, foundational knowledge base in the field of psychology.

(12) The core program shall require every student to demonstrate competence in each of the following substantive areas, with a reliance on the current evidence-base.

- » Research to include statistical analysis and psychometrics
- » Foundational knowledge in biological, cognitive, developmental, and social bases of behavior
- » Ethical and legal standards
- » Individual and cultural diversity
- » Professional values, attitudes, and behaviors
- » Communication and interpersonal skills
- » Assessment
- » Intervention
- » Supervision
- » Consultation and interprofessional/ interdisciplinary skills

(13) All programs in fields within health service psychology education programs shall include course requirements in developed practice areas/specialties.

(14) The program must demonstrate that it provides training relevant to the development of competence to practice in a diverse and multicultural society.

When a new area of professional psychology is recognized as being a developed practice area and within the accreditation scope of the APA, doctoral programs within that area will be afforded a transition period of eight years from their first class of students to the time of their accreditation. During that transition period, graduates of such programs may sit for licensure examination whether or not the program has been accredited. The same principle applies as well to new doctoral programs in traditional practice areas previously recognized within the scope of APA accreditation.

Applicants trained in institutions outside the United States shall meet requirements established by the Board as defined in its rules and regulations.

Psychologists trained in an area that falls outside the scope of APA accreditation (e.g., experimental, developmental, social) and who intend to practice in a health service psychology practice area must complete a retraining program and/or appropriate supervised experience (e.g., internship in the practice area).

The Board shall issue a provisional license to applicants for licensure as a Psychologist in accordance with the rules and regulations promulgated by the Board. A provisional licensee shall work under the supervision of a Licensed Psychologist until the provisional licensee is granted a license as a "Licensed Psychologist."

b. Experience requirements

APA recommends that legislation requires the equivalent of two full-time years of sequential, organized, supervised, professional experience before obtaining a license. For applicants prepared for practice in the health services domain of psychology, one of those two years of supervised professional experience shall be a predoctoral internship which may be completed as a part-time intern over a two-year period provided that the total experience is the equivalent of one year of full-time experience. In rules and regulations, the Board must define

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386 acceptable supervised experience at the predoctoral and postdoctoral levels as well as mechanisms for evalu-
387 ation of this experience. Boards may accept practicum hours as part of the required sequential supervised
388 professional experience. Boards are encouraged to create definitions that are flexible and capture the variety
389 of existing training and supervisory models . Psychologists are required to limit their practice to their demon-
390 strated areas of professional competence. Experience should be compatible with training.

391
392 *To obtain licensure, applicants shall demonstrate that they have completed the equivalent of two full-time years of*
393 *sequential, organized, supervised professional experience. One of those two years of supervised professional experience*
394 *shall be an APA or CPA accredited (or equivalent) predoctoral internship. The criteria for appropriate supervision shall*
395 *be in accordance with regulations to be promulgated by the Board. Experience shall be compatible with the knowledge*
396 *and skills acquired during formal doctoral and/or postdoctoral education in accordance with professional requirements*
397 *and relevant to the intended area of practice. Applicants shall be required to show evidence of good character, e.g.,*
398 *that they have not been convicted of a criminal offense that bears directly on the fitness of the individual to be licensed.*

399
400 c. Examinations

401
402 APA recommends that the Act specify the requirements for examination and the conditions under which the
403 Board is authorized to waive an examination. All examinations serve the purpose of verifying that a candidate
404 for licensure has acquired a basic core of knowledge in the discipline of psychology and can apply that knowledge
405 to the problems confronted in the practice of psychology within the applicant’s area of practice as a health service
406 provider. While written examinations typically evaluate the applicant’s basic core of knowledge, any additional
407 examinations such as oral examinations or work samples shall be representative of the applicant’s area of practice.
408 Boards should clearly specify the conditions under which the endorsement of another license will be granted.

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409
410 *The Board shall administer, or approve for administration, a national licensing examination that evaluates the basic*
411 *knowledge and skills required for the practice of health service psychology to qualified applicants. At its discretion,*
412 *the Board may require additional examination(s) of relevant jurisprudence, oral knowledge and ability, or require*
413 *work samples, representative of the applicant’s area of practice as a health service provider. The Board shall administer*
414 *examinations for qualified applicants on a regular schedule to ensure the timely completion of the licensure process.*
415 *Applicants for licensure must pass the required licensing examination(s) approved by the Board before independent*
416 *licensure. The passing score for a national licensing exam should be at the recommended pass point established by*
417 *the exam developer and approved by the Board.*

418
419 *The Board may, at its discretion, waive the examination requirement for any applicant who: (a) holds a valid, unrestricted*
420 *license as a licensed psychologist or equivalent title as determined by the Board in another state or territory of the*
421 *United States, or in a Canadian province, under requirements substantially equivalent to those of this state; (b) has*
422 *continuously maintained such licensure in good standing for a minimum of 5 years; (c) provides satisfactory evidence*
423 *of having passed the national exam at or above the passing score as established by the exam developer and required*
424 *by this state at the time of licensure; and (d) meets all other requirements for licensure in this state. It is recommended*
425 *that individuals applying for licensure be eligible to sit for the examination upon completion of all the requirements*
426 *of the doctoral degree.*

427
428 d. Prior credentials

429
430 APA recommends that the Act provide for continued licensure of persons already licensed as a psychologist at
431 the time of enactment of a new law.

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432
433 *A person who is licensed as a psychologist under the provisions of (cite relevant section(s) of previous licensing*
434 *law) as of the effective date of this Act shall be deemed to have met all requirements for licensure under this Act*

and shall be eligible for renewal of licensure in accordance with the provisions of this Act.

e. Applications from individuals licensed in other jurisdictions

Jurisdictions are strongly encouraged to adopt regulations to facilitate the mobility and portability of licensure. Jurisdictions may set criteria to determine conditions under which verification of education, experience, and examination requirements will be waived. These criteria may include holding a credential that verifies education and experiences of individuals (e.g. American Board of Professional Psychology (ABPP), National Register of Health Service Psychologists, Association of State and Provincial Psychology Boards' Certificate of Professional Qualification in Psychology (ASPPB's CPQ)), or Board determination that the criteria of the other jurisdiction are comparable to the Board's criteria, or other specified mechanism.

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An individual applying for licensure with the Board who holds an active psychology license in good standing in another jurisdiction and shows evidence of good character is considered an eligible candidate for licensure in the jurisdiction. The Board may waive verifying the education, experience, and examination requirements for individuals who meet these criteria and for whom the Board's mechanism for verifying comparability of education, experience, and examination requirements is met. The Board retains the right to administer any required jurisdiction-specific examinations (written, oral, jurisprudence) before awarding the license.

2. For Practitioners of Psychology

Applicants for licensure as a Licensed Practitioner of Psychology shall possess:

a. Educational requirements

A master's degree in health services psychology from a regionally accredited institution of higher education or from a Canadian university that is provincially or territorially chartered that meets all of the following requirements:

- (1) The master's degree program in a field within health services psychology is accredited by the American Psychological Association (APA) or the Canadian Psychological Association or other substantially equivalent accreditation body recognized by the Board;
- (2) The curriculum shall encompass a minimum of sixty (60) semester hours or equivalent credit hours in health services psychology and includes a minimum of two academic years of full-time graduate study;
- (3) The program may include distance education, but a minimum of one (1) continuous academic year shall be obtained in residence at the educational institution granting the master's degree;
- (4) The core program shall require every student to demonstrate competence in each of the following substantive areas
 - Discipline-Specific Knowledge (Affective, Biological, Cognitive, Developmental, and Social Aspects of Behavior, Research Methods, Psychometrics), and;
 - Profession-wide competencies (Integration of science and practice, ethical and legal standards, individual and cultural diversity, professional values and behavior, communication/interpersonal skills, assessment, intervention, supervision, consultation/interprofessional skills);
- (5) The program must include supervised practicum and internship appropriate to the individual's chosen area of practice of psychology that consists of a total of eight hundred (800) hours that includes:

- Four hundred (400) hours of direct service, of which one hundred (100) hours can include observation of others (e.g., shadowing) or co-therapy;
- At least one direct observation of student clinical work (synchronous or asynchronous) by a supervisor for each specified evaluation period (e.g., semester or clinical rotation); and
- Practicum is completed while in residence at the program.

(6) The program must demonstrate that it provides training relevant to the development of competence to practice in a diverse and multicultural society.

Applicants trained in institutions outside the United States shall meet requirements established by the Board.

Individuals trained in an area that falls outside of health service psychology must complete a retraining program and/or appropriate supervised experience (e.g., internship in the developed practice area) as determined by the Board.

Applicants from programs without accreditation may be eligible for licensure as long as the program meets the requirements of Section 2.a.(2)-(6).

The Board shall issue a provisional license to applicants for licensure as a Practitioner of Psychology in accordance with the rules and regulations promulgated by the Board. Licensees shall work under the supervision of a Licensed Psychologist or Licensed Practitioner of Psychology until the provisional licensee is granted a license as a "Licensed Practitioner of Psychology."

b. Experience requirements

To obtain independent licensure as a Licensed Practitioner of Psychology, applicants shall demonstrate that they have completed at least two full-time years of post-degree, supervised professional experience. This supervised training shall include a total of 3,000 hours: 2,200 hours of which must be in the direct provision of services. Supervision must include one (1) hour of supervision per 10 hours of direct client service for the first 1,000 hours of practice, and then one (1) hour of supervision per 20 hours of direct client service for remaining direct client service hours. Supervision must be provided by a Board approved Licensed Psychologist or Licensed Practitioner of Psychology who has primary oversight and responsibility for the supervisee's training and practice. With Board approval, the supervising Licensed Psychologist/Licensed Practitioner of Psychology may designate up to 50% of supervision to an appropriately trained and licensed mental health professional. After the first 1,000 hours of direct client contact, up to 50% of supervision may be group supervision.

During this period of post-degree supervised experience, applicants shall demonstrate acquisition of 100 hours of didactic education in the intended scope of practice. Examples may include but are not limited to formal coursework, certification training or continuing professional development courses or training related to specific interventions or assessment techniques. The board will determine, by rulemaking, the eligibility criteria for supervisors and the responsibilities for supervisors and supervisees, respectively.

c. Examinations

The Board shall administer, or approve for administration of, a national licensing examination that evaluates the basic knowledge and skills required for the practice of health service psychology to qualified applicants. At its discretion, the Board may require additional examination(s) of relevant jurisprudence, oral knowledge and ability or require work samples representative of the applicant's area of practice as a health service provider. The Board shall administer examinations for qualified applicants on a regular schedule to ensure the timely completion of the licensure process. Applicants for licensure must pass the required licensing examination(s) approved by the

Board before independent licensure. The passing score for a national licensing exam should be at the recommended pass point established by the exam developer and approved by the Board.

d. Applications from individuals licensed in other jurisdictions

The Board may, at its discretion, waive the examination requirement for any applicant who: (a) holds a valid, unrestricted license as an LPP or equivalent title as determined by the Board in another state or territory of the United States, or in a Canadian province, under requirements substantially equivalent to those of this state; (b) has maintained such licensure in good standing for a minimum of 5 years; (c) Provides satisfactory evidence of having passed the national exam at or above the passing score as established by the exam developer and required by this state at the time of licensure; and (d) meets all other requirements for licensure in this state.

E. TEMPORARY PRACTICE AND INTERSTATE PRACTICE OF PSYCHOLOGY

This section provides for time-limited in-person or telepsychology practice in a jurisdiction other than the state in which the psychologist is licensed and the interstate practice of psychology. This is not intended to eliminate the necessity for licensure for those who are setting up regular professional practice in that jurisdiction.

Boards are encouraged to develop specific mechanisms by which psychologists licensed in other jurisdictions may provide professional assistance during disaster response situations. The psychologist must have an earned doctoral degree and be actively licensed in good standing in another jurisdiction.

Mechanisms have been developed to provide for interstate recognition of licensure for psychologists. Jurisdictions are encouraged to adopt and implement mechanisms such as multi-state licensing compacts or state telehealth provider registries as appropriate. Although the statutory language below reflects psychologists, it is presumed that as the practice of Licensed Practitioners of Psychology continues to evolve, jurisdictions will adopt and implement similar mechanisms for temporary and interjurisdictional practice for Licensed Practitioners of Psychology.

Nothing in this Act shall be construed to prohibit the practice of psychology in this state by a person holding an earned doctoral degree in psychology from an institution of higher education who is actively licensed in good standing as a psychologist under the laws of another jurisdiction, provided that the aggregate of thirty (30) days per year of professional in person or telepsychology services as a psychologist under the provision of this subsection is not exceeded. Before providing services in this state, a doctoral level licensed psychologist from another jurisdiction should provide written notice to the Board as more fully described in the regulations, specifying the type of services to be provided, approximate duration of such services along with documentation of licensure and consent to practicing under the jurisdiction, laws, and regulations of this state. Notice does not require approval of the Board before delivery of service if the aggregate of 30 days of services is not exceeded and the individual does not establish an ongoing, regular, professional practice in the jurisdiction.

In disaster situations, the time frame and conditions under which psychologists actively licensed in good standing under the laws of another jurisdiction may provide disaster services under this state's jurisdiction shall be defined by the Board. To the extent that the jurisdiction has adopted the Uniform Emergency Volunteer Health Practitioners Act or similar enabling legislation, that law will apply in times of disaster.

F. MOBILITY AND PORTABILITY OF AUTHORIZATION TO PRACTICE

This portion of the Act provides for the conditions under which a Licensed Psychologist may practice until obtaining licensure in another jurisdiction. Jurisdictions are encouraged to adopt regulations to facilitate the mobility and

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portability of licensure. Provision is also made for the Board to waive examination if the requirements met by the psychologist in the original jurisdiction are judged to be equivalent to those in this state. Until there is more uniformity across jurisdictions for Licensed Practitioners of Psychology on which to build licensure portability, the statutory language below remains focused on psychologists. However, jurisdictions are encouraged to adopt mechanisms for licensure portability for Licensed Practitioners of Psychology as appropriate.

A psychologist holding a current, active license in good standing under the laws of another jurisdiction may be authorized by the Board to practice psychology as defined in this Act for a maximum of six months, provided that the psychologist has made application to the Board for licensure and has met the educational and experience requirements for licensure in this state. Denial of licensure terminates this authorization. The Board may choose to waive examination if a psychologist is licensed in another jurisdiction if that jurisdiction's qualifications are not less than those required for licensure in this state.

G. LIMITATION OF PRACTICE; MAINTAINING AND EXPANDING COMPETENCE

This provision of the Act is intended to ensure licensed psychologists and licensed practitioners of psychology who provide services will not practice outside the limits of their competence. The burden of proof is on the licensure applicant to provide evidence acceptable to the Board that the applicant has obtained the education and training necessary to engage in the practice of psychology in the specified area of competence. The Board may wish to develop a process that provides for the specification of the intended area of practice and the evidence necessary to document competence. The Board should recognize that training in psychology includes broad and general training in scientific psychology and in the foundations of practice. Practice areas include: clinical psychology, counseling psychology, and school psychology.

Licenses provide services to populations and in areas within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience and do not practice beyond their areas of competence. The Board develops requirements or structures (e.g., continuing education in general areas of practice as well as in specific areas such as ethics, domestic violence, and multicultural competence; declaration and documentation of competence) to ensure that licensees undertake ongoing efforts to identify, develop, and maintain competence and ethical practice. Boards may choose to require applicants for licensure and renewal of licensure to self-declare their areas of practice competence. Should a licensee's area of practice change significantly, then the licensee maybe required by the Board to provide documentation of the training, supervision, and/or mentoring undertaken to achieve competence in the new area at the time of license renewal. Licensees practicing in emerging areas take reasonable steps to ensure the competence of their work by using relevant research, training, consultation, or study.

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The Board shall ensure through regulations and enforcement that licensees limit their practice to demonstrated areas of competence as documented by relevant professional education, training, and experience. The Board shall develop a process to ensure that licensees undertake ongoing efforts to maintain competence and ethical practice. The Board adopts as its standard of conduct the Ethical Standards of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association.

H. REINSTATEMENT OF LICENSURE

1. *Inactive or Lapsed License*

A licensee in good standing who will not be practicing in the state for at least one year may petition the Board to have their license placed on inactive status without penalty. When such licensee wishes to return to practice, the individual must submit an application to the Board, which includes payment of the renewal fee and compliance

with the continuing [education or professional development] requirements.

If the licensee seeks to reinstate a lapsed license due to failure to renew the license and comply with the licensing renewal requirements on a timely basis, the licensee must pay a late renewal fee in addition to the requirements for individuals seeking to reactivate their inactive license to active status.

Any individual with an inactive or lapsed license is prohibited from practicing psychology within the state until the requirements for active licensure are met and the individual's license is reinstated on active status.

2. Emeritus status

A licensee may apply for emeritus status if the following conditions are met:

- a. The licensee is 65 years of age or older;
- b. The licensee is licensed in good standing in the state for a minimum as determined by the Board; and
- c. Plans to provide limited services such as volunteer service, disaster response, or training not more than 20 hours per week.

A licensee must apply for emeritus status. If granted, the emeritus licensure fee may be a reduced rate of the permanent licensure fee as determined by the Board. However, the [annual or biennial] continuing [education or professional development] requirements remain the same. If the individual elects to give up emeritus status and seeks permanent licensure, the individual must contact the Board in writing to reactivate their license and comply with those requirements.

I. PRACTICE WITHOUT A LICENSE

The Act must clearly specify what constitutes a violation of law and what penalties may be imposed for practice without a license or for misrepresentation of oneself as a psychologist or practitioner of psychology. State legislatures have the latitude to determine penalties for such illegal activities. Boards have the authority to suspend or revoke licenses and to prescribe conditions for reinstatement.

**RATIONALE:
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It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to represent themselves as a psychologist or a practitioner of psychology unless otherwise exempted from licensure as described in Section J. It shall be a violation of this Act for any person not licensed in accordance with the provisions of this Act to engage in the practice of psychology as defined in this Act, whether practicing as an individual, firm, partnership, corporation, agency, or other entity.

Any person who shall represent themselves as a licensed psychologist or licensed practitioner of psychology in violation of this Act, or who shall engage in the practice of psychology in violation of this Act, shall be guilty of a misdemeanor and fined accordingly, and, in addition, may be imprisoned, depending on the state's criminal code. Any person filing or attempting to file, as their own, a diploma or license of another or a forged affidavit of identification shall be subject to the punishment prescribed for fraud, forgery and/or misrepresentation as defined in state law.

Whenever a license to practice psychology in the state has been suspended or revoked, it shall be unlawful for that person to practice psychology in this state. The Board may issue, with or without reexamination, a new license whenever it deems such course safe and just.

The Board may investigate any evidence or allegation that appears to show that any person is or may be in violation of any provision of this Act.

J. EXEMPTIONS

1. There should be an exemption from licensure for psychologists engaged solely in teaching in academic institutions, conducting research in academic and/or research institutions, or working in the applied areas of the psychology field. The exemption should not be allowed if the individual engages in the direct delivery or supervision of psychological services for the purposes of assessing, evaluating, diagnosing, preventing, or treating behavioral or emotional functioning, health, or impairment. Psychologists engaged in teaching, research, or applied areas of psychology are not prohibited from pursuing licensure if they meet the statutory requirements for licensure.

RATIONALE: FOR REFERENCE ONLY

Licensure requirements defined in the provisions of this Act shall not apply to individuals with doctoral degrees in psychology from an accredited institution of higher education whose doctoral degrees in psychology are in areas outside of health service psychology provided they do not engage in nor supervise the provision of psychological services described in Section B.9. of this Act.

Individuals with a doctoral degree in psychology from an accredited institution of higher education may refer to themselves as psychologists when:

- a. teaching psychology in academic institutions;
- b. conducting psychological research;
- c. providing applied psychology services; or
- d. providing expert witness services for areas of psychology not specified in Section B.9. of this Act.

Nothing in this Section shall be construed to prevent psychologists as described here in Section 1 from pursuing licensure under the provisions of this Act should they choose to do so.

2. Members of other established professions, such as physicians, attorneys, and clergy, may provide services that are similar or related to the scope of practice of psychology. They should be exempted from licensure under this Act on the condition that they do not represent themselves as psychologists.

RATIONALE: FOR REFERENCE ONLY

Nothing in this Act shall be construed to prevent members of other recognized professions, including but not limited to physicians, other mental health providers, or attorneys who are licensed, certified, or regulated under the laws of this state from rendering services consistent with their professional education and training, lawful scope of practice, and code of ethics, provided that they neither represent themselves to be psychologists, nor incorporate the following words in describing the services they offer to the public: psychological, psychologist, psychology, or derivatives thereof. Duly recognized members of the clergy shall not be restricted from functioning in their ministerial capacity, if they neither represent themselves as psychologists nor incorporate the words psychological, psychologist, psychology, or derivatives thereof in the services they offer the public.

3. The prior version of this Act included an exemption for the use of the terms "school psychologist" or "certified school psychologist" for all individuals credentialed by the state agency regulating practice in public schools (e.g., the Department of Education). This version acknowledges the authority of the relevant state education agency or appropriate regulatory body to credential and limit individuals to provide school psychological services in only educational settings under their jurisdiction. Additionally, the title of such practitioners must include the word "school" (e.g., "school psychologist") to reflect accurately their practice scope within such settings.

RATIONALE: FOR REFERENCE ONLY

Nothing in this Act shall be construed to prevent [cite relevant state education authority or statutory provisions] from credentialing individuals to provide school psychological services in those settings that are under the purview of the state education agency or appropriate regulatory body. Such individuals shall be restricted in their practice to provide school psychological services at school and educational settings and the use of the title so conferred, shall include the word "school."

This provision is not intended to restrict the activities of Licensed Psychologists.

4. Graduate students, interns, unlicensed postdoctoral trainees, and applicants for licensure are permitted to function under the supervision of a licensed psychologist, as are assistants not eligible for licensure in some states. None may use the title psychologist, but titles that would be permissible under this exemption include "psychological trainee," "psychological intern," "psychological resident," "psychological testing technician," or "psychological assistant." The supervising psychologist is responsible for the professional actions of the student, trainee, or assistant. The Board is required to adopt regulations defining the nature and extent of training for qualified technicians or assistants and supervision for each category.

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Nothing in this Act shall be construed to prevent persons under the supervision of a licensed psychologist from engaging in activities defined as the practice of psychology, provided that such persons shall not represent themselves with the title "psychologist," in accordance with regulations promulgated by the Board. Such persons who are preparing for the profession of psychology may use terms such as "psychological trainee," "psychological practica student," "psychological intern," or "psychological resident." Other supervised persons may use terms such as "psychological assistant," "psychological technician," or "testing technician." All such persons must perform their activities under the supervision and responsibility of a licensed psychologist in accordance with regulations promulgated by the Board.

Nothing in this section shall be construed to apply to any person other than:

- a. a matriculated graduate student in psychology whose activities constitute a part of the course of study for a graduate degree in a psychology program at an institution of higher education;
- b. an unlicensed individual pursuing post-degree training or experience in psychology, including persons seeking to fulfill the requirements for licensure under the provisions of this Act; or
- c. a qualified assistant or, technician employed by, or otherwise directly accountable to, a licensed psychologist. Such individuals may, among other things, administer and score psychological tests at the request of the supervising psychologist, but may not interpret such tests. The Board shall issue regulations determining the number of assistants and technicians that a psychologist may employ, their qualifications, and the conditions under which their work must be overseen.

5. This provision clarifies that the focus of licensure is the individual providing the services. Where the individual providing services is duly licensed and qualified to provide them, the goal of assuring the public that the services will be provided by licensed and qualified professionals is served.

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Nothing in this Act shall be construed to require a license under this Act in order for a firm, partnership, corporation, limited liability company or other entity to provide psychological services where such services are performed by an individual: (a) duly licensed in this state to provide psychological services under this Act; or (b) supervised by a licensed psychologist in this state and permitted to provide psychological services with such supervision under this Act.

K. GROUNDS FOR SUSPENSION OR REVOCATION OF LICENSES

778 *A licensee and anyone under their supervision shall conduct their professional activities in conformity with the*
779 *ethical and professional standards of the APA Ethical Principles of Psychologists and Code of Conduct and those*
780 *standards promulgated by the Board under its rules and regulations.*

781
782 *The Board shall have the power and duty to suspend, place on probation, or require remediation for any licensee*
783 *for a specified time, to be determined at the discretion of the Board, or to revoke any license to practice psychology*
784 *or to take any other action specified in the rules and regulations whenever the Board shall find by a preponderance*
785 *of the evidence that the licensee has engaged in any of the following acts or offenses:*

- 787 1. *fraud in applying for or procuring a license to practice psychology;*
- 788
- 789 2. *unprofessional conduct as defined in the rules and regulations promulgated by the Board;*
- 790
- 791 3. *practicing psychology in such a manner as to endanger the welfare of clients or patients;*
- 792
- 793 4. *conviction of a felony (a copy of the record of conviction, certified to by the clerk of the court entering the*
794 *conviction shall be conclusive evidence);*
- 795
- 796 5. *conviction of any crime or offense that reflects the inability of the practitioner to practice psychology with due*
797 *regard for the health and safety of clients or patients;*
- 798
- 799 6. *harassment, intimidation, or abuse, sexual or otherwise, of a client or patient;*
- 800
- 801 7. *engaged in sexual intercourse or other sexual contact with a client, patient or the individual who is the direct*
802 *recipient of psychological services (where services are provided to an organization, client refers only to the*
803 *individuals who are direct recipients of psychological services);*
- 804
- 805 8. *use of repeated untruthful or deceptive or improbable statements concerning the licensee's qualifications or*
806 *the effects or results of proposed treatment, including functioning outside of one's professional competence*
807 *established by education, training, and experience;*
- 808
- 809 9. *gross malpractice or repeated malpractice or gross negligence in the practice of psychology;*
- 810
- 811 10. *aiding or abetting the practice of psychology by any person not licensed by the Board;*
- 812
- 813 11. *conviction of fraud in filing Medicare or Medicaid claims or in filing claims to any third party payor (a copy*
814 *of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive*
815 *evidence);*
- 816
- 817 12. *exercising undue influence in such a manner as to exploit the client, patient, student, or supervisee for financial*
818 *or other personal advantage to the practitioner or a third party;*
- 819
- 820 13. *received disciplinary action by another state on a license to practice psychology (a certified copy of the record*
821 *of disciplinary action by the state making such a decision shall be conclusive evidence thereof);*
- 822
- 823 14. *refusal to appear before the Board after having been sent notice to do so in writing by the executive officer or*
824 *chair of the Board;*
- 825
- 826 15. *making any fraudulent or untrue statement to the Board;*

- 827 16. *violation of the relevant ethical standards of the APA Ethical Principles of Psychologists and Code of Conduct*
828 *or other standards adopted in the rules and regulations of the Board; and*
829
- 830 17. *inability to practice psychology with reasonable skill and safety to patients or clients as a result of any condition*
831 *or circumstance that significantly interferes with professional competence or ethical practice, such as but*
832 *not limited to substance use, cognitive, emotional, medical, or behavioral dysregulation or impairment.*
833
- 834 18. *When the issue is whether a licensee experiences a circumstance that is affecting their ability to practice*
835 *psychology with reasonable skill and safety to patients or clients, a showing of probable cause (e.g., it is*
836 *more likely than not) to the Board is required that the licensee is not capable of practicing psychology with*
837 *reasonable skill and safety to patients or clients. Upon such a showing, the Board may petition a court of*
838 *competent jurisdiction to order the licensee in question to submit to a psychological examination by a licensed*
839 *psychologist to determine psychological status and/or a medical examination by a licensed physician to*
840 *determine physical impairment. Such psychologist and/or physician is to be designated by the Board. The*
841 *expense of such examination shall be borne by the Board. The licensee shall also be permitted to obtain their*
842 *own evaluation at their expense. When competency to practice is at issue, every psychology licensee in the*
843 *state shall be deemed to have given consent to submit to a professional examination(s) as related to the*
844 *areas of competence in question and to waive all objections to the admissibility of the examination, or to*
845 *previously adjudicated evidence of incompetence.*
846

847 **L. BOARD HEARINGS AND INVESTIGATIONS**
848

849 *The Board may investigate or cause to be investigated any allegation or evidence that appears to show that a*
850 *licensee in this state is, or may be, in violation of this Act or of any of the acts, offenses, or conditions set forth by*
851 *the Board in rules and regulations. Investigations will be limited to the allegation or evidence upon which they*
852 *were initially based, except in situations when the investigation uncovers evidence of serious misconduct on the*
853 *part of the licensee that is unrelated to the initial allegation or evidence.*
854

- 855 1. *Any accusation filed against a licensee in this state shall be filed within three years from the date the Board*
856 *discovers the alleged act or omission that is the basis for disciplinary action, or within seven years from the*
857 *date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first. If*
858 *an alleged act or omission involves a minor, the seven-year limitations period provided for shall be tolled until*
859 *the minor reaches the age of majority.*
860
- 861 2. *The following are exceptions to the limitations period in paragraph (1):*
862
- 863 a. *acts or offenses involving a violation of Sections K(1), K(13), or K(15) ;*
864
 - 865 b. *acts or offenses involving a violation of Sections K4, where there is an element of dishonesty or fraud,*
866 *and Section K5;*
867
 - 868 c. *acts or offenses involving fraudulent, deceptive or dishonest conduct that adversely affects the person's*
869 *ability or fitness to practice psychology;*
870
 - 871 d. *acts or offenses involving allegations of sexual misconduct with a patient or client, or with a former*
872 *patient or client for a period of two years following the date of the last professional contact with the*
873 *former patient or client.*
874

875 *Any licensee in this state is required to report to the Board any information such individual in good faith may have*

876 that appears to show that any licensee in this state may be in violation of this Act or guilty of any of the acts,
877 offenses, or conditions set forth by the Board and such violation has substantially harmed or is likely to substantially
878 harm a person or organization, unless such intervention would violate confidentiality rights under this statute or
879 when the knowledge comes from a peer review process qualifying under the state peer review statute or when a
880 licensed psychologist has been retained to review the work of that licensee whose professional conduct is in
881 question. Any licensee who in good faith makes such a report to the Board shall be immune from civil liability to
882 any person and/or entity for any statement or opinion made in such report. Licensees who make false claims
883 against a peer, however, do not have such immunity.
884

885 If, in the opinion of the Board majority, there is probable cause that the information provided to it under the
886 provisions of this section may be valid, the Board shall request by registered mail a formal interview with the
887 licensee. If the licensee refuses to appear for a formal interview before the Board, the licensee's refusal shall be
888 considered grounds for the Board, at its discretion, to impose disciplinary measures which may include but is not
889 limited to suspension or revocation of the individual's license. Any proceeding for suspension or revocation of a
890 license to practice psychology in this state shall be conducted in accordance with procedures established by the
891 Board. In the event these provisions conflict with the state's general administrative procedures, these specific
892 provisions will take precedence. The licensee shall be informed of their rights concerning Board hearings and
893 investigations:
894

- 895 1. the right to notice that a complaint has been filed and to be provided with a copy of the complaint within [x]
896 days of receipt of the complaint and the licensee and the complainant are provided notification, at least every
897 three months as to the status of any outstanding complaint unless the Board makes an affirmative determi-
898 nation that the disclosure would prejudice the investigation of the complaint and notifies the licensee of the
899 determination or disposes of the complaint within 120 days of the date of receipt of the complaint;
- 900 2. the right to see a signed (electronically or otherwise) complaint (non anonymous);
- 901 3. the right to have access to the Board's rules and procedures;
- 902 4. the right to ensure that the investigation is completed and a determination is made as to whether the complaint
903 has merit on a timely basis not to exceed [x] days from the Board's receipt of the complaint;
- 904 5. the right to self-representation or representation by counsel;
- 905 6. the right to a hearing within a reasonable period after the Board receives the allegation or evidence that
906 serves as the basis for an investigation by the Board and 30 days' notice of the hearing;
- 907 7. the right to discovery: each side can request from the other side relevant documents, a list of witnesses, and
908 for any expert witnesses, the name, C.V. and a detailed report of the expert's expected testimony;
- 909 8. the right to compel the attendance of, and produce, witnesses and to confront and cross examine opposing
910 witnesses, and to have witnesses testify under oath;
- 911 9. the right to recusal from participation in the Board's investigations and hearings any Board member who may
912 have a conflict of interest with the licensee who is the subject of the complaint;
- 913 10. the right to a written decision setting forth the violation, findings of fact, sanctions, and reasons for the
914 sanctions, within a reasonable period following the hearing;
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- 924

- 925 11. *a determination of the size of the vote necessary to find a violation;*
926
927 12. *a determination whether the hearing will be closed or open to the public;*
928
929 13. *the right not to have Board members who were on the investigative committee also appear on the formal*
930 *hearing panel;*
931
932 14. *the right to an appeal to an administrative board of review and/or to a court of competent jurisdiction.*
933

934 *The licensee may knowingly and voluntarily waive in writing their right to the formal adversary proceeding described*
935 *in this section.*
936

937 *The Board shall have the right to conduct an ex parte hearing if, after due notice, the individual fails or refuses to*
938 *appear. The Board shall have the right to issue subpoenas for production of documents and witnesses and to*
939 *administer oaths. The Board shall have the right to apply to a court of competent jurisdiction to take appropriate*
940 *action should a subpoena not be obeyed.*
941

942 *In the event that the Board finds evidence during its investigation indicating that the licensee's ongoing practice*
943 *may constitute an immediate danger to the public, the Board shall temporarily suspend the license of a psychologist*
944 *[or practitioner of psychology] without a hearing simultaneously with the institution of proceedings for a hearing*
945 *provided under this section. The Board shall provide the individual with due notice that includes a written statement*
946 *of the allegations against the licensee as more fully described in the Board's rules and regulations. The Board will*
947 *schedule a hearing to be held within 60 days to determine the merits of the evidence. Appropriate officials may*
948 *petition the court for an injunction barring further practice unless or until the person is properly licensed. The*
949 *injunction may be issued in addition to, or in lieu of, the criminal sanctions provided for in this section.*
950

951 *A psychologist [or practitioner of psychology] may surrender their license when such person is charged with*
952 *unethical conduct and upon receipt of that charge, that person decides to surrender the license, such surrender*
953 *and acceptance by the Board shall constitute acknowledgment by the licensee of being guilty as charged. A licensee*
954 *may request in writing to the Board that a restriction be placed upon their license to practice psychology. The*
955 *Board, in its discretion, may accept a surrender or grant such a request for restriction and shall have the authority*
956 *to attach such restrictions to the individual's license to practice psychology within this state or otherwise to*
957 *discipline the licensee.*
958

959 *After the holding of a hearing and the taking of evidence by the Board as provided for in this section, if a majority*
960 *of the Board finds that a licensee is in violation of this Act or guilty of any of the acts, offenses, or conditions as*
961 *enumerated by the Board, the following actions may be taken:*
962

- 963 1. *The Board may revoke or suspend the license and impose a monetary penalty.*
964
965 2. *The Board may suspend imposition of a revocation or suspension of a license and/or a monetary penalty.*
966
967 3. *The Board may impose revocation or suspension of a license and/or a monetary penalty but suspend enforce-*
968 *ment thereof by placing the licensee on probation, which probation shall be revocable if the Board finds the*
969 *conditions of the probation order are not being followed by the licensee.*
970
971 4. *The Board may require the licensee to submit to care, counseling, or treatment by a professional designated*
972 *by the Board. Such action may, but is not required to, be a condition of probation. The expense of such action*

shall be borne by the licensee.

- 5. After investigation at its discretion, the Board may dismiss or suspend a complaint without a finding as delineated in the rules and regulations so that a licensee who is the subject of the complaint may participate in a colleague-assistance program acceptable to the board. The board may dismiss or suspend a complaint contingent upon the licensee complying with directions issued by the board. The board may reinstate any dismissed or suspended complaint at any time it deems that the individual is not in compliance with the directions of the board.
- 6. The Board may, at any time, modify the conditions of the probation and may include among them any reasonable condition for the purpose of the protection of the public, or for the purpose of the rehabilitation of the probationer, or both.
- 7. The Board shall have the power to require restitution, when necessary.
- 8. The Board shall have the power to assess the costs of the disciplinary proceeding.
- 9. The Board shall report any formal adverse actions to the National Practitioner Data Bank as required by law.

The Board shall define by rulemaking under what circumstances the Board may consider instituting non-disciplinary actions (e.g., verbal warnings or letters of concern), referral to confidential treatment programs, or formal disciplinary actions. In the case of non-disciplinary actions, the Board will define by rule what actions are confidential and not subject to public disclosure.

M. PRIVILEGED COMMUNICATION

This section regulates and limits the powers of the judicial system. The courts or other administrative agencies with subpoena power have the right to make use of all relevant information in the judicial fact-finding process unless this right of access to information is specifically limited. Historically, courts and legislatures have been charged with fact-finding to seek truth and administer justice. At the same time, they have attempted to maintain the integrity of the confidential and private relationship between the psychology professional and patient or client. Some societal issues have emerged, such as child abuse and sexual abuse, that have changed the absolute nature of privileged communication. Though the privilege between the client or patient and the psychology professional is not absolute, it is designed to be sufficiently broad to cover all situations except those specifically enumerated. It is a privilege “owned” by the patient or client, who may assert it or waive it, and the psychology professional may assert the privilege for a patient or client who wishes to maintain such privilege of communication. It is understood that the privilege encompasses only communications between the patient or client and the psychology professional in a professional relationship. The provisions herein relate only to the disclosure of confidential communications in judicial, legislative, and administrative proceedings. They do not speak about the disclosure of confidential communications in other contexts, such as, for example, disclosures required or permitted by law or disclosures relating to consultations. Disclosure of confidential communications outside of judicial proceedings is governed by the relevant sections of the APA Ethics Code.

**RATIONALE:
FOR REFERENCE
ONLY**

The relations and communications between the patient or client and the licensed psychologist or licensed practitioner of psychology and their supervisees are confidential and privileged. Licensees should ensure that all persons working under their authority comply with the requirements for confidentiality of patient or client information. Those communications may not be disclosed except in specific circumstances as described below.

In judicial proceedings, whether civil, criminal, or juvenile; in legislative and administrative proceedings; and in proceedings preliminary and ancillary thereto, a patient or client, or their guardian or personal representative, may refuse to disclose or prevent the disclosure of confidential information, including information contained in administrative records, communicated to a psychologist or practitioner of psychology licensed or otherwise authorized to practice psychology under the laws of this jurisdiction, or to persons reasonably believed by the patient or client to be so licensed, or to students, interns, and trainees under the supervision of a licensed psychologist or licensed practitioner of psychology, and their agents, for the purpose of diagnosis, evaluation, or treatment of any mental or emotional condition or disorder. In the absence of evidence to the contrary, the licensee or their supervisee is presumed authorized to claim the privilege on the patient's or client's behalf.

This privilege may not be claimed by the patient or client, or on their behalf by authorized persons, in the following circumstances:

1. where abuse or harmful neglect of children, older adults, or disabled or incompetent individuals is known or reasonably suspected;
2. where the validity of a will of a former patient or client is contested;
3. where such information is necessary for the licensee to defend against a malpractice action brought by the patient or client;
4. where an immediate threat of physical violence against a readily identifiable victim is disclosed to the licensee;
5. in the context of civil commitment proceedings, where an immediate threat of self-inflicted damage is disclosed to the licensee;
6. in any proceeding in which the party relies upon their mental or emotional condition as an element of the party's claim or defense;
7. where the patient or client is examined under court order; or
8. in the context of investigations and hearings brought by the patient or client and conducted by the Board, where violations of this Act are at issue.

N. SEVERABILITY

As with any law, one provision may be subject to court challenge and ruled invalid or unconstitutional. For example, it is not legally clear whether state licensing boards can regulate persons working for federal agencies. Thus, if any provision is ruled invalid or unconstitutional, it is important that the entire Act not be affected. This can only be achieved by inserting a clause at the end of the Act stating that each provision of the Act is severable from all other provisions and that the declaration that one section is invalid or unconstitutional will not affect the constitutionality or enforceability of any other section.

**RATIONALE:
FOR REFERENCE
ONLY**

If any section in this Act or any part of any section thereof shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder of any section or part thereof.

O. EFFECTIVE DATE

1069 In any law regulating a profession there needs to be a specific date establishing when the law shall become
1070 effective. Thus, the final paragraph states:

1071
1072 *This Act shall become effective upon the date it is signed by the Governor or on the date it otherwise becomes*
1073 *effective by operation of law.*

1074
1075
1076 **REFERENCES**

1077 American Psychological Association. (2011). Model act for state licensure of psychologists. *American Psychologist*,
1078 66(3), 214-226.

1079 American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended
1080 effective June 1, 2010, and January 1, 2017). <https://www.apa.org/ethics/code/>

1081 APA Committee on Legislation. (1955). Joint report of the APA and CSPA (Conference of State Psychological
1082 Associations). *American Psychologist*, 10, 727-756.

APA's Model License Act Revision Review of the Draft for Comments

Alex Siegel, JD PhD

Peter M. Oppenheimer, PhD

January 8, 2026

Presented to the Division 31

Credit to Alex Siegal, Mira Jourdan, APA Committee for Accreditation, and APA Staff
for their contributions to the slides

1

1

American Psychological Association Anti Trust Guidelines – 2025

It is the unqualified policy of the **American Psychological Association (“APA”)** to conduct its operations in strict compliance with the antitrust laws of the United States.

Therefore, while psychologists are free to individually exercise their independent professional judgment in setting rates and fees for services; dealing with patients, health care payors, clients, vendors and employers; and choosing where to offer services, the APA prohibits any discussions in its meetings which constitute or imply an agreement or understanding concerning any of these areas. Additionally, specifically prohibited are:

- Any agreement or understanding concerning what is a fair or appropriate fee for service, insurance reimbursement rates, profit, minimum salaries, or the like;
- Any agreement or understanding to boycott insurers or on the selection, rejection, or termination of agreements with specific health care payors or vendors;
- Any agreement or understanding restricting the scope of services provided by specific providers or types of provider, the locations in which psychologists may practice, or the classes of employees, patients, or collaborators with whom a psychologist may practice;
- Any agreement or understandings regarding amounts that will be paid for employed psychologist salaries, other employment benefits, or other financial terms or conditions of employment.

Nothing in this policy or in the antitrust laws prevents the APA, its members, and/or its affiliated organization, APA Services Inc., from jointly/collectively presenting issues of concern to federal, state, and local legislative and regulatory authorities to seek an appropriate government response for the discipline and to promote quality accessible health care for the public, including those in underrepresented communities.

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APA Comment Portal

<https://commentinggov.apa.org/>

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History of the Model License Act

- 1955
- 1967
- 1979 Rejected by Council
- 1987
- 2010

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Proposed Major Changes in 2026 MLA

- Master's practice of Psychology
 - Endorsing licensing people with master's degrees as practitioners of psychology at an independent level by including model legislation in the MLA
- Applied Consulting Psychologists
 - Removing nonhealthcare practice from the scope of practice, but does not clearly define HSP and nonHSP practice
 - Endorsing that the practice of applied psychology does not require licensure
 - Allowing anyone with a doctoral degree in psychology to proclaim themselves a "psychologist" practicing applied psychology

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History of APA Actions Related to the Master's Degree in Psychology

1947: Policy and Planning Board recommended training at the master's level in clinical psychology be discontinued

1950: Boulder Conference recommended training programs in clinical psychology be at the doctoral level

1956: Committee on Subdoctoral Education and Training recommended a study of accreditation procedures for subdoctoral training programs

1969: Board of Professional Affairs (BPA)/Board of Education and Training Subcommittee on Subdoctoral Manpower recommended APA set policy on training and services provided by those with subdoctoral training

1970: Task force on master's level education recommended individuals with master's degrees in psychology be eligible for APA membership

1978: Resolution on the master's level issue affirmed title of "psychologist" for those with doctorate degree

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History of the Master's Part II

- 1988: Board of Directors' Subcommittee on the Future of Professional Psychology recognized the need for workforce data on levels of training for different services
- 1991: Task force authorized to pursue needed workforce data
- 1998: APA policy approved on APA Activities Bearing on Licensure Challenges that encouraged recognition of master's degree holders provided that state statutes do not impact psychologist title or practice
- 2006: Board of Educational Affairs (BEA) formed study group on the master's degree in psychology
- 2009: BEA convened working group with members from BPA, the Board of Scientific Affairs (BSA), and the Board for the Advancement of Psychology in the Public Interest (BAPPI), which proposed a policy statement but did not pursue Council approval based on comments received
- 2013: BPA and the Committee for the Advancement of Professional Practice (CAPP) Master's Workgroup prepared a position paper on the development of APA policy and a competency model for appropriate practice for master's-trained individuals in psychology
- 2014: BEA convened task force to draft Guidelines for Master's Programs in Psychology (pending Council approval in August 2017)
- 2016: Minority Fellowship Program held a Summit on Master's Training in Psychology Practice

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History of the Master's Part III

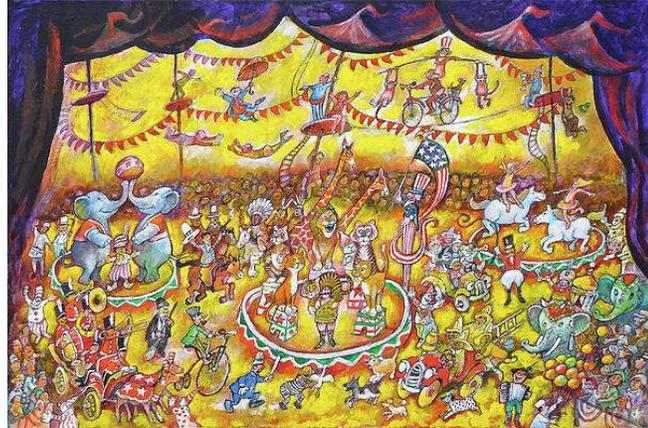
- 2016: The APA Minority Fellowship Program held a Summit on Master's Training in Psychological Practice to explore issues related to the possibility of APA embracing training of psychology professionals holding master's degrees with a goal of identifying key considerations, potential solutions and their impacts, areas of consensus, and concerns.
- 2018: APA Council of Representatives voted to move forward with accreditation of master's degree programs in health service psychology.
- 2019: BEA and BPA formed the joint task force to delineate competencies for individuals trained at the master's level in health service psychology (HSP) from individuals trained at the doctoral level.
- 2019: BEA and BPA formed the joint task force to update the doctoral competencies with the expectation that doing so would then delineate the difference between those with a doctoral degree and those with a master's degree in psychology.
- 2020: APA's Board of Directors and Council of Representatives held focused conversations on the future of psychology practice and education.
- 2021: The joint BEA/BPA Task Force on Doctoral Competencies in Health Service Psychology was convened.
- 2021: APA Practice and Education Directorates convened an Assembly on the Value/Distinctiveness of the Doctoral Degree in Health Service Psychology where attendees representing constituencies across the association. Attendees considered how the doctoral degree and psychology license adds value to a future Psychology profession that would be multi-tiered.
- 2022: BPA and BEA formed a joint working group to recommend an appropriate master's title and scope in health service psychology that would inform future updates to the APA Model Licensure Act.
- 2022: ASPPB forms the Potential Regulatory Implications of Master's Licensure Task Force (PRI-LM)
- 2024: BPA formed a working group to update the APA Model Licensure Act
- 2025: Council approves policies endorsing licensing people with master's degrees
- 2025: Model License Act Task Force Subgroup J terminated / BOD creates Applied Psychology Task Force
- 2025: BPA approve sending Model License Act Task Force draft for public comment
- 2026 MLA draft commentary period

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What needs to be included in developing standards for master's level practice

- Accreditation
- Competencies
- Regulation



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What is APA's policy regarding licensing people with master's degrees?

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August 2017

On Wednesday afternoon, Council participated in small and large group discussions related to master's level training and practice in psychology. At the conclusion of the discussion, there was agreement among Council members that current issues and developments have risen to the level that APA should take a position on master's level training and/or practice and that staff and governance should identify and explore options for APA to pursue.

March 2018

IX. EDUCATIONAL AFFAIRS

A.(6) Council voted to support pursuing accreditation of master's level programs in psychology in areas where APA already accredits.

On Friday morning, Council participated in small and large group discussions related to master's level practice in psychology. At the conclusion of the discussion, there was agreement among Council members that 1) there is a benefit to uniformity in title and 2) there should be standards for the scope of practice of master's level practitioners. Council was informed that staff will compile the notes from each table in order to inform recommended next steps for potential future action by Council on these two issues.

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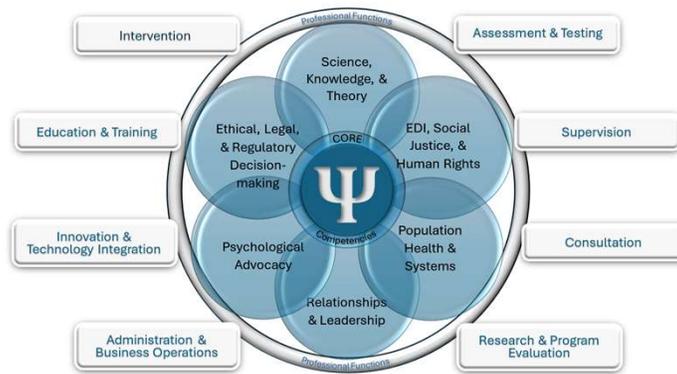
Accreditation of Master's programs in Health Service Psychology

- Approved in February 2021
- First Programs approved 2024

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A Unified Competency Framework for Doctoral and Master's Degrees in Health Service Psychology



Not yet public

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February 2025 Council Agenda Item # 5

- **COUNCIL OF REPRESENTATIVES FEBRUARY 21 & 22, 2025**
- **ACTION ITEM # 5**
- **IX. EDUCATIONAL AFFAIRS**
- **GUIDELINES FOR A COMPETENCY FRAMEWORK FOR MASTER'S AND DOCTORAL DEGREE EDUCATION AND TRAINING IN HEALTH SERVICE PSYCHOLOGY**
- **SUMMARY**
- Council is asked to adopt as APA policy the *Guidelines for a Competency Framework for Master's and Doctoral Degree Education and Training in Health Service Psychology* and approves December 31, 2025 as the expiration date.

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February 2025 Council Agenda Item # 4

- **COUNCIL OF REPRESENTATIVES DECEMBER 13 & 14, 2025 ACTION ITEM # 4**
- **X. PROFESSIONAL AFFAIRS**
- **AMENDMENTS TO POLICIES RELATED TO THE DOCTORAL DEGREE REQUIREMENT FOR PROFESSIONAL PRACTICE OF PSYCHOLOGY**
- **SUMMARY**
- Council is asked to approve revisions to the policies currently entitled Doctorate as the Minimum Entry into the Professional Practice of Psychology (2006) and Policy on Challenges to the Doctoral Standard for Psychology (2002) as detailed to better align APA's efforts to support and integrate master's degree psychology professionals into the profession.

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Item # 4 Main Motion-I

- 1 That Council approves the following revisions to the policy on the Doctorate as Minimum Entry Into the
- 2 Professional Practice of Psychology (bracketed/strikethrough material to be deleted; underlined
- 3 material to be added):
- 4
- 5 2006
- 6 **Doctorate [as Minimum Entry Into the] Required for Professional Practice [of Psychology] as a**
- 7 **Psychologist**

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Item #4 Main Motion-II

- 4 2002
- 5 **Policy on challenges to the doctoral standard for [psychology] psychologists**
- 6 1. Uphold use of the title "psychologist" by only those with a doctoral degree in the field of
- 7 psychology.
- 8 2. Encouragement and assistance to State, Provincial, and Territorial Psychological Associations
- 9 (SPTAs) and state licensing boards [~~to move to single level doctoral licensure~~]choosing to update
- 10 jurisdictional licensing regulations.
- 11 3. Active consulting to SPTAs in states that have dual level licensure or choose to implement dual
- 12 level licensure.
- 13 4. Encourage the recognition of individuals holding terminal master's degrees in psychology under
- 14 existing or new state statutes, provided that such statutes [~~do not recognize, regulate or govern~~
- 15 ~~the title or practice of psychology~~]define an appropriate scope of practice consistent with APA
- 16 policies, and do not use the term "psychologist[~~call~~]" in defining the title [or scope of practice]
- 17 for such persons.
- 18 5. Continue convening [exploratory] meetings focusing on issues involving education, training and
- 19 credentialing[~~at the Consolidated meetings~~] with the Board of Directors, [Committee for the
- 20 Advancement of Professional Practice,] Board of Professional Affairs, Board of Educational
- 21 Affairs, American Psychological Association of Graduate Students, the Association of State and
- 22 Provincial Psychology Boards and other relevant groups.]

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August 2025 Council Agenda Item #6

- Licensed Practice for Master's HEALTH SERVICE PSYCHOLOGY PROFESSIONALS: OPERATIONAL PRINCIPLES
- A.(6) Council voted to approve the following operational principles to guide the current and future work to develop a licensure pathway for master's level health service psychology (M-HSP) that is competitive with other master's level mental health providers and distinct from doctoral psychologists:
 - The title and scope of practice for M-HSP practitioners should meet public health needs and protect and educate the public about this group of providers
 - Master's level practitioners in psychology should have an appropriate title that does not include "psychologist" but establishes its base in psychology
 - M-HSP practitioners should have a scope of practice that ensures they are competitive in the marketplace with other behavioral health master's level practitioners outside of psychology
 - M-HSP practitioners should be able to provide some services, independently without supervision and within a defined standard appropriate to the master's level of education, training, and supervision, including psychotherapy and diagnostic intake
 - M-HSP are included in health service psychology (HSP)
 - M-HSP are distinct from other mental health practitioners (in that they are grounded in psychology science, education and training)
 - The doctoral degree is the highest credential in psychology. The scope of practice for doctoral psychologists is distinct from that of M-HSPs, reflecting more advanced training, broader competencies, and a higher level of preparation across clinical, scientific and leadership domains. This distinction reinforces the doctorate's recognized professional contribution, advanced expertise, and professional standing within the field.
 - The licensure pathway for M-HSP should be consistent with the scope of practice and not
 - inherently more burdensome than that of other master's behavioral health professionals

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APA Health Service Psychology Workforce Optimization

- <https://www.apa.org/education-career/grad/national-standards-masters>
- The bottom line: Psychology is expanding to include master's-level HSP practitioners to help address America's mental health crisis. This optimization preserves the term "psychologist" for doctoral professionals, while creating clear scope boundaries and opportunities for both HSP doctoral psychologists and master's-level practitioners.

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BPA/BEA Task force on Master's Scope and Title

- <https://www.apa.org/practice/leadership/bpa/masters-health-service-psychology-working-group>
- (2021-2023)

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MLA Task Force 2024-2025

- 2024: This working group was just formed and will begin their work within the next few weeks.
 - Title NOT=TO Psychologist (top: psychology associate/practitioner)
 - Some level of independence like LCP, LICSW, LMFT
 - Psychotherapy is okay; we don't want these individuals to be second class citizens compared to what other master's level mental health folks can do
 - Issues yet to be resolved are supervision, testing & assessment.
 - 2024: BPA has formed a subgroup to work on combining the reports from the two TFs to create one Unified Competency Framework – every behavioral anchor has clear distinctions
- *text from APA

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APA MLA Task Force progress

- Task force worked solely on master's scope and title till December 2024
- Some TF members expressed that they were only interested in working on the master's, so some have suggested revising the task force membership
- Worked on doctoral issues in 2025
- Applied Consulting Psychologists not addressed until April 2025
- APA management has postponed bringing MLA to Council since February 2025. Now slated for August 2026.

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Regulatory Issues with master's licensure

- Around 22 states allow for some type of master's licensure in psychology.
 - In the 1980 and 1990s, APA's position was psychology was a doctoral level practice. Most states which had licensed on the doctoral and master's level(same title and scope) eliminated master's licensure.
 - Some states North Carolina and Michigan continued with master's licensure but masters under supervision of doctoral level
 - Some states Alaska and Kentucky no difference in scope
 - In last 5 years, some states North Carolina and Virginia have updates/changed their laws with regard to masters

24

Problems with opening Psychology Licensing Act and Regulations

- Antiregulatory climate
- Other groups may want to add or subtract language from the Act.
- Defining what is psychological practice
 - Differentiating masters from doctoral level practice
 - Does this reduce the profession to masters level
 - Why get a doctorate if can practice psychology with a masters
 - Distinguishing psychological practice from other groups who may want to encroach on it or having masters expand their scope in a few years
 - If anyone with a doctoral degree can call themselves a psychologist, is that all psychological practice
 - APA MLA does not define "providing applied psychological services"

25

Problems II

- To add or change, states need to open up their Act and Regulations
 - Decide the title (Psychological Associate, Psychology Associate)
 - License Practitioner of Psychology (LPP) (ASPPB and now APA MLA)
 - APA MLA really does not distinguish the scope between LPP and Psychologist
 - Diagnosis, treatment and management of mental and emotional disorders, mental developmental or intellectual disability, substance use disorder, disorders of behavior or conduct, as well as of the psychological aspects of physical illness, accident, injury, disability or chronic health conditions
 - Provisions of evidence-based therapeutic, including, psychotherapy (eg CBT, DBT, ACT), hypnosis, biofeedback and the ability to order and/use emerging interventions (ie digital therapeutics and digital tools) and behavior analysis for individuals, families and/or groups to improve mental health and wellness

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Exclusions to Master's Practice

- Exclusions to practice areas include, comprehensive specialty and subspecialty assessment and consultations, which require advance psychology doctoral or post doctoral education and training, including the practice of neuropsychology, forensic assessments, child custody and parental fitness evaluations, medical capacity evaluations, medical presurgical evaluations (transplant surgery, bariatric surgery, neurostimulator implantation surgery), acute medical specialty consultations (inpatients medical hospital, sleep medicine), projective testing and public safety employment evaluations such as fitness for duty.

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Regulatory Issues with Applied Consulting Psychologist (ACP)

- Exempt for the APA MLA practice of psychology
- Use of the title without being licensed
 - All jurisdictions only individuals licensed can use the the title psychologist
 - Confusing to the public as to who or what is a psychologist
- Scope or Practice
 - APA MLA restricts/limits practice to mental or behavior health
 - Is it possible for psychologist to provide wellness or enhancement services without a diagnosis
 - Can a psychologist see parents to help them learn how to deal with their substance using son

28

Discipline

- I have worked with Philly Sports Teams and individual athletes, attorneys and law firms as well as individuals involved in civil and criminal matters, can I say these activities require a license and those activities do not require a license. If a complaint is file against me as a psychologist, I will say board does not have authority over me since you do not need a license to provide those services
- If psychologist get discipline and licensed removed, can they now call themselves ACP and continue to practice since no longer under authority of licensing board
- If ACP does something to harm the health, safety and welfare of the public, is there any recourse the state has to prevent that behavior from happening again.

29

Issues Impacting HSP Doctoral Practice

- Colleague assistance programs
- Standard exemption for out of state psychologists
- Emeritus
- Application equivalency versus requiring accreditation

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Meta issues beyond the content of the MLA

- Are the requirements for master's education and training sufficient to meet the proposed scope of practice?
- Will APA's guidelines for titles hold?
- What are the implications of licensing Master's practitioners for doctoral psychologists?
- Can boards implement this license?
- How would allowing people to self-declare themselves as "psychologists" impact psychologists who are licensed.
- What are the implications of removing nonHSP services from the scope of practice?
- Do these proposed changes create a risk to public safety?

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APA Comment Portal

<https://commentinggov.apa.org/>

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33

ASPPB Townhall Proposed APA Model Licensure Act (MLA)

January 28, 2026



WELCOME

 ASPPB | 65
YEARS

Discussion Points for the Meeting



Public comment period – American Psychological Association Model Act for State Licensure of Psychology Professionals (MLA)



What led up to the proposed 2026 APA-MLA document



Potential impact on the regulation of psychology by Boards and Colleges



Highlight Areas



Reminder of ASPPB's Model Regulations for Licensure and Registration of Psychologists



Open Discussion

History of the APA Model License Act



APA MLA Task Force Overview



Proposed Major Changes to the 2010 APA MLA

- Master's practice of Psychology
 - Endorsing licensing people with master's degrees as practitioners of psychology at an independent level by including model legislation in the MLA.
- The proposed MLA applies to whom
 - Removing non-healthcare practice from the scope of practice.
 - Endorsing that the practice of applied psychology does not require licensure.
 - Allowing anyone with a doctoral degree in psychology to proclaim themselves a "psychologist" practicing applied psychology.

Regulatory Issues with Applied Consulting Psychologist (ACP)

Exempt from the APA MLA practice of psychology

Use of the title without being licensed

- In all jurisdictions, only individuals licensed can use the title Psychologist.
- It is confusing to the public as to whom or what is a Psychologist.

Scope of Practice

- APA MLA restricts/limits practice to assessment and treatment for psychological and other health-related disorders or concerns.
- Is it possible for a psychologist to provide wellness or enhancement services for individual development or behavioral change without a diagnosis.

Regulatory Issues with Applied Consulting Psychologist (ACP)

No Applied Consulting Psychologist (ACP) as part of the MLA but would allow them to be appointed to a licensing board.

- “Diversity of practice specialties both in health care and other applications and including representation from teaching, training, and practice.”
- “Public board member shall not be a licensed psychologist...” but could it be an ACP psychologist.
- “States shall solicit professional board member nominations from psychological organizations.”

Highlight Areas

Emeritus Status

- 65 years, licensed, in good standing, and provides limited services such as volunteering, disaster relief training, not more than 20 hours a week.

Provide the complainant with a copy of the complaint and, at least every 3 months, the status of any outstanding complaint.

Shall report to the National Practitioner Data Bank and add ASPPB Disciplinary Data Bank.

Does *Privilege Communication* apply to ACP “communicated to a psychologist...”

Highlight Areas

Educational Equivalency & Credential Review

- Aside from APA, CPA, and in some cases, PCSAS Accreditation, equivalency is allowed. This may result in significant variations in licensure practices and impact mobility.
- Would this impact the current time needed to process applications?
- Would additional staff be required?

The document seems to interchange the use of terms throughout, psychologists, psychology practice, practitioner of psychology, and the regulated title Psychologist for those who do not desire to be licensed.

- Do you see this as a concern?
- How would this impact you and the work of your board/college?
- Are you concerned about those providing psychology services in your jurisdiction without your knowledge or oversight?
- Could this be confusing or negatively impact the public?

Highlight Areas

Temporary Practice

- Aside from the requirements set forth by the PSYPACT Commission. Are there any concerns with the following language?

“Notice does not require approval of the Board before delivery of service if the aggregate of 30 days of services is not exceeded and the individual does not establish an ongoing, regular, professional practice in the jurisdiction.”

Board Hearings and Investigations

- Throughout this section, there are several timelines that have been set for action.
- Are these timelines achievable?
- If not, what are the potential consequences?

Highlight Areas

Doctoral program in psychology that is accredited by APA, CPA, or other substantially accredited body recognized by the Board (MPCAC?).

Where APA or CPA accreditation does not exist for that area of professional psychology, the applicant must meet CoA Guidelines vs. Standards.

The Board adopts as its standards of conduct the Ethical Standards of the Ethical Principles of Psychologists and the Code of Conduct of the APA.

Challenges Regulatory Boards or Colleges Might Have if APA MLA is Adopted

- Licensure requirements are to be reserved for **psychology professionals** educated in clinical, counseling, school psychology, or a combination thereof who provide health service psychology.
 - Others are excluded from the APA MLA.
 - I/O, Sport Psychology, but also Neuropsychology, and Forensic Psychology.
- Patient or Client
 - Direct recipients of psychological healthcare services.
 - Direct recipients of psychological services that are not treatment-related.
- Psychological Testing
 - Describe specific psychological attributes of individuals.

Regulatory Issues with Master's Licensure

Around 22 states allow for some type of master's licensure in Psychology.

- In the 1980s and 1990s, APA's position was that Psychology was a doctoral-level practice. Most states that had licensed at the doctoral and master's levels (with the same title and scope) eliminated master's licensure.
- Some states, such as North Carolina and Michigan, continued with a master's licensure but master's under the supervision of a doctoral level.
- Some states, Alaska and Kentucky, have no difference in scope.
- In last 5 years, some states North Carolina and Virginia have updates/changed their laws regarding master's licensure.

ASPPB MLA vs. APA MLA on Master's Licensing

In response to the Board and College Executives (BARC) and Board and College Chairs (BCCC), the ASPPB BOD set up the Potential Regulatory Implications of Licensing Master's Trained Individuals Task Force (PRI-LM)

- To provide information to boards, if needed, to work with your legislators.
- With a different title and scope of practice.

APA is advocating for master's licensure

- Different title.
- Similar scope as with a doctoral psychologist, but some exceptions.
- MLA out for public comment until March 3, 2026.

ASPPB MLA vs. APA MLA on Master's Licensing

To add or change language, states will need to open their Acts and Regulations

- Decide the title (Psychological Associate, Psychology Associate).
- License Practitioner of Psychology (LPP) (ASPPB and now APA MLA).
- APA MLA really does not distinguish the scope between LPP and Psychologist.
 - Diagnosis, treatment, and management of mental and emotional disorders, mental developmental or intellectual disability, substance use disorder, disorders of behavior or conduct, as well as the psychological aspects of physical illness, accident, injury, disability, or chronic health conditions.
 - Provisions of evidence-based therapeutic, including psychotherapy (i.e., CBT, DBT, ACT), hypnosis, biofeedback, and the ability to order and/use emerging interventions (i.e., digital therapeutics and digital tools) and behavior analysis for individuals, families, and/or groups to improve mental health and wellness.

Exclusions to Master's Practice

Exclusions to Practice Areas Include

Comprehensive specialty and subspecialty assessment and consultations, which require advance psychology doctoral or post-doctoral education and training, including the practice of neuropsychology, forensic assessments, child custody and parental fitness evaluations, medical capacity evaluations, medical presurgical evaluations (transplant surgery, bariatric surgery, neurostimulator implantation surgery), acute medical specialty consultations (inpatients medical hospital, sleep medicine), projective testing and public safety employment evaluations such as fitness for duty.

Board/College Discipline Dilemmas

- I have worked with Philly Sports Teams and individual athletes, attorneys and law firms as well as individuals involved in civil and criminal matters, can I say these activities require a license and those activities do not require a license. If a complaint is filed against me as a psychologist, I will say the Board does not have authority over me since you do not need a license to provide those services.
- If a psychologist gets disciplined and their license is removed, can they now call themselves an ACP and continue to practice since they are no longer under the authority of the licensing board?
- If an ACP does something to harm the health, safety, and welfare of the public, is there any recourse the state has to prevent that behavior from happening again?

Issues Impacting HSP Doctoral Practice

- Colleague assistance programs
- Standard exemption for out-of-state psychologists
- Application equivalency versus requiring accreditation

Problems with Opening Psychology Licensing Acts and Regulations

Antiregulatory Climate

Other groups may want to add or subtract language from the Act.

Defining what a psychological practice is.

- Differentiating master's from doctoral-level practice.
 - Does this reduce the profession to a master's level?
 - Why get a doctorate if one can practice psychology with a master?
- Distinguishing psychological practice from other groups who may want to encroach on it or having a master's degree to expand their scope in a few years.
- If anyone with a doctoral degree can call themselves a psychologist, is that all psychological practice?
- APA MLA does not define "providing applied psychological services."

Questions Regulators Are Forced to Consider

- Are the requirements for master's education and training sufficient to meet the proposed scope of practice?
- Will my jurisdiction have to utilize APA's guidelines for titles and scope of practice?
- Based on the proposed language, what are the implications of licensing master's practitioners and doctoral psychologists?
- Can boards and colleges operationalize the elements noted in this document?
- How would allowing people to self-declare as "psychologists" impact licensed psychologists?
- What are the implications of removing non-HSP services from the scope of practice?
- Will Boards and Colleges be able to meet the timelines set throughout the document?
- Do these proposed changes create a risk to public safety?
- Why is a "Psychologist" not defined in this document?
- Why are there two MLAs instead of one?

APA Comment Portal

<https://commentinggov.apa.org/>

Open Comment Period
January 2 - March 3, 2026

Questions and Thank you

Alex Siegel, J.D., Ph.D.

ASPPB's Director of Professional Affairs

asiegel@asppb.org

(610)724-3555



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Executive Director

TITLE: AI in Psychology Practice

INTRODUCTION TO THE TOPIC:

Articles of note for the Board to consider around AI use in practice and regulation.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
The New Regulatory Reality for AI in Healthcare: How Certain States are Reshaping Compliance by:	1/26/2026	Cover Memo
AI Integration and Regulatory Compliance in Healthcare - Vanderbilt Law University	1/26/2026	Cover Memo
Among Psychologists, AI Use is Up, But So Are Concerns	1/26/2026	Cover Memo
First Therapy Chatbot Trial Yields Mental Health Benefits_ Dartmouth	1/26/2026	Cover Memo
Ethical Implications of Embodied Artificial Intelligence in Psychiatry, Psychology, and Psychotherapy	1/26/2026	Cover Memo

September 29, 2025

The New Regulatory Reality for AI in Healthcare: How Certain States Are Reshaping Compliance

By: [Jennifer Yoo](#) , [Ana Razmazma](#) , [Sari Heller Ratican](#) ,
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What You Need To Know

- California, Nevada, Texas, and Illinois are bringing artificial intelligence-related healthcare regulations into sharper focus by limiting how AI is portrayed and what kind of care can be provided with the help of AI.
- California laws prohibit AI systems from implying the presence of licensed medical oversight where none exists and create new compliance considerations by giving the state professional

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licensing boards direct authority to investigate violations.

- Illinois’ law prohibits the use of AI in providing mental health and therapeutic decision making, unless an individual, corporation, or entity falls under an exemption.
- Nevada’s law prohibits AI providers from utilizing AI systems to provide or claim to provide professional mental or behavioral healthcare.
- Texas laws require providers to disclose AI use in clinical care and maintain oversight of AI-generated medical records.

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The landscape for AI in healthcare is shifting dramatically as state legislators move beyond general guidelines to establish concrete enforcement mechanisms. Healthtech companies’ success using AI may be aided by integrating regulatory readiness into core business strategy rather than treating compliance as an afterthought. Below we provide an overview of these laws, as well as questions companies can use to guide their analysis on how such laws may apply to their AI use.

California Targets Misleading Systems and Design

California had already targeted the regulation of generative AI use in the healthcare setting with [AB 3030](#), which took effect on January 1, 2025. It imposes disclosure requirements on healthcare providers, including clinics, hospitals, and

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physician offices, that use generative AI to produce written or verbal communications containing clinical information. Under AB 3030, such communications must include (1) a disclaimer indicating that the content was produced by generative AI and (2) clear instructions for patients on how to contact a licensed human healthcare provider. These requirements were designed to ensure transparency and preserve patient trust in clinical communications.

California's [AB 489](#) represents a critical evolution in healthcare AI regulation by targeting systems (rather than healthcare practitioners) that could mislead patients about the presence of licensed medical oversight. Signed into law on September 2, 2025, and effective October 1, 2025, AB 489 prohibits AI systems from using professional terminology, interface elements, and post-nominal letters (like M.D., D.O., or R.N.) suggesting users are receiving care from licensed human healthcare professionals when no such oversight exists. This extends beyond obvious misrepresentations and is meant to capture subtle design choices that could convey professional authority. Thus, healthtech companies should consider avoiding any language, design, or branding that could be interpreted as implying medical authority or licensed professional involvement, such as "Virtual Physician," "AI Doctor," or "Nursebot." Additionally, healthtech companies should not (1) use clinical terminology implying that the care or advice being offered is provided by a person in possession of a professional license or (2) market products by using

terms implying a medical professional may be involved.

AB 489's enforcement mechanism begins October 1, 2025, when state professional licensing boards will have direct authority to investigate violations with each prohibited term, letter, or phrase constituting a separate offense. This creates a new compliance consideration alongside existing privacy, security, and consumer protection requirements companies must navigate.

Companies developing diagnostic AI tools or virtual health assistants should consider conducting a comprehensive review of all product features, user interfaces, and marketing materials to assess whether their systems use any language, design, or branding that could be interpreted as implying medical authority.

Illinois Takes a Comprehensive Approach to AI in Mental Health

Illinois has enacted even more sweeping restrictions through the [Wellness and Oversight for Psychological Resources Act \(HB 1806\)](#) (WOPRA). Effective August 4, 2025, WOPRA prohibits the use of AI to (1) make independent therapeutic decisions, (2) directly interact with clients in any form of therapeutic communication, or (3) generate therapeutic recommendations or treatment plans without review and approval by the licensed professional.

WOPRA permits the use of AI systems for "administrative or supplementary support," defined as tasks performed to assist a licensed professional in the delivery of therapy or psychotherapy services not

involving therapeutic communication. Such tasks include:

- Appointment scheduling
- Processing billing and insurance claims
- Preparing and maintaining client records (including therapy notes)
- Analyzing anonymized data to track client progress or identify trends, subject to review by a licensed professional
- Identifying and organizing external resources or referrals for client use
- Drafting general communications related to therapy logistics that do not include therapeutic advice or recommendations

Section 25 of WOPRA provides that WOPRA does not apply to religious counseling, peer support, or publicly available self-help materials and educational resources not offering therapy or psychotherapy services. As a result, services delivered for these purposes (including mental health coaching) may fall outside the scope of WOPRA. However, organizations should conduct careful legal analysis to determine whether a particular service qualifies for an exemption.

The law, enforced by the Illinois Department of Financial and Professional Regulation with penalties up to \$10,000 per violation, establishes the nation's first statutory restriction on AI therapy while imposing strict conditions on how licensed professionals may incorporate AI into care delivery. Such financial penalties add to the [existing risks](#) of eroding client trust and privacy that may result from misuse of AI in therapeutic contexts.

For healthtech companies and AI providers, these restrictions require a clear separation between administrative and therapeutic functions, robust oversight by licensed professionals, and careful review of product features to enhance compliance. The law may limit the scope of AI-driven mental health solutions in Illinois, necessitating product redesign, enhanced compliance protocols, and ongoing legal review for businesses operating in this space.

Nevada Targets AI Providers Offering Mental Health Services

Nevada's [AB 406](#), signed into law on June 5, 2025, and effective on July 1, 2025, prohibits AI providers from offering and programming AI systems that provide services constituting the practice of mental or behavioral healthcare. AB 406 defines "professional mental or behavioral health care" as mental or behavioral healthcare or services relating to the diagnosis, treatment, or prevention of mental illness or emotional or behavioral disorders which are typically provided by a provider of mental or behavioral healthcare within their authorized scope of practice.

Under Nevada's AB 406, AI providers face clear prohibitions designed to safeguard the delivery of mental and behavioral health care:

- **Prohibition on Misleading Titles or Claims:** AI providers may not represent or make statements that (1) AI systems are capable of providing professional mental or behavioral health care; (2) allow users to interact with conversational features that simulate human conversation for the purpose of

obtaining professional mental or behavioral healthcare; or (3) use features, avatars, or titles such as therapist, clinical therapist, counselor, psychiatrist, doctor, or any similar term that implies the system is a licensed provider of professional mental health or behavioral care.

- **Ban on Direct Care Delivery:** AI systems cannot be made available to individuals in Nevada if (1) they are programmed to provide any service or experience constituting the practice of professional mental or behavioral healthcare as if performed by a human provider or (2) the provider makes a representation or statement explicitly or implicitly indicating that such AI system is capable of providing professional mental or behavioral healthcare.
- **Restrictions in Telehealth and Schools:** The law extends to telehealth platforms and prohibits public schools from using AI systems to perform the functions of school counselors, psychologists, or social workers related to student mental health. Using AI systems in connection with providing professional mental and behavioral health care directly to a patient is also prohibited.

Like Illinois' WOPRA, AB 406 permits the use of AI systems designed for use by mental and behavioral health providers to perform administrative support tasks, such as scheduling, managing records, analyzing operational data, and organizing, tracking, and managing files and notes pertaining to students. Additionally, AB 406 does not prohibit any advertisement,

statement, or representation for or relating to materials, literature, and other products meant to provide advice and guidance for self-help relating to mental or behavioral health, if the material, literature, or product does not purport to offer or provide professional mental or behavioral healthcare. Thus, like WORPA, services delivered for either administrative purposes or for purposes such as self-help may fall outside the scope of AB 406. However, a careful analysis should be conducted to see if a company qualifies for an exemption.

Violations of the Nevada law may result in civil penalties up to \$15,000 per instance and disciplinary action for licensed providers.

For healthtech companies and AI providers, Nevada's AB 406 calls for a clear separation between administrative support functions and any features that could be construed as clinical care, along with careful review of product language and marketing to avoid any implication of professional mental or behavioral health services. The law may restrict the deployment of AI-driven mental health solutions in Nevada, compelling businesses to redesign products, enhance compliance oversight, and regularly consult legal counsel to mitigate the risk of substantial penalties and regulatory action.

Texas' Approach to AI Disclosure, Oversight, and Utilization by Health Care Providers

Under the Texas Responsible Artificial Intelligence Governance Act ([HB 149](#), TRAIGA), signed into law on June 22,

2025, and effective January 1, 2026, health care providers must disclose to patients or their personal representatives when AI systems are used in diagnosis or treatment. This disclosure must be made before or at the time of interaction in clinical settings, except in emergencies, when it must be provided as soon as reasonably possible. The law is designed to ensure patients are fully informed about the involvement of AI in their care and allow them to make decisions accordingly. TRAIGA also includes a cure period, in which the company has 60 days after the receipt of a written notice of violation from the state attorney general to cure the alleged violation, provide supporting documentation to show the manner in which the violation was cured, and make any necessary changes to internal policies to prevent further such violations. However, it is unclear whether the failure to timely disclose AI use in diagnosis or treatment will be deemed curable under this mechanism.

Additionally, [SB 1188](#), effective September 1, 2025, imposes further requirements on providers using AI in diagnostic contexts. Licensed practitioners may use AI to support diagnosis and treatment planning only if all AI-generated records are reviewed to ensure the data is accurate and properly managed. Providers must review any AI-generated recommendations and retain ultimate responsibility for clinical decisions.

Healthtech companies and AI providers should ensure their systems enable clear patient disclosures for diagnosis or treatment, support practitioner oversight,

and comply with all licensure and record review requirements under Texas Medical Board standards. These laws may require product modifications, enhanced transparency features, and ongoing collaboration with legal and compliance teams. On August 18, 2025, Texas Attorney General Ken Paxton opened an investigation into AI chatbot platforms for potentially engaging in deceptive trade practices and misleadingly marketing themselves as mental health tools, signaling heightened enforcement risk for companies operating in this space.

Compliance Decision Models

The evolving patchwork of state laws creates a complex compliance landscape for AI deployment in mental health and healthcare. Each statute draws clear boundaries between what is permitted, restricted, or prohibited, often hinging on the AI system's function and the degree of human oversight. The following decision models may help organizations evaluate the applicability of these laws to their products and practices.

California

Key Question	If Yes, How It Affects Compliance
Does your AI system use professional titles or post-nominal letters (e.g., M.D., D.O., R.N.)?	Likely prohibited unless licensed oversight is present; may trigger investigation.
Does the AI interface imply professional authority (e.g., icons, tone, terminology)?	Prohibited unless there is a licensed professional; each

Key Question	If Yes, How It Affects Compliance
	instance could be a separate offense.
Is the AI marketed as providing care from licensed professionals?	Misrepresentation is prohibited; marketing language must be carefully vetted.
Is there licensed medical oversight for the AI system?	Oversight may allow AI use but must be clearly disclosed.
Is the AI used only for administrative support (e.g., scheduling)?	Permitted, but must avoid misleading design or terminology.

Illinois

Key Question	If Yes, How It Affects Compliance
Does your product diagnose, treat, or support mental health conditions?	Product is likely considered therapy and must comply with WOPRA.
Does the AI interact with users in an emotional or therapeutic context (e.g., conversations)?	Likely prohibited unless a licensed provider is directly involved and specific consent is obtained.
Is the AI used only for administrative or back-end support with oversight from a licensed professional?	Permitted, but requires informed consent and confidentiality protections.

Key Question	If Yes, How It Affects Compliance
Is the service framed as “wellness” or “health coaching” with no clinical language or claims?	Possibly outside WOPRA’s scope, but marketing language must be carefully vetted.
Are licensed professionals directly supervising the AI’s therapeutic output?	Permitted, but professional review, documented consent, and confidentiality compliance are critical during use.

Nevada

Key Question	If Yes, How It Affects Compliance
Does your AI system provide or claim to provide mental/behavioral health care?	Prohibited; violations may result in penalties up to \$15,000 per instance.
Is the AI used for administrative support (e.g., scheduling, billing)?	Permitted, but outputs must be independently reviewed for compliance.
Is the AI used in technical platforms or public schools for counseling?	Prohibited; schools may only use AI for administrative tasks.
Does the AI use titles like “therapist,” “psychiatrist,” or similar?	Prohibited; misleading titles or claims are not allowed.
Are clinical decisions made by AI without human review?	Prohibited; all decisions must be made by licensed practitioners.

Texas

Key Question	If Yes, How It Affects Compliance
Was AI used in diagnosis or treatment of a patient?	Permitted, so long as disclosure to the patient or their representative is made before or during interaction, unless in emergencies.
Was the disclosure made clearly and timely?	Required; failure to disclose may violate TRAIGA and trigger enforcement actions.
Are AI-generated records reviewed by the provider?	Required; the provider must review all AI outputs per Texas Medical Board standards.
Is the AI marketed as a mental health tool without oversight?	Prohibited; may trigger investigation for deceptive trade practices.

Strategic Considerations for Product Development and What's Next for Healthcare AI Regulation

Given these regulatory developments, healthtech companies and AI providers should consider embedding compliance considerations into early-stage product design, rather than treating them as post-launch modifications. Companies should consider conducting comprehensive audits to classify all AI tools as administrative, supplementary, or potentially therapeutic, and implement geofencing controls to disable prohibited features for users in regulated states.

The emphasis on clear disclosure and transparency creates opportunities for companies to build competitive advantages through proactive compliance. Healthtech companies and products that clearly communicate AI capabilities and limitations, implement explainable decision pathways, and engage licensed practitioners in development processes may find stronger market acceptance as regulatory scrutiny intensifies.

The future belongs not to the fastest AI innovators, but to those who earn and maintain public trust through responsible development and deployment practices.

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AI Integration and Regulatory Compliance in Healthcare

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By Isaac Stovall

The emergence of Artificial Intelligence and Machine Learning (“AI/ML”) in recent years has drastically reshaped a wide range of industries, with the healthcare field being no exception. Healthcare systems have been implementing AI/ML technologies for assistance with clinical decision-making, improvement of the efficiency of administrative tasks, and as a tool for diagnostic and medical testing.

[1]

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developers and vendors, HIPAA requirements of patient data protection and limits on disclosure without patient authorization apply to “business associates,” which are entities that a covered entity may contract with to carry out certain functions, which could include many of the tasks that AI/ML models are already being used for today. Experts have highlighted a few compliance issues that could arise when integrating AI/ML models into healthcare systems, including that healthcare AI/ML models are trained on patient datasets, and the collection by a third-party vendor may make such data vulnerable to being intercepted by malicious actors. [3] Additionally, although such patient data is de-identified, scholars have discussed the issue of this data being re-identified when large tech companies gain access to it when they themselves integrate AI/ML models into their own technologies. [4]

Other various laws could potentially implicate the use of AI/ML technologies in healthcare systems, including the Federal Food, Drug, and Cosmetic Act (FDCA). [5] These technologies will often be used in a manner that classifies them as a “medical device” for the purposes of the FDCA, which, in pertinent part, defines medical devices as technologies that can be used in the diagnosis or treatment of disease or other conditions. [6] Therefore, AI developers will need to make submissions for approval by the Food and Drug Administration (“FDA”). The FDA has issued various documents to guide AI vendors as they develop and market their devices, and the agency has already approved the use of over 1,000 AI technologies as medical devices. [7]

AI/ML technologies hold great promise in revolutionizing healthcare delivery. Remaining cognizant of HIPAA, FDCA, and other laws and regulations that govern health systems will be essential in maximizing the potential of these models in this

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[2] 45 C.F.R. § 160.103 (2024).

[3] See DOUGLAS MCNAIR & W. NICHOLSON PRICE II, HEALTH CARE ARTIFICIAL INTELLIGENCE: LAW, REGULATION, AND POLICY, IN ARTIFICIAL INTELLIGENCE IN HEALTH CARE: THE HOPE, THE HYPE 1, 222 (Michael Matheny, Sonoo Thadaney Israni, Mahnoor Ahmed & Danielle Whicher eds., 1990).

[4] See Delaram Rezaeikhonakdar, *AI Chatbots and Challenges of HIPAA Compliance for AI Developers and Vendors*, 51 J. L. MED. ETHICS, March 2024, at 988, 991.

[5] See *FDA Issues Comprehensive Draft Guidance for Developers of Artificial Intelligence-Enabled Medical Devices*, UNITED STATES FOOD AND DRUG ADMIN. (Jan. 6, 2025), <https://www.fda.gov/news-events/press-announcements/fda-issues-comprehensive-draft-guidance-developers-artificial-intelligence-enabled-medical-devices>

[6] 21 U.S.C. § 321(h)(1)

[7] See U.S. FOOD & DRUG ADMINISTRATION, ARTIFICIAL INTELLIGENCE/MACHINE LEARNING (AI/ML)-BASED SOFTWARE AS A MEDICAL DEVICE (SAMD) ACTION PLAN , <https://www.fda.gov/media/145022/download?attachment;%20https://www.fda.gov/regulatory-information/search-fda-guidance-documents/artificial-intelligence-enabled-device-software-functions-lifecycle-management-and-marketing> (last visited Sep. 24, 2025); U.S. FOOD & DRUG ADMINISTRATION, PROPOSED REGULATORY FRAMEWORK FOR MODIFICATIONS TO ARTIFICIAL INTELLIGENCE/MACHINE LEARNING

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Among psychologists, AI use is up, but so are concerns

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Two-thirds of psychologists worry artificial intelligence tools may bring data breaches, unanticipated harm to society

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WASHINGTON — More than half of psychologists experimented with artificial intelligence tools in their practices in the past year, but almost all cite concerns about how the technology may affect their patients and society, according to the [American Psychological Association's 2025 Practitioner Pulse Survey \(/pubs/reports/practitioner/2025\)](#).

This annual survey, conducted by APA and its companion organization, APA Services, Inc., was completed by 1,742 psychologists in September 2025. It found that 56% of psychologists reported using AI tools to assist with their work at least once in the past 12 months, up from 29% in 2024. And close to three in 10 psychologists (29%) said they used AI on at least a monthly basis—more than twice as many who said the same in 2024 (11%). These technologies can support psychologists in various ways, from providing administrative support to augmenting clinical care.

However, as psychologists grow more familiar with AI, they are also becoming more attuned to its potential risks. More than nine in 10 psychologists (92%) cited concerns about the use of AI tools in psychology, most commonly potential data breaches (67% vs. 59% in 2024), unanticipated social harms (64% vs. 54%), biases in the input and output (63% vs. 54%), a lack of rigorous testing to mitigate risks (61% vs. 51%) and inaccurate output or “hallucinations” (60% vs. 44%).

“Artificial intelligence can help ease some of the pressures that psychologists are facing—for instance, by increasing efficiency and improving access to care—but human oversight remains essential,” said APA CEO Arthur C. Evans Jr., PhD. “Patients need to know they can trust their provider to identify and mitigate risks or biases that arise from using these technologies in their treatment.”

While 38% of psychologists worried that AI may make some of their job duties obsolete in the future, few psychologists are relying on AI to help with the complex tasks required to treat their patients. Approximately one in 10 psychologists who used AI (8%) said that they used it to assist with clinical diagnosis, and only 5% said they used chatbot assistance for patients or clients.

Among psychologists who used AI to assist with their work, the most common uses included assistance with writing emails and other materials (52%), generating content (33%), summarizing clinical notes or articles (32%) and note-taking (22%)—routine tasks that often demand time and energy from psychologists that they'd rather spend with patients. Overall, more than three in five psychologists (62%) said that advancements in technology are helping them work more efficiently and accurately.

“Psychologists are drawn to this field because they’re passionate about improving people’s lives, but they can lose hours each day on paperwork and managing the often byzantine requirements of insurance companies,” said Evans. “Leveraging safe and ethical AI tools can increase psychologists’ efficiency, allowing them to reach more people and better serve them.”

Before using AI tools to assist with clinical care, [APA recommendations for psychologists \(PDF, 458KB\)](#) (</topics/artificial-intelligence-machine-learning/ethical-guidance-professional-practice.pdf>) include:

- Obtain informed consent from patients by clearly communicating the use, benefits and risks of AI tools.
- Evaluate AI tools for potential biases that could potentially worsen disparities in mental health outcomes.
- Review AI tools to check for compliance with relevant data privacy and security laws and regulations.
- Understand how patient/client data are used, stored or shared by companies that provide AI tools.

Despite the use of new technology to manage administrative burdens, the survey revealed that psychologists continue to struggle with insurance requirements and demands for treatment. Fewer than two-thirds of psychologists (62%) said that they accept some form of insurance, often because of insufficient reimbursement rates and struggles with pre-authorization requirements, audits and other administrative issues.

And while psychologists’ stress levels and work-life balance have improved since the onset of the COVID-19 pandemic, nearly half of all psychologists said that they do not have openings for new patients (46%) and that their patients’ symptoms are increasing in severity (45%), indicating that the mental health crisis is not resolved yet.

Methodology

The APA Practitioner Pulse Survey series has been conducted annually since 2020. The survey was conducted online and distributed via email using a probability-based random sample. Invitations were sent to a sample of 30,000 on September 3, 2025, and several reminder emails were sent to encourage survey completion. The survey closed on September 29, with a completion rate of 6.6%. [A full methodology is available \(PDF, 250KB\)](#) (</pubs/reports/practitioner/2025/methodology.pdf>).

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Study participants likened Dartmouth's AI-powered "Therabot" to working with a therapist.



Geisel School of Medicine professors Michael Heinz, left, and Nicholas Jacobson led the first clinical trial of any generative-AI therapy chatbot with their Therabot software. (Graphic by Katie Lenhart)



3/27/2025

Dartmouth researchers conducted the first-ever clinical trial of a generative AI-powered therapy^{Morgan Kelly} chatbot and found that the software resulted in significant improvements in participants' symptoms, according to results **published March 27 in NEJM AI**.

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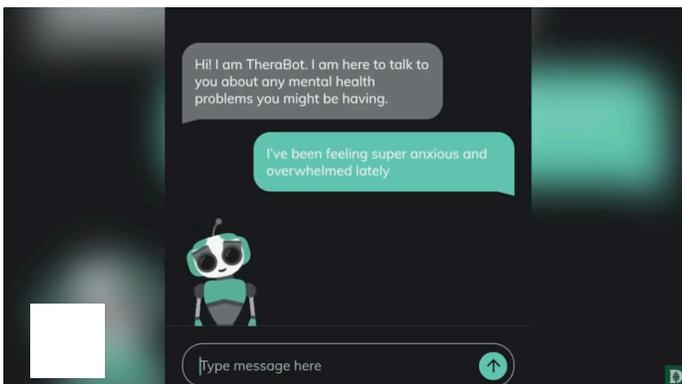
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People in the study also reported they could trust and communicate with the system, known as Therabot, to a degree that is comparable to working with a mental health professional.

The trial consisted of 106 people from across the United States diagnosed with major depressive disorder, generalized anxiety disorder, or an eating disorder. Participants interacted with Therabot through a smartphone app by typing out responses to prompts about how they were feeling or initiating conversations when they needed to talk.

People diagnosed with depression experienced a 51% average reduction in symptoms, leading to clinically significant improvements in mood and overall well-being, the researchers report. Participants with generalized anxiety reported an average reduction in symptoms of 31%, with many shifting from moderate to mild anxiety, or from mild anxiety to below the clinical threshold for diagnosis.

Among those at risk for eating disorders—who are traditionally more challenging to treat—Therabot users showed a 19% average reduction in concerns about body image and weight, which significantly outpaced a control group that also was part of the trial.



This demonstration video shows Therabot responding to a user with generalized anxiety with open-ended dialog developed from therapy best practices. (Video courtesy of Michael

The researchers conclude that while AI-powered therapy is still in critical need of clinician oversight, it has the potential to provide real-time support for the many people who lack regular or immediate access to a mental-health professional.

“The improvements in symptoms we observed were comparable to what is reported for traditional outpatient therapy, suggesting this AI-assisted approach may offer clinically meaningful benefits,” says **Nicholas Jacobson**, the study’s senior author and an associate professor of biomedical data science and psychiatry at the **Geisel School of Medicine**.

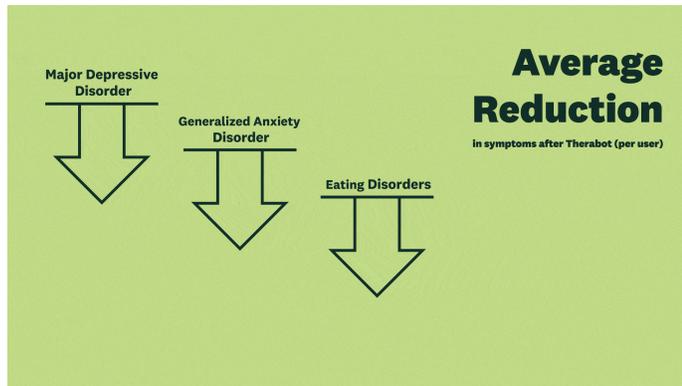
“There is no replacement for in-person care, but there are nowhere near enough providers to go around,” Jacobson says. For every available provider in the United States, there’s an average of 1,600 patients with depression or anxiety alone, he says.

“We would like to see generative AI help provide mental health support to the huge number of people outside the in-person care system. I see the potential for person-to-person and software-based therapy to work together,” says Jacobson, who is the director of the treatment development and evaluation core at Dartmouth’s **Center for Technology and Behavioral Health**.

Michael Heinz, the study’s first author and an assistant professor of psychiatry at CTBH and Geisel, says the trial results also underscore the critical work ahead before generative AI can be used to treat people safely and effectively.

“While these results are very promising, no generative AI agent is ready to operate fully autonomously in mental health where there is a very wide range of high-risk scenarios it might encounter,” says Heinz, who also is an attending psychiatrist at **Dartmouth Hitchcock Medical Center**. “We still need to better understand and quantify the risks associated with generative AI used in mental health contexts.”

Therabot has been in development in Jacobson's **AI and Mental Health Lab** at Dartmouth since 2019, and included continuous consultation with psychologists and psychiatrists affiliated with Dartmouth and Dartmouth Health.



Therabot users, all previously diagnosed with a mental health disorder, experienced significant improvements in symptoms after eight weeks. (Graphic by LaDarius Dennison)

When people initiate a conversation with the app, Therabot answers with natural, open-ended text dialog based on an original training set the researchers developed from current, evidence-based best practices for psychotherapy and cognitive behavioral therapy, Heinz says.

For example, if a person with anxiety tells Therabot they have been feeling very nervous and overwhelmed lately, it might respond, "Let's take a step back and ask why you feel that way." If Therabot detects high-risk content such as suicidal ideation during a conversation with a user, it will provide a prompt to call 911, or contact a suicide prevention or crisis hotline, with the press of an onscreen button.

The clinical trial provided the participants randomly selected to use Therabot with four weeks of unlimited access. The researchers also tracked the control group of 104 people with the same diagnosed conditions who had no access to Therabot.

Almost 75% of the Therabot group were not under pharmaceutical or other therapeutic treatment at the time. The app asked about people's well-being, personalizing its questions and responses based on what it learned during its conversations with participants. The researchers

evaluated conversations to ensure that the software was responding within best therapeutic practices.

After four weeks, the researchers gauged a person's progress through standardized questionnaires clinicians use to detect and monitor each condition. The team did a second assessment after another four weeks when participants could initiate conversations with Therabot but no longer received prompts.

After eight weeks, all participants using Therabot experienced a marked reduction in symptoms that exceed what clinicians consider statistically significant, Jacobson says.

“We did not expect that people would almost treat the software like a friend. It says to me that they were actually forming relationships with Therabot.”

**NICHOLAS JACOBSON, ASSOCIATE PROFESSOR OF
BIOMEDICAL DATA SCIENCE AND PSYCHIATRY**

These differences represent robust, real-world improvements that patients would likely notice in their daily lives, Jacobson says. Users engaged with Therabot for an average of six hours throughout the trial, or the equivalent of about eight therapy sessions, he says.

“Our results are comparable to what we would see for people with access to gold-standard cognitive therapy with outpatient providers,” Jacobson says. “We’re talking about potentially giving people the equivalent of the best treatment you can get in the care system over shorter periods of time.”

Critically, people reported a degree of “therapeutic alliance” in line with what patients report for in-person providers, the study found. Therapeutic alliance relates to the level of trust and collaboration between a patient and their caregiver and is considered essential to successful therapy.

One indication of this bond is that people not only provided detailed responses to Therabot's prompts—they frequently initiated conversations, Jacobson says. Interactions with the software also showed upticks at times associated with unwellness, such as in the middle of the night.

“We did not expect that people would almost treat the software like a friend. It says to me that they were actually forming relationships with Therabot,” Jacobson says. “My sense is that people also felt comfortable talking to a bot because it won't judge them.”

The Therabot trial shows that generative AI has the potential to increase a patient's engagement and, importantly, continued use of the software, Heinz says.

“Therabot is not limited to an office and can go anywhere a patient goes. It was available around the clock for challenges that arose in daily life and could walk users through strategies to handle them in real time,” Heinz says.

“But the feature that allows AI to be so effective is also what confers its risk—patients can say anything to it, and it can say anything back.”

The development and clinical testing of these systems need to have rigorous benchmarks for safety, efficacy, and the tone of engagement, and need to include the close supervision and involvement of mental-health experts, Heinz says.

“This trial brought into focus that the study team has to be equipped to intervene—possibly right away—if a patient expresses an acute safety concern such as suicidal ideation, or if the software responds in a way that is not in line with best practices,” he says. “Thankfully, we did not see this often with Therabot, but that is always a risk with generative AI, and our study team was ready.”

In evaluations of earlier versions of Therabot more than two years ago, more than 90% of responses were consistent with therapeutic best-practices, Jacobson says. That gave the team the confidence to move forward with the clinical trial.

“There are a lot of folks rushing into this space since the release of ChatGPT, and it’s easy to put out a proof of concept that looks great at first glance, but the safety and efficacy is not well established,” Jacobson says. “This is one of those cases where diligent oversight is needed, and providing that really sets us apart in this space.”

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Original Paper

Your Robot Therapist Will See You Now: Ethical Implications of Embodied Artificial Intelligence in Psychiatry, Psychology, and Psychotherapy

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Abstract

Background: Research in embodied artificial intelligence (AI) has increasing clinical relevance for therapeutic applications in mental health services. With innovations ranging from ‘virtual psychotherapists’ to social robots in dementia care and autism disorder, to robots for sexual disorders, artificially intelligent virtual and robotic agents are increasingly taking on high-level therapeutic interventions that used to be offered exclusively by highly trained, skilled health professionals. In order to enable responsible clinical implementation, ethical and social implications of the increasing use of embodied AI in mental health need to be identified and addressed.

Objective: This paper assesses the ethical and social implications of translating embodied AI applications into mental health care across the fields of Psychiatry, Psychology and Psychotherapy. Building on this analysis, it develops a set of preliminary recommendations on how to address ethical and social challenges in current and future applications of embodied AI.

Methods: Based on a thematic literature search and established principles of medical ethics, an analysis of the ethical and social aspects of currently embodied AI applications was conducted across the fields of Psychiatry, Psychology, and Psychotherapy. To enable a comprehensive evaluation, the analysis was structured around the following three steps: assessment of potential benefits; analysis of overarching ethical issues and concerns; discussion of specific ethical and social issues of the interventions.

Results: From an ethical perspective, important benefits of embodied AI applications in mental health include new modes of treatment, opportunities to engage hard-to-reach populations, better patient response, and freeing up time for physicians. Overarching ethical issues and concerns include: harm prevention and various questions of data ethics; a lack of guidance on development of AI applications, their clinical integration and training of health professionals; ‘gaps’ in ethical and regulatory frameworks; the potential for misuse including using the technologies to replace established services, thereby potentially exacerbating existing health inequalities. Specific challenges identified and discussed in the application of embodied AI include: matters of risk-assessment, referrals, and supervision; the need to respect and protect patient autonomy; the role of non-human therapy; transparency in the use of algorithms; and specific concerns regarding long-term effects of these applications on understandings of illness and the human condition.

Conclusions: We argue that embodied AI is a promising approach across the field of mental health; however, further research is needed to address the broader ethical and societal concerns of these technologies to negotiate best research and medical practices in innovative mental health care. We conclude by indicating areas of future research and developing recommendations for high-priority areas in need of concrete ethical guidance.

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KEYWORDS

artificial intelligence; robotics; ethics; psychiatry; psychology; psychotherapy; medicine

Introduction

Research in embodied artificial intelligence (AI) has increasing clinical relevance for therapeutic applications in mental health services, that is, in psychiatry, psychology, and psychotherapy. Innovations range from ‘virtual psychotherapists’ [1] to social robots in dementia care and autism disorder [2] and robots for sexual disorders [3]. Increasingly, artificially intelligent virtual and robotic agents are not only available for relatively low-level elements of mental health support, such as comfort or social interaction, but also perform high-level therapeutic interventions that used to be offered exclusively by highly trained, skilled health professionals such as psychotherapists [4]. Importantly, such ‘virtual’ or ‘robotic therapists’ include an artificially intelligent algorithm that responds independently of any expert human guidance to the client or patient through a virtually embodied presence, such as a face icon, or a physically embodied presence, such as a robotic interface. As such, these emerging applications are distinct from the many varieties of Web-based therapy, which usually involve either a human therapist, albeit remotely (telemedicine), or the patient herself, working independently with manuals, questionnaires, or other self-help materials [5].

Embodied AI applications in mental health care carry hopes of improving quality of care and controlling expenditure [6]. In addition, they also hold the promise of reaching underserved populations in need of mental health services and improving life opportunities for vulnerable groups. However, there is a persistent gap between current, rapid developments in AI mental health and the successful adoption of these tools into clinical environments by health professionals and patients. In addition, it has been demonstrated that the interventions are often designed without any explicit ethical considerations [7]. Furthermore, although studies often examine the effectiveness or ethical use of a single application, rarely do they consider the implications for the integration of AI across the field of mental health more broadly. In this paper, we argue that virtually and physically embodied artificially intelligent agents and applications have great potential in mental health care. However, their societal and ethical implications require further probing to identify pertinent concerns surrounding trust, privacy, and autonomy, as well as to anticipate concerns that may arise in the future. Identifying the broader ethical and societal implications of embodied AI is crucial for negotiating best research and medical practices in innovative mental health care. We conclude by indicating areas of future research and identifying points in need of ethical caution.

Overview: Existing Embodied Intelligent Applications

Although AI-enabled virtual and robot therapy has long been used across a number of medical fields [8-10], the integration of AI through the use of embodied agents is still at an early stage in mental health care; it is arguably the most recent addition to psychotherapeutic practice, supporting a host of emotional, cognitive, and social processes [11]. In what follows,

we have sketched a range of applications with the aim of characterizing some of the embodied artificially intelligent innovations across the field of mental health. To maintain focus amid a broad and growing field, we have chosen to exclude from our analysis applications that are not intended to interact with patients, or that have no virtual presence or robotic interface; this includes AI-supported scanning and diagnostic tools. We have also excluded applications that may have a virtual or robotic interface but do not employ AI, such as telemedicine therapy (for further scholarship on this topic, please see [12-19]).

Virtually Embodied Artificially Intelligent Agents

AI-supported virtually embodied psychotherapeutic devices are currently developing at a rapid speed. For example, therapeutic apps such as Tess and other “chatbots” such as Sara, Wysa, and Woebot, which work over short message service text messaging, WhatsApp, or internet platforms, are being explored for addressing depression and anxiety. These applications come with interactive screen presences. Woebot and other programs engage with the patient like a virtual psychotherapist, with the aim of helping patients to recognize their emotions and thought patterns and to develop skills such as resilience or techniques for reducing anxiety. For example, using natural language processing, Tess is programmed to flag expressions that indicate emotional distress. Often cited as a digital tool to reach underserved populations across the world that lack mental health services, the bots can explain to users the clinical terms for what they are experiencing—such as cognitive distortions—or provide concrete advice for recognizing and dealing with difficult situations [20]. Initial studies found that depression symptoms decreased with the use of Woebot more than groups who relied on electronic book resources [21], and another study found that Tess helped to reduce depression and anxiety among users [20].

A similar approach involves the use of avatars, such as the Avatar Project, for addressing persistent auditory hallucinations for patients with psychosis [22]. These usually involve computer-generated images of faces on computer screens or tablets that interact with a patient via intelligent algorithms. Avatars are also being explored in treatment of schizophrenia, for example, to improve medication adherence [23]. Similar to the Avatar Project, virtual reality–assisted therapy for schizophrenia often encourages patients to engage with the voices they hear through the use of an AI avatar. Initial studies found that the therapy could help in developing therapeutic targets [24] and also in particularly difficult cases of schizophrenia [25]. Another study found improvements in auditory visual hallucinations, symptoms of depression, and overall quality of life following therapy sessions for treatment-resistant schizophrenia patients [26]. ‘Avatar coaches’ have also been employed as part of an immersive virtual reality situation for treating the fear of heights [27] or as ‘virtual patients’ to provide medical students with lifelike interviewing practice [28]. Finally, avatars are also being implemented in risk prevention education, such as the Kognito program, which

uses an avatar to help college students and faculty identify others at risk for suicide [29].

Artificially Intelligent Robot Therapy

In addition to these virtually embodied therapeutic applications, clinicians and scientists are exploring the translation of innovations at the intersection of AI and robotics into the clinic. For example, intelligent animal-like robots such as Paro, a fuzzy harp seal, are increasingly being used to help patients with dementia. Paro, along with the large furry eBear, is part of a class of ‘companion bots,’ engaging individuals as at-home health care assistants, responding to speech and movement with dynamic ‘dialog’, or seeking to help elderly, isolated, or depressed patients through companionship and interaction. Several studies have examined the role of such robots in reducing stress, loneliness, and agitation and in improving mood and social connections [30,31]. Thus far, the outcomes are promising [32,33].

AI robots also provide opportunities for different forms of engagement with children suffering from autism spectrum disorders (ASDs) [34]. Children with autism have been found to react positively to robots, even in cases where they have trouble interacting with others [35]. The Kaspar robot has demonstrated potential for integration in current education and therapy interventions [36] and is being investigated for the potential to improve social skills among children [37]. Similarly, RoboTherapy is an example of socially assistive robotics designed to help children with ASDs to develop social skills, and the robot Nao is designed to improve facial recognition and appropriate gaze response. The aim of such robotic interaction is to learn appropriate social skills (eg, imitation, taking turns, staying engaged, and empathy), with the hope that children can then apply the skills learned with the robot peer to their relationships with human peers. Initial studies are promising; individuals with ASDs performed better with their robot partners than human therapists, responded with social behaviors toward robots, and improved spontaneous language during therapy sessions [38]. However, the devices are still being developed and are not yet in wider therapeutic use.

AI-enabled robots are also being explored across a variety of other mental health areas including mood and anxiety disorders, children with disruptive behavior, and patients who may not have a specific diagnosis but who would benefit from assistance with mental health concerns [39]. Perhaps, most controversially, artificially intelligent robots have entered the field of human sexuality. Companies are now offering adult sex robots such as Roxxy, which can speak, learn their human partners’ preferences, register touch, and provide a form of intimate companionship. Although the range of medical applications that sex robots can reportedly address remains debated, these include meeting the sexual needs of disabled and elderly individuals or as part of therapy for concerns such as erectile dysfunction, premature ejaculation, and anxiety surrounding sex [40]. Furthermore, some researchers have asked if sex robots could help to reduce sex crimes such as rape and assault or be used for treatment of paraphilia, such as pedophilia [3,41].

Methods

Based on a thematic literature analysis and established principles of medical ethics, an analysis of the ethical and social aspects of currently embodied AI applications was conducted across the fields of Psychiatry, Psychology, and Psychotherapy. To enable a comprehensive evaluation, the analysis was structured around the following three steps: assessment of potential benefits; analysis of overarching ethical issues and concerns; discussion of specific ethical and social issues of the interventions.

Results

Ethical and Social Implications and Concerns

The devices and applications described above have yet to be integrated into widespread clinical use. However, in view of the speed of research and development trajectories of these applications, it is reasonable to expect that therapeutic chatbots, avatars, socially assistive devices, and sex robots will soon translate into broader clinical applications in earnest. In some cases, initial ethical assessments are already available [42,43]; however, most of these studies focus on a single application. In general, for most of the applications we are discussing, large-scale rigorous research studies have not yet been conducted or are still in pilot stages [44-47]. Even in Web-based non-AI applications, evidence of patient acceptance and treatment outcomes in routine care is still limited and mixed [48,49]; there has so far been very little research on patient acceptance and contingent treatment outcomes of embodied AI applications in mental health fields. As with any medical innovation, the effects, impacts, and clinical utility of the applications can only be fully assessed once evidence has improved [50,51].

To enable responsible and responsive innovation and clinical translation into the field of mental health, further and more in-depth analysis of the ethical and social implications of embodied AI is necessary to flag areas of concern. Early identification of ethical issues can help researchers, designers, and developers consider these concerns in the design and construction of the next generation of AI agents and robots for mental health. In the following sections, we have provided an analysis of benefits, challenges, and risks of embodied AI in mental health from an ethical perspective. Beginning with a discussion of potential benefits, we have then turned to risks and challenges, followed by immediate concerns in clinical application and long-term effects.

Anticipated Benefits

All of the aforementioned intelligent applications promise significant benefits for the field of mental health, satisfying many aspects of the ethical principle of beneficence [52]. From a clinical point of view, the use of embodied AI applications holds the potential to open new avenues for intervention in places where there are still significant unmet health needs. AI interventions might be particularly well placed for detecting mental health concerns early on, for reaching high-risk groups such as veterans, or for those who are concerned about the social

stigma associated with psychotherapy [53]. In some cases, patients may respond positively and productively to the fact that the counterpart is *not* a human therapist [54-56]. In one study, subjects overwhelmingly preferred the virtual agent over the human counterpart when being discharged from the hospital because they could self-direct the pace of information—something that is especially important for low-literacy patients [57]. Thus, in mental health services, nonhuman virtual or robotic applications might be preferable for some patients, reducing embarrassment when asking for specific information or services or feelings of shame when admitting noncompliance with a treatment plan. Embodied AI in mental health could also help to empower particular patient groups (such as those who are less familiar with the medical system), thereby helping to improve trust and openness between patients and the medical system. Another important advantage of AI applications is that many of them are low-threshold and self-administered, such that people who do not have an acute condition can elect services without going through the time-consuming process of being screened and admitted into the health care system.

Arguably, the greatest benefit of AI applications is structural, namely the potential to reach populations that are difficult to treat via traditional routes of provision. The provision of some mental health services, for example, through low-threshold, convenient therapeutic interventions via chatbots or avatars may be particularly beneficial for populations living in resource-poor settings. For those living in remote or rural locations or in settings where on-site mental health services are scarce, intelligent applications can increase geographical access and provide some minimal mental health care services where they are otherwise absent. The same may also be true for individuals living in higher income countries who do not have insurance or whose insurance does not cover therapy. Furthermore, it is likely that there are individuals who, for various reasons, do not respond to more traditional clinical services and might prefer low-threshold interventions that can be conducted in the privacy of their homes or on the go. For all of these patients, AI applications could complement existing services or constitute an entry point for pursuing more standard clinical interventions in the future.

In sum, embodied AI interventions may offer entirely new modes of treatment that are potentially more successful than traditional modalities either because they address hard-to-reach populations or because patients respond better to them. Whether, and for which conditions this is the case, requires further investigation. However, given that broadly speaking, conditions such as ASD and sexual dysfunction are increasing in incidence and patient populations with these and many other mental health conditions continue to have unmet health needs [58-62], increased exploration of embodied AI in these fields is promising.

Finally, there are also clear benefits of having a virtual or robotic therapist that is always accessible, has endless amounts of time and patience, never forgets what a patient has said, and does not judge [63,64], thus potentially offering a service that is highly reliable and particularly well-suited to certain patient populations. If integrated into a scaled provision of services,

AI-enabled applications could provide support for mild cases of depression and other nonacute conditions [65], therefore helping health professionals to devote more time to the most severe cases. In view of overall increasing burden of illness in mental health and against a background of limited resources, these are important benefits to consider. However, it is likely that embodied AI may not be warmly received by all mental health care professionals, and some may even have serious misgivings about its use because of ethical or clinical concerns. Thus far, there has been no substantial review of the reception of AI across or within specific mental health fields, marking an area in need of further research.

Overarching Ethical Concerns

Harm Prevention and Data Ethics Issues

To satisfy the well-established ethical principle of nonmaleficence, more robust research is needed on embodied AI applications in mental health to prevent harm both within therapeutic encounters and in cases where robots could malfunction or operate in unpredictable ways. For instance, in interviewing respondents working with AI robotic technologies, Cresswell et al discuss an example of a woman who was stuck in an elevator with a robot and another who was run over by a robot [6]. Chatbots and avatars could also stop working or malfunction. Hence, it needs to be discussed if embodied AI devices—potentially including virtual agents and freely available mental health applications—should require the same kind of rigorous risk assessment and regulatory oversight that other medical devices are subject to before they are approved for clinical use.

Similar to other devices employed in medical settings, the use of any AI applications in mental health care requires careful consideration surrounding data security of devices that communicate personal health information, the ways that the data generated is used, and the potential for hacking and nonauthorized monitoring [66,67]. Clear standards are needed on issues surrounding confidentiality, information privacy, and secure management of data collected by intelligent virtual agents and assistive robots as well as their use for monitoring habits, movement, and other interactions [68,69]. Concerns around privacy may be amplified as the amount of data collected continues to expand; for example, we anticipate that applications that integrate video data would need to have specific privacy protections in place for the communication of sensitive information, or information pertaining to individuals other than the consenting patient.

Lack of Guidance on Development, Clinical Integration, and Training

With embodied AI being one of the newest and most rapidly changing areas of psychological and psychiatric research and treatment, existing legal and ethical frameworks are often not closely attuned to these changes. Rather than providing regulatory guidance, there is the risk that the ‘gaps’ between application and ethical frameworks would only be addressed once harm had already occurred [6]. Again, this is the case with many forms of emerging medical technologies; however, in view of the rapid pace of translation of embodied AI into

practice in settings where traditional health technology assessment and medical oversight systems are not fully applicable—for example, through freely available therapy chatbots—this is an important concern. Although anticipating the ethical and legal questions that will emerge alongside future developments is difficult, active reflection on the ‘regulatory fit’ for embodied mental health AI is necessary. Initiatives for establishing guidelines are emerging, including the online collaboratively generated document “Moral Responsibility for Computing Artifacts: The Rules,” or the recent “An Ethical Framework for a Good AI Society: Opportunities, Risks, Principles, and Recommendations” [70]. However, thus far, no guidance exists that is specific to the field of mental health services; pointing to the need for the development of further recommendations to better guide advances in this area.

In addition to a lack of guidance on the development of these interventions for design, use, and regulatory questions, so far, there are also no frameworks available on how medical professionals can effectively engage with and train for increased use of embodied AI in the clinic; that is, although there is an increasing body of both academic and popular literature on how embodied AI can be integrated into clinical practice in mental health, there remains a lack of high-level guidance from professional bodies on the best use of AI in mental health services [15,71-73]. There are also no recommendations available on how to train and prepare young doctors for a mental health field in which such tools will increasingly be used by patients. Thus, further ethical guidelines are needed that are specific to assisting mental health professionals who will be supervising patients who have, or possibly will, engage with AI services.

Potential for Misuse to Reduce Service Provision

An ethically informed integration of AI should also consider questions of a just provision of mental health care [52]. There is the worry that the incorporation of embodied AI in mental health could be a justification for replacing established services, resulting in fewer available health resources or principally AI-driven services, thereby potentially exacerbating existing health inequalities. Many proponents insist that although informed by evidence-based psychotherapeutic approaches, chatbots, for instance, are not intended to replace therapists entirely. In some cases, forms of ‘blended’ care involving both in-person and virtual forms of therapy are being explored [74], which might also be appropriate for intelligent applications. Blended care models potentially offer the opportunity to draw on the strengths of both AI applications and in-person clinical supervision. However, whether or not it is appropriate to implement AI applications in mental health care depends in part on the availability of other resources in that area. As noted, in cases with limited mental health services, AI applications could provide a needed resource that is decidedly better than no services at all. However, at this point, AI mental health services are not a substitute or a stand-in for the kind of robust, multitiered mental health care available in high-resource health care systems. Appropriately considering the status quo of mental health resources in each context is thus highly relevant from an ethical perspective [75]. Otherwise, AI tools in mental health could be used as an excuse for reducing the provision of

high-quality, multilayered care by trained mental health professionals in low-resource settings.

Discussion

Specific Challenges in Application

Risk-Assessment, Referrals, and Supervision

Considering the application of embodied AI tools in mental health practice, a host of specific challenges need to be kept in mind: mental health professionals have an ethical responsibility to inform other service providers as well as third parties or authorities if a patient indicates that they are a threat to themselves or to another individual. How this would work in artificially intelligent interventions, particularly when there is no supervision of the interaction between the AI agent and the patient by a qualified health professional, remains to be determined. It is unclear when, and how, assistive robots that patients have in their homes, or freely available virtual agents and chatbots, would effectively connect at-risk individuals with appropriate services, including hospitalization and other protections. This scenario is particularly relevant in the aforementioned situation of using AI mental health applications to extend access to rural, hard to reach, or uninsured populations. In these cases, some provision of service is arguably better than nothing. However, what should be done if, for example, a therapy bot detects through speech patterns that an individual is at higher risk for self-harm, yet appropriate referral services are not available in the area?

AI applications engaged in therapeutic relationships with clients will likely also need to be bound by similar ethical guidelines as those that bind mental health professionals. However, so far, how an AI duty of care or a code of practice on reporting harm should be operationalized is entirely unclear. An obvious suggestion would be to always mandate supervision through a qualified mental health clinician—when a human therapist evaluates a patient’s expression of self-harm, she also considers contextual information in her interpretation of the level of risk. Whether, and to what degree, robotic therapists are able to do this remains unclear. However, many AI applications are available outside established mental health settings; in addition, the capacity of computerized methods to identify and predict psychiatric illness are increasing [12,13], as are their skills of therapeutic interaction and communication. Thus, the question of whether supervision of embodied AI in health should always be provided, and how such a requirement could be successfully implemented, remains a subject for further debate.

Respecting and Protecting Patient Autonomy

Another concern for the application of embodied AI in mental health practice centers on enabling and respecting patient autonomy [52]. These are novel technologies that require assessment to guarantee that patients fully understand how the application or avatar works in order to ensure that a patient does not misunderstand or mistake the intelligent system for a human-driven application. For instance, it would be problematic if a patient were to assume that ‘at the other end’ of the chatbot there is a doctor communicating or reviewing her messages. Furthermore, obtaining consent for applications used outside

of medical systems raises thorny concerns. For instance, an elderly person or a person with intellectual disabilities may not be able to understand what a robot is or what a robot does when it is installed at home to monitor the patient's activities, risking privacy infringement [42], manipulation, and even coercion if the conditions for informed consent are not satisfied. Such questions make consenting to surveillance, interaction, and data collection with the robot challenging matters. Distinctions could be drawn between interventions that are seen as helping and monitoring, as opposed to those that run the risk of manipulation and coercion; however, these lines are often blurred both in theory and in practice [76]. How AI applications should evaluate if a patient has fully understood the information provided when giving consent, and how to proceed in cases where it is not possible for individuals to provide consent, such as children, patients with dementia, those with intellectual disabilities, or those in acute phases of schizophrenia, needs to be addressed.

Another area of particular concern in relation to matters of promoting autonomy in the use of AI in mental health care is the engagement of vulnerable populations. People have been shown to be more compliant when a robot asks them to do something as compared with a person [9]. Although this could lead to better results when helping patients with autism or those needing to make difficult behavioral changes, the concern exists that people could be manipulated or coerced into doing things that they should not or that they have not fully thought through, either because of the novelty of the device or because of a lack of companions with whom to discuss alternatives. Some studies have made a distinction between a "suspension of disbelief" when anthropomorphizing a robot caregiver and deception *per se* [42,77], but this is a line that requires further investigation in practice.

Nonhuman Therapy?

In general, the question remains as to whether there are aspects of the therapeutic encounter that cannot be achieved through AI. Some therapeutic benefits may be difficult to anticipate, or highly specific to a particular individual's relationship to his or her therapist. One study found that embodied conversational agents had difficulty evaluating a user's emotional state in a real-time dialog and that the absence of a human therapist in Web-based mental health interventions for treating depression and anxiety had a negative effect on user adherence to the programs [78]. In the treatment of insomnia, some patients indicated that they missed having a human therapist [79]. Relatedly, because robots and artificially intelligent systems blur previously assumed boundaries between reality and fiction, this could have complex effects on patients. Similar to therapeutic relationships, there is the risk of transference of emotions, thoughts, and feelings to the robot. In particular, given that many of the target populations are vulnerable because of their illness, age, or living situation in a health care facility, there is the additional concern that patients would be vulnerable in their engagements with the robot because of their desire for company or to feel cared for [80]. Unlike with a therapist, however, there is no person on the other side of this transference. Whether robot therapists will ever be able to deal adequately with such transference remains to be seen. Further concerns are likely to emerge in practice; thus, embodied AI therapeutic aids

need to also be evaluated carefully for unanticipated differences with standard therapy modalities.

Ethical Issues in Algorithms

It is necessary to note that AI mental health interventions work with algorithms, and algorithms come with ethical issues. It has been well-established that existing human biases can be built into algorithms, reinforcing existing forms of social inequality [81]. This raises the concern that AI-enabled mental health devices could also contain biases that have the potential to exclude or harm in unintended ways, such as data-driven sexist or racist bias or bias produced by competing goals or endpoints of devices [82,83]. Following other calls for transparency [84], the algorithms used in artificially intelligent applications for mental health purposes could be similarly open to scrutiny. This may require investing additional time in explaining to patients (and their families) what an algorithm is and how it works in relation to the therapy provided [85]. However, how to best do this, in particular with patients with compromised mental capacities, requires further consideration.

Concerns Regarding Long-Term Effects

Apart from these more immediate concerns, the implementation of embodied AI into mental health services also raises a number of broader questions regarding long-term impacts on patients, the mental health community, and society more widely. For instance, it has been noted that long-term use of AI interventions could lead to some patients or patient groups becoming overly attached to these applications. A study by Cresswell et al noted that robots that aim to alleviate loneliness or provide emotional comfort carry the risk that the patients they work with could become dependent on them [6]. More broadly, others have raised questions about ways that robots could contribute to changing social values surrounding care or situations in which caregiving is increasingly 'outsourced' to robotic aids. The impact of intelligent robots on relationships, both human-robot and human-human relationships, is an area that requires further probing, as do potential effects on identity, agency, and self-consciousness in individual patients. Specifically, research into the effectiveness of these applications needs to cover not only if the social skills of children with ASD are improved by working with robots but also their ability to apply these skills to relationships with other humans. Similarly, if a sex robot is provided therapeutically to an individual with paraphilia, the effects of this on the targeted behaviors with other humans also needs to be evaluated. The risk exists that if robotic interventions are not translatable to improving human interaction, that they merely remain a way of improving human relations with machines, or worse, an outlet that further limits human-to-human relationships. Similarly, engagement with embodied intelligent devices could also have important effects on the individual, such as on personal sense of identity or agency.

The integration of AI devices into our everyday lives and medical care is undoubtedly changing social expectations and practices of communication. There are essential differences between communicating with an AI device and communicating with another human. Anecdotal findings suggest that some users often speak to assistive devices such as Siri or Alexa in a curter or ruder manner than they would to a human [86]. Importantly,

perceptions of the devices can vary by users: children often understand these devices differently than adults, sometimes attributing human characteristics to the device or believing that the device has a real individual inside [87]. Extrapolating from this example, it is clear that the ways that individuals interact with the AI applications in their lives can have implications for communication and social interaction. How this will evolve as more patients have the opportunity to interact with AI applications as part of their mental health care requires further empirical investigation to catch problematic trends early and correct for future development.

A related concern of objectification exists for some areas of AI applications, such as sex robots. The use of ‘sexbots’ has already been notably controversial, with scholars objecting that sexual dysfunction depends on a range of physical, psychological, and sociocultural factors that are profoundly relational and reciprocal. Rather than addressing issues of isolation associated with sexual dysfunction, robots might aggravate it or contribute to reductionist understandings of sexual violence [88]. It has been cautioned that the use of sex robots—also available in childlike models or programmed with personalities such as “Frigid Farrah” to resist sexual advances—could instead increase the occurrence of sex crimes, normalize the production of social inequalities surrounding the male gaze [89], and contribute to unwanted sexual encounters. Furthermore, the creation of humanoid robots for use in sexual dysfunction raises concerns that it could reinforce or even legitimize the objectification of humans, in particular women and children [3,88]. As the use of AI in many therapeutic applications has not yet been validated in randomized controlled trials (RCTs), there is the risk that particular applications might make problems such as sexual violence worse. More broadly, embodied AI applications necessarily involve a relatively narrow understanding of illness. For instance, sex robots may help with some medical concerns but do not address other determinants of illness that would have to be taken into account from a bio-psycho-social understanding of mental health illness. Widespread AI use could thus exacerbate trends of reductionism in mental health.

Ideas around embodied AI are culturally and historically shaped. Whether providing motivational interviews in therapy [64], acting as embodied conversational agents for mental disorders [47], or working with populations with intellectual disabilities [90], discussion of embodied AI often turns to worries surrounding the limits of human control over technology. Conjuring images of the Terminator or other depictions of the nonhuman in science fiction or cinema, such tools can carry with them negative or scary associations that bring the issue of trust in medical practice into new light [6]. However, exposure to robotic devices, or living in places with positive or caring associations with robots, can influence the adoption of AI devices in different settings [91]. Initiatives that integrate embodied AI into health care practices need to be duly attuned to existing cultural understandings of the role of technology in social lives, and work to ensure that trust between patient and provider, or patient and the health care system, is not eroded.

Finally, AI agents for mental health raise fundamental questions about what it is to be human [6]. One of the principal contributions of science and technology studies scholarship has

been to show how humans do not simply act upon objects but rather our relationships with objects also alters, transforms, and imposes limits upon human activity [92]. Interaction with embodied AI agents, just like interaction with other individuals or a therapist, alters behaviors and understandings of the world. Although social relationships are characterized by reciprocity, relationships with intelligent devices are neither mutual nor symmetric. In particular, some have raised the concern that interacting more with artificial agents may lead some individuals to engage less with other people around them or to develop forms of intimacy with intelligent robots [93], raising concerns specific to the use of robots with children or those with intellectual disabilities. As mentioned, people develop attachments to objects and have been shown to also develop attachments to simpler robotic systems such as AIBO. Thus, it is likely that as more intelligent and autonomous devices are developed, human relationships with them will become even more complicated [94].

Conclusions

In light of the demonstrated benefits and potential, such as expanding the reach of services to underserved populations or enhancing existing services provided by mental health professionals, embodied AI has emerged as an exciting and promising approach across the field of mental health. At present, the quality of research on embodied AI in psychiatry, psychology, and psychotherapy is varied, and there is a marked need for more robust studies including RCTs on the benefits and potential harms of current and future applications.

This is still an emerging field, and any analysis of ethical implications can only be preliminary at this point. However, a few conclusions and recommendations are warranted, based on the considerations presented in this paper:

1. It is necessary to develop clear guidance on whether (and which) embodied AI applications should be subject to standard health technology assessment and require regulatory approval. This should include a set of broader provisions for the use of AI services outside the supervision of a health care professional.
2. Professional associations in mental health should develop guidelines on the best use of AI in mental health services as well as recommendations on how to train and prepare young doctors for wide-spread use of embodied AI in mental health, including blended care models.
3. AI tools in mental health should be treated as an additional resource in mental health services. They should not be used as an excuse for reducing the provision of high-quality care by trained mental health professionals, and their effect on the availability and use of existing mental health care services will need to be assessed.
4. To satisfy duties of care and reporting of harm, ideally embodied AI should remain under the supervision of trained mental health professionals. Any applications offered outside of mental health care settings, such as apps and bots, should be required to demonstrate reliable pathways of risk-assessment and referral to appropriate services.
5. Embodied AI should be used transparently. Guidance on how to implement applications in a way that respects patient

- autonomy needs to be developed, for example, regarding when and how consent is required and how to best deal with matters of vulnerability, manipulation, coercion, and privacy.
6. AI algorithms in mental health need to be scrutinized, for example, for bias. Ideally, health professionals should be trained in communicating to their patients the role of the algorithms used in different applications they might be using or consider using, and such algorithms should be open for public debate and shaping.
 7. Increased use of embodied AI should be accompanied by research that investigates both direct and indirect effects on the therapeutic relationship, other human-human relationships, and effects on individual self-consciousness, agency, and identity. Long-term effects, ranging from health reductionism to increased objectification and impacts on our understandings of what it means to be human, need to be monitored.

Conflicts of Interest

None declared.

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Abbreviations

AI: artificial intelligence

ASD: autism spectrum disorder

RCT: randomized controlled trial

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- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

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
Second Quarter Expenses	1/29/2026	Cover Memo
Second Quarter Revenues	1/29/2026	Cover Memo
ASPPB Midyear Meeting 2026	1/30/2026	Cover Memo
FARB 2026 Leadership Summit	1/30/2026	Cover Memo
ED Report	1/30/2026	Cover Memo

December 2025

	CURRENT ANNUAL BUDGET	AVAILABLE BALANCE	1ST QUARTER EXPENDED	2ND QUARTER EXPENDED	3RD QUARTER EXPENDED	4TH QUARTER EXPENDED	TOTAL YR TO DATE EXPENDED	% SPENT OF TOTAL BUDGET	SYSTEM PROJECTION- ENCUMBERED
PSYCHOLOGY OPERATIONS - FUND 1201 - H7V1111									
FULL - TIME SALARY	\$707,000.00	\$574,006.01	\$132,993.99	\$164,288.32	\$0.00	\$0.00	\$297,282.31	42.05%	\$409,717.69
PART-TIME, SEASONAL	\$94,000.00	\$76,034.88	\$17,965.12	\$23,337.95	\$0.00	\$0.00	\$41,303.07	44.00%	\$52,696.93
OVER-TIME PAY	\$5,000.00	\$5,000.00	\$0.00	\$268.57	\$0.00	\$0.00	\$268.57	5.37%	\$4,731.43
OTHER BENEFITS- PER DIEMS	\$20,000.00	\$18,768.00	\$1,232.00	\$2,250.00	\$0.00	\$0.00	\$3,782.00	19.00%	\$16,218.00
SPACE RENTAL, MAINT & UTIL	\$122,000.00	\$92,232.50	\$29,767.50	\$30,577.50	\$0.00	\$0.00	\$60,345.00	49.00%	\$61,155.00
PRINTING & ADVERTISING	\$5,000.00	\$4,997.25	\$2.75	\$6.86	\$0.00	\$0.00	\$9.61	0.00%	\$2,459.15
PROF/TECH SERVICES	\$90,000.00	\$90,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$6,000.00
IT PROF/TECH SERVICES	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted	\$0.00
COMPUTER/SYSTEM SERVICE	\$1,000.00	\$1,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$500.00
COMMUNICATIONS	\$5,000.00	\$4,880.46	\$119.54	\$942.60	\$0.00	\$0.00	\$1,062.14	21.00%	\$4,737.86
TRAVEL, IN STATE	\$20,000.00	\$20,023.33	(\$23.33)	\$4,553.05	\$0.00	\$0.00	\$4,529.72	23.00%	\$8,750.00
TRAVEL, OUT STATE	\$20,000.00	\$19,720.04	\$279.96	\$909.89	\$0.00	\$0.00	\$1,189.85	5.95%	\$6,550.00
EMPLOYEE DEVELOPMENT	\$20,000.00	\$18,010.00	\$1,990.00	\$348.00	\$0.00	\$0.00	\$2,338.00	11.69%	\$6,752.00
AGY PROVIDED PROF/TECH	\$30,000.00	\$24,266.00	\$5,734.00	\$1,627.12	\$0.00	\$0.00	\$7,361.12	25.00%	\$8,105.00
Rate Based MNIT Services	\$158,000.00	\$147,082.72	\$10,917.28	\$34,192.71	\$0.00	\$0.00	\$45,109.99	28.55%	\$85,890.01
Agency Specific MNIT Services	\$20,000.00	\$19,293.28	\$706.72	\$1,181.48	\$0.00	\$0.00	\$1,888.20	9.44%	\$15,111.80
SUPPLIES	\$10,000.00	\$9,783.09	\$216.91	\$194.68	\$0.00	\$0.00	\$411.59	4.12%	\$5,158.28
EQUIPMENT	\$10,000.00	\$9,533.46	\$466.54	\$466.54	\$0.00	\$0.00	\$933.08	9.33%	\$4,639.88
REPAIRS, MAINTENANCE	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$10.99
STATEWIDE INDIRECT COSTS	\$0.00	\$0.00	\$0.00	\$6,821.00	\$0.00	\$0.00	\$6,821.00		\$0.00
OTHER OPERATING COSTS	\$105,000.00	\$103,699.33	\$1,300.67	\$588.44	\$0.00	\$0.00	\$1,889.11	1.80%	\$22,510.89
EQUIPMENT - Capital	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$0.00
EQUIPMENT - NON CAPITAL	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$0.00
TOTAL OPERATION COSTS	\$1,457,000.00	\$980,429.01	\$203,669.65	\$272,554.71	\$0.00	\$0.00	\$476,570.99	34.00%	\$980,429.01
Behavior Analysts Licensure - Fund H7V30000		\$4,272.00		\$7,456.00			\$9,184.00		\$2,816.00
Other Operating Costs	\$80,505.00	\$63,234.01	\$0.00	\$17,270.93	\$0.00	\$0.00	\$17,270.93	21.00%	\$63,234.07
				\$297,281.64			\$503,025.92		
PSYCHOLOGY CRIMINAL BACKGROUND CHECK FUND - 2000 - H7V30000									
AGY PROVIDED PROF/TECH	\$6,000.00	\$4,272.00	\$1,728.00	\$7,456.00	\$0.00	\$0.00	\$9,184.00	153.07%	\$2,816.00
TOTAL CRIMINAL BACKGROUND	\$6,000.00	\$4,272.00	\$1,728.00	\$7,456.00	\$0.00	\$0.00	\$9,184.00	153.07%	\$2,816.00
REPORT TOTAL	\$1,556,505.00	\$1,047,935.02	\$205,397.65	\$297,281.64	\$0.00	\$0.00	\$503,025.92	32.00%	\$1,046,479.08

**BOARD OF PSYCHOLOGY
ACTUAL RECEIPT REPORT**

Through December 2025

	REVENUE SOURCE CODE #	CURRENT REVENUE BUDGET	ESTIMATED UNCOLLECTED RECEIPTS	1ST QUARTER RECEIPTS	2ND QUARTER RECEIPTS	3RD QUARTER RECEIPTS	4TH QUARTER RECEIPTS	TOTAL YR TO DATE RECEIPTS	% RECEIPTS OF TOTAL BUDGET
Civil Penalties	512417	\$10,000.00	\$10,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Credit Card Clearing	553094	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted
H7V Professional Firms Initial	608263	\$8,000.00	\$5,575.00	\$1,300.00	\$1,125.00	\$0.00	\$0.00	\$2,425.00	30.00%
H7V Professional Firms Annual	608264	\$8,000.00	\$7,500.00	\$450.00	\$3,650.00	\$0.00	\$0.00	\$4,100.00	51.25%
Licensure Volunteer Practice	643000	\$1,000.00	\$500.00	\$250.00	\$250.00	\$0.00	\$0.00	\$500.00	50.00%
Bd Psych Appl Admission EPPP	643002	\$20,000.00	\$12,200.00	\$4,350.00	\$3,450.00	\$0.00	\$0.00	\$7,800.00	39.00%
Bd Psych Appl Adm Prof Resp E	643003	\$25,000.00	\$11,200.00	\$7,350.00	\$6,450.00	\$0.00	\$0.00	\$13,800.00	55.20%
Lic Psych Appl For License	643004	\$90,000.00	\$46,500.00	\$25,000.00	\$18,500.00	\$0.00	\$0.00	\$43,500.00	48.00%
Lic Psych Appl For Renewal	643005	\$1,000,000.00	\$499,000.00	\$232,500.00	\$268,500.00	\$0.00	\$0.00	\$501,000.00	50.10%
Lic Psych Late Renewal Fee	643006	\$8,000.00	\$3,500.00	\$2,750.00	\$1,750.00	\$0.00	\$0.00	\$4,500.00	56.25%
Bd Psych Emeritus Registration	643010	\$3,500.00	\$2,750.00	\$300.00	\$450.00	\$0.00	\$0.00	\$750.00	21.43%
Bd Psych Degree Upgrade	643011	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted
Be Psych Mailing/Duplication	643013	\$300.00	\$205.00	\$50.00	\$45.00	\$0.00	\$0.00	\$95.00	32.00%
Bd Psych Verification Receipts	643015	\$95,000.00	\$46,840.00	\$21,320.00	\$26,840.00	\$0.00	\$0.00	\$48,160.00	51.00%
Psychologist Guest Licensure	643018	\$4,000.00	\$2,050.00	\$1,200.00	\$750.00	\$0.00	\$0.00	\$1,950.00	49.00%
Continuing Ed Sponsrshp Fee	643019	\$35,000.00	\$18,520.00	\$6,240.00	\$10,240.00	\$0.00	\$0.00	\$16,480.00	47.00%
Post DR Sup Exper Pre Appr	643023	\$500.00	\$300.00	\$200.00	\$0.00	\$0.00	\$0.00	\$200.00	40.00%
BA Initial Application License Fee	643025	\$20,000.00	(\$24,325.00)	\$23,400.00	\$20,925.00	\$0.00	\$0.00	\$44,325.00	221.00%
TOTAL REVENUE		\$1,328,300.00	\$642,315.00	\$326,660.00	\$362,925.00	\$0.00	\$0.00	\$689,585.00	51.91%
Fund 2000									
Criminal Background Check Fee	643022	\$6,000.00	\$660.50	\$5,339.50	\$4,409.75	\$0.00	\$0.00	\$9,749.25	162.00%
TOTAL REVENUE		\$1,334,300.00	\$1,003,300.50	\$331,999.50	\$367,334.75	\$0.00	\$0.00	\$699,334.25	52.00%

Guardians of the Future: Regulating Psychology

40th MIDYEAR MEETING

Charlotte, North Carolina

April 16th – 19th, 2026



THURSDAY, APRIL 16, 2026

10:00 a.m. – 3:00 p.m. EDT BARC Meeting
RSVP needed

11:00 a.m. – 2:30 p.m. BCCC Meeting
RSVP needed

5:30 p.m. – 7:30 p.m. Welcome Reception and Registration
(Dinner on your own)

FRIDAY, APRIL 17, 2026

7:30 a.m. – 8:45 a.m. EDT General Session Breakfast and Registration

7:30 a.m. – 8:45 a.m. First-time Attendees Breakfast

FRIDAY, APRIL 17, 2026

8:30 a.m.

Welcome and Call to Order

Jennifer C. Laforce, PhD, CPsych, President

:

Welcome from the North Carolina Psychology Board

Kate Brody Nooner, PhD

Midyear Meeting Program

Cindy Olvey, PsyD, ASPPB Secretary-Treasurer, Chair, Midyear Meeting Committee

Continuing Education and CE-Go Instructions

Bryan Gardner, ASPPB Meetings and Events Coordinator

**SESSION 1
(CE PROGRAM BEGINS)**

9:00 a.m.

**Who Is Responsible? Governing Psychological Practice in an Era of Artificial Intelligence
Q and A**

10:30 a.m.

1.5 hours CE

10:45 a.m.

Break

SESSION 2

11:00 a.m.

Jurisdictions that Train Licensees

12:00 p.m.

Q and A

1.25 hours CE

12:15 p.m.

Lunch

SESSION 3

1:45 p.m.

ASPPB and Other Updates

2:45 p.m.

Break

SESSION 4

3:00 p.m.

Jurisdictional Updates

4:30 p.m.

Recess

6:00 p.m. – 9:00 p.m.

President's Dinner



SATURDAY, APRIL 18, 2026

7:30 a.m. – 8:45 a.m. EDT

General Breakfast



SATURDAY, APRIL 18, 2026

8:30 a.m.

Call to Order and Announcements

Jennifer C. Laforce, PhD, CPsych

Consider Volunteering for ASPPB

Ramona N. Mellott, PhD, President-Elect, ASPPB Board of Directors

Running for the Board of Directors/Awards

Hugh D. Moore, PhD, MBA, Past-President, ASPPB Board of Directors, Chair,
Nominations Committee

SESSION 5

8:45 a.m. Dr. ChatBot Will See You Now: A Regulator's Guide to AI, Digital Ethics, and Public Safety
Q and A

10:15 a.m.
1.5 hours CE

10:30 a.m. Break

SESSION 6

10:45 a.m. Table Talk: Potential Uses of AI in Regulation

1.5 hours CE

12:15 p.m. LUNCH

SESSION 7

1:30 p.m. Addressing Impairment in Psychologists: Jurisdictional Approaches

2:30 p.m. Q and A

1.25 hours CE

2:45 p.m. Recess

5:30 p.m. – 7:00 p.m. President's Reception
Dinner on Your Own



SUNDAY APRIL 19, 2026

7:30 a.m. – 8:30 a.m. EDT Breakfast

SUNDAY APRIL 19, 2026

8:30 a.m. **Call to Order and Announcements**
Jennifer C. Laforce, PhD, CPsych

SESSION 8

8:30 a.m. **Jurisdictions Taking Action on AI**
9:30 a.m. **Q and A**
1.25 hours CE

9:45 a.m. **Break**

SESSION 9

10:00 a.m. **Discussion on the Proposed American Psychological Association's Model Act**
10:45 a.m. **Q and A**
1.00 hour CE

11:00 a.m. **Adjourn**
Jennifer C. Laforce, PhD, CPsych

2026 FARB SUMMIT ON REGULATORY EXCELLENCE

Cultivating Courageous Leadership

Leading with conviction, collaboration, and clarity.

The annual FARB Summit on Regulatory Excellence is the premier gathering for regulatory law professionals, licensure board members and staff, and leaders of national regulatory associations. This conference is designed to explore the intersection of law, policy, and innovation in professional regulation. Over the course of three days, attendees will gain insights from thought leaders, engage in dynamic discussions, and collaborate on best practices to enhance the future of licensure and regulation.

Conference Highlights

The Summit will feature a combination of plenary sessions for all attendees, led by national thought leaders on regulatory innovation, public protection, and licensure trends. Breakout sessions will provide tailored content for:

- Regulatory Law Professionals – Sessions will address legal implications of regulatory reform, litigation trends in licensure, and ethical challenges in regulatory law.
- Licensure Board Members & Staff – Topics will explore effective board governance, sunset reviews, and strategies for upholding professional standards through enforcement and discipline.
- National Regulatory Associations – Discussions will focus on leveraging data for policy development, global perspectives on licensure, and advancing thought leadership in regulatory innovation.

Thursday, July 23 2026	
Afternoon	Pre-Conference Workshop
Evening	Welcome Reception
Friday, July 24 2026	
8:00am - 9:00am	Breakfast
9:00am - 12:00pm	AM Plenary & Breakout Sessions
12:00pm - 1:30pm	Networking Lunch
1:30pm - 5:00pm	PM Plenary & Breakout Sessions
Saturday, July 25 2026	
8:00am - 9:00am	Breakfast
9:00am - 12:00pm	AM Plenary & Breakout Sessions
12:00pm - 1:00pm	Networking Lunch
1:00pm - 3:00pm	PM Plenary & Breakout Sessions





Minnesota Board of Psychology Executive Director Report January 30, 2026

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 been contacting LP applicants that have not had movement in their application in more than a year. This has resulted in a couple of licenses being issued since the last Board meeting. The team has also initiated contact with roughly 60 BA applicants that have not made their application intent clear. Thus far about ten applicants have conveyed they no longer wish to pursue licensure and a handful have responded to express they wish to continue with the application process. One BA applicant has been licensed because of staff's efforts.

As of this week, the Board has issued approximately 925 Behavior Analyst Licenses. The average number of applications completed per week, with fees paid, continue to be three to four. The average time for staff and final reviews for BA applications continues to consistently be a day or two. With applicants that have recently been issued licenses, the entire process from the start of submitting the application, satisfying fees, completing background studies and moving through the final reviews is about three weeks or less.

Staff have updated the Board's website with LP and BA application FAQ's. The licensure team is currently working on documents needed for the Licensed Behavior Analyst renewal procedure as well as developing a checklist for LP applicants that have been trained in an educational institution outside of the United States or Canada.

II. Executive Director's Report

a. ASPPB Conference Registration Open

The Association of State and Provincial Psychology Boards Midyear Meeting will be held in Charlotte, North Carolina from April 17-19th. The Theme of the conference is "Guardians of the Future: Regulating Psychology" and will include modules on regulating artificial intelligence.

b. Federation of Associations of Regulatory Boards

The Federation of Associations of Regulatory Boards ("FARB") is holding a regulatory excellence summit in Minneapolis on July 23-25th. The title of the summit is, "Cultivating Courageous Leadership," and the agenda is attached. FARB is asking for a significant host state presence from the Minnesota Health Licensing Boards. Behavior Analyst

c. Renewal Process:

Board staff are working to devise a renewal process that will allow for licensees to complete the renewal process through our online database. Staff will be collaborating with IT to test and put this process into action. Starting in October of this year, Behavior Analyst licensees will begin renewing their licenses through the online portal. Staff anticipates a high number of renewals at that time. Historically between October 1, 2024, and mid November 2024 the Board issued over 300 Behavior Analyst licenses. The Council will be reviewing the renewal requirements for the process as well.

d. Quarterly Financial Update:

The second quarter financials have been provided for your review. The revenues and expenses are through December 2025. As the Board is halfway through FY26, the expenses continue to be well managed, and revenues are steady. One observation in revenues is that application fees for BA and LP applicants are similar being \$46,350 and \$44,500, respectively. There are half as many psychology applications for licensure completed as there are applications for behavior analysts. At midpoint of the fiscal year, there are 206 behavior analyst applications completed, and 89 licensed psychologist applications completed.



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Executive Director

TITLE: Psilocyban Draft Legislation

INTRODUCTION TO THE TOPIC:

This draft legislation was recently provided to the Board by the Chair of the Psychedelic Medicine Task Force. The task force was created in the 2023 legislative session.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Draft Legislation	1/27/2026	Cover Memo

A bill for an act relating to health; establishing a psilocybin therapeutic use program; establishing protections for registered patients, registered cultivators, registered facilitators, and health care practitioners; authorizing rulemaking; authorizing civil actions; establishing fees; classifying data; establishing an advisory committee; providing criminal penalties; appropriating money; proposing coding for new law in Minnesota Statutes, chapter 152.

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

Section 1. **PURPOSE.**

The purpose of this act is to establish a legal, regulated framework for the therapeutic use of psilocybin by individuals who are 21 years of age or older with a licensed facilitator, have been diagnosed with a qualifying medical condition, and meet the other requirements for enrollment in the program.

Sec. 2. **[152.40] DEFINITIONS.**

Subdivision 1. **Application.** For the purposes of sections 152.40 to 152.53, the following terms have the meanings given.

Subd. 2. **Administration session.** "Administration session" means a session supervised by a registered facilitator during which a registered patient consumes and experiences the effects of psilocybin.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 4. **Registered cultivator.** "Registered cultivator" means an individual or entity licensed by the state to cultivate psilocybin for facilitated use in administration sessions.

Subd. 5. **Health care practitioner.** "Health care practitioner" means a Minnesota-licensed physician, advanced practice registered nurse, or physician assistant.

Subd. 6. **Integration session.** "Integration session" means a meeting between a registered patient and a registered facilitator that occurs after the completion of an administration session.

Subd. 7. **Preparation session.** "Preparation session" means a meeting between a registered patient and a registered facilitator that occurs before an administration session. Preparation session does not mean an initial consultation between a registered patient and registered facilitator regarding psilocybin use, an inquiry from a registered patient to a registered facilitator regarding psilocybin use, or a registered facilitator's response to a registered patient's inquiry regarding psilocybin use.

Subd. 8. **Program.** "Program" means the psilocybin therapeutic use program established under sections 152.40 to 152.53.

Subd. 9. **Psilocybin.** "Psilocybin" means any mushroom, in raw, dried, or prepared form, that contains the psychoactive compound psilocybin or its metabolite psilocin.

Subd. 10. **Psychedelic Medicine Advisory Committee or advisory committee.** "Psychedelic Medicine Advisory Committee" or "advisory committee" means the advisory committee established under section 152.53..

Subd. 11. **Qualifying medical condition.** "Qualifying medical condition" means a medical condition designated by the commissioner for which psilocybin shows evidence for an

appropriate therapeutic use, based upon the recommendations of the psychedelic medicine task force report and ongoing scientific research studies and clinical trials, including, but not limited to, posttraumatic stress disorder, depression, substance use disorders, anxiety, and chronic pain.

Subd. 12.**Registered facilitator.** "Registered facilitator" means an individual registered with the commissioner to provide services in preparation sessions and integration sessions and to supervise administration sessions.

Subd. 13.**Registered patient.** "Registered patient" means a Minnesota resident certified by a health care practitioner as having a qualifying medical condition and enrolled in the psilocybin therapeutic use program.

Subd. 14.**Testing facility.** "Testing facility" means a Minnesota resident or entity who is certified by the state to test the quality and dose of psilocybin to be used for treatment sessions, with no less than 3 certified facilities for the program, can be located at the registered cultivator site.

Subd. 15.**Treatment facility.** "Treatment facility" means a Minnesota health clinic or center that has been licensed by the state with appropriately trained staff and safety equipment for facilitated sessions. For accommodations for homebound patients, treatment facilities can be at home with a registered facilitator and appropriate safety equipment provided by the registered facilitator.

Subd. 16.**Program research.** "Program research" means a Minnesota institute, such as a nonprofit or academic institution who advises and assists with data collection for public health monitoring, and program registrant training, continuing education, and ethical oversight requirements.

Sec. 3. [152.41] PSILOCYBIN THERAPEUTIC USE PROGRAM.

Subdivision 1.**Establishment.** The commissioner of health must establish and administer a psilocybin therapeutic use program according to sections 152.40 to 152.53 in which individuals age 21 and older who have a qualifying medical condition and meet the other eligibility requirements may enroll in the program and are able to access and use psilocybin with a registered facilitator at a treatment facility.

Subd. 2.**Rulemaking; commissioner of health.** (a) The commissioner must adopt rules to govern the operation of the program. The rules must at least:

- (1) specify the qualifying medical conditions that an individual must be diagnosed with to enroll in the program, based upon emerging evidence from scientific research and clinical trials evaluated in the psychedelic medicine task force legislative report, including, but not limited to posttraumatic stress disorder, depression, substance use disorders, anxiety, chronic pain, and other conditions where scientific evidence shows there may be therapeutic benefit;
- (2) specify the maximum number of registered patients and amount for whom a designated cultivator may cultivate psilocybin;
- (3) specify testing standards in collaboration with program research for psilocybin mushrooms to ensure safety, appropriate dosing for treatment sessions, and preventing diversion;
- (4) establish a standardized questionnaire in collaboration with program research for use by health care practitioners to conduct health screenings of individuals seeking to enroll in the

program;

(5) establish a standardized formal risk assessment tool in collaboration with program research for use by health care practitioners to evaluate identified contraindications in individuals seeking to enroll in the program; and

(6) establish qualifications in collaboration with program research to register with the commissioner as a facilitator, including any additional subjects on which individuals must demonstrate competency and how individuals must demonstrate competency in the required subjects.

(7) establish qualifications to register with the commissioner as a cultivator in collaboration with program research, including any additional subjects on which individuals must demonstrate competency in the required subjects and standards for cultivation. Cultivators must work with testing facilities to ensure appropriate quality and dosing of psilocybin prior to releasing to registered facilitators and patients for treatment.

(b) The commissioner must consult with the advisory committee and program research in adopting rules under this subdivision.

(c) Rules for which notice is published in the State Register before July 1, 2027, may be adopted using the expedited rulemaking process in section 14.389. The notice of the proposed rule for the items in paragraph (a) must be published in the State Register no later than January 1, 2027.

Subd. 4. Evaluation and research. (a) The commissioner must collect from registered patients de-identified data on the frequency with which registered patients use psilocybin in administration sessions, the qualifying medical conditions for which psilocybin is used, outcomes from psilocybin use experienced by registered patients, and adverse effects of psilocybin use experienced by registered patients, as well as any changes to utilization of other healthcare, social services or government funded programs. Registered patients and their facilitators must provide data to the commissioner in a form and manner specified by the commissioner. The commissioner must use data collected under this paragraph to evaluate the program and, in consultation with the advisory committee and in collaboration with program research, develop recommendations to improve the program. Research should consult and where possible partner with federal health and research agencies (e.g. Department of Health and Human Services, National Institutes of Health).

(b) The commissioner may support research that investigates novel therapeutic uses of psilocybin and psilocin. In determining whether to support research initiatives, the commissioner must consider the recommendations of the task force authorized under Laws 2023, chapter 70, article 4, section 99.

Sec. 4. [152.42] ELIGIBILITY AND ENROLLMENT IN PROGRAM.

Subdivision 1. Registration system. The commissioner must administer a secure registration system to track patients enrolled in the program while protecting their privacy.

Subd. 2. Eligibility for enrollment. (a) To enroll in the program, an individual must:

(1) be 21 years of age or older;

(2) submit to the commissioner a written certification from a health care practitioner dated within 90 days of submission and verifying the individual's diagnosis with a qualifying medical

condition;

(3) submit to the commissioner a written certification or certifications from one or more health care practitioners dated within 90 days of submission and verifying either:

(i) that the detailed health screening conducted according to subdivision 3 did not identify contraindications to the individual's use of psilocybin; or

(ii) that the detailed health screening identified contraindications to the individual's use of psilocybin but a health care practitioner conducted a further evaluation using a formal risk assessment tool and determined the individual's identified contraindications should not preclude the individual from using psilocybin; and

(4) submit an application to the commissioner in a form and manner specified by the commissioner.

(b) Individuals may apply for enrollment in the program beginning January 1, 2027.

Subd. 3. **Health screening; evaluation.** An individual who wishes to enroll in the program must have a detailed health screening performed by a health care practitioner to identify whether the individual has a qualifying medical condition and if any significant physical or mental health conditions or medications that are contraindications to the use of psilocybin. Contraindications conditions may include but are not limited to cardiovascular disease, psychosis, and bipolar disorders, and contraindicated medications include but are not limited to lithium, monoamine oxidase inhibitors (MAOIs), tramadol, and amphetamine stimulants. If the health care practitioner determines in the screening that the individual has one or more contraindications to the use of psilocybin, the individual must have the contraindication further evaluated by a health care practitioner using a formal risk assessment tool. An individual who has an additional evaluation performed may proceed with an application under subdivision 2 only if the health care practitioner performing the additional evaluation determines the individual's identified contraindications should not preclude the individual from using psilocybin.

Subd. 4. **Informed consent.** Upon receiving the individual's complete application and certifications required under subdivision 2, the commissioner must provide the individual with information on the nature of psilocybin use for therapeutic purposes, potential adverse effects of psilocybin use, and possible interactions between psilocybin and other commonly used drugs, along with a document, to be signed and returned by the individual, that the individual has read and understood the information provided and wishes to enroll in the program. An individual who wishes to proceed with the individual's application must sign and date the informed consent form and return it to the commissioner.

Subd. 5. **Enrollment.** The commissioner must approve or deny the individual's application within 60 days after receiving the individual's informed consent form under subdivision 4. Upon approval of an individual's application and receipt of the enrollment fee required under section 152.52, the commissioner must register the individual in the program and issue the individual a card that permits the registered patient to access psilocybin with a registered facilitator at a treatment facility.

Subd. 6. **Renewal.** (a) A registered patient's registration is valid for 12 months from the date of issuance. A registered patient who wishes to renew the registration must, at least 60 days before the registration expires, submit an application for registration renewal; written certifications that meet the requirements in subdivision 2, paragraph (a), clauses (2) and (3); and the fee required under section 152.52. The commissioner must approve or deny a

registered patient's renewal application within 60 days after receiving the complete application and written certifications. (b) A registered patient whose registration expired less than 31 days ago may renew the registration under paragraph (a). A registered patient whose registration expired 31 or more days ago must apply for enrollment according to subdivision 2.

Subd. 7. **Permitted acts.** (a) Subject to section 152.46, a registered patient is permitted to:

(1) Designate a registered facilitator;

(2) Consume the recommended amount at a treatment center with an approved facilitator according to the recommended dosing limit;

(b) Subject to section 152.46, a designated cultivator and testing facility registered with the commissioner is permitted to cultivate and possess psilocybin, provided the cultivation and testing is performed according to section 152.43 and the total amount possessed does not exceed the limit designed by the program.

(c) Subject to section 152.46, a registered facilitator is permitted, according to section 152.44, to obtain psilocybin from a registered cultivator, transport psilocybin to the treatment center, provide services to registered patients in preparation sessions and integration sessions and to administer psilocybin and supervise administration sessions of registered patients.

(d) No civil or criminal penalty shall be imposed on:

(1) a registered patient solely for engaging in an act listed in paragraph (a);

(2) a registered designated cultivator and testing facility solely for engaging in an act listed in paragraph (b); or

(3) a registered facilitator solely for engaging in an act listed in paragraph (c).

Subd. 8. **Program initiation.** The commissioner shall approve a phased initiation of the program, approving an initial cohort of 20-50 facilitators who are licensed healthcare practitioners who have experience either conducting clinical trials with psilocybin or have administered ketamine assisted therapy and no less than three cultivation and testing facilities, and enroll up to 1000 patients with qualifying medical conditions into the program during the first 3 years. The program will be evaluated at the end of the 3 year period by the commissioner, the advisory committee, and program research for expansion and modifications based on program outcomes.

Sec. 5. **[152.43] CULTIVATION.**

Subdivision 1. **Cultivation authorized.** (a) A registered patient and facilitator may compensate a designated cultivator who cultivates psilocybin for the program at a licensed facility. Compensating a designated cultivator for cultivation under this clause does not constitute the sale or commercial distribution of psilocybin, but rather for their services and labor.

(b) Before cultivating psilocybin for the program, they must register with the commissioner. (c) A designated cultivator must:

(1) cultivate psilocybin only for approved treatment centers, registered facilitators and their registered patients in an amount that does not exceed the cultivation limit as established by the commissioner of health; and

(2) not cultivate psilocybin for more than their license allows, as designated by the commissioner.

Subd. 2. **Secure location.** Cultivation by a licensed cultivator must take place at an approved location in an enclosed, locked space that is not accessible to the public or by individuals under age 21 and contains on-site testing facilities for quality and potency testing.

Sec. 6. [152.44] LOCATION AND FACILITATOR; ADMINISTRATION SESSIONS.

Subdivision 1. **Location.** A registered patient may use psilocybin in an administration session only:

- (1) at an approved private residence, including the curtilage or yard of the residence, unless the property owner prohibits the use of psilocybin on the property; or
- (2) at a licensed treatment facility, unless the property owner prohibits the use of psilocybin on the property.

Subd. 2. **Registered facilitator.** A registered facilitator must be physically present with a registered patient during an administration session to supervise the registered patient's use of psilocybin and to contact emergency services if necessary during the administration session. As a condition of supervising an administration session for a registered patient, a registered facilitator may require the registered patient to also participate in a preparation session and an integration session with the registered facilitator. A registered facilitator may charge a reasonable fee for the registered facilitator's services.

Subd. 3. **Informed consent.** (a) Before a registered facilitator supervises a registered patient's administration session, the registered facilitator must provide the registered patient with information on the nature of psilocybin use for therapeutic purposes, what to expect in an administration session, potential adverse effects of psilocybin use, and possible interactions between psilocybin and other commonly used drugs. Registered patients will also be allowed to opt in for consent to data collection for program monitoring

(b) A registered patient who wishes to proceed with an administration session must sign and date a document stating that the patient has been informed of and understands the information provided according to paragraph (a). Registered facilitators must maintain the signed informed consent documents for two years after receipt.

Subd. 4. **Chain of custody for psilocybin/psilocin.** (a) Before a registered facilitator supervises a registered patient's administration session, the registered facilitator must procure the recommended dose from a registered cultivator, with both the facilitator and the cultivator signing out the dose, and before the treatment session starts, the facilitator and patient must sign in the dose to ensure the dose received from the cultivator matches what will be used for the treatment session to prevent diversion. This will be to prevent diversion and ensure the correct dosage is used at the approved treatment location, either the clinic or home of the patient.

Sec. 7. [152.45] REGISTERED FACILITATOR.

Subdivision 1. **Registration required; qualifications.** (a) An individual must register with the commissioner as a facilitator in order to supervise administration sessions for registered patients and to provide registered patients with services in preparation sessions and integration sessions. In order to register as a facilitator, an individual must:

(1) be 21 years of age or older; and
(2) demonstrate competency, in a manner determined by the commissioner and in collaboration with program research, on facilitator ethics; the safe use of psilocybin; duties of a facilitator during preparation sessions, administration sessions, and integration sessions; and other topics as determined by the Commissioner and program research.

(b) An individual who holds a license, registration, or certification from a health-related licensing board as defined in section 214.01, subdivision 2; from the Office of Emergency Medical Services; or from the commissioner authorizing the individual to practice a health-related occupation may also serve as a registered facilitator and dual licensure will be granted and approved by the relevant state licensing board, in addition to their psilocybin facilitator license (dual licensure).

Subd. 2. **Application for registration; registration renewal.** (a) An individual who wishes to register as a facilitator must apply to the commissioner in a form and manner specified by the commissioner.

(b) A registration issued under this section is valid for 12 months from the date of issuance. An individual who wishes to renew the individual's registration must apply for registration renewal, in a form and manner specified by the commissioner, at least 60 days before the individual's registration expires. In evaluating an application for registration renewal, the commissioner must consider any complaints reported to the commissioner under subdivision 3 and may decline to renew an individual's registration if the commissioner determines, based on complaints received or other evidence, that the individual did not perform the duties of a facilitator in a safe or ethical manner. The commissioner must approve or deny a registered facilitator's renewal application within 60 days after receiving the facilitator's complete application.

(c) A registered facilitator whose registration expired less than 31 days ago may renew the registration under paragraph (b). A registered facilitator whose registration expired 31 or more days ago must apply for registration according to paragraph (a), except the commissioner must consider any complaints reported to the commissioner under subdivision 3 and may decline to register the individual if the commissioner determines, based on complaints received or other evidence, that the individual did not perform the duties of a facilitator in a safe or ethical manner.

(d) Individuals may apply for registration as a facilitator beginning October 1, 2026.

Subd. 3. **Complaints.** The commissioner must accept complaints from registered patients and other interested individuals regarding a registered facilitator's failure to supervise an administration session in a safe or ethical manner or failure to provide services in a preparation session or an integration session in a safe or ethical manner.

Subd. 4. **List of registered facilitators.** The commissioner must post on the Department of Health website the names of and contact information for registered facilitators.

Sec. 8. **[152.46] LIMITATIONS.**

Nothing in sections 152.40 to 152.53 permits an individual to:

- (1) participate in the psilocybin program if the individual is under 21 years of age;
- (2) violate existing crimes related to intoxicated driving;
- (3) violate existing crimes related to use or possession of psilocybin;
- (4) facilitators to give psilocybin to an individual who is not a registered patient or cultivators to cultivate psilocybin not intended for the program for registered patients;

- (5) sell psilocybin to an individual or engage in the distribution of psilocybin to anyone not registered in the program;
- (6) establish treatment centers on the grounds of a public school, as defined in section 120A.05, subdivisions 9, 11, and 13, or a charter school governed by chapter 124E, including all owned, rented, or leased facilities and all vehicles that a school district owns, leases, rents, contracts for, or controls;
- (7) establish treatment centers in a state correctional facility; or
- (8) if the individual is a registered facilitator, supervise the administration session of an individual who is not a registered patient.

Sec. 9. **[152.47] CRIMINAL AND CIVIL PROTECTIONS.**

Subdivision 1. **Forfeiture.** Psilocybin cultivated or obtained under sections 152.40 to 152.53 and associated property are not subject to forfeiture under sections 609.531 to 609.5316.

Subd. 2. **Protections for public employees.** Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may 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 their office or employment under sections 152.40 to 152.53.

Subd. 3. **Search warrant.** Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.40 to 152.53 except when acting pursuant to a valid search warrant.

Subd. 4. **Evidence in criminal proceeding.** No information contained in a report, document, or registry or obtained from a patient under sections 152.40 to 152.53 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.40 to 152.53. Any person who violates this subdivision is guilty of a gross misdemeanor.

Subd. 5. **Possession of registry card or application.** The possession of a registry card or application for enrollment in the program by an individual entitled to possess a registry card or apply for enrollment in the program does not constitute probable cause or reasonable suspicion, and shall not be used to support a search of the person or property of the individual possessing the registry card or application, or otherwise subject the person or property of the individual to inspection by any governmental agency.

Subd. 6. **Employment.** An employer must not discriminate against a registered patient, registered cultivator, or registered facilitator in hiring, termination, or any term or condition of employment, or otherwise penalize a registered patient, registered cultivator, or registered facilitator based on the lawful cultivation, possession, transportation, provision of services in preparation sessions or integration sessions, supervision of administration sessions, or use of psilocybin under sections 152.40 to 152.53, unless:

- (1) the employer's failure to act would violate federal law or regulations or would cause the employer to lose a monetary or licensing-related benefit under federal law or regulations; or
- (2) the registered patient's use of psilocybin directly impacts the registered patient's job performance or safety requirements of the registered patient's job position.

Subd. 7. **Housing.** No landlord may refuse to lease to a registered patient or registered cultivator or registered facilitator or evict a registered patient or registered cultivator or registered facilitator solely for lawfully partaking in their respective treatment or duties for the psilocybin program under sections 152.40 to 152.53, unless the landlord's Failure to do so would violate federal law or regulations or would cause the landlord to lose a monetary or licensing-related benefit under federal law or regulations.

Subd. 8. **Education.** No school may refuse to enroll a registered patient or registered cultivator or registered facilitator solely for lawfully engaging with their respective treatment or duties for the psilocybin program under sections 152.40 to 152.53, unless the school's failure to do so would violate federal law or regulations or would cause the school to lose a monetary or licensing-related benefit under federal law or regulations.

Subd. 9. **Custody; visitation; parenting time.** A registered patient, registered cultivator, or registered facilitator must not be denied custody of a minor child or visitation rights or parenting time with a minor child based solely on the registered patient's, registered cultivator's, or registered facilitator's lawful cultivation, possession, transportation, provision of services in preparation sessions or integration sessions, supervision of administration sessions, or use of psilocybin under sections 152.40 to 152.53, unless the registered patient's, designated behavior creates an unreasonable danger to the safety of the minor as demonstrated by clear and convincing evidence.

Subd. 10. **Action for damages.** In addition to any other remedy provided by law, a registered patient, registered cultivator, or registered facilitator who is injured by a violation of subdivision 6, 7, 8, or 9 may bring an action for damages against a person who violates subdivision 6, 7, 8, or 9. A person who violates subdivision 6, 7, 8, or 9 is liable to the registered patient, registered cultivator, or registered facilitator injured by the violation for the greater of the registered patient's, registered cultivator's, or registered facilitator's actual damages or a civil penalty of \$100, plus reasonable attorney fees.

Sec. 10. [152.48] VIOLATIONS.

Subdivision 1. **Diversion by registered patient, registered cultivator, or registered facilitator.** In addition to any other applicable penalty in law, a registered patient, registered cultivator, or registered facilitator who intentionally sells or otherwise transfers psilocybin to a person other than a registered patient is guilty of a felony punishable by imprisonment for not more than two years or by payment of a fine of not more than \$3,000, or both.

Subd. 2. **False statement.** An individual who intentionally makes a false statement to a law enforcement official about any fact or circumstance relating to the therapeutic use of psilocybin to avoid arrest or prosecution is guilty of a misdemeanor punishable by imprisonment for not more than 90 days or by payment of a fine of not more than \$1,000, or both. The penalty is in addition to any other penalties that may apply for making a false statement or for the possession, cultivation, or sale of psilocybin not protected by sections 152.40 to 152.53. If a person convicted of violating this subdivision is a registered patient, registered cultivator, or registered facilitator, the person is disqualified from further participation under the program.

Sec. 11. [152.49] PROTECTIONS FOR HEALTH CARE PRACTITIONERS AND

REGISTERED FACILITATORS.

Subdivision 1. **Health care practitioners.** The Board of Medical Practice or Board of Nursing must not impose civil or disciplinary penalties on, or limit or condition the practice of, a health care practitioner licensed by the Board of Medical Practice or Board of Nursing solely for certifying that an individual has a diagnosis of a qualifying medical condition according to section 152.42, subdivision 2, or performing health screenings or additional evaluations according to section 152.42, subdivision 3.

Subd. 2. **Registered facilitators.** A health-related licensing board as defined in section 214.01, subdivision 2; the Office of Emergency Medical Services; or the commissioner must not impose civil or disciplinary penalties on, or limit or condition the practice of, a registered facilitator who also holds a license, registration, or certification from the health-related licensing board; Office of Emergency Medical Services; or commissioner solely for obtaining and transporting psilocybin for registered patients, providing services to registered patients in preparation sessions and integration sessions and administering psilocybin and supervising administration sessions of registered patients, provided the services are provided or supervision is performed according to sections 152.40 to 152.53.

Sec. 12. [152.50] PUBLIC EDUCATION AND HARM REDUCTION.

Subdivision 1. **Public education program.** The commissioner in collaboration with program research must develop and implement a public education program that makes information available to the public on the responsible use of psilocybin, potential risks of using psilocybin, harm reduction strategies related to psilocybin use, and mental health resources related to psilocybin use.

Subd. 2. **Training programs for first responders.** The commissioner in collaboration with program research must develop and offer training programs for emergency medical responders, ambulance service personnel, peace officers, and other first responders on best practices for handling situations involving the use of psilocybin. The training programs must be developed and offered in coordination with the Office of Emergency Medical Services, the Peace Officer Standards and Training Board, the Minnesota State Patrol, and local law enforcement agencies.

Sec. 13. [152.51] DATA PRACTICES; ACCESS TO AND USE OF DATA.

(a) Except for the data specified in section 152.45, subdivision 4, data submitted to the commissioner under section 152.42, 152.43, or 152.45:

(1) is private data on individuals as defined in section 13.02, subdivision 12, or nonpublic data as defined in section 13.02, subdivision 9; and

(2) may only be used to comply with chapter 13, to comply with a request from the legislative auditor or state auditors in the performance of official duties, and for purposes specified in sections 152.40 to 152.53.

(b) The data specified in paragraph (a) must not be combined or linked in any manner with any other list, dataset, or database, and must not be shared with any federal agency, federal department, or federal entity unless specifically ordered by a state or federal court, or as part of

a federally approved research project for monitoring of the program where a certificate of confidentiality is obtained by a federal agency to protect the identities of the program registrants.

Sec. 14. **[152.52] FEES.**

(a) The commissioner must collect an annual fee of \$..... from each patient whose enrollment application or renewal application is approved by the commissioner.

(b) Notwithstanding paragraph (a), if the patient provides evidence to the commissioner of receiving Social Security disability insurance, Supplemental Security Income, or veterans disability or railroad disability payments, or of being enrolled in medical assistance or MinnesotaCare, the commissioner must collect an annual fee of \$..... from the patient after approving the patient's enrollment application or renewal application.

(c) Fees collected under this section must be deposited in the state treasury and credited to the state government special revenue fund. The commissioner may request appropriations of fee revenue to distribute as grants to fund Minnesota-based research exploring the effectiveness of psilocybin for additional conditions.

Sec. 15. **[152.53] PSYCHEDELIC MEDICINE ADVISORY COMMITTEE.**

Subdivision 1. **Establishment.** The commissioner must establish a Psychedelic Medicine Advisory Committee to advise the commissioner on the operation of the psilocybin therapeutic use program under sections 152.40 to 152.53.

Subd. 2. **Membership.** (a) The advisory committee shall consist of:

(1) ... members with knowledge or expertise regarding the therapeutic use of psilocybin and other psychedelic medicines or regarding integration resources associated with the use of psilocybin, as well as cultivation and testing of psilocybin. The commissioner must make recommendations to the governor for members appointed under this clause, and the governor must appoint members under this clause; and

(2) one member representing Tribal Nations in the state, appointed by the Indian Affairs Council.

(b) Initial appointments must be made to the advisory committee by November 1, 2026.

Subd. 3. **Chairperson.** Members of the advisory committee must elect a chairperson from among the advisory committee's members.

Subd. 4. **Terms; compensation; removal of members.** The advisory committee is governed by section 15.059, except the advisory committee does not expire.

Subd. 5. **Meetings.** The advisory committee must meet at least four times per year or at the call of the chairperson. The initial meeting of the advisory committee must occur by December 1, 2026, and must be called by the commissioner.

Subd. 6. **Staff support; office space; equipment.** The commissioner must provide the advisory committee with staff support, office space, and access to office equipment and services.

Sec. 16. **APPROPRIATIONS.**

Subdivision 1. A public-private fund will be created to pay for the program (including philanthropic contributions) with matching support, with licensing fees, donations, and any state funds that can be allocated from a given year from the general fund to support the costs associated with regulation and program implementation. Funds will be used for research, patient

registry/database, workforce development, continuing medical education programs, and be adapted based upon ongoing program evaluation

(a) \$..... in fiscal year 2026 and \$..... in fiscal year 2027 are appropriated from the general fund to the commissioner of health and program research for purposes of Minnesota Statutes, sections 152.40 to 152.53.

Sec. 17. RESCHEDULING [152.02].

Subdivision 1. Psilocybin and psilocin will be removed from schedule I and placed into schedule III (or IV).



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 1/30/2026

SUBMITTED BY: Licensure Specialist

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:

Name	License	Expiration Date
Tom Kern	LP0289	10/31/2025
Karen King	LP3822	10/31/2025