MINNESOTA BOARD OF PSYCHOLOGY
March 20, 2026
Board Meeting

Order of Business

PUBLIC SESSION:

1. **Call to Order**
2. **Adoption of Tentative Agenda**
3. **Announcements**
    - A. **Link to the Board Meeting**
4. **Approval of the Board Minutes**
    - A. **Board Meeting Minutes**
5. **Consent Agenda**
    - A. **Staff Delegated Authority Report**
6. **New Business**
    - A. **AI in Psychology Practice**
    - B. **Master's Level Licensure**
    - C. **Executive Director's Report**
    - D. **CE Variance Request**
    - E. **Board Administrative Terminations**
7. **Committee Reports**
8. **Adjournment**

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Link to the Board Meeting

INTRODUCTION TO THE TOPIC:

Please contact the Board office to request information about attending the Board meeting remotely: psychology.board@state.mn.us

BOARD ACTION REQUESTED:

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Board Meeting Minutes

INTRODUCTION TO THE TOPIC:

Board meeting minutes for February 2026 are respectfully submitted.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
February Board Meeting Minutes	3/16/2026	Cover Memo

MINNESOTA BOARD OF PSYCHOLOGY

MINNESOTA BOARD OF PSYCHOLOGY
Minutes of February 20, 2026, Board Meeting

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

Guests: Nick Lienesch and Daniel Schuppert.

PUBLIC SESSION

1. Call to Order

Sonal Markanda called the meeting to order at 9:35 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

Michael Thompson moved, seconded by Nancy Cameron Motion: to adopt the tentative agenda. There being 10 "ayes" and 0 "nays" the motion Passed.

3. Announcements

4. Approval of the Board Minutes

Pamela Freske moved, seconded by Seb Rilen Motion: to adopt January 30, 2026, Board Meeting Minutes. There being 8 "ayes" and 0 "nays" the motion Passed

5. Consent Agenda

A. Staff Delegated Authority Report

6. New Business

A. Master's Level Licensure

Sam Sands noted he is preparing comments, in conjunction with Board members, on the draft APA Model Act for State Licensure of Psychology Professionals. The Board discussed Master's level licensure and the Board's role in crafting or responding to proposed legislation, and determined the Legislative Committee should consider the issue in depth and provide the full Board with a proposal.

B. AI in Psychology Practice

The Board received articles related to the use of AI in the practice of psychology.

C. Psilocybin Draft Legislation

The Board discussed draft legislation to regulate the use of psilocybin for therapeutic purposes.

D. Executive Director's Report

Trisha Hoffman stated that the Licensure Unit has continued to process Behavior Analyst applications at a steady pace and has issued nearly 950 licenses to date. The Licensure Unit also has continued to engage with applicants for both Psychologist and Behavior Analyst licenses whose applications have stalled.

Sam Sands reported that Dr. Burnetti-Atwell of ASPPB has confirmed a visit to Minnesota August 21. He highlighted upcoming presentations by Board staff and noted that the Board has put in place policies to support staff pursuing further education relevant to their work at the Board. Finally, he noted introduction of various legislative bills at the Legislature.

Joel Bakken moved, seconded by Daniel Hurley Motion: to approve the cost of Board member and staff attendance at the upcoming ASPPB meeting. There being 10 "ayes" and 0 "nays" the motion passe.

7. Committee Reports

8. Adjournment

Adjourned at 11:40 AM.

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

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.

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

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

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

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Psychologist Licensure Consent Agenda	3/18/2026	Cover Memo
Behavior Analyst Consent Agenda	3/18/2026	Cover Memo
Compliance Consent Agenda	3/19/2026	Cover Memo

MINNESOTA
BOARD OF PSYCHOLOGY

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
Simone Schriger, Ph.D.
Jordan King, Psy.D.
Laura Sue Elias, Ph.D.
Shayna Williams, Ph.D.
Natalia Cristina Montero Vazquez, Psy.D.
Abyan Bashir, Psy.D.
Brittany King, Psy.D.
Cole Toovey, Ph.D.
Abigail Rosenkrans, Ph.D.
Jaylene Arnett, Psy.D.
Jessica Blalock, Psy.D.
Joshua Beulke, Ph.D.
Mackenzie Turner, Psy.D.
Heather Simmer, 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)
Ann Tran, Ph.D.
Laura Sue Elias, Ph.D.
Shayna Williams, Ph.D.
Jessica Blalock, Psy.D.
Katherine Winderman, Ph.D.
Moriah Splonskowski, Ph.D.
Laura Cunningham, Psy.D.
Alexandra Lenzen, Ph.D.
Joanna Woo, Psy.D.

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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
LP7321	Michael Hamilton, Ph.D.
LP7322	Bradley Nevins, Ph.D.
LP7323	April Owen, Psy.D.
LP7324	Kristin Robinson, Ph.D.
LP7325	Jaime Myler, Psy.D.
LP7326	Rachel Bock, Ph.D.
LP7327	Norah Kennedy, Ph.D.
LP7328	Alison Riley-Schmida, Psy.D.
LP7329	Anna Dammann, Ph.D.
LP7330	Meishon Behboudi, Psy.D.
LP7331	Katherine Winderman, Ph.D.
LP7332	Kayleigh Darling, Psy.D.
LP7333	Meegan, Murray, Psy.D.
RL00115	Maryanne Edmundson

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
GL0150	Daniel Meyerson

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
ER00214	Caroline Burke

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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
LP5471	Caroline Burke
LP3061	Mitchell Wittenberg
LP3056	Lori Sternal
LP0859	Scott TenNapel
LP0869	Robert Wilson
LP3045	Susan Eckfeldt
LP5232	Dion Darveaux
LP3106	Jana Reinhart

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
LP6512	Stacie Darke
LP3955	Catherine Hedberg

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: 15

Of applications filed, number of LP applications still in review: 1

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: 1

Of applications filed, number of Guest License applications still in review: 0

Reasons for continued review: N/A

Guest License applications days to license: 1 day

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CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Licensed Behavior Analyst (LBA)

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

License Number	Licensee
LBA0945	Fatema Tejani
LBA0946	Anastasia Kokina
LBA0947	Taylor Pelsis
LBA0948	Zachary Lomenda
LBA0949	Savannah Jane Mendoza
LBA0950	Shayconna Miller
LBA0951	Eric Lent
LBA0952	Jasmine Dursun
LBA0953	Jennifer Simmons
LBA0954	Emily Hagstrom
LBA0955	Josephine Thorman
LBA0956	Abigail Hinckley
LBA0957	Kimaya Khanolkar
LBA0958	Amel Khalife
LBA0959	Mya Ndiaye
LBA0960	Alli Rach
LBA0961	Lisa Byrne
LBA0962	Natali Sigala
LBA0963	Samantha Sheehan
LBA0964	Macey Fischer
LBA0965	Cody Buss
LBA0966	Kimberly Richards
LBA0967	Katie Bunting
LBA0968	Sahar Egbunu
LBA0969	Patrice Brown
LBA0970	Angela Doyle
LBA0971	Natalie Nelson
LBA0972	Jordan Leamy
LBA0973	Bridgid McQuown
LBA0974	Kathleen Cook
LBA0975	Jenna Raad
LBA0976	Hannah Code
LBA0977	Shante Williams

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Licensure Progression Statistics

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

Total Number of LBA Applications Filed Since Last Council Meeting: 25 (Plus 15 Awaiting Payment and Pending.)

Of applications filed, number of LBA applications that have satisfied all license fees: 25

Of these applications, number submitted to CBC program (anticipated timeline to process CBC is 30 days): 24

Of all applications filed (and paid fees), number in compliance review: 8

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

Of applications filed, number of Behavior Analyst License applications still in review: 10

Reasons for continued review: Applications are In Progress.

MINNESOTA
BOARD OF PSYCHOLOGY

Minnesota Board of Psychology
Consent Agenda Items:
Staff Delegated Compliance Report
Data from 2/20/26 – 3/19/26

Complaint Data – Open/NJ/FWD
Data on complaints that have been received since the February 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
4	2	2	2

Behavior Analysts:

Total Complaints	Opened	Non-Jurisdictional	Forwarded
1	1	0	0

Complaint Data – Reviews
Compliance data that has been reviewed since the February Board meeting.

Licensed Psychologists:

Triage Cases	Dismissed Cases	Disciplinary Conferences	SCOs Offered	NOC Assigned	Disciplinary/ Corrective Action Assigned
10	8	2	1 (ACA)	0	0

Behavior Analysts:

Triage Cases	Dismissed Cases	Disciplinary Conferences	SCOs Offered	NOC Assigned	Disciplinary/ Corrective Action Assigned
6	3	2	1 (ACA)	0	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 2/20/26 – 3/19/26.

Licensed Psychologists:

Currently Open Complaints (under review)	**Days Taken** (average amt of days since 1/28/26)	**Closed Complaints**
Investigative review: 54	<1	6
Committee review: 24		

Behavior Analysts:

Currently Open Complaints (under review)	**Days Taken** (average amt of days since 1/28/26)	**Closed Complaints**
Investigative review: 2	<1	0
Committee review: 6		

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

SUBMITTED BY: Executive Director

TITLE: AI in Psychology Practice

INTRODUCTION TO THE TOPIC:

Articles relevant to AI in Psychology are provided for your review.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
HF3893 - AI Therapy in Minnesota Bill	3/13/2026	Cover Memo
"Feasible but Fragile": An Inflection Point for Artificial Intelligence in Mental Health Care	3/13/2026	Cover Memo
The Role of Artificial Intelligence in Clinical Psychology: How AI and NLP Systems Are Reshaping Psychological Interventions. A Systematic Review	3/13/2026	Cover Memo
Ethical Guidance for AI in the Professional Practice of Health Service Psychology	3/13/2026	Cover Memo
APA is Impacting AI for the better	3/13/2026	Cover Memo
Proposed New York law would bar AI chatbots from posing as lawyers, allow duped users to sue	3/13/2026	Cover Memo

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3893

03/02/2026 Authored by Scott, Liebling, Robbins, Keeler and Tabke
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health occupations; regulating use of artificial intelligence in psychotherapy services; providing for civil penalties; proposing coding for new law in Minnesota Statutes, chapter 214.

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

Section 1. **[214.165] REGULATING USE OF ARTIFICIAL INTELLIGENCE IN PSYCHOTHERAPY SERVICES.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Administrative or supplementary support" means tasks performed to assist a licensed professional in the delivery of therapy or psychotherapy services that do not involve therapeutic communication. Administrative or supplementary support includes but is not limited to:

(1) preparing and maintaining client records, including but not limited to therapy notes;

(2) managing appointment scheduling and reminders;

(3) processing billing and insurance claims;

(4) analyzing anonymized data to track client progress or identify trends for review by a licensed professional;

(5) identifying and organizing external resources or referrals for client use; and

(6) drafting general communications related to therapy logistics that do not include therapeutic advice.

(c) "Artificial intelligence system" means any machine-based system that, for any explicit or implicit objective, calculates from the inputs the system receives how to generate outputs, including but not limited to content, decisions, predictions, or recommendations, that can influence physical or virtual environments.

(d) "Health-related licensing board" has the meaning given in section 214.01, subdivision 2.

(e) "Licensed professional" means an individual who holds a valid license issued in Minnesota to provide therapy or psychotherapy services, including but not limited to:

(1) a licensed psychologist providing clinical services under sections 148.88 to 148.981;

(2) a licensed social worker or independent clinical social worker under chapter 148E;

(3) a licensed professional counselor or licensed professional clinical counselor under sections 148B.50 to 148B.75;

(4) a licensed marriage and family therapist under sections 148B.06 to 148B.392;

(5) a licensed alcohol and drug counselor authorized to provide therapy or psychotherapy services under chapter 148F;

(6) a licensed behavioral analyst under sections 148.9981 to 148.9995;

(7) a licensed physician under chapter 147; and

(8) any other health professional authorized in Minnesota to provide therapy or psychotherapy services.

(f) "Peer support" means services provided by individuals with lived experience of mental health conditions or recovery from substance use that are intended to offer encouragement, understanding, and guidance without clinical intervention.

(g) "Religious counseling" means counseling provided by clergy members, pastoral counselors, or other religious leaders acting within the scope of their religious duties if the services are explicitly faith based and are not represented as clinical mental health, therapy, or psychotherapy services.

(h) "Therapeutic communication" means any verbal, nonverbal, or written interaction conducted in a clinical or professional setting that is intended to diagnose, treat, or address an individual's mental, emotional, or behavioral health concerns. Therapeutic communication includes but is not limited to:

(1) directly interacting with clients for the purpose of understanding or reflecting the client's thoughts, emotions, or experiences;

(2) providing guidance, therapeutic strategies, or interventions designed to achieve mental health outcomes;

(3) offering emotional support, reassurance, or empathy in response to psychological or emotional distress;

(4) collaborating with clients to develop or modify therapeutic goals or treatment plans; and

(5) offering behavioral feedback intended to promote psychological growth or address mental health conditions.

(i) "Therapy or psychotherapy services" means services provided to diagnose, treat, or improve an individual's mental health or behavioral health.

Subd. 2. **Prohibited uses of artificial intelligence.** (a) An individual, corporation, or entity must not provide, advertise, or otherwise offer therapy or psychotherapy services to the public in Minnesota unless the therapy or psychotherapy services are conducted by an individual who is a licensed professional.

(b) A licensed professional must not use artificial intelligence systems 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.

Subd. 3. **Permitted uses of artificial intelligence.** A licensed professional may use artificial intelligence systems to assist in providing administrative or supplementary support in therapy or psychotherapy services if the licensed professional maintains full responsibility for all interactions, outputs, and data use associated with the system.

Subd. 4. **Enforcement, penalties, and hearings.** (a) Any individual, corporation, or entity found in violation of this section must pay a civil penalty to the health-related licensing board responsible for regulating the relevant profession in an amount not to exceed $10,000 per violation.

(b) The health-related licensing board responsible for regulating the relevant profession must determine the amount of the penalty so as to deprive the licensee of any economic advantage gained by reason of the violation, to discourage similar violations, or to reimburse

the board for the cost of investigation and proceeding, including but not limited to fees paid for services provided by the Court of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(c) The health-related licensing board responsible for regulating the relevant profession must provide the individual, corporation, or entity with written notice of the finding of a violation and the imposition of a civil penalty that includes the reasons for the finding, the amount of the civil penalty, and the right to request a hearing under chapter 14. An individual, corporation, or entity must request a contested case hearing under chapter 14 from the health-related licensing board within 30 days of receiving the notice in this paragraph.

(d) An individual, corporation, or entity found in violation of this section must pay the civil penalty within 60 days after notice of the violation and imposition of civil penalty under paragraph (c) or after the date of an order issued following a contested case hearing under chapter 14, whichever is later.

(e) Each health-related licensing board responsible for regulating a licensed professional under this section has the authority to investigate any actual, alleged, or suspected violation of this section.

Subd. 5. **Exceptions.** This section does not apply to:

(1) religious counseling;

(2) peer support; or

(3) self-help materials and educational resources that are available to the public and do not purport to offer therapy or psychotherapy services.

EFFECTIVE DATE. This section is effective the day following final enactment.

News and Perspective

"Feasible but Fragile": An Inflection Point for Artificial Intelligence in Mental Health Care

Kayleigh-Ann Clegg, JMIR Correspondent

Key Takeaways

- The future of artificial intelligence (AI) tools in mental health care is at an inflection point; regulators are taking both the potential benefits and the risks of these tools seriously.
- Whether these tools succeed or fail to meet their potential for improving mental health care depends on the extent to which stakeholders are able to successfully seize the moment and collaborate on transparent, high-quality research; establish and incentivize safety and efficacy; adopt patient-centric benchmarks; and think beyond traditional therapeutic models.

On November 18, 2025, a congressional hearing was held in Washington, DC, by the US House Energy and Commerce's Subcommittee on Oversight and Investigations, examining the risks and benefits of artificial intelligence (AI) chatbots [1,2].

Marlynn Wei, MD, JD; Jennifer King, PhD; and John Torous, MBI, MD (director of digital psychiatry at Beth Israel Deaconess Medical School and associate professor of psychiatry at Harvard Medical School) provided expert testimony at the congressional hearing [3-5]. I sat down with Torous to discuss his reflections on the future of AI in mental health.

An Inflection Point

Following on the heels of several lawsuits [6] and mounting concerns about the safety of commercially available AI chatbots and their widespread "off-label" use as psychological support [7,8], November's congressional hearing was somewhat anomalous—in a good way.

"I actually am optimistic," says Torous, "because we never saw a congressional oversight committee form in the early days when social media came out or when apps came out or when VR [virtual reality] came out. It's exciting to see a body like Congress taking the time and attention to try to understand what the issue is."

He remarks that it's a different trajectory than we've seen over the past 25 years of digital health innovation, one that simultaneously signals that "we're seeing the end of AI exceptionalism in mental health." It suggests that regulators are taking the risks seriously and that AI—whether purpose-built or used de facto—will not be exempt from the same scrutiny applied to other clinical tools.

It's also a potential inflection point from the otherwise rapid and underregulated growth and proliferation of AI tools for mental health, including many chatbots whose safety and efficacy remain to be definitively established [9,10]. The shape of the trajectory now—whether these tools succeed or fail to materialize their potential for improving mental health care—depends on what we do from here.

Shift the Incentive Structures

To shift toward the development of sustainable, effective AI tools for mental health, Torous says, we need to shift the incentive structures—through clear, enforceable standards—for companies developing them. Instead of optimizing for engagement, we should be optimizing for privacy, safety, and efficacy.

"It's better that we have competition based on what are safer and more effective products," he says, for both the end users and the companies themselves. Otherwise, "it's only going to be the people with the most marketing budget who win. It's anti-innovation if we don't have some standards."

We can draw lessons from the trajectories of other digital health tools for mental health, like mental health apps, and avoid repeating past mistakes: "We tried winning on number of clicks and engagement; it did not make apps safer. It did not make them more effective, and it kind of destroyed the market for apps," he says. "Competing on engagement is a zero-sum game, it's a race to the bottom—and the bottom is pretty bleak."

Prioritize Collaboration, Transparency, and Research

Developing the standards necessary to shift those incentive structures first and foremost requires collaboration between all stakeholders.

Establishing the "rules of the road" for that collaboration can be tricky, Torous says, but necessary. While there need to be penalties, for example, when companies act in bad faith, the core aims of regulation and oversight should be encouraging transparency and data sharing, and treating improvements in AI chatbots and other tools as a mutual endeavor.

Funding rigorous, well-designed, replicable research should follow. "I think the first study would need to be a large, open, transparent study to set the bar and understand what we're dealing with," says Torous. Foundational research is needed to determine and confirm, among other things, patterns of use, causes and base rates of potential risks, and potential benefits associated with use of both commercially available and purpose-built AI tools.

Adopt Patient-Centric Benchmarks

Ensuring real benefit and minimizing harm from AI tools for mental health will require centering the patient and patient needs. The human should be the focus of any research conducted or standards adopted.

This is something that Torous and his research team are already working on, and a value that has been at the core of their work for many years. Building on their experience developing MindApps.org [11], an assessment framework and free app library to help people make informed decisions about which mental health apps might best suit their needs, they have partnered with the National Alliance on Mental Illness (NAMI) on a project they're calling "MindBench.ai" [12].

MindBench.ai will function similarly as an assessment framework and platform that people can use to make decisions about large language models (LLMs) and LLM-based mental health tools. But instead of using static evaluation criteria, the team will develop dynamic, rigorous safety and performance benchmarks based on patient input.

"We're going to meet with patient groups around the country," says Torous. "And we're going to say: 'What are you most excited about? What are you most worried about? Let's build these benchmarks that will help us understand if these chatbots meet your needs as real people on the ground.' We're really excited that this is going to bring the voice of patients to the forefront."

In co-designing and standardizing benchmarks, the project will not only protect and help patients but also help incentivize and give companies something to work toward. "No one wakes up and says, 'I'm so excited my chatbot is causing harm,'" Torous says. "I really have full confidence that, with guidance, companies will love it because they want to make [their products] better."

While MindBench.ai will initially be focused on chatbots designed for mental health, if useful, it could eventually be expanded to incorporate other kinds of tools or used as an example to guide the development of similar frameworks.

Think Beyond Traditional Models

There's a further vision that Torous is excited about, one which speaks to a sometimes underrecognized harm: missed opportunity. It involves the importance of thinking outside the box and beyond traditional therapeutic models.

"The next generation [of mental health tools] is going to be much more powerful, much more personalized," he says. "When you're bringing in that much new information about people's environments, their physiology, their emotions, and their words, we could consider redefining [existing nosologies], making functional definitions of mental illnesses."

We could also, he says, move beyond using chatbots to replicate already-established kinds of treatment. "I think what we're seeing about to happen in 2026 is the first time we can not only collect such personalized raw data about mental health, but we also have the computing power to now turn that into personalized insights," he says. "You could imagine there's a world where we could actually build new therapy treatments. We have this whole new world of personal insights that can drive personalized treatments."

This immense potential, however, hinges on regulation, safety, and trust. "Of course there's tremendous risk when you have a lot of personal data. And I think that's also why it makes sense to have more safety and regulation in place, because then there's a trust to really think about rebuilding what mental health treatment is and to use this [opportunity] for what it is."

Feasible but Fragile

Torous comes across as level-headed, pragmatic, and principled—prone to neither nostalgic hand-wringing nor uncritical techno-optimism. His vision of the potential for AI in mental health is both measured and forward-looking. For me, as a cautious psychologist and occasional hand-wringer, it inspires optimism.

"There's real potential here," he says. With rigorous, collaborative research and regulation to shape it, the "AI bubble" need not burst or engulf us all; instead, it can solidify into something genuinely transformative for mental health. "It's feasible, but fragile."

"Feasible, but fragile"—an apt description and a call to action for researchers, regulators, patients and patient advocates, innovators, and clinicians alike.

Keywords: artificial intelligence; chatbots; mobile apps; telemedicine; digital health; psychiatry; mental health; mental disorders; disease models; theoretical

Conflicts of Interest

John Torous is the editor in chief of *JMIR Mental Health*, a JMIR Publications journal, at the time of this publication.

References

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2. O&I hearing: innovation with integrity: examining the risks and benefits of AI chatbots. House Energy and Commerce Committee YouTube page. Nov 18, 2025. URL: https://www.youtube.com/watch?v=6rGZxWs-TA0 [Accessed 2025-12-11]
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The Role of Artificial Intelligence in Clinical Psychology: How AI and NLP Systems Are Reshaping Psychological Interventions. A Systematic Review

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ABSTRACT

Artificial Intelligence (AI) technologies are rapidly evolving and their integration into psychological practices has progressively expanded, offering new tools for diagnosis, treatment and therapeutic monitoring. This review examines the transformative role of AI, particularly Natural Language Processing (NLP) systems, in reshaping clinical psychology and digital mental health interventions (DMHIs). In particular, it explores how AI and NLP can facilitate human-machine interaction in therapy by analysing how language is used within clinical conversations and providing personalized, real-time interventions. Following PRISMA guidelines, a systematic review of literature from 2019 to 2025 identified 17 studies that met inclusion criteria, emphasizing AI's use in psychological assessment and intervention. The review focuses on two key aspects: the functions and applications of NLP-based systems in clinical practice and the advantages and benefits they offer for both psychologists and patients. Findings suggest that NLP-driven AI systems enhance both patient engagement and clinician efficiency, offering scalable, cost-effective solutions that improve access and personalization. However, challenges remain, including ethical concerns around data privacy, lack of standardization, limited generalizability across disorders and reduced human empathy. Moreover, current systems are primarily designed for well-defined conditions like anxiety and depression, with limited applicability to complex or comorbid psychological presentations. This review underscores the importance of supervised, ethically governed AI implementation. While AI holds substantial promise in augmenting clinical psychology, its success depends on maintaining human oversight, ensuring transparency and establishing shared scientific and ethical standards across the psychological community.

1 | Introduction

In recent years, rapid advancements in Artificial Intelligence (AI) have made it an integral part of people's everyday life. The overarching goal is to develop increasingly precise AI systems, capable of mastering a wide range of tasks such as learning, planning, reasoning and language comprehension (Stuart and Peter 2016). AI systems can be understood as integrated architectures that coordinate multiple components to handle complex tasks (Stuart and Peter 2016). They are based on a series of mathematical approaches employed to teach AI how to process data and make decisions to increase efficiency, analytics and automation capabilities (Sarker 2022).

The main techniques currently adopted include: Machine Learning (ML), which is a core subfield of AI that enables machines to learn from data and make decisions based on them without being explicitly programmed to do so (Alpaydin 2020);

Summary

- Through the systematic review of the existing literature regarding the use of AI in clinical psychology, practitioners could know how AI and NLP systems are (re)shaping psychological interventions to improve them for digital mental health (DMH).
- The study describes characteristics, features and tasks of AI systems in clinical psychology, the main techniques currently adopted, from which practitioners can find information to choose the best tools for their work objectives, adapting to specific individual psychological needs.
- Practitioners could evaluate AI systems' impact on DMH promotion: beneficial effects of AI systems for patients' mental health and related challenges. Indeed, while on one hand the implementation of AI in clinical psychology has demonstrated significant improvements in psychological well-being, on the other hand some studies have reported less conclusive findings.

Deep Learning—a class of ML algorithms using multiple layers to extract features from raw inputs—which uses artificial neural networks (NNs) to analyse large amounts of complex data (Goodfellow et al. 2016); Natural Language Processing (NLP), a subfield of AI addressing human-machine interactions, which allows for understanding, interpreting and responding to natural language (Chang et al. 2018; Jurafsky and Martin 2023). Another category of models that boosted the adoption of AI across various domains is Large Language Models (LLMs), which are designed to understand, process and generate natural language (Raiaan et al. 2024). LLMs are a class of AI systems trained on vast amounts of textual data in order to learn the distinctive features of natural language, such as structure, meaning and context, and perform several language tasks (Bommasani et al. 2022). After learning such features, they can produce new meaningful content in the form of text, images or audio (Feuerriegel et al. 2024).

Based on these AI models, increasingly sophisticated tools capable of generating content and interacting with humans have emerged. AI tools are particular applications or algorithms that perform a specific task (Stuart and Peter 2016). Notable examples include chatbots such as ChatGPT, Gemini, LLama and Bard. These are AI-based systems that, leveraging NLP and ML techniques, can interact with users through natural language (Radziwill and Benton 2017). As AI knowledge and understanding have advanced, these tools have evolved significantly, finding applications across diverse fields such as economics, finance, engineering, education, medicine and psychology (Stone et al. 2022).

In psychology, AI was first introduced in 1966, with the development of ELIZA: the first chatbot designed to simulate psychotherapy (Adamopoulou and Moussiades 2020). Rather than providing interpretative responses, ELIZA merely rephrased users' statements through a combination of text recognition models (Pattern Matching) and predefined rules, identifying keywords and generating responses accordingly (Gwon and Seo 2021).

Since ELIZA, AI began to be utilized as a supportive tool in psychiatric diagnosis, enabled by ML and big data analysis. Nowadays, ML techniques are being developed for screening models that assess the risk of mental disorders (Shatte et al. 2019). For example, neuroimaging techniques help distinguish Alzheimer's symptoms from normal aging (Doan et al. 2017), detect vulnerability to depression (Sato et al. 2015) and assess the risk of psychosis (Koutsouleris et al. 2012). Regarding the diagnostic process, AI applications use large datasets to enable early diagnoses (Dimitriadis et al. 2018) and to improve detection for disorders with overlapping symptomatology (Bosl et al. 2017). For example, ML integrated with electroencephalogram (EEG) can differentiate autism spectrum disorders from epilepsy, while audio-visual data models enhance diagnostic accuracy for Alzheimer (König et al. 2015), schizophrenia (Tron et al. 2016) and suicidal intent (Pestian et al. 2016). ML-based models help distinguish ADHD (Attention Deficit Hyperactivity Disorder) from bipolar disorders and ML techniques have been used for prognosis of certain disorders. Specifically, they have been applied to predict the long-term outcomes of conditions such as Alzheimer, depression, psychosis and PTSD (Shatte et al. 2019). Lastly, ML techniques are also applied to monitor behavioural changes linked to mental disorders and direct patients to appropriate support systems (Orrù et al. 2024), particularly for suicide risk or addiction treatments (Shatte et al. 2019).

Linked to this, online interactions' analysis has been employed to predict individuals' ability to recover from nicotine and alcohol abuse (Shatte et al. 2019). Here is where NLP is applied. Indeed, NLP tools allow the automated analysis of large volumes of textual data, helping clinicians to identify meaningful linguistic patterns, track patient progress and improve research on therapeutic processes, ultimately providing data-driven insights for personalized treatment (Atzil-Slonim et al. 2024; Kuo et al. 2024). NLP models that analyse textual data (Orrù et al. 2024; Turchi et al. 2024) have been used to detect suicidal intentions from transcripts of psychological sessions (Oseguera et al. 2017), schizophrenia symptoms (Strous et al. 2009) and depressive signs from social media data (Wu et al. 2012).

Both Machine Learning and NLP have contributed to the development of more sophisticated psychological tools, especially apps and chatbots (Natale 2019). In psychological intervention, chatbots are the most employed tools: they are used, for example, for suicide prevention, widely in Cognitive-Behavioural Therapy (CBT) – a psychotherapeutic intervention focused on identifying and modifying negative thought patterns affecting emotions and behaviours (Hofmann et al. 2012; Nakao et al. 2021) – and provide support for various disorders such as anxiety, depression and PTSD (Bertl et al. 2022). They also offer anonymous access to interventions for individuals reluctant to seek professional help due to stigma or fear of judgement, ensuring immediate support beyond traditional therapist hours (Pretorius et al. 2019).

Examples of such tools include Tess, Wysa and Woebot (Fitzpatrick et al. 2017; Fulmer et al. 2018; Gionet 2018; Inkster et al. 2018), interactive agents that can detect, report and explain expressions of emotional distress. These tools not only provide clinical explanations of users' experiences but also offer tailored advice, helping patients recognize emotional patterns and develop coping strategies for anxiety and depressive symptoms

(Haque and Rubya 2023). Other examples are Kognito (Rein et al. 2018), an educational platform for suicide risk prevention and the Avatar Project (Craig et al. 2018), which helps patients manage persistent auditory and visual hallucinations related to psychosis. These latter are computer-generated avatars interacting dynamically with patients that are used in interventions targeting disorders such as psychosis, schizophrenia, depression and phobias.

Thus, the application of AI in clinical psychology aims to enhance the efficiency and accessibility of psychological services. Particularly in the field of Digital Mental Health Interventions (DMHIs), AI-based systems have demonstrated a broad spectrum of applications, improving both therapists' practices and users' experiences (Olawade et al. 2024). Currently, these systems can be categorized into three macro-categories: apps and bots, avatars and robots that range from basic messaging applications with instant messaging to interactive agents. However, ethical and practical concerns remain regarding the adoption of AI, particularly in the psychological field (Dwyer et al. 2018). Key issues include privacy, data security, transparency, informed consent, bias, over-standardization and replicability, impact on practitioners, unknown long-term effects (Chenneville et al. 2024). Risks vary across AI applications in training, evaluation and intervention. For instance, if improperly trained, Large Language Models might reinforce diagnostic stigma and fail to comply with established ethical standards in clinical psychology (Lawrence et al. 2024). Additionally, psychotherapy frameworks differ significantly from one another, making it challenging to integrate AI systems capable of providing effective responses for highly complex conditions with comorbidities (Stade et al. 2024).

A further concern is the potential dependency patients may develop on these AI-driven tools, hindering their ability to generalize coping strategies to real-world human interactions. Vulnerable groups, including children, the elderly and individuals with cognitive disabilities may struggle to understand AI functionalities or mistakenly assume clinical supervision is involved (Meadi et al. 2025). Additionally, AI systems may face ethical dilemmas: for instance, detecting a high suicide risk without the ability to evaluate broader contextual clues, which are crucial in human decision-making.

Despite these issues, AI applications in digital mental health (DMH) are expanding, given their potential for reliability, effectiveness and efficiency in clinical practice. In this context, reviewing AI integration in clinical psychology is essential to understanding both its benefits and limitations (Lee and Ahn 2020).

Considering all of the above, this study aims to provide an overview of studies examining the use of AI, with particular focus on NLP-based systems, in the field of clinical psychology. The reason that grounded the choice to focus our investigation solely on these was that psychotherapy and clinical sessions are characterized by the patient-practitioner interaction through question, answer and discourses, thus concerning what is continuously being said through natural language. Specifically, the review focuses on two key aspects: (1) the (functions and) applications of NLP-based systems in clinical practice; (2) the advantages and benefits they offer for both psychologists and patients.

The review is structured as follows: the 'Methods and Procedures' section outlines the systematic review methodology, detailing the research process and criteria for study selection. The "Results" section presents findings from the eligible studies divided into two paragraphs, respectively (1) characteristics and tasks of AI systems; (2) beneficial effects of these systems on patients and practitioners, also highlighting the clinical pictures and interventions. Lastly, the 'Discussion' section synthesizes and critically discusses the main findings including ethical issues associated with AI adoption in clinical settings. It also provides an informed perspective on the future implementation of AI and NLP in psychological practice.

2 | Methods and Procedures

2.1 | Search and Selection Strategy

This review was conducted in accordance with the PRISMA guidelines (Preferred Reporting Items for Systematic reviews and Meta-Analysis).

A systematic search was performed using the PsycNet, Web of Science and Scopus databases. The search query by keywords is shown in Table 1; it was the same for all three databases. Articles were automatically extracted from all databases on 8 April 2025.

These keywords were selected to align with the dual objective of this review: (1) to examine the applications of AI systems in the field of clinical psychology; (2) to evaluate their impact on DMH promotion and positive effects for patients and therapists.

In addition, the following filters were applied in the search:

- Publication year: > 2018 and < 2025;
- Article type: only research papers (no reviews, commentary, letters nor conference papers);
- Language: English and Italian;
- Publishing stage: only already published papers in peer-reviewed journals (no pre-prints, grey literature, etc.).

Subject area: Psychology, Computer Science. It was decided to search articles published from 2019 mainly due to the recency of the topic, for which it was evaluated as adequate to consider papers non-older than 5 years. Moreover, the year before (2018) was pivotal for the developments in that field. Indeed, BERT—one of the most known Transformer models—was developed in 2018 and in

TABLE 1 | Relevant keywords for articles selection.

'artificial intelligence', OR 'machine learning'	AND	'change', OR 'clinical psychology', OR 'mental health', OR 'psychotherapy', OR 'cognitive assistant', OR 'psychologist'

2019 Google began to use it to compute research queries. Also, in 2018 the OpenAI GPT transformer series became the state-of-the-art in natural language generation (NLG). Thus, selecting papers published from the following year (2019) was considered strategic for the aim of the review.

The data collection process began at the end of November 2024 and concluded in April 2025. All retrieved studies were compiled into a unified dataset and duplicate entries were removed. Following this first screening phase, a total of 883 papers were identified.

The second screening involved evaluating the relevance of title and abstract concerning the topics of this review. The titles and abstracts of the identified studies were independently screened by two reviewers, in order to determine their relevance: the reviewers were not blinded to each other's decisions but discussed differences openly, resolving disagreements through discussion. If consensus was not reached, a third reviewer was involved to make the final decision. Decisions regarding study inclusion were recorded in an Excel spreadsheet, where each entry included the study reference, reasons for inclusion/exclusion and reviewer comments. This phase resulted in 165 selected papers.

At this point, the focus was narrowed exclusively to those addressing text analysis and NLP applications, reducing the count to 34 papers that were fully analysed. This last criterion allowed us to focus on research that delves deeper into DMH promotion in clinical psychology through the study of conversations about psychological treatments between patients and practitioners. Indeed, within the clinical psychology field, it is paramount to have access to the patients' text (their narrative) in order to be able to carry out the anamnesis, diagnosis and intervene on the reported symptoms and health configuration. The risk of bias and quality of the included studies were assessed by two independent reviewers, with a third reviewer available to resolve any disagreements and to assess internal validity. The assessment has been done at outcome level, evaluating the relevance and coherence of the data to the review questions, completeness of outcome data and handling of missing data. The results of the risk of bias assessment have been considered for the interpretation of findings, discussing studies with high risk of bias will be discussed with caution.

During this in-depth analysis, the following additional inclusion criteria were applied: (3) psychological assessment or intervention as the primary focus of the paper, (4) AI used for supporting and/or enhancing interventions and (5) discussion of psychological/clinical impact of AI-assisted intervention. Furthermore, the exclusion criteria were defined as follows: (6) Studies not related to human psychological conditions.and (7) studies describing theoretical protocols without application results. These further criteria were applied in order to guarantee relevance to the review's aims and for the field of application: indeed, as an example, maintaining studies without application results would not provide fruitful insights for clinical psychologists. Again, this process was conducted by two independent reviewers as described above. It is specified that, for both phases, inter-rater reliability was not assessed. They extracted the data from the selected studies using a standardized data extraction form, based on the two review questions (stated above). Thus, information will relate to: name and/or type of AI system; psychological theories, methods and techniques on which the system is based; technology on which the system is based; the presence or absence of effects on patients and practitioners; beneficial effects on patients and practitioners. Ultimately, 17 papers met the full eligibility criteria and were included in this review. Figure 1 summarizes all the steps now described, from identification to screening and inclusion.

3 | Results

3.1 | Characteristics of Included Studies

Table 2 reports the 17 studies included in this review. The table shows some bibliographic details as well as the positioning of them in relation to:

- main target of the system (patients or therapists)
- type of intervention (supportive or substitutional)
- type of disorder (psychological or psychological on medical-base) and sample
- psychological theory of reference

Appendix S1 explains the categorization used to classify systems.

Appendix S2 reports a summary table of the included studies, showing for each paper its aim(s), sample, intervention/tool, disorder, study design, key results and effect sizes (if present).

3.2 | Characteristics, Features and Tasks of AI Systems in Clinical Psychology

From the studies reviewed, it can be noted that a range of diverse sets of tools aimed at supporting mental health have been developed. These include intelligent chatbots designed for emotional support and therapeutic guidance, systems for real-time risk assessment and mood tracking and analytical platforms for assisting clinicians in evaluating therapeutic processes. Together, these systems reflect the growing integration of AI across both user-facing mental health interventions and backend clinical workflows.

Starting with systems developed as conversational agents, the Behavioural Activation-based AI chatbot by Rathnayaka et al. (2022) provides personalized conversation, emotional support and remote mental health monitoring. The conversation engine has BA-oriented NLP modules, divided in (a) feature extractor, for preprocessing and representation learning of the user-generated text; (b) intent and entity extraction, used to identify and annotate the intention of user utterances; (c) response selection. The emotional support recommends activities (from a bank of common ones and based on the user feedback and mood) that positively impact the user's mood. The remote mental health monitoring is based on Ecological Momentary Assessment (EMA): starting from the emotions expressed in the previous components, it calculates a mood

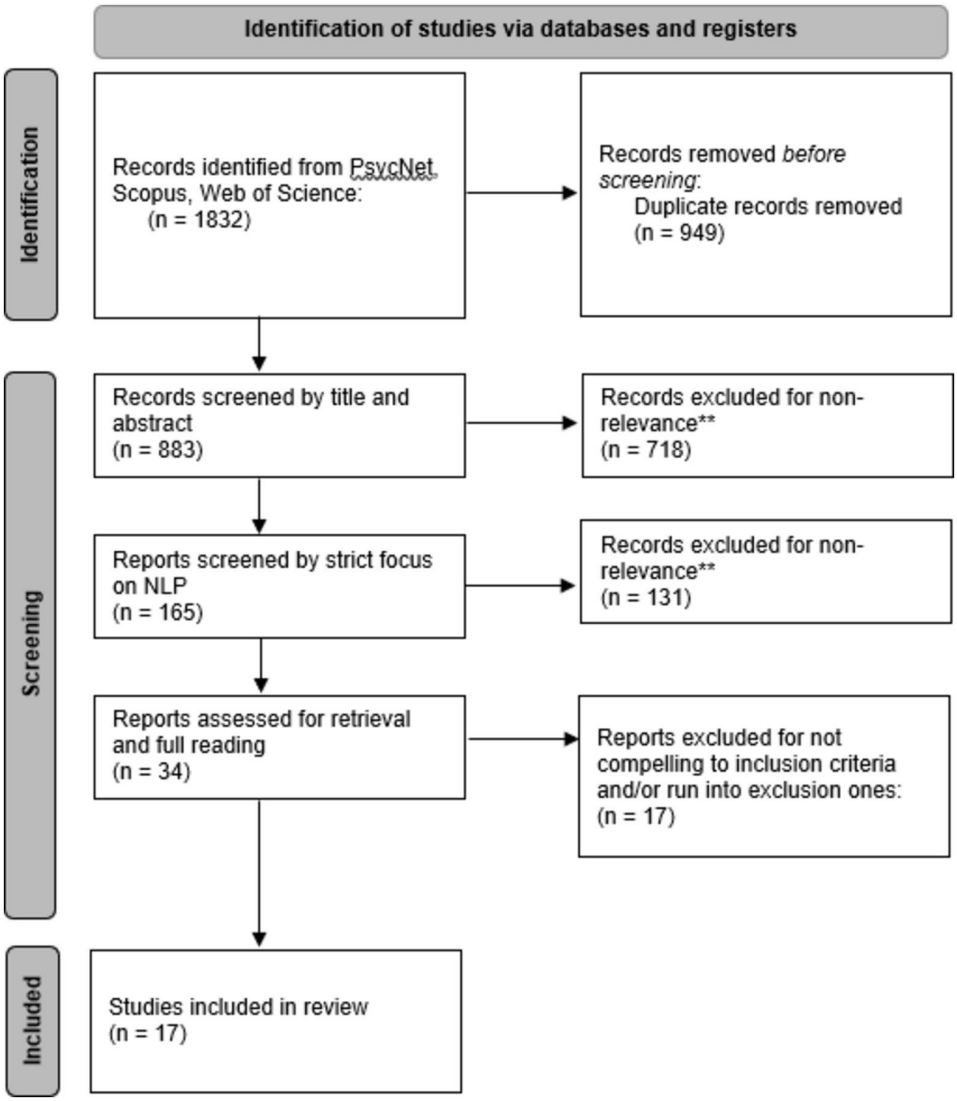

FIGURE 1 | PRISMA review flowchart.

score between 0 and 10 during a seven-days rolling period by using pre-trained NLP emotion recognition and sentiment analysis models. This focus on personalized, responsive interactions is also central in other chatbot-based solutions. Omarov et al. (2023) built an AI-enabled mobile chatbot psychologist leveraging Artificial Intelligence Markup Language (AIML) and Cognitive Behavioural Therapy (CBT) to offer personalized psychological interventions, while Pandey et al. (2022) built 'Ted', a web-based chatbot using NLP and Deep Learning approaches to help people with mental health-related issues. In the first one, the use of AIML allows the chatbot to engage users in natural and effective conversations, fostering a sense of connection by understanding their inputs and generating contextually appropriate responses. The chatbot is designed to adapt to the user's needs, detecting their emotional state and providing personalized support accordingly in order to ensure its intervention effectiveness. On the other hand, Ted allows its users to interact through natural language: user messages are lemmatized and pre-processed before being passed to the Deep Learning model that generates the appropriate response (which also continuously improves over time). Specifically, it identifies the intents and contexts from users' text to interact with them.

Some studies provide data of chatbots with therapeutic aims tested in real-world interventions. Chiauzzi et al. (2024) adopted Woebot for Mood and Anxiety (W-MA-02), a relational agent that guides users through psychotherapeutic content (based on CBT, Interpersonal Psychotherapy [IPT] and Dialectical Behaviour Therapy [DBT]) using text-based messages. It uses proprietary NLP to help users develop emotion regulation skills in relation to everyday life problems. In particular, it helps users address mood monitoring and management, also employing progress reflection, gratitude journaling and mindfulness practice. Despite not being developed as disorder-specific, in Chiauzzi et al.'s study it was used to assess depressive or anxiety symptoms changes after 8 weeks of usage participants self-reporting clinical levels of such symptoms. Similarly, Beatty et al. (2022) investigated Wysa, a free-text AI-based mobile conversation agent aimed at promoting wellbeing, positive self-expression and mental resilience. In particular, they studied the therapeutic alliance between the conversational agent and users, considering that it was demonstrated that a higher engagement leads to improvement in self-reported depressive symptoms. Using CBT-based techniques, Wysa provides a therapeutic virtual space where users can discuss their emotions and events in their lives: the conversational agent provides them with AI-guided

TABLE 2 | Selected studies with bibliographic details and main characteristics (see Appendix S1 for the explanation of the categorization used to classify systems).

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Demographic and clinical characteristics associated with anxiety and depressive symptom outcomes in users of a digital mental health intervention incorporating a relational agent	Chiauzzi, E., Williams, A., Mariano, T. Y., Pajarito, S., Robinson, A., Kirvin-Quamme, A. and Forman-Hoffman, V.	2024	BMC Psychiatry	Woebot for Mood and Anxiety (W-MA-02), a relational agent that utilizes thoughtful conversational design and some NLP to deliver intervention.			Delivers intervention following CBT, IPT and DBT through a text-based interface on a smartphone app.	Depression, Anxiety.256 participants, of which: 111 with elevated baseline levels of depressive symptoms; 107 with elevated baseline levels of anxiety symptoms.	
Computational psychotherapy system for mental health prediction and behaviour change with a conversational agent	Kolenik, T., Schiepek, G. and Gams, M.	2024	Neuropsychiatric Disease and Treatment	Novel artificial cognitive architecture that, from real-time free text, understands its user and offers effective personalized help for relieving SAD symptoms.		LLMs generate linguistic outputs as a response to the input text in the form of motivational messages personalized to the user's personality. At the end of a specific conversation the system re-evaluates the user's well-being and (a) offers adapted strategies if it has not changed or (b) teach new strategies for future use if it has improved.		SAD (Stress, Anxiety and Depression)	
Future of ADHD Care: Evaluating the Efficacy of ChatGPT in Therapy Enhancement	Berrezueta-Guzman, S., Kandil, M., Martín-Ruiz, M. L., Pau de la Cruz, I. and Krusche, S.	2023	Healthcare	Developed a Custom ChatGPT (to be validated by therapeutic experts before being implemented) for a robotic assistant supporting ADHD therapies.			In the interaction between ChatGPT and the therapists three categories have been measured: (1) Insight into Patient's Emotional State; (2) Tailored and Personalized Responses; (3) Overall Effectiveness as a Therapeutic Tool.		ADHDSample of 10 esteemed experts in therapies for children with ADHD.

(Continues)

TABLE 2 | (Continued)

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Improving the Well-being of Adolescents With Type 1 Diabetes During the COVID-19 Pandemic: Qualitative Study Exploring Acceptability and Clinical Usability of a Self-compassion Chatbot	Boggiss, A., Consedine, N., Hopkins, S., Silvester, C., Jefferies, C., Hofman, P. and Serlachius, A.	2023	JMIR diabetes	COMPASS, a chatbot app intervention for adolescents T1D. Examines acceptability and potential clinical utility in adolescents with T1D and their diabetes health care professionals.		The COMPASS chatbot is designed to deliver daily content in 14 conversational lessons daily across 2 weeks, aimed at facilitating self-compassion coping skills for adolescents with T1D.			Type 1 Diabetes (T1D). 15 to 20 adolescents with T1D (aged between 12 and 16 years) and 10 to 15 diabetes health care professionals.
Artificial Intelligence Enabled Mobile Chatbot Psychologist using AIML and Cognitive Behavioural Therapy	Omarov, B., Zhumanov, Z., Gumar, A. and Kuntunova, L.	2023	International Journal of Advanced Computer Science and Applications	AI-enabled mobile chatbot psychologist that leverages AIML and CBT to offer personalized psychological interventions. It adapts to user's needs, recognizing their emotional state and providing personalized support accordingly.			Alternative to traditional therapy for accessible, cost-effective and efficient mental health care solutions. It provides personalized psychological support through a mobile platform, mental health professionals and individuals.	Mental health issues for which CBT has been proven effective: anxiety, depression, stress and phobias.	
Evaluating the Therapeutic Alliance with a Free-Text CBT Conversational Agent (Wysa): A Mixed-Methods Study	Beatty, C., Malik, T., Meheli, S. and Sinha, C.	2022	Frontiers in Digital Health	Mixed-methods investigation of the therapeutic alliance between a free-text, CBT-based conversational agent (Wysa) and users.			AI-based emotionally intelligent mobile conversational agent app aimed at promoting wellbeing, positive self-expression and mental resilience using a text based conversational interface.	Anxiety and Depression. 1205 users screen positively on the PHQ-4 for anxiety or depression symptoms.	

(Continues)

TABLE 2 | (Continued)

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Mental healthcare chatbot based on natural language processing and deep learning approaches: Ted the therapist	Pandey, S., Sharma, S. and Wazir, S.	2022	International Journal of Information Technology	Chatbot called 'Ted', developed to help the patients who require support through natural language processing and deep learning approaches.			Ted identifies the intents and contexts from natural language, allowing to interact with the users through appropriate responses for achieve their goals.	Mixed, including suicidal ideation, anxiety and depression.	
A Mental Health Chatbot with Cognitive Skills for Personalized Behavioural Activation and Remote Health Monitoring	Rathnayaka, P., Mills, N., Burnett, D., De Silva, D., Alahakoon, D. and Grey, R.	2022	Sensors	Intelligent chatbot setting using AI to provide recurrent emotional support, personalized assistance and remote mental health monitoring capabilities.		Companion that provides conversational emotional support and continuous personalized engagement (while not attempting to replace existing healthcare services). It is a technological automation that simplifies the BA tasks into an efficient and scalable process.		Anxiety and Depression	
A Virtual Agent to Support Individuals Living With Physical and Mental Comorbidities: Co-Design and Acceptability Testing	Easton, K., Potter, S., Bec, R., Bennion, M., Christensen, H., Grindell, C. ... and Hawley, M. S.	2019	Journal of medical Internet research	Avachat, an autonomous agent for supporting people with comorbid physical LTCs and mental health problems, providing acceptable support and guidance based on self-management principles.		System structured around a persona (Ava), acting as a focus for the user's interactions through natural language, with which he/she would form something akin to a therapeutic relationship.			20 participants (adults) with Chronic Obstructive Pulmonary Disease (COPD): higher prevalence of condition-related anxiety and depression and up to 10 times more likely to experience panic attacks than the general population.

(Continues)

TABLE 2 | (Continued)

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Leveraging Natural Language Processing to Study Emotional Coherence in Psychotherapy	Atzil-Slonim, D., Eliassaf, A., Warikoo, N., Paz, A., Haimovitz, S., Mayer, T. and Gurevych, I.	2024	Psychotherapy		Automatically label clients' utterance-level emotions during psychotherapy conversations by using state-of-the-art language models for emotion recognition.	Automatic emotion recognition models can be integrated into existing feedback systems to provide an indication of emotional coherence in psychotherapy sessions and allow therapists to modify their interventions accordingly.		872 transcribed sessions from 68 clients in individual psychotherapy. Mixed diagnosis: comorbid anxiety and affective disorders (25.7%), followed by other comorbid disorders (17.1%), anxiety disorders (14.3%) and affective disorders (5.7%). 22.9% of clients had one diagnosis, 20.0% had two and 25.7% had three or more.	
Machine-Learning-Based Prediction of Client Distress From Session Recordings	Kuo, P. B., Tanana, M. J., Goldberg, S. B., Caperton, D. D., Narayanan, S., Atkins, D. C. and Imel, Z. E.	2024	Clinical Psychological Science		Developed and evaluated NLP models that automatically predict client symptom ratings (improvement) of a given session based on transcripts of their previous therapy session.	Quickly predict client outcome trajectories and provide therapists with information to tailor and improve quality of care. Highlight how session recordings contain meaningful linguistic signals that could provide contextual information for client and therapist session process ratings.		Mixed; first ten disorders (in order of frequency): anxiety (69.7%), depression (63.3%), academic performance (43.1%), self-esteem (41.0%), loneliness (36.4%), social anxiety (33.2%), relationship concerns with partner (26.9%), family of origin (21.8%), relationship concerns with friends (19.9%) and body image (17.1%).	
Integrating Bert With CNN and BiLSTM for Explainable Detection of Depression in Social Media Contents	Xin, C. and Zakaria, L. Q.	2024	IEEE Access		To develop three BERT-based models for depression detection (fine-tuned BERT, BERT-BiLSTM and BERTCNN), improving the explainability of the depression detection model.	Assisting mental health professionals in early identification (and intervention) of depression using social media data. Demonstrating the effectiveness of BERT-based models for depression detection across diverse datasets and conducting a comparative analysis with Mental-BERT.		Depression	

(Continues)

TABLE 2 | (Continued)

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Automated evaluation of psychotherapy skills using speech and language technologies	Flemotomos, N., Martinez, V. R., Chen, Z., Singla, K., Ardulov, V., Peri, R. ... and Narayanan, S.	2022	Behaviour Research Methods		Demonstrate and analyse a platform to process the raw recording of a psychotherapy session and provideperformance-based feedback according to therapeutic skills and behaviours expressed both at the utterance and at the session level.	The NLP algorithms predicts the behavioural codes reflecting target constructs related to therapist behaviours and skills. The analysis is summarized into a comprehensive feedback report to review the raw MISC predictions of the system, theory-driven functionals of those, session statistics. The platform can be used as a self-assessment method as a supportive tool to deliver more effective training.		Not specified (alcohol and poly-drug abuse)	
Predicting the language of depression from multivariate twitter data using a feature-rich hybrid deep learning model	Kour, H. and Gupta, M. K.	2022	Concurrency and Computation: Practice and Experience		Designing a hybrid Deep Learning model for predicting the sentiments of depressed online users.		Differentiate depressed and nondepressed users by analysing through sentiment analysis their texts posted on Twitter. The model handles continuous and categorical features and is used as a binary text classification procedure to predict whether or not the text is depressed.	Depression (+ suicide)	

(Continues)

TABLE 2 | (Continued)

				Main target of the system		Type of intervention		Type of disorder	
Title	**Authors**	**Year**	**Journal**	**Patients**	**Therapists**	**Supportive**	**Substitutional**	**Psychological**	**Psychological on medical-base**
Using Topic Models to Identify Clients' Functioning Levels and Alliance Ruptures in Psychotherapy	Atzil-Slonim, D., Juravski, D., Bar-Kalifa, E., Gilboa-Schechtman, E., Tuval-Mashiach, R., Shapira, N. and Goldberg, Y.	2021	Psychotherapy		Assess whether topic models could identify clients' functioning levels and alliance ruptures, whether and to what extent the topics identified would change over the course of treatment and whether this change was associated with treatment outcome.	Topic models may enable therapists to be better attuned to specific topics that may signal important events in therapy. The information provided by its outputs allows for conceptual exploration of the therapy process, accessing a summary of topics discussed in a session, locate specific themes associated with rupture or clients' deterioration and direct interventions to improve the situation.		873 sessions from 58 clients in individual psychotherapy. Mixed diagnosis: comorbid anxiety and affective disorders (25.7%), other comorbid disorders (17.1%), anxiety disorders (14.3%) and affective disorders (5.7%). 22.9% of clients had one diagnosis, 20.0% had two and 25.7% had three or more.	
Just in time crisis response: suicide alert system for telemedicine psychotherapy settings	Bantilan, N., Malgaroli, M., Ray, B. and Hull, T. D.	2021	Psychotherapy research		Designed and validated a NLP machine learning model on psychotherapy transcripts to automatically identify and label the level of suicide risk and content expressed by the patient (i.e., risk factors, ideation, method and plan).	Supporting clinical decision and enhancing the response-time by creating a classification system to assist therapists in suicidality evaluation.		Already available corpus of patient-therapist transcripts. Data from text communications of 1864 psychotherapy dyads from the telemedicine platform Talkspace	

(Continues)

TABLE 2 | (Continued)

Title	Authors	Year	Journal	Main target of the system			Type of intervention		Type of disorder	
				Patients	Therapists	Supportive	Substitutional	Psychological	Psychological on medical-base
Natural language processing of clinical mental health notes may add predictive value to existing suicide risk models	Levis, M., Westgate, C. L., Gui, J., Watts, B. V. and Shiner, B.	2021	Psychological medicine		REACH VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment), a machine-learning-based suicide prediction model.Evaluated whether REACH VET's ability to predict death by suicide could be improved by including NLP-derived variables from unstructured EMR data.	Building on established REACH-VET predictor variables to determine whether linguistic analysis of free-text clinical notes could improve prediction of death by suicide.		PTSD. The study utilized a cohort of veterans diagnosed with PTSD cohort (because of associations linking PTSD and suicide).	

listening and empathetic support as well as CBT-based tools and techniques (such as positive reflection and cognitive reframing) specific to the user's concerns. Wysa is trained in-house by clinicians and uses interventive conversations created by an internal team. It is able to understand a wide range of emotions, such as uncertainty, disagreement and confusion, from users' text.

Some of the systems developed are tailored to specific populations or comorbidities. Easton et al. (2019) presented Avachat, an autonomous virtual agent system for supporting people with comorbid Chronic Obstructive Pulmonary Disease and mental health problems. The system is structured around a character, called Ava that personifies the support mechanism through a visible and audible presence: it acts akin to a therapeutic relationship for the user to interact with. Similarly, Boggiss et al. (2023) developed COMPASS, a chatbot app intervention for adolescents with Type 1 Diabetes aimed at promoting self-compassion coping skills through conversational lessons (14 during 2 weeks). The chatbot provides prewritten conversational lessons—based on a standardized 8-week self-compassion program and a 2-week adaptation developed by the authors—using a decision tree 'rule-based' programming. Through 'quick' text options it directs the user-chosen path and using AI it identifies emotions, risk words and the degree of Type 1 Diabetes' management expressed: thus, it is able to deliver tailored and empathetic replies. Furthermore, Berrezueta-Guzman et al. (2024) explored the integration of ChatGPT into a robotic assistant accompanying children with ADHD in completing their school homework. It has been tested by a panel of therapists working with children diagnosed with ADHD in realistic simulations where the robot would react to specific inputs—such as behavioural events exhibited by the child or commands given through the interface—evaluating its performance across pivotal categories of therapy sessions. Therapists assessed each category by interacting with text-based questions and simulated events through a dedicated interface offering a realistic simulation.

Expanding beyond chatbots, other systems incorporate broader behavioural modelling and mental state prediction. Kolenik et al. (2024) introduced a computational psychotherapy system for mental health prediction and efficient behaviour change, simulating the theory of mind. Specifically, it targets the non-clinical population with Stress-Anxiety-Depression (SAD) symptoms that have barriers to entry into the mental healthcare system. The system uses AI and ML (but not only) to understand its users by building various idiographic, detection and forecasting models combined with novel ontologies on mental health and behaviour change. Through LLMs, the system generates linguistic outputs as a response to the input text in the form of motivational messages personalized to the user's personality. Moreover, at the end of a conversation, the system re-evaluates the user's well-being post-support to provide further tailored strategies.

Differently, other AI systems serve more as clinical tools to support professionals. An example comes from Flemotomos et al. (2022), who developed a platform for processing the raw recording of psychotherapy sessions and providing timely performance-based feedback aligned to therapeutic skills and behaviours expressed both at the utterance and at the session level—which reflect target constructs related to therapist

behaviours and skills. Such platform can be used by the therapist as a self-assessment method or by a supervisor as a training supportive tool. In detail, NLP algorithms predict behavioural codes from the linguistic information of sessions' transcription. The behavioural analysis is then summarized into a comprehensive report, delivered on an interactive web platform through which the therapist can: review the raw Motivational Interviewing Skill Code (MISC) predictions of the system (e.g., empathy score and utterances labelled as reflections) and the related theory-driven functionals (e.g., ratio of questions to reflections); session statistics (e.g., ratio of client's to therapist's talking time); take notes and make comments linked to specific timestamps or utterances.

Remaining in the context of therapy evaluation and monitoring, Atzil-Slonim et al. (2021) assessed the potential of topic models to identify clients' functioning levels and alliance ruptures by examining therapy sessions transcripts: in particular, if and to what extent the topics changed over time and if this change was associated with treatment outcome. It functions by adopting latent Dirichlet allocation that, employing Bayesian probabilistic modelling, finds clusters of terms (topics) that tend to co-occur in subsets of the transcripts. Similarly, Kuo et al. (2024) developed and evaluated NLP models for predicting client symptom ratings of a therapy session, based on transcripts of their previous one. In particular, they employed RoBERTa as the primary representation of the texts, which can take sentences or paragraphs and output numeric vectors that can be used for prediction tasks. Following on predictive tasks, Levis et al. (2021) employed REACH-VET to evaluate its capability in predicting death by suicide in veterans with a PTSD (Post Traumatic Stress Disorder) diagnosis by integrating NLP-derived variables in analysing free-text clinical notes. These latter were processed by Sentiment Analysis and Cognition Engine [SÉANCE], a Python-based NLP package. Further exploring suicide prediction in clinical populations, Bantilan et al. (2021) designed and validated an NLP model to automatically detect, from psychotherapy transcripts, the level of suicide risk expressed by the patient and related contents (i.e., risk factors, ideation, method and plan). Trained on large-scale clinical data from a tele-behavioural health provider, the most accurate model scored patient texts every 30 min, updating the suicide risk score linked with a therapist-client transcript as the psychotherapy proceeded.

Again, from therapy transcripts and conversions other studies focus on emotion recognition and mental state classification. Atzil-Slonim et al. (2024) employed state-of-the-art BERT-based language models (and their corresponding lightweight adapter solutions) to automatically label clients' utterance-level emotions during psychotherapy conversations. In detail, they fine-tuned several BERT-based models for patients' emotion recognition through text. Extending this direction, Xin and Zakaria (2024) developed three BERT-based models for depression detection and compared them with MentalBERT, in order to evaluate their effectiveness against a state-of-the-art benchmark tailored for mental health applications. Aiming to explain how the models work and perform their decision-making process, the authors employed a comprehensive and intuitive interface. After the user submits the text, the depression detection model processes the input and decides if it is a signal of depression. It does so by using colours and related intensity to display the importance for each word in the input text. Lasty, Kour and Gupta (2022) designed a hybrid Convolutional Neural Network and Long-Short Term Memory (CNN-LSTM) Deep Learning model useful for predicting sentiments related to depression—this time in online users—distinguishing depressed and non-depressed ones. The online users' text posted on Twitter are examined through sentiment analysis. This hybrid system can extract deep features from sentences, based on their semantic and syntactic properties: LSTM is able to manage both "vanishing gradient" and "exploding gradient" problems and can learn the word-level semantic information.

3.3 | Beneficial Effects of AI Systems for Patients' Mental Health and Practitioners Work in Clinical Psychology

The selected studies highlight the potential benefits that the use of AI could offer to both users' mental health and practitioners' work.

Starting with user-facing systems that prioritize direct psychological support and emotional engagement, the Behavioural Activation-based chatbot by Rathnayaka et al. (2022) was effective in supporting users with mental health issues, in particular by providing personalized interactions, scheduling actions and tracking mood changes. It was able to enhance mood awareness and self-reflection, as reported by one of the users: 'By using the app, I am more aware of how my moods fluctuate. [...] alleviated some negativity I was experiencing at the time'. Similarly, the study by Beatty et al. (2022) showed that Wysa users were satisfied with the use of the tool, as it provided a safe, comfortable and supportive environment—elements that are all considered necessary for the development of the therapeutic alliance. In the study by Berrezueta-Guzman et al. (2024), the ChatGPT-based support tested seemed to be effective in enhancing therapy: in particular, it adapted to each child's needs and therapeutic progress by offering tailored interventions and interactions. With interactive dialogue and gamified sessions, it helped keep children engaged and motivated, thereby increasing the overall effectiveness of the therapy. The COMPASS system by Boggiss et al. (2023) demonstrated notable benefits for users by offering personalization, self-management support, ease of use and connectivity with others, making it a valuable tool for enhancing well-being. Furthermore, Ted, developed by Pandey et al. (2022), offered significant benefits for users, helping them reduce the stigmatization often experienced when interacting with professionals: in particular, it enables users to interact naturally, generating appropriate responses based on their input, thus offering a more comfortable and confidential means of seeking help. Indeed, it offers a promising alternative to traditional therapy for patients, providing additional support and resources to those in need and enabling them to take charge of their mental well-being in an accessible, cost-effective and efficient way. Similarly, the system by Easton et al. (2019) enhances users' self-management skills, offering immediate support and in turn increasing accessibility and availability. In particular, patients positively value the peer-driven support as well as the emotional well-being advice, the behaviour change techniques provided and the triangulation of clinically accurate information. Participants reported that the system was actually supportive, providing personalized

interventions adapted to the specific user's emotional and cognitive profile. Indeed, it was able to provide more effective stress and anxiety relief compared to state-of-the-art alternatives as well as the same capacity to alleviate depression symptoms. In a similar manner, the system by Chiauzzi et al. (2024) showed a significant reduction both in self-reported depressive symptoms and anxiety symptoms of patients across the intervention period (starting from an elevated level of them). In the study by Xin and Zakaria (2024), where BERT was integrated with Convolutional Neural Network (CNN) and Bidirectional Long-Short Term Memory (BiLSTM) for the detection of depression by analysing social media content, these models were highly effective in their task, thus enhancing the reliability of depression diagnoses. For users, these models enable timely interventions and support for individuals suffering from depression. Lastly, the NLP model implemented by Bantilan et al. (2021) provides an accurate assessment of individual suicide risk at the sentence level, an individualized approach that can help ensure that therapy is tailored to the unique needs of each patient, promoting more personalized and potentially life-saving interventions.

Moving to the effects for practitioners (professionals, psychologists and therapists working in clinical psychology), the remote-control mood tracking described by Rathnayaka et al. (2022) was useful in the changing behaviour process by detecting dangerous conversations. For professionals, ChatGPT generates insights into therapeutic outcomes, offering guidance that can inform and improve future treatment strategies (Berrezueta-Guzman et al. 2024). COMPASS (Boggiss et al. 2023) provided clinical utility by complementing standard care, particularly during the pandemic. Ted (Pandey et al. 2022) reduces the resources and time required for training, ultimately decreasing the workload for them. The AI-enabled mobile chatbot psychologist developed by Omarov et al. (2023) moves in the same direction: by providing personalized psychological support, it helps to reduce the burden on mental health professionals, serving as a valuable adjunct to existing mental health services. The system by Chiauzzi et al. (2024) can be integrated with concurrent mental health treatments as well as detect crises with resource delivery. Benefits for professionals also come from the system by Flemotomos et al. (2022), which could provide fast and low-cost feedback to them, in turn improving the quality of services and more positive clinical outcomes. Indeed, performance-based feedback is essential for practitioners, both for training new ones and for maintaining the already acquired skills. It can also be used for evaluation, keeping in mind the degree of reliability of the system itself. Additionally, practitioners could use the system by Kolenik et al. (2024) to monitor their users, considering the reliability of its diagnosis, thus reducing their workload burden. Moreover, their system featured a forecasting ability useful to predict the likelihood of future depressive episodes (up to 7 days in advance) and intervene in a timely manner. In line with the latter, the study by Levis et al. (2021) suggests that the NLP-derived variables added in REACH VET could help in better identifying and monitoring suicide risk over time, leading to more timely and targeted interventions. For professionals, this enhanced predictive capability offers more precise insights into patients' distinct risk sensitivities, ultimately supporting more effective treatment strategies. The system by Bantilan et al. (2021) helped professionals in identifying critical situations, alerting telehealth clinicians to potential suicide risk in a patient's content and allowing them to provide timely crisis resources. In the study by Kour and Gupta (2022), the use of this feature-rich hybrid deep learning model can enhance the diagnostic process by providing deeper insights into the behavioural and clinical aspects of depression, ultimately supporting more effective treatment planning and decision-making. The system by Atzil-Slonim et al. (2024) offers an opportunity for professionals to examine emotional processes on a larger scale and with higher specificity, improving their ability to understand and intervene in patients' emotional experiences. Practitioners can benefit from being more receptive to subtle expressions of positive emotions and can tailor their interventions to help clients better align their emotional experiences with their verbal expressions. Similarly, in the study by Easton et al. (2019), the empathetic ability of the system to identify and react to non-verbal clues from people's text will be pivotal to enhance the therapeutic relationship between agent and patient. The ML model by Kuo et al. (2024) improves therapist feedback and helps predict treatment outcomes. The development of NLP models to predict client symptoms from session recordings shows promising results, with potential for integration into outcome-monitoring systems, ultimately enhancing the quality of care provided. Lastly, tool by Atzil-Slonim et al. (2021) is confirmed to be effective in supporting therapists by providing a summary of topics discussed in a session, enabling them to identify themes related to alliance ruptures or clients' deterioration. This helps them to orient their interventions more effectively, in turn improving clients' functioning. Additionally, the thematic model can be integrated with existing monitoring tools, allowing therapists to track significant language processes during therapy sessions.

4 | Discussion

This study aimed to systematically review the existing literature regarding the use of AI in clinical psychology to improve psychological interventions for DMH. AI systems and solutions have been increasingly integrated into DMH care to enhance the processes of prevention, diagnosis, intervention and monitoring of digital mental health as well as to personalize interventions and provide immediate support for individuals with psychological distress. The potential of AI lies in its ability to process large amounts of data, detecting patterns in patient behaviours and symptoms and providing interventions tailored to users' psychological needs. Due to this, AI systems have proven effective in providing clinicians with deeper insights into patient symptomatology and complementing traditional clinical assessments and interventions.

A systematic review of studies (dated from 2019 to 2024) related to this topic was conducted, focusing on the task performed by AI systems, specifically with NLP and Machine Learning (ML) features. The selected studies were related to research about clinical conversations between patients and their therapists or texts generated in clinical settings, also showing the benefits for patients' mental health and practitioners' work. In the previous section, the results of this review have been described to now provide some related considerations.

AI systems in psychological interventions include DMH apps, therapeutic chatbots and wearable monitoring devices.

Particularly relevant AI applications are therapeutic chatbots, which leverage NLP to process users' linguistic and emotional input to provide them with structured psychological support in response to the detected mental states. Systems such as Wysa adopt Cognitive-Behavioural Therapy (CBT) techniques to assist users in managing their emotions and improving psychological resilience through personalized interventions. Wysa, in particular, has demonstrated efficacy in enhancing therapeutic alliance and improving self-reported depressive symptoms, especially when engagement levels are high (Beatty et al. 2022). Similarly, chatbots like the Behavioural Activation-based system by Rathnayaka et al. (2022) use NLP-driven modules to personalize conversations and monitor users' moods over time using EMA. These systems integrate sentiment and emotion recognition to generate dynamic mood scores and suggest mood-improving activities, reinforcing emotional self-awareness and adaptive behaviour. AI systems diagnostic tools have also emerged as a valuable resource for the diagnostic process. They facilitate the detection and classification of psychological disorders through ML algorithms capable of analysing linguistic patterns and behavioural indicators. For instance, systems such as those developed by Xin and Zakaria (2024) and Kour and Gupta (2022) utilize BERT-based or hybrid deep learning models to perform sentiment analysis on user-generated text—such as social media data—to detect depressive symptoms with high accuracy. Similarly, AI models that incorporate text-based sentiment analysis have been used to predict depressive symptoms, enhancing early detection and intervention strategies. These predictive models, including those employed by Bantilan et al. (2021) and Levis et al. (2021), also enable risk assessment for suicide based on clinical notes or therapy session transcripts, thus supporting both crisis detection and personalized care delivery.

Considering their characteristics and applications, from the studies reviewed it emerges that the implementation of AI systems could have both benefits and challenges. First and foremost, these digital technologies could help to overcome financial and geographical barriers, thus improving access to psychological support to a wider range of people (Gual-Montolio et al. 2022; Naslund et al. 2020). Chiauzzi et al. (2024) have shown that DMHIs provided by using phones can be effective for reducing anxiety and depression levels. Young adults and adolescents are the ones showing the higher acceptance of DMH (Rideout et al. 2018): in fact, by allowing individuals to seek help without direct exposure, they help to reduce the stigma often associated with DMH issues (Grist et al. 2019). Lastly, DMH enables continuous and real-time monitoring that allows for providing prompt interventions.

However, the implementation of AI in clinical psychology has not only advantages. The effectiveness of DMH tools varies across populations and while some studies have demonstrated significant improvements in psychological well-being, others have reported less conclusive findings. For example, Ogawa et al. (2022) and Kolenik and Gams (2021) found no statistically significant changes in symptom reduction following chatbot interactions. These preliminary findings suggests that further refinements are needed to optimize these technologies. Furthermore, one of the main challenges and issues is the lack of standardization and scientific validation: indeed, Leigh and Flatt (2015) found that less than 5% of DMH apps had been adequately validated. Moreover, some studies do not compare their results with control trials or groups (Chiauzzi et al. 2024; Gual-Montolio et al. 2022)—an already rarely performed process in psychotherapy—thus reducing their robustness and making the application of such AI systems only self-referential. In turn, these issues could diminish overall reliability and replicability of the study (Gual-Montolio et al. 2022). Indeed, the absence of control groups makes it difficult to determine whether observed improvements are due to the AI intervention itself or, instead, to external, nonspecific factors such as expectancy effects, time or user motivation. This limitation could significantly weaken the robustness of the (still preliminary) evidence base and the validity of clinical outcomes (Andersson et al. 2019). In addition, AI systems could produce biases due to their training that could lead to mistakes in diagnosis or ineffective interventions for some individuals. For example, findings from some studies show that AI could indeed detect early signs of mental disorders or psychological difficulties through social media analysis (Guntuku et al. 2019; Taccini and Mannarini 2024), but others show how AI systems can produce false positives (Haghish and Czajkowski 2024) and fail to recognize symptoms in some populations (Rai et al. 2024). A prime example comes from Mehrabi et al. (2021), showing that AI diagnostic tools focused on depression may be less accurate in relation to ethnic minorities. This is a very important issue for health assessment (also gender, age, etc.). In fact, the literature in general (Moudden et al. 2025; Muntaner et al. 2013; Sellers et al. 2009; Snowden 2003; Williams 2003) has explored this issue in depth. With regard to the contribution proposed here, it should be noted that the selected articles do not explore this issue, which should certainly be considered in future studies. Such variability in outcomes underscores the need for further research to ensure their effectiveness across diverse user groups. Indeed, the stronger effectiveness reported for anxiety and depression-related interventions may be linked to the extensive scientific knowledge of such disorders: over the years, these conditions have been deeply studied and conceptualized within structured diagnostic and therapeutic frameworks, making them more amenable to algorithmic modelling and in turn facilitating the creation of effective AI systems (Kazdin and Rabbitt 2013). In contrast, more complex or less codified psychological issues—such as personality disorders, relational trauma or comorbid presentations—pose a greater challenge for algorithmic tractability (Topaz and Pruinelli 2017). Therefore, current findings may reflect more the maturity of scientific understanding in these specific domains than the general applicability of AI across all mental health conditions. This last observation also highlights that AI systems are usually—if not always—bound to deal with a single specific disorder in a predefined way, based on the data and techniques they are trained on. Referring to the studies reviewed, the psychological disorders mainly addressed were anxiety and depression, followed at a distance by suicidal ideation, PTSD, stress and affective disorders. In relation to the psychological techniques implemented, most followed behaviour-related approaches, such as CBT (predominantly), DBT or Behavioural Activation (BA), and only a small portion referred to other like theory of mind, schema therapy or short term psychodynamic psychotherapy. Thus, even though their responses-suggestions may be tailored to the users' peculiar situation, they cannot aid if other symptoms or criticalities arise. This could affect not only clinical trials, which suffer in terms of data shareability and

replicability of results (Smith et al. 2023), but also clinical intervention, inasmuch as some situations may require multiple of them. Thus, hybrid models where the therapist's supervision is assured and AI acts as support (rather than a replacement) may be ideal Topol (2019). Indeed, as emphasized by Flemotomos et al. (2022), AI-based technologies are best positioned as assistive, augmenting the capabilities of clinicians rather than replacing them. Misinterpretation of automatically generated feedback or uncritical acceptance of AI-driven conclusions could have serious implications for patient care. It is therefore vital that users are trained to understand the scope and limits of these tools and that human oversight remains central to any clinical deployment. Conversely, an excessive dependence and reliance on AI risks reducing human supervision. If this latter is overlooked, automated clinical praxis may lead to misdiagnosis or rigid intervention plans, potentially compromising mental health care quality (Floridi et al. 2018; Torous et al. 2019).

Last but not least, AI systems are less understanding of human feelings and struggle to develop empathetic relationships with patients (Bickmore and Picard 2005): while some chatbots like Woebot and Wysa provide effective CBT interventions (Fitzpatrick et al. 2017), they are not able to fully replicate human emotional understanding and connection (Bickmore and Picard 2005), which is a key element in therapy that provides long-term therapy success (Naslund et al. 2020). So, this leads to a higher and quicker abandonment of digital programs compared to therapy provided by human professionals (Baumel et al. 2019). This latter also guarantees a correct data treatment, which is crucial for building a relationship of trust from the patient, while using AI systems leaves some ethical concerns (Smith et al. 2023). Indeed, AI-driven interventions collect and process sensitive people's DMH data that need secure storage and protection from unauthorized access. Regulations like GDPR and HIPAA exist, but a unified ethical framework for AI in psychology is missing and gaps related to its implementation remain (Ruggieri et al. 2021). For example, the EU has a more careful approach compared to the United States and China, which are more permissive: this leads to debates over appropriate governance (Jobin et al. 2019). Table 3 reports a brief comparison between regional regulatory approaches with some related practical recommendation for clinicians.

Thus, issues of data ownership and patient consent are concerning (Huckvale et al. 2019), particularly in AI systems that continuously monitor users (Murdoch 2021). Also, many patients are not aware of how AI algorithms function and collect data; therefore, an ethical AI use demands clear, informed consent and potentially dynamic consent models (Luxton 2014; Sharkey and Sharkey 2021). This scenario highlights the need to develop clear and recognized (by the scientific community) protocols for the use of therapeutic chatbots and AI-driven interventions within psychological interventions, designed to protect human health while ensuring the responsible deployment of AI.

This is in line with several recommendation provided by the American Psychological Association (APA): indeed, they suggest to: (1) not rely on generative AI to deliver psychotherapy and psychological treatments; (2) protect users from misinformation, algorithmic bias and illusory effectiveness; (3) create specific safeguards for vulnerable populations and (4) implement comprehensive AI and digital literacy education (APA 2025). Regarding point 1, APA states that GenAI chatbots and app should not be used in substitution to a qualified therapist but only as a support, inasmuch as relying solely on them may pose several risks, such as risk of bias and misinformation, misrepresentation of services, creating a false sense of therapeutic alliance and incomplete assessment. Thus, they recommend specific training on these emerging technologies as well as following the available ethical guidelines (although still not fully adequate to the reality of using AI for promoting mental health) and asking users about their use of such apps. In line with this, regarding Point 2 the APA also suggest to educate patients on algorithmic bias, since this digital tools (and especially general-purpose models) are trained to agree to users. In particular, clinicians should pay particular attention to the use of GenAI chatbots and apps among vulnerable populations (Point 3—e.g. adolescents, socially isolated individuals and people with confirmed diagnosis), because these could act as powerful amplifiers of already existing vulnerabilities or issues. Thus, therapist and mental health expert should learn and know how such AI-based tools work, in order to be aware of their potential misuse, reduce the possible negative effects and maximize their benefits for patients (APA 2025).

A key ethical dilemma could arise: in order to safely use AI systems and tools, it is necessary to understand how they work—yet to understand them it may need to expose users to them, thereby potentially putting their well-being at risk. This epistemological paradox calls for rigorous, ethically sound experimentation frameworks that safeguard participants while advancing scientific knowledge (Mittelstadt 2019; Morley et al. 2020). Indeed, without such standards the clinical application of AI remains vulnerable to misuse or unintended harm.

In conclusion, some questions remain unanswered: can AI adapt to specific individual psychological needs? And can it provide adequate care? Current AI systems work on predefined models, which limit their flexibility. Conversely, Adaptive AI raises concerns about privacy and algorithmic over-personalization (Mandal et al. 2025). However, it is also true that, in global regions where mental health professionals are lacking, AI therapy might be the best, if not the only option available (van Heerden et al. 2023).

The preliminary findings from the reviewed studies show that AI can most definitely improve DMH access, but it must remain inclusive, transparent and human-supervised to ensure patient rights and clinical integrity. Ultimately, while AI technologies hold immense promise for enhancing psychological practice, their development and implementation must be governed by a set of rules and professional standards internationally shared by the scientific community. This echoes the historical evolution of psychological assessment tools: decades of scientific effort were dedicated to building standardized protocols for test administration, scoring and interpretation, where the establishment of clear operational criteria and validation methods was essential for the legitimacy and ethical use of those instruments (Hunsley and Allan 2019; Institute of Medicine 2015). A similar path now lies ahead for AI in mental health: shared rules must be developed to define how, when and by whom these tools can be used, with the aim of ensuring both clinical efficacy and the protection of human health (He et al. 2019; Sebastian et al. 2020). In

TABLE 3 | Regional regulations and related practical recommendations for clinicians.

Region (framework)	Key regulatory principles	Practical recommendations for clinicians	Consent wording recommendations	Data storage and security checklist
EU (GDPR)	- Lawful basis for processing (Art. 6); special category data: health and genetic (Art. 9); right to access, rectification and erasure; data minimization and purpose limitation	Clinicians must ensure patients understand data use: Explicit, informed consent required for sensitive health data and must include withdrawal options. Use secure electronic health record systems compliant with GDPR.	*I consent to the collection, storage and use of my health data for the purpose of my clinical care and related research.*	- Data pseudonymization/ anonymization; encryption in transit and at rest; access controls (role-based); audit logging.
USA (HIPAA)	- Protected health information (PHI); privacy rule: patient rights to access and correct PHI; security rule: administrative, physical and technical safeguards	Clinicians must provide notice of privacy practices: Consent for use and disclosure of PHI (for treatment, payment and operations). Train staff on HIPAA compliance.	*I authorize the use and disclosure of my health information as described in this notice for treatment, payment and healthcare operations.*	- Encrypt PHI in storage and transmission; limit access to minimum necessary; regular risk assessments; secure backup and disaster recovery.
UK (NHS and Data Protection Act 2018)	- Aligns with GDPR; confidentiality and Caldicott principles; explicit consent for processing sensitive data	Follow Caldicott Guardian recommendations and document consent in patient record: Use plain language consent forms; Explain data sharing with secondary uses (research and audits).	/	- Secure NHS systems; role-based access; data sharing agreements for research.
Canada (PIPEDA and Provincial Laws)	- Personal Information Protection and Electronic Documents Act—Health information acts vary by province	Clinicians must follow provincial health information regulations: Must obtain meaningful consent. Ensure cross-border data transfers comply with law.	*I consent to the collection, use and disclosure of my health information for my care and as required by law.*	- Access restrictions; - Audit trails; - Secure electronic systems.
Australia (Privacy Act 1988 and My Health Records Act)	- Australian Privacy Principles (APPs); special rules for health information—Patient right to access and correct	Clinicians should check patient consent before sharing info and keep accurate audit records:- Explicit consent for My Health Record uploads.	*I consent to my health information being included in My Health Record and shared with healthcare providers involved in my care.*	- Secure My Health Record systems;- strong authentication;- staff training on privacy.
Other frameworks (WHO guidance, ISO 27799)	- WHO: Health data should be confidential, secure and used for care/research ethically; ISO 27799: Guidelines for information security management in health	Useful for institutions without strong national laws. Integrated with EHR policies. Use clear, informed consent; document consent digitally or on paper.	/	- Risk assessment; encryption and access control; incident response plan.

light of this, fostering an ethical AI integration in psychology requires collaboration between psychologists, AI researchers, ethicists and policymakers.

In light of all this, the potential of AI in the clinical setting clearly emerges as well as its current limitations. It is clear that AI use must be governed and not just supervised by individual professionals. This implies the possibility of creating global scientific protocols for AI use in clinical settings, with rules that can guide professionals—but also developers—aimed at sharing clear and agreed criteria for the development and use of such tools. In particular, rules that are not only oriented towards technological development but also towards the ultimate goal of improving and preserving human health are needed.

5 | Conclusions

The use of AI and NLP definitely holds transformative potential for clinical psychology, offering new avenues for enhancing mental health care delivery. Using AI in clinical psychology can provide more accurate data for anticipating how therapy is going to develop. Moreover, thanks to improved accessibility to them, AI systems for DMH can be used to reach more people than in-person therapy, using all patients' data to monitor the progress of their symptomatology and adjust the intervention. Through tools such as AI-enabled chatbots and emotion recognition systems, NLP can support scalable, cost-effective and immediate psychological interventions. These technologies not only help to reduce the burden on traditional services but also contribute to the destigmatization of mental health care by increasing accessibility and personalization of support. Furthermore, NLP-based models demonstrate the capability to extract meaningful linguistic signals from therapy sessions, providing clinicians with timely, contextualized insights to tailor interventions and improve the quality of care. The integration of ML into psychotherapy research—via tools like emotion annotation, session trajectory prediction or rupture detection—suggests promising pathways for augmenting traditional therapeutic processes.

Nonetheless, the current state of AI and NLP technologies in clinical psychology is marked by significant limitations. Models are often developed and validated in constrained environments, limiting their generalizability across diverse populations and therapy contexts. NLP tools still lack the capacity to interpret non-verbal and paraverbal communication cues, which are central to therapeutic interactions. Ethical, technical and cultural gaps remain in the application of AI, particularly in understanding nuanced emotional dynamics and non-verbal aspects of client expression. These criticalities underscore the importance of continued research and longitudinal evaluation, particularly across varied socio-demographic groups. Crucially, while NLP systems can offer valuable support, they must not be seen as substitutes for human clinicians. Human supervision is essential—not only in interpreting the output of these tools but also in ensuring that automated systems are used responsibly and ethically. Moreover, all the sensitive and personal information provided by patients in therapy needs strict security measures in order to prevent privacy breaches. Thus, using AI systems in clinical psychology does not come without ethical issues linked to data privacy, transparency as well as to the quality and effectiveness of their interventions. Early-stage co-design with clinicians and patients could guide the development of these technologies in socially responsible and clinically meaningful ways. Ensuring that AI systems are interpretable, transparent and integrated into clinical supervision practices will help mitigate risks and foster trust. As the field evolves, a sceptical, critical approach towards machine-generated outputs will not hinder progress; rather, it will serve as a catalyst for refining these technologies and deepening their integration into practice.

Therefore, it is paramount to avoid a complete delegation of the intervention to AI; conversely, its use should be strictly supervised by professionals and integrated with an ethical approach that ensures patient well-being and data protection. As AI continues to evolve, its potential to enhance DMH care remains vast. However, ensuring its ethical implementation, optimizing intervention efficacy and addressing existing limitations will be crucial in maximizing its benefits for both practitioners and patients. In conclusion, NLP technologies are poised to significantly enhance psychological care but their successful and ethical implementation demands robust human involvement. Supervision, interpretation and ethical scrutiny by trained professionals are not optional safeguards—they are fundamental requirements for aligning technological innovation with therapeutic integrity and patient well-being.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Appendix S1:** Explanation of the categorization used to classify systems. **Appendix S2:** Summary table with included studies.

AMERICAN PSYCHOLOGICAL ASSOCIATION

Ethical Guidance for AI in the Professional Practice of Health Service Psychology

UPDATED: JULY 2025

The integration of artificial intelligence (AI) into behavioral health is evolving rapidly, presenting opportunities and challenges for health service psychologists. AI has the potential to enhance psychological clinical decision-making and outcomes, improve access to care, and enhance provider workflow and efficiency. As AI tools become increasingly integrated into health care and other workforce settings, human oversight and thoughtful human-technology interaction are critical. While we do not yet have all the answers, we do know that AI is already supporting clinical decision-making and improving outcomes for some providers and patients/clients.

However, in its current state, significant ethical issues exist, including transparency, bias, data security, and misinformation. In addition, there are issues of professional liability. As AI's influence on health care continues to grow, psychologists are encouraged to take a proactive role in shaping its development and implementation to ensure its ethical, responsible, and equitable use. We need a balanced, flexible approach that allows us to learn and adapt as these technologies evolve—especially since many tools are already being deployed in practice.

This document outlines some key considerations for health service psychologists who use AI in professional practice. This document is not exhaustive and does not represent official APA policy but was informed by relevant APA standards and guidelines, including the *APA Ethical Principles of Psychologists and Code of Conduct* (APA, 2017). The considerations included in this document are intended to educate and inform psychologists, and are aligned with fundamental Ethical Principles, including Beneficence and Nonmaleficence, Fidelity and Responsibility, Integrity, Justice, and Respect for People's Rights and Dignity. They do not reflect standards that are mandatory, exhaustive, or accompanied by an enforcement mechanism, nor are they intended to guide regulatory action. Psychologists are also aware of the

standards of practice for the settings in which they practice, and they are expected to comply with those standards, including any federal and state laws and regulations.

1. TRANSPARENCY & INFORMED CONSENT

AI use in settings where psychological services are offered are encouraged to be disclosed to other relevant providers, individuals who are receiving direct care services, and any third parties who may be considered a patient/client of psychological services (e.g., the court) in a culturally and linguistically appropriate manner. Psychologists have an ethical obligation to obtain informed consent by clearly communicating the purpose, application, and potential benefits and risks of relevant AI tools. Transparent communication maintains patient/client trust and upholds Principle E: Respect for People's Rights and Dignity.

Recommendations for Health Service Psychologists:

- Be thoughtful in the disclosure of use of AI tools as it relates to patient/client care. While certain AI use cases may be considered more subtle and/or innocuous (e.g., using predictive text when writing provider notes), others may be considered more substantial and would require greater discussion and disclosure with patients/clients (e.g., a health care system using AI to determine the best mental health treatment approach for an individual). Discussion with the patient/client includes specific mention of the AI tool being used in the delivery of patient care as needed.
- In their written informed consent, psychologists may consider adding information regarding when, how, and the type of AI tool(s) they use in the delivery or support of patient care.
- Communicate information in a culturally, developmentally, and linguistically appropriate manner.
- Inform patients/clients about AI's role, limitations, risks, and benefits to ensure true autonomy.
- Inform patients/clients that they have the right to opt out of certain AI-driven interventions and will be provided with alternative options if available.
    - » Best practice would involve clearly explaining the available alternative options (e.g., non-AI facilitated care with the current provider, remaining on the waitlist, referral to another provider, etc.) and reviewing the associated pros and cons of each option.
    - » Patients/clients should be informed of whom to contact if they have concerns regarding the use of AI or wish to withdraw consent for the use of AI tools in their care.

2. MITIGATING BIAS & PROMOTING EQUITY

AI systems should ideally be evaluated with a focus on addressing bias and preventing exacerbation of existing health care disparities. Responsible AI development considers the full range of lived experiences to avoid unfair discrimination. The APA Ethics Code (2017) Principle E: Respect for People's Rights and Dignity calls on psychologists to strive to eliminate the effect of biases on their work.

Recommendations for Health Service Psychologists:

- Evaluate AI tools for potential biases that could potentially worsen disparities in mental health outcomes.
    - » For example, psychologists are encouraged to review how tools are/were normed and what data the AI was trained on, including diverse lived experiences to reduce inadvertently reinforcing discrimination and/or harmful stereotypes.
- To ensure AI serves everyone equitably, psychologists should strive to play a role in helping to build high-quality, representative datasets, especially from underrepresented regions, which are consistent with data privacy requirements. This includes supporting health systems in these communities to participate in data creation and infrastructure development, so they too can shape and benefit from AI.

3. DATA PRIVACY & SECURITY

AI systems handling sensitive behavioral health data pose risks related to privacy breaches and unethical data use. Psychologists must ensure that any tools they select can be used in a manner that is in compliance with HIPAA and other relevant data privacy regulations; this necessitates advocating for robust cybersecurity strategies to protect patient/client information. Data privacy and security also aligns with professional standards of conduct and the APA Ethics Code (2017) Principles of Beneficence and Nonmaleficence, Fidelity and Responsibility, and Respect

for People's Rights and Dignity in maintaining privacy, confidentiality, and trust.

Recommendations for Health Service Psychologists:

- Review AI tools to check for compliance with relevant data privacy and security laws and regulations such as HIPAA, or other relevant federal or state privacy requirements to protect patient information. Health service psychologists should strive to avoid and/or discontinue using AI tools when security concerns arise.
- Be knowledgeable about how patient/client data are used, stored, or shared, including aggregated or de-identified data and inform patients/clients of this information.
- Strong cybersecurity measures should be in place to prevent data breaches or misuse.

4. ACCURACY & MISINFORMATION RISKS

AI tools should ideally be rigorously validated before implementation in psychological practice. Health service psychologists should strive to critically evaluate AI-generated content before applying it in clinical settings to the greatest extent possible and are encouraged to critically evaluate AI tools they recommend patients/clients to use. Psychologists should strive to assess AI tools for their quality, performance, and appropriateness in behavioral health settings, aligning with Principle A: Beneficence and Nonmaleficence . Upholding the Ethical Principle of Integrity, psychologists take responsibility for the quality of information used in their practice, including promptly discontinuing the use of AI tools if misinformation concerns arise.

Recommendations for Health Service Psychologists:

- Critically evaluate AI-generated content, both at the start of use and in ongoing applications.
- Health service psychologists are encouraged to review AI tools for information on how the tool was validated during development by health care experts and supported by transparent, high-quality evidence.
- Psychologists in health service settings are encouraged to use products and services that rely on AI models that have undergone rigorous accuracy testing to ensure reliability. This information should be easily identified by the developers (e.g., the model developers have published their testing/reliability data and outcomes).
- Psychologists should strive to integrate tools that disclose their training data source and provide evidence of validation.
- Psychologists should strive to integrate tools that offer recommendations for auditing model performance/effectiveness in health service contexts.

5. HUMAN OVERSIGHT & PROFESSIONAL JUDGMENT

AI should augment, not replace, human decision-making. Psychologists remain responsible for final decisions and must not blindly rely on AI-generated recommendations. Maintaining professional oversight ensures adherence to the Ethical Principles of Beneficence and Nonmaleficence, and Fidelity and Responsibility, protecting patients/clients from potential harm.

Recommendations for Health Service Psychologists:

- Psychologists should strive to be competent regarding any AI tools they use
- Establish clear human intervention points (i.e., human in the loop) within AI-driven workflows to maintain professional accountability and to ensure that AI-generated insights are reviewed critically.
- Psychologists should strive for autonomy in approving or rejecting AI-generated recommendations based on their professional judgment and in line with available research evidence and/or professional standards.

6. LIABILITY & ETHICAL RESPONSIBILITY

The legal implications of AI in behavioral health are still emerging. Health service psychologists are encouraged to consider liability risks related to AI tool selection and ensure that they provide proper training and understanding of AI systems that can help mitigate legal and ethical risks.

Recommendations for Health Service Psychologists:

- Health service psychologists understand legal and ethical risks associated with AI tool selection and use in health service settings.
- Negligent reliance on AI without proper validation or oversight could create liability issues.
- Transparency and competence in AI are crucial for managing legal risks and ensuring ethical practice.
- In alignment with best practice standards, psychologists should participate in continuing education about developments in mental health AI and how to leverage it in psychological practice.

CONCLUSION

Health service psychologists have an ethical obligation to prioritize patient/client safety, protect confidentiality and data privacy, promote equity, and function competently and transparently when integrating AI into their work. AI should serve as a tool to support, not replace, professional judgment in health care settings. The above considerations are meant to help health service psychologists assess whether their selection and use of AI-driven interventions aligns with existing principles and standards within the practice of psychology while safeguarding patient/client well-being and trust. When using AI-powered tools, health service psychologists have an ethical duty to act in the best interests of patients/clients and avoid contributing to greater disparities or harm when possible. Engaging in proactive discussions and continuing education, advocating for ethical AI development, and upholding professional standards will help shape a responsible and equitable AI-integrated future.

When opportunities arise, health service psychologists are encouraged to actively participate in interdisciplinary discussions (including with professionals from other subdisciplines of psychology), collaborate with AI developers, and engage with organizations shaping AI policies. Failure to engage in these conversations risks leaving critical decisions to those without the necessary psychological expertise. AI's expansion in mental health care necessitates that health service psychologists stay informed and adapt to technological changes. The practice of psychology must balance innovation with ethical responsibility to ensure long-term sustainability and public trust.

AUTHOR'S NOTE

In January 2025, APA's Mental Health Technology Advisory Committee (MHTAC) hosted a day-and-a-half hybrid meeting in Washington, D.C., to develop a thought leadership paper about navigating the responsible and ethical incorporation of AI into mental health practice for psychologists. MHTAC members in attendance included: Jessica Jackson, PhD (chair), Victoria Bangieva, PhD, David Cooper, PsyD, Ellen Fitzsimmons-Craft, PhD, Karen Fortuna, PhD, Andrea Graham, PhD, Charmain Jackman, PhD, Eric Kuhn, PhD, Kay Nikiforova, MA, Marie Onakomaiya, PhD, Pooja Raghani, PsyD, and Hilary Weingarden, PhD. Additional stakeholders in attendance included: Deborah Baker, JD (APA Professional Legal & Regulatory Affairs), Lindsay Childress-Beatty, JD, PhD (APA Ethics), Corbin Evans, JD (APA Science & Technology), Kamieka Gabriel, PhD (APA Board of Professional Affairs), Tony Habash, DSc (APA Information Technology Services), Dominique Haywood (APA Public Interest), Keely Kolmes, PsyD (Independent Psychological Practice), Laura Lamminen, PhD, ABPP (Former APA Ethics Committee Member; Independent Psychological Practice), Lauren Sommers, PhD, JD (APA Public Interest), Dennis Stolle, JD, PhD (APA Applied Practice), Andrew Strickland, JD (APA Public Policy & Engagement) and Wendy R. Williams, PhD (APA Education). MHTAC members drafted this document based on top themes and consensus areas of importance that emerged during the hybrid meeting. All attendees reviewed the draft document and contributed editorial feedback, as did Ashley Batastini, PhD (MHTAC), Ashleigh Golden, PsyD (MHTAC), and Clifton Berwise, PhD (Liaison to APA Committee on Early Career Psychologists). The APA Ethics Committee has adopted this document. The initiative was supported by APA's Office of Health Care Innovation: Leanna Fortunato, PhD, Aaron Jones, MA, and C. Vaile Wright, PhD.

APA RESOURCES

Artificial Intelligence in Mental Health Care

APA's Technology in Practice

Artificial Intelligence and Machine Learning

APA's Mental Health Technology Advisory Committee

APA's Ethical Principles of Psychologists and Code of Conduct

APA Ethics Committee's Frequently Asked Questions Regarding Ethical Issues related to the Use of Artificial Intelligence and Social Media in Psychology

CONTINUING EDUCATION RESOURCES

Bringing the Power of Artificial Intelligence to Your Clinical Practice: A Hands-on Guide

From Couch to Computer: Converting Psychological Expertise to Digital Health

The Future is Now: How Digital Interventions Could Address the Mental Health Crisis

The Chatbot Cannot Replace You: Using Digital Technologies to Expand Your Positive Impact on Mental Health

OTHER RESOURCES

Describing the Framework for AI Tool Assessment in Mental Health and Applying It to a Generative AI Obsessive-Compulsive Disorder Platform

Readiness Evaluation for AI-Mental Health Deployment and Implementation (READI):

A Review and Proposed Framework

Google Generative AI-Powered Healthcare: The Future is Now

FROM THE CEO

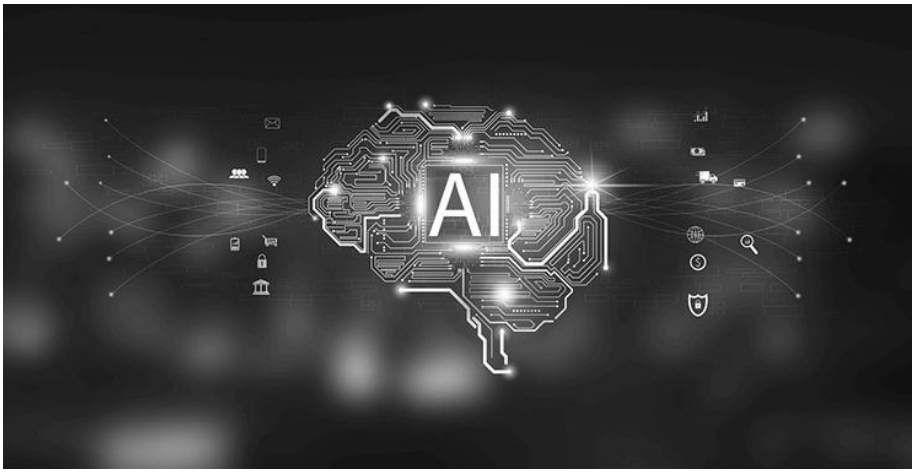
Impacting AI for the better

APA is holding AI technology companies accountable and helping to shape their work

By Arthur C. Evans, Jr., PhD Date created: March 1, 2026 2 min read

Vol. 57, No. 2
Print version: page 10

Artificial Intelligence Social Media and Internet



Whether you are a clinician seeing the mental health impacts of social media, a researcher studying algorithmic bias, or an educator preparing the next generation of psychologists, you are experiencing firsthand how artificial

intelligence is reshaping society at unprecedented speed. Psychology is essential to getting it right.

That means APA must operate on two simultaneous fronts. APA should serve as a critical steward of behavioral science to make AI safer, holding tech companies accountable when they fall short. We should also work directly with these companies, bringing psychological science into the rooms where new tools are being developed.

Three dimensions define our approach to this work.

■ **How we partner.** Our collaboration with Google and YouTube is a good example of what a strong partnership looks like. Independently, APA identified, assessed, and synthesized the best research on healthy teen video viewing—entirely on our terms, with no industry influence. Partnership was essential for dissemination, broadening the reach of our parent guides and other content based firmly on our science. Partnerships must enhance the impact of our work, not compromise its credibility.

■ **What we bring.** Many organizations focus solely on AI's risks. APA firmly believes in preventing harm resulting from AI as well as maximizing its potential benefits. Knowledge from developmental, social, and cognitive psychology informs how we both mitigate harm and shape scalable systemic solutions. This dual focus ensures we are not just reacting but actively guiding technology to benefit society and promote well-being.

■ **Where we show up.** Our members consistently tell us that they want APA to have an impact on major societal issues. Few forces are reshaping society more profoundly than AI. Rather than waiting for tech leaders to come to us, we are bringing psychology to them and showcasing why it is invaluable to their work. Our programs on behavioral science and technology at global industry conferences like the Consumer Electronics Show in Las Vegas have been extremely well-received. We are inserting psychological expertise into the conversations that matter most, in the spaces where technological decisions are being made.

This approach requires sophisticated vigilance. Maintaining our critical voice while engaging directly is sometimes complicated, but it is necessary if we truly want psychology to impact AI for the better. We must ensure scientific rigor, leverage strategic partnerships, and stay committed to preventing harm and advancing human flourishing. AI demands nothing less from us.

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Arthur C. Evans Jr., PhD, is the chief executive officer of APA. You can follow him on LinkedIn.

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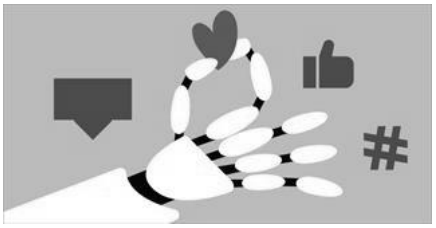

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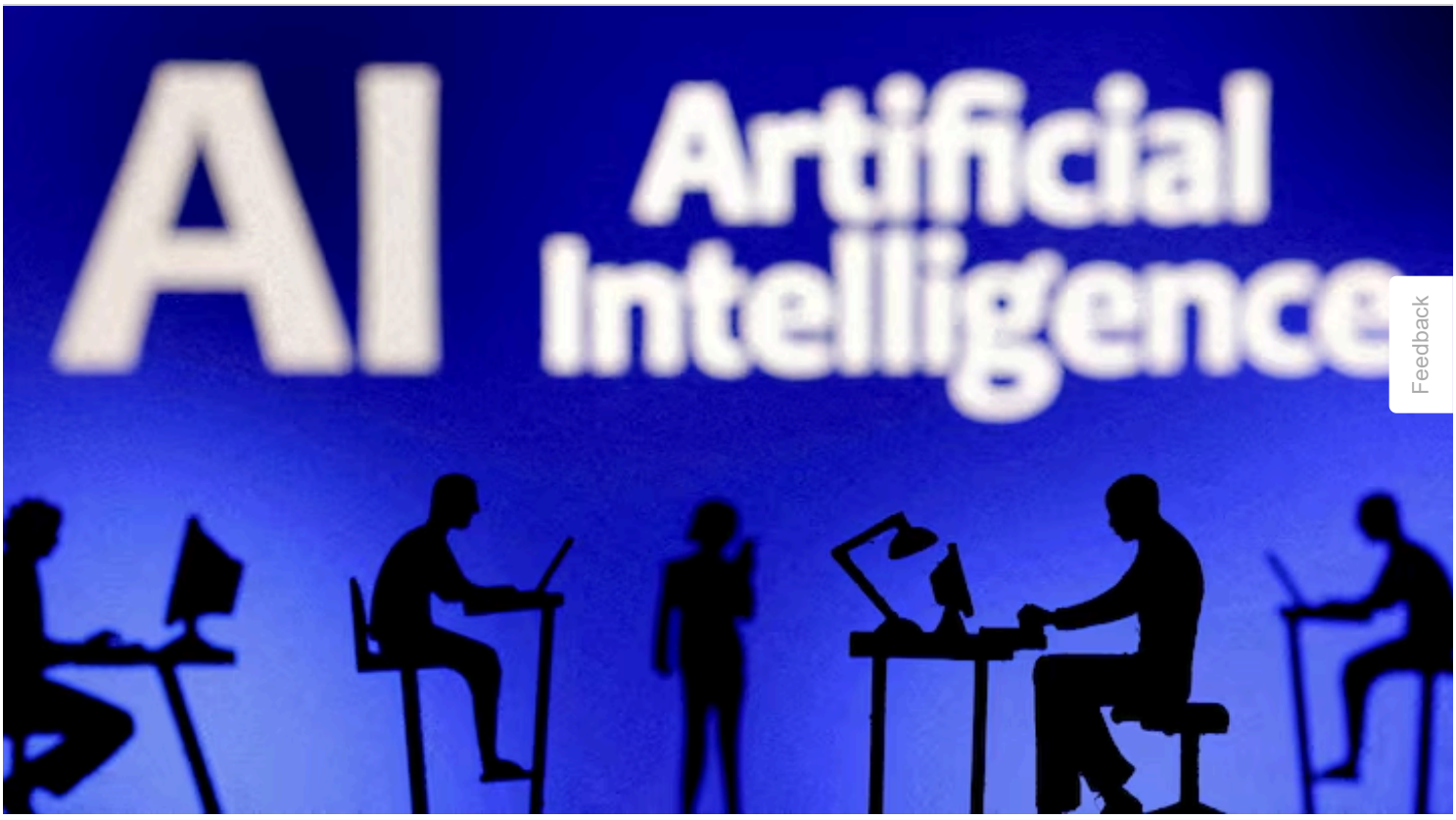
Proposed New York law would bar AI chatbots from posing as lawyers, allow duped users to sue

By **Karen Sloan**

March 5, 2026 1:43 PM CST · Updated March 5, 2026



Figurines with computers and smartphones are seen in front of the words "Artificial Intelligence AI" in this illustration taken, February 19, 2024. REUTERS/Dado Ruvic/Illustration/File Photo Purchase Licensing Rights

March 5 (Reuters) - A proposed law working its way through New York's legislature would bar artificial intelligence chatbots from impersonating lawyers and other licensed professionals in the state, opening up AI platforms to lawsuits by users.

The bill, whose sponsor called it the first of its kind in the country, would bar AI chatbots from giving substantive responses and offering advice that "if taken by a natural person" would constitute the unauthorized practice of law.

"Today, there is no law that says that a large language model cannot tell you that it is a lawyer, that it is a licensed therapist, and then give you legal advice or therapy accordingly," New York State Senator and bill sponsor Kristen Gonzalez told Reuters Thursday. "I think that's really concerning."

Chatbot users should be able to sue if they rely on erroneous legal information provided by a platform that represents itself as a lawyer, Gonzalez said.

AI platforms under the bill would not be able to avoid liability by notifying users that they are interacting with a "non-human chatbot," and users could seek damages in court against companies that violate the law.

New York, like all U.S. states, prohibits people from representing themselves as lawyers or offering legal services without being licensed to practice law.

The bill would apply to law and other licensed professions such as doctors and mental health providers. It is part of a larger suite of New York bills seeking to regulate AI, including one that would protect minors from unsafe AI chatbot features and one that would require AI platforms to "conspicuously" display a notice that outputs may be inaccurate.

OpenAI and Anthropic, which operate two of the most popular AI chatbots, did not immediately respond to requests on Thursday for comment on the proposed professional impersonation law.

The bill, which advanced out of the New York Senate's Internet and Technology Committee late last month, comes as AI platforms face mounting scrutiny over the impacts and ethics of the rapidly expanding technology. ChatGPT maker OpenAI, Google's Gemini, and Character.AI are each facing lawsuits alleging that the tools led to users' suicides. The companies have denied wrongdoing but settled some cases.

Debates are also growing over the technology's use in law. Nippon Life Insurance Company of America sued OpenAI on Wednesday, accusing ChatGPT of practicing law without a license and helping a former disability claimant breach a settlement and flood a federal court docket with meritless filings. OpenAI said the case lacks merit.

A growing number of lawyers have separately faced court sanctions for submitting briefs with AI-generated fictitious case citations and other hallucinated material, with some judges imposing fines.

Read more:

US appeals court orders lawyer to pay $2,500 over AI hallucinations in brief

OpenAI hit with lawsuit claiming ChatGPT acted as an unlicensed lawyer

Reporting by Karen Sloan

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- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

SUBMITTED BY: Executive Director

TITLE: Master's Level Licensure

INTRODUCTION TO THE TOPIC:

Updates regarding Master's level licensure.

BOARD ACTION REQUESTED:

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

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
HF3893 - Artificial Intelligence Bill	3/13/2026	Cover Memo
HF3859 - Psychology Educational Requirements Modified	3/13/2026	Cover Memo
HF3563 - Requiring Board Disciplinary Action	3/13/2026	Cover Memo
HF2590 - Clinical Art Therapist Bill	3/13/2026	Cover Memo
HF 2590 Amendment Language	3/13/2026	Cover Memo
HF3348 - Child Life Specialists	3/13/2026	Cover Memo
HF2998 - Medical Aid in Dying	3/13/2026	Cover Memo
HF2937 - Parenting Time Consultant	3/13/2026	Cover Memo
HF936 - Cost Benefit Analysis in Rules Modified	3/13/2026	Cover Memo
HF3978 - Healthcare Provider Wellness Program	3/13/2026	Cover Memo
ED Report	3/19/2026	Cover Memo

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3893

03/02/2026 Authored by Scott, Liebling, Robbins, Keeler and Tabke
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health occupations; regulating use of artificial intelligence in psychotherapy services; providing for civil penalties; proposing coding for new law in Minnesota Statutes, chapter 214.

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

Section 1. **[214.165] REGULATING USE OF ARTIFICIAL INTELLIGENCE IN PSYCHOTHERAPY SERVICES.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Administrative or supplementary support" means tasks performed to assist a licensed professional in the delivery of therapy or psychotherapy services that do not involve therapeutic communication. Administrative or supplementary support includes but is not limited to:

(1) preparing and maintaining client records, including but not limited to therapy notes;

(2) managing appointment scheduling and reminders;

(3) processing billing and insurance claims;

(4) analyzing anonymized data to track client progress or identify trends for review by a licensed professional;

(5) identifying and organizing external resources or referrals for client use; and

(6) drafting general communications related to therapy logistics that do not include therapeutic advice.

(c) "Artificial intelligence system" means any machine-based system that, for any explicit or implicit objective, calculates from the inputs the system receives how to generate outputs, including but not limited to content, decisions, predictions, or recommendations, that can influence physical or virtual environments.

(d) "Health-related licensing board" has the meaning given in section 214.01, subdivision 2.

(e) "Licensed professional" means an individual who holds a valid license issued in Minnesota to provide therapy or psychotherapy services, including but not limited to:

(1) a licensed psychologist providing clinical services under sections 148.88 to 148.981;

(2) a licensed social worker or independent clinical social worker under chapter 148E;

(3) a licensed professional counselor or licensed professional clinical counselor under sections 148B.50 to 148B.75;

(4) a licensed marriage and family therapist under sections 148B.06 to 148B.392;

(5) a licensed alcohol and drug counselor authorized to provide therapy or psychotherapy services under chapter 148F;

(6) a licensed behavioral analyst under sections 148.9981 to 148.9995;

(7) a licensed physician under chapter 147; and

(8) any other health professional authorized in Minnesota to provide therapy or psychotherapy services.

(f) "Peer support" means services provided by individuals with lived experience of mental health conditions or recovery from substance use that are intended to offer encouragement, understanding, and guidance without clinical intervention.

(g) "Religious counseling" means counseling provided by clergy members, pastoral counselors, or other religious leaders acting within the scope of their religious duties if the services are explicitly faith based and are not represented as clinical mental health, therapy, or psychotherapy services.

(h) "Therapeutic communication" means any verbal, nonverbal, or written interaction conducted in a clinical or professional setting that is intended to diagnose, treat, or address an individual's mental, emotional, or behavioral health concerns. Therapeutic communication includes but is not limited to:

(1) directly interacting with clients for the purpose of understanding or reflecting the client's thoughts, emotions, or experiences;

(2) providing guidance, therapeutic strategies, or interventions designed to achieve mental health outcomes;

(3) offering emotional support, reassurance, or empathy in response to psychological or emotional distress;

(4) collaborating with clients to develop or modify therapeutic goals or treatment plans; and

(5) offering behavioral feedback intended to promote psychological growth or address mental health conditions.

(i) "Therapy or psychotherapy services" means services provided to diagnose, treat, or improve an individual's mental health or behavioral health.

Subd. 2. **Prohibited uses of artificial intelligence.** (a) An individual, corporation, or entity must not provide, advertise, or otherwise offer therapy or psychotherapy services to the public in Minnesota unless the therapy or psychotherapy services are conducted by an individual who is a licensed professional.

(b) A licensed professional must not use artificial intelligence systems 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.

Subd. 3. **Permitted uses of artificial intelligence.** A licensed professional may use artificial intelligence systems to assist in providing administrative or supplementary support in therapy or psychotherapy services if the licensed professional maintains full responsibility for all interactions, outputs, and data use associated with the system.

Subd. 4. **Enforcement, penalties, and hearings.** (a) Any individual, corporation, or entity found in violation of this section must pay a civil penalty to the health-related licensing board responsible for regulating the relevant profession in an amount not to exceed $10,000 per violation.

(b) The health-related licensing board responsible for regulating the relevant profession must determine the amount of the penalty so as to deprive the licensee of any economic advantage gained by reason of the violation, to discourage similar violations, or to reimburse

the board for the cost of investigation and proceeding, including but not limited to fees paid for services provided by the Court of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(c) The health-related licensing board responsible for regulating the relevant profession must provide the individual, corporation, or entity with written notice of the finding of a violation and the imposition of a civil penalty that includes the reasons for the finding, the amount of the civil penalty, and the right to request a hearing under chapter 14. An individual, corporation, or entity must request a contested case hearing under chapter 14 from the health-related licensing board within 30 days of receiving the notice in this paragraph.

(d) An individual, corporation, or entity found in violation of this section must pay the civil penalty within 60 days after notice of the violation and imposition of civil penalty under paragraph (c) or after the date of an order issued following a contested case hearing under chapter 14, whichever is later.

(e) Each health-related licensing board responsible for regulating a licensed professional under this section has the authority to investigate any actual, alleged, or suspected violation of this section.

Subd. 5. **Exceptions.** This section does not apply to:

(1) religious counseling;

(2) peer support; or

(3) self-help materials and educational resources that are available to the public and do not purport to offer therapy or psychotherapy services.

EFFECTIVE DATE. This section is effective the day following final enactment.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3859

03/02/2026 Authored by Bahner
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health occupations; modifying education requirements for licensure and continuing education topics in certain health-related occupations; amending Minnesota Statutes 2024, sections 148.907, subdivision 2; 148.911; 148B.31; 148B.33, subdivision 1; 148B.53, subdivision 1; 148B.54, subdivision 2; 148E.055, subdivision 5.

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

Section 1. Minnesota Statutes 2024, section 148.907, subdivision 2, is amended to read:

Subd. 2. **Requirements for licensure as licensed psychologist.** To become licensed by the board as a licensed psychologist, an applicant shall comply with the following requirements:

(1) pass an examination in psychology;

(2) pass a professional responsibility examination on the practice of psychology;

(3) pass any other examinations as required by board rules;

(4) pay nonrefundable fees to the board for applications, processing, testing, renewals, and materials;

(5) attained the age of majority, be of good moral character, and have no unresolved disciplinary action or complaints pending in the state of Minnesota or any other jurisdiction;

(6) earned a doctoral degree with a major in psychology, with course work that included at least three credit hours of graduate-level courses related to domestic violence, from a regionally accredited educational institution meeting the standards the board has established by rule; and

(7) completed at least one full year or the equivalent in part time of postdoctoral supervised psychological employment in no less than 12 months and no more than 60 months. If the postdoctoral supervised psychological employment goes beyond 60 months, the board may grant a variance to this requirement.

Sec. 2. Minnesota Statutes 2024, section 148.911, is amended to read:

148.911 CONTINUING EDUCATION.

(a) Upon application for license renewal, a licensee shall provide the board with satisfactory evidence that the licensee has completed continuing education requirements established by the board. Continuing education programs shall be approved under section 148.905, subdivision 1, clause (10). The board shall establish by rule the number of continuing education training hours required each year and may specify subject or skills areas that the licensee shall address.

(b) At least four of the required continuing education hours must be on increasing the knowledge, understanding, self-awareness, and practice skills to competently address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression;

(4) understanding cultural humility; and

(5) understanding human diversity, meaning individual client differences that are associated with the client's cultural group, including race, ethnicity, national origin, religious affiliation, language, age, gender, gender identity, physical and mental capabilities, sexual orientation, and socioeconomic status.

(c) At least two of the required continuing education hours must be in courses related to domestic violence.

Sec. 3. Minnesota Statutes 2024, section 148B.31, is amended to read:

148B.31 DUTIES OF THE BOARD; CONTINUING EDUCATION.

(a) The board shall:

(1) adopt and enforce rules for marriage and family therapy licensing, which shall be designed to protect the public;

(2) develop by rule appropriate techniques, including examinations and other methods, for determining whether applicants and licensees are qualified under sections 148B.29 to 148B.392;

(3) issue licenses to individuals who are qualified under sections 148B.29 to 148B.392;

(4) establish and implement procedures designed to assure that licensed marriage and family therapists will comply with the board's rules;

(5) study and investigate the practice of marriage and family therapy within the state in order to improve the standards imposed for the licensing of marriage and family therapists and to improve the procedures and methods used for enforcement of the board's standards;

(6) formulate and implement a code of ethics for all licensed marriage and family therapists; and

(7) establish continuing education requirements for marriage and family therapists.

(b) At least four of the 40 continuing education training hours required under Minnesota Rules, part 5300.0320, subpart 2, must be on increasing the knowledge, understanding, self-awareness, and practice skills that enable a marriage and family therapist to serve clients from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression; and

(4) understanding cultural humility.

(c) At least two of the 40 continuing education training hours required under Minnesota Rules, part 5300.0320, subpart 2, must be on courses related to domestic violence.

Sec. 4. Minnesota Statutes 2024, section 148B.33, subdivision 1, is amended to read:

Subdivision 1. **Documentary evidence of qualifications.** An applicant for a license shall furnish evidence that the applicant:

(1) has attained the age of majority;

(2) is of good moral character;

(3) is a citizen of the United States, or is lawfully entitled to remain and work in the United States;

(4) has at least two years of supervised postgraduate experience in marriage and family therapy satisfactory to the board;

(5)(i) has completed a master's or doctoral degree in marriage and family therapy from a program in a regionally accredited educational institution or from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education of the American Association for Marriage and Family Therapy, with course work that included at least three credit hours of graduate-level courses related to domestic violence; or (ii) has completed a master's or doctoral degree from a regionally accredited educational institution in a related field for which the course work is considered by the board to be equivalent to that provided in clause (5)(i);

(6) will agree to conduct all professional activities as a licensed marriage and family therapist in accordance with a code of ethics for marriage and family therapists to be adopted by the board; and

(7) has passed an examination approved by the board by rule.

Sec. 5. Minnesota Statutes 2024, section 148B.53, subdivision 1, is amended to read:

Subdivision 1. **General requirements.** (a) To be licensed as a licensed professional counselor (LPC), an applicant must provide evidence satisfactory to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) has completed a master's or doctoral degree program in counseling or a related field, as determined by the board based on the criteria in paragraph (b), that includes a minimum of 48 semester hours or 72 quarter hours and a supervised field experience of not fewer than 700 hours that is counseling in nature;

(4) has submitted to the board a plan for supervision during the first 2,000 hours of professional practice or has submitted proof of supervised professional practice that is acceptable to the board; and

(5) has demonstrated competence in professional counseling by passing the National Counseling Exam (NCE) administered by the National Board for Certified Counselors, Inc. (NBCC) or an equivalent national examination as determined by the board, and ethical, oral, and situational examinations if prescribed by the board.

(b) The degree described in paragraph (a), clause (3), must be from a counseling program recognized by the Council for Accreditation of Counseling and Related Education Programs (CACREP) or from an institution of higher education that is accredited by a regional accrediting organization recognized by the Council for Higher Education Accreditation (CHEA). Specific academic course content and training must include course work in each of the following subject areas:

(1) the helping relationship, including counseling theory and practice;

(2) human growth and development;

(3) lifestyle and career development;

(4) group dynamics, processes, counseling, and consulting;

(5) assessment and appraisal;

(6) social and cultural foundations, including multicultural issues;

(7) principles of etiology, treatment planning, and prevention of mental and emotional disorders and dysfunctional behavior;

(8) family counseling and therapy;

(9) research and evaluation; ~~and~~

(10) professional counseling orientation and ethics; and

(11) domestic violence.

(c) To be licensed as a professional counselor, a Minnesota licensed psychologist need only show evidence of licensure from the Minnesota Board of Psychology and is not required to comply with paragraph (a) or (b).

Sec. 6. Minnesota Statutes 2024, section 148B.54, subdivision 2, is amended to read:

Subd. 2. **Continuing education.** (a) At the completion of the first four years of licensure, a licensee must provide evidence satisfactory to the board of completion of 12 additional postgraduate semester credit hours or its equivalent in counseling as determined by the board, except that no licensee shall be required to show evidence of greater than 60 semester hours or its equivalent. In addition to completing the requisite graduate coursework, each licensee shall also complete in the first four years of licensure a minimum of 40 hours of continuing education activities approved by the board under Minnesota Rules, part 2150.2540. Graduate credit hours successfully completed in the first four years of licensure may be applied to both the graduate credit requirement and to the requirement for 40 hours of

continuing education activities. A licensee may receive 15 continuing education hours per semester credit hour or ten continuing education hours per quarter credit hour. Thereafter, at the time of renewal, each licensee shall provide evidence satisfactory to the board that the licensee has completed during each two-year period at least the equivalent of 40 clock hours of professional postdegree continuing education in programs approved by the board and continues to be qualified to practice under sections 148B.50 to 148B.593.

(b) At least four of the required 40 continuing education clock hours must be on increasing the knowledge, understanding, self-awareness, and practice skills that enable a licensed professional counselor and licensed professional clinical counselor to serve clients from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, culture's functions, and strengths that exist in varied cultures;

(2) understanding clients' cultures and differences among and between cultural groups;

(3) understanding the nature of social diversity and oppression; and

(4) understanding cultural humility.

(c) At least two of the required 40 hours of continuing education clock hours must be on courses related to domestic violence.

Sec. 7. Minnesota Statutes 2024, section 148E.055, subdivision 5, is amended to read:

Subd. 5. **Qualifications for licensure by examination as a licensed independent clinical social worker (LICSW).** (a) To be licensed as a licensed independent clinical social worker, an applicant for licensure by examination must provide evidence satisfactory to the board that the applicant:

(1) has received a graduate degree in social work from a program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body that the board designates, or a doctorate in social work from an accredited university;

(2) has completed 360 clock hours (one semester credit hour = 15 clock hours) in the following clinical knowledge areas:

(i) 108 clock hours (30 percent) in differential diagnosis and biopsychosocial assessment, including normative development and psychopathology across the life span;

(ii) 36 clock hours (ten percent) in assessment-based clinical treatment planning with measurable goals;

(iii) 108 clock hours (30 percent) in clinical intervention methods informed by research and current standards of practice;

(iv) 18 clock hours (five percent) in evaluation methodologies;

(v) 72 clock hours (20 percent) in social work values and ethics, including cultural context, diversity, and social policy, of which 30 clock hours must be in courses related to domestic violence; and

(vi) 18 clock hours (five percent) in culturally specific clinical assessment and intervention;

(3) has practiced clinical social work as defined in section 148E.010, including both diagnosis and treatment, and has met the supervised practice requirements specified in sections 148E.100 to 148E.125;

(4) has passed the clinical or equivalent examination administered by the Association of Social Work Boards or a similar examination body that the board designates. An examination is not valid if the applicant took and passed the examination eight or more years prior to submitting an application for licensure under this section;

(5) has submitted a completed, signed application form that the board has provided. For electronic applications, a "signed application" means providing an attestation that the board has specified;

(6) has completed the criminal background check according to section 214.075 and paid the required fees;

(7) has paid all applicable license fees specified in section 148E.180; and

(8) has not engaged in conduct that was or would be in violation of the standards of practice specified in sections 148E.195 to 148E.240. If the applicant has engaged in conduct that was or would be in violation of the standards of practice, the board may take action according to sections 148E.255 to 148E.270.

(b) The requirement in paragraph (a), clause (2), may be satisfied through:

(1) a graduate degree program accredited by the Council on Social Work Education, the Canadian Association of Schools of Social Work, or a similar accreditation body that the board designates; or a doctorate in social work from an accredited university. An academic institution must certify clinical clock hours in the clinical knowledge areas on a form that the board has provided to meet this requirement;

(2) graduate coursework from an accredited institution of higher learning. An academic institution must certify clinical clock hours in the clinical knowledge areas on a form that the board has provided to meet this requirement; or

(3) up to 120 continuing education hours, which the applicant may complete via continuing education independent learning as defined in section 148E.010, subdivision 7d. The applicant must include documents verifying completion of clinical clock hours in the clinical knowledge areas to meet this requirement as specified in section 148E.130, subdivision 11.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3563

02/23/2026 Authored by Anderson, P. E.; Robbins; Harder; Niska; Hudson and others
The bill was read for the first time and referred to the Committee on Fraud Prevention and State Agency Oversight Policy
02/26/2026 By motion, recalled and re-referred to the Committee on Health Finance and Policy

A bill for an act

relating to fraud prevention; requiring licensing boards to take action against a license or application when a licensee or applicant is convicted of certain theft or fraud offenses; amending Minnesota Statutes 2024, section 214.10, subdivision 2a.

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

Section 1. Minnesota Statutes 2024, section 214.10, subdivision 2a, is amended to read:

Subd. 2a. **Proceedings.** A board shall initiate proceedings to suspend or revoke a license or shall refuse to renew a license of a person licensed by the board who is convicted in a court of competent jurisdiction of violating section 256.98, 609.2231, subdivision 8, 609.23, 609.231, 609.2325, 609.233, 609.2335, 609.234, 609.465, 609.466, 609.496, 609.497, 609.52, 609.542, or 609.72, subdivision 3.

EFFECTIVE DATE. This section is effective the day following final enactment.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2590

03/20/2025 Authored by Norris, Perryman, Agbaje, Falconer, Reyer and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health professions; establishing licensure for clinical art therapists; modifying the membership of the Board of Behavioral Health and Therapy; imposing fees and civil penalties; appropriating money; amending Minnesota Statutes 2024, sections 148B.51; 245I.04, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 148B.

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

Section 1. Minnesota Statutes 2024, section 148B.51, is amended to read:

148B.51 BOARD OF BEHAVIORAL HEALTH AND THERAPY.

(a) The Board of Behavioral Health and Therapy consists of ~~13~~ 18 members appointed by the governor. Five of the members shall be professional counselors licensed or eligible for licensure under sections 148B.50 to 148B.593. Five of the members shall be alcohol and drug counselors licensed under chapter 148F. Five of the members shall be clinical art therapists licensed under sections 148B.80 to 148B.95. Three of the members shall be public members as defined in section 214.02. The board shall annually elect from its membership a chair and vice-chair. The board shall appoint and employ an executive director who is not a member of the board. The employment of the executive director shall be subject to the terms described in section 214.04, subdivision 2a. Chapter 214 applies to the Board of Behavioral Health and Therapy unless superseded by sections 148B.50 to 148B.593.

(b) At the time of their appointments, at least three members must reside outside of the seven-county metropolitan area.

(c) At the time of their appointments, at least three members must be members of:

(1) a community of color; or

(2) an underrepresented community, defined as a group that is not represented in the majority with respect to race, ethnicity, national origin, sexual orientation, gender identity, or physical ability.

Sec. 2. **[148B.80] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 148B.80 to 148B.95, the terms in this section have the meanings given.

Subd. 2. **Accredited educational institution.** "Accredited educational institution" means a university or college accredited by the Commission on Accreditation of Allied Health Education Programs, another nationally recognized accrediting agency of institutions of higher education, or an institution and clinical program approved by the American Art Therapy Association.

Subd. 3. **Art therapy.** "Art therapy" means an evidenced-based clinical practice that integrates and applies psychotherapeutic principles, techniques, and methods with specialized training in art therapy theory, art media, the neurobiological implications of art making, the creative process, and art-based assessment models to assist an individual, family, or group to:

(1) alleviate mental and emotional disorders and psychopathologies;

(2) improve cognitive and sensory-motor functions;

(3) increase self-awareness and self-esteem;

(4) cope with grief and traumatic experiences;

(5) resolve conflicts and distress; and

(6) enhance daily functioning in a professional relationship.

Subd. 4. **Art therapy services.** "Art therapy services" means providing services to accomplish art therapy goals, which includes using art media, creative techniques, nonverbal communication, psychotherapy, art-based assessment models, and the creative process in a therapeutic relationship between a licensed clinical art therapist or a provisional licensed clinical art therapist and their clients. Art therapy services also includes using evaluation and assessment to define and implement goals to address developmental, rehabilitative, habilitative, mental health, preventive, wellness care, or educational needs of the clients.

Subd. 5. **Board.** "Board" means the Board of Behavioral Health and Therapy established in section 148B.51.

Subd. 6. **Certified art therapist.** "Certified art therapist" means a person who holds the registered art therapist with board certification (ATR-BC) credential in good standing with the Art Therapy Credentials Board or a substantially similar successor credentialing organization.

Subd. 7. **Clinical art therapy.** "Clinical art therapy" means the application of art therapy services and clinical decision-making skills in the evaluation, assessment, diagnosis, prevention, treatment, and amelioration of mental, developmental, behavioral, and emotional disorders and conditions in children, adolescents, and adults. Clinical art therapy also includes the utilization of appropriate knowledge and specialized training in art therapy to inform and determine the appropriate course of action within the clinician's scope of art therapy practice while tailored to the context of each specific clinical setting.

Subd. 8. **Licensed clinical art therapist.** "Licensed clinical art therapist" means a person who is licensed by the board and meets the requirements of section 148B.84.

Subd. 9. **Privileged communication.** "Privileged communication" means any information, including but not limited to client records, artwork, verbal or artistic expressions, assessment results, or assessment interpretations developed during a professional relationship between a clinical art therapist and a client.

Subd. 10. **Provisional licensed clinical art therapist.** "Provisional licensed clinical art therapist" means a person who has been issued a provisional license by the board and meets the requirements under section 148B.85.

Subd. 11. **Student.** "Student" means a person who is enrolled in an art therapy academic program at an accredited educational institution or who is engaged in the practice of art therapy in a supervised practicum or internship as part of an approved course of professional education in art therapy.

Subd. 12. **Supervised experience.** "Supervised experience" means the regular oversight of the functions and activities of a graduate art therapy student, either as part of an internship or practicum experience by a qualified art therapy supervisor as defined in section 148B.89, subdivision 2.

Subd. 13. **Supervision.** "Supervision" means a formalized professional relationship between a qualified art therapy supervisor, as defined in section 148B.89, and supervisee in which the qualified art therapy supervisor directs, guides, monitors, instructs, and evaluates the supervisee's professional art therapy practice while promoting the development of the supervisee's knowledge, skills, and abilities to provide professional art therapy services in an ethical and competent manner.

Sec. 3. **[148B.81] DUTIES OF THE BOARD; ART THERAPY.**

The board shall exercise the following duties:

(1) adopt rules necessary to implement sections 148B.80 to 148B.95;

(2) prescribe licensure application forms and issue licenses to individuals who are qualified under sections 148B.80 to 148B.95;

(3) establish and implement procedures designed to assure that licensed clinical art therapists comply with the provisions of sections 148B.80 to 148B.95;

(4) establish and implement requirements and procedures for renewal of clinical art therapist licenses and provisional clinical art therapist licenses in accordance with the provisions of sections 148B.80 to 148B.95; and

(5) establish and implement continuing education requirements for licensed clinical art therapists in accordance with section 148B.88.

Sec. 4. **[148B.82] SCOPE OF PRACTICE.**

The practice of clinical art therapy includes:

(1) implementing art therapy services, including evaluation, assessment, diagnosis, treatment planning, intervention, and referral;

(2) developing an individualized art therapy treatment plan to address the cognitive, developmental, behavioral, and emotional disorders of a client;

(3) systematically evaluating and comparing the individual's response to the individualized art therapy treatment plan and suggesting modifications, as appropriate;

(4) using therapeutic interventions to facilitate alternative modes of receptive and expressive communication therapeutic interventions that can circumvent the limitations of verbal articulation;

(5) using treatment interventions that include psychotherapy or counseling integrated with art therapy theory, the creative process, or art media to facilitate human development and to identify and remediate mental, emotional, or behavioral disorders and associated distress that interferes with daily functioning;

(6) using art media, the creative process, and the resulting artwork to assist clients in coping with and reducing psychiatric symptoms and posttraumatic stress; enhancing neurological, cognitive, and verbal abilities; and promoting appropriate skills development;

(7) crisis intervention; and

(8) art-based treatments that effectively respond to multicultural and diverse populations.

Sec. 5. **[148B.83] UNAUTHORIZED PRACTICE; TITLE PROTECTION.**

Subdivision 1. **Unlicensed practice prohibited.** Effective July 1, 2025, no person shall practice clinical art therapy unless the person is licensed as a clinical art therapist or as a provisional licensed clinical art therapist pursuant to sections 148B.80 to 148B.95, except as otherwise provided.

Subd. 2. **Protected titles.** No person shall use the title "clinical art therapist," "licensed clinical art therapist," "licensed art therapist," or "provisional licensed art therapist" or the abbreviations "LCAT" or "LCAT-P" or any words, letters, abbreviations, or insignia indicating or implying the person is licensed by the state as a clinical art therapist or is eligible for licensure as a clinical art therapist unless the person is licensed in accordance with sections 148B.80 to 148B.95.

Subd. 3. **Sanctions.** Any person who violates a provision of this section is guilty of a misdemeanor and is subject to sanctions or actions according to section 214.11.

Subd. 4. **Exceptions.** Nothing in this section prevents:

(1) the practice of art therapy by students or interns or individuals preparing for the practice of art therapy under qualified supervision of a professional who is recognized and approved by the board in an educational institution or agency as part of an accredited educational institution in graduate art therapy, provided such students, interns, or individuals are designated by titles such as "student," "trainee," "intern," or other titles clearly indicating their training status; or

(2) qualified individuals from doing work within the standards, scope, and ethics of their respective professions and callings provided the individuals do not hold themselves out to the public by any title, initials, or description of services as being a licensed clinical art therapist or a provisional licensed clinical art therapist.

Sec. 6. **[148B.84] REQUIREMENTS FOR LICENSURE.**

Subdivision 1. **General requirements.** To be licensed as a clinical art therapist, an applicant must submit an application on a form prescribed by the board and provide evidence to the board that the applicant:

(1) is at least 18 years of age;

(2) is of good moral character;

(3) received a master's or doctoral degree in art therapy that includes at least 700 hours of supervised internship experience from an accredited educational institution at the time of graduation;

(4) received a master's or doctoral degree or higher in a related field, including but not limited to psychology, counseling, social work, or creative arts therapies, from an accredited educational institution and:

(i) completed a minimum of 30 graduate credit hours in the following subject areas: theory and practice of art therapy, art therapy media and techniques, history of art therapy, human growth and development, dynamics in art, application of art therapy with people in different treatment settings, art therapy appraisal, diagnosis and assessment, group art therapy, ethical and legal issues of art therapy practice, matters of cultural and social diversity affecting the practice of art therapy, and standards of good art therapy practice; and

(ii) completed at least 700 hours of supervised internship experience;

(5) has demonstrated competence in clinical art therapy by passing the Board Certification Examination administered by the Art Therapy Credentials Board;

(6) completed 4,000 hours of supervised, post-master's degree professional experience in the delivery of clinical art therapy; and

(7) submitted all applicable fees as required under section 148B.95.

Subd. 2. **Transition period.** (a) Until July 1, 2027, the board may waive the requirements of subdivision 1, clauses (3), (4), and (6), and issue a clinical art therapist license to an applicant who provides satisfactory evidence to the board that the applicant:

(1) holds a credential in good standing as a certified art therapist; and

(2) has at least five years of full-time experience in the practice of clinical art therapy.

Sec. 7. **[148B.85] PROVISIONAL LICENSE.**

Subdivision 1. **Requirements.** (a) The board may issue a provisional license to practice clinical art therapy if the applicant submits an application on a form prescribed by the board and submits to the board:

(1) satisfactory evidence that the applicant meets the requirements of section 148B.84, subdivision l, clauses (1) to (4); and

(2) the applicable fees required under section 148B.95.

(b) An applicant seeking a provisional license under this section must submit with the application a plan for supervised clinical experience that meets the requirements described in section 148B.89. Upon any change in the supervision plan, a provisional licensee shall submit to the board a revised plan for supervised clinical practice that continues to meet the requirements of section 148B.89.

(c) A provisional licensed clinical art therapist practicing under this section:

(1) must use the title "Provisional Licensed Clinical Art Therapist" or the abbreviation "LCAT-P" in professional activities; and

(2) is subject to all statutes and rules to the same extent as an individual who is licensed under section 148B.84, except the individual is not subject to the continuing education requirements of section 148B.88.

Subd. 2. **Renewal of provisional license.** (a) A provisional licensed clinical art therapist practicing with a provisional license must renew the provisional license annually in accordance with section 148B.87, with the exception of the submitting attestation of completing continuing education requirements.

(b) A provisional license is automatically terminated if not renewed as required under this subdivision or upon the granting or denial by the board of the applicant's application for licensure as a clinical art therapist.

(c) A provisional license must not be renewed more than five times.

Sec. 8. **[148B.86] LICENSURE BY RECIPROCITY.**

The board shall issue a clinical art therapist license to an individual who holds a current license as a clinical art therapist or its equivalent from another jurisdiction if the board determines that the standards for licensure in the other jurisdiction are at least equivalent to or exceed the requirements of section 148B.84.

Sec. 9. **[148B.87] LICENSE RENEWAL.**

Subdivision 1. **Renewal.** A licensee must annually renew a license issued by the board by submitting a complete renewal application, paying the required renewal fee under section 148B.95, and attesting to the completion of the continuing education requirements under section 148B.88.

Subd. 2. **Notice of renewal.** The board shall send a licensee a renewal notice. The board shall send the notice to the licensee's last known address on record with the board. The board may send the notice electronically.

Subd. 3. **Receipt of renewal.** A licensee must send the renewal application to the board so that the application is postmarked or electronic renewal is completed on or before the expiration date of the current license.

Subd. 4. **Late fee.** A licensee must pay a late fee in accordance with section 148B.95 if the licensee's renewal application is postmarked or received by the board after the expiration date of the license, but is postmarked or received by the board within 30 days after the license expiration date.

Subd. 5. **Failure to renew.** If the licensee fails to submit the renewal application, the required continuing education information, or the renewal and late renewal fees within 30 days after the license expiration date, the licensee's license expires and the licensee's right to practice terminates.

Sec. 10. **[148B.88] CONTINUING EDUCATION.**

Licensees must complete 40 hours of board-approved continuing education every two years. Of the 40 hours, at least 20 hours must involve content related to the practice of art therapy and at least:

(1) three hours must involve ethical and professional studies education including but not limited to professional ethics, legal issues, and interprofessional cooperation; and

(2) three hours must involve cultural responsiveness by increasing knowledge, understanding, self-awareness, and practice skills to serve clients from diverse socioeconomic, social, and cultural backgrounds. Topics include but are not limited to:

(i) understanding culture, culture's functions, and strengths that exist in varied cultures;

(ii) understanding clients' cultures and differences among and between cultural groups;

(iii) understanding the nature of intersectionality, social diversity, and oppression; and

(iv) understanding cultural humility.

Sec. 11. **[148B.89] SUPERVISED EXPERIENCE.**

Subdivision 1. **Supervision requirements.** (a) To qualify as a licensed clinical art therapist, an applicant must complete 4,000 hours of post-master's degree supervised work or volunteer experience in the delivery of clinical art therapy services in the diagnosis and

treatment of mental illnesses and disorders in both children and adults. The supervised experience must meet the requirements in paragraphs (b) to (f).

(b) The first 2,000 hours of supervised experience must involve clinical practice of art therapy with supervision by a qualified art therapy supervisor approved by the board in accordance with subdivision 2. The second 2,000 hours of supervision may be provided by either a qualified art therapy supervisor or a qualified licensed mental health professional as determined by the board.

(c) An individual must obtain supervision hours at the rate of two hours of supervision per 40 hours of professional experience. Supervision must be evenly distributed over the course of the supervised professional experience. At least 75 percent of the required supervision hours must be received in person or through real-time, two-way interactive audio and visual communication. The board must allow an applicant to satisfy this supervision requirement with all required hours of supervision received through real-time, two-way interactive audio and visual communication. The remaining 25 percent of the required hours may be received by telephone or by audio or audiovisual electronic device. At least 50 percent of the required hours of supervision must be received on an individual basis. The remaining 50 percent of the required hours may be received in a group setting.

(d) The supervised experience must be in clinical practice and must include at least 1,800 hours of clinical client contact.

(e) An individual must complete qualifying supervised experience in no fewer than 24 consecutive months and no more than 72 consecutive months.

(f) A doctoral internship may be applied toward the required postgraduate supervised experience.

Subd. 2. **Qualified art therapy supervisors.** (a) The following individuals are eligible for approval by the board as a qualified art therapy supervisor: an art therapy certified supervisor (ATCS), a licensed clinical art therapist (LCAT), a licensed marriage and family therapist who is a certified art therapist, a licensed professional clinical counselor who is a certified art therapist, and a certified art therapist (ATR-BC).

(b) To be approved by the board as a qualified art therapy supervisor, an individual must submit an application on a form prescribed by the board with the following:

(1) a letter of recommendation from a licensed clinical art therapist or a certified art therapist attesting to the individual's competence to provide art therapy supervision;

(2) evidence of completion of at least two years of postlicensure professional experience; and

(3) evidence of the successful completion of a graduate level course in clinical supervision of at least three semester credit hours, or credit equivalent from an accredited college or university, or a minimum of 45 continuing education credits involving courses or training in clinical supervision and art therapy supervision. At least six credits must be in clinical art therapy supervision.

(c) Notwithstanding paragraph (a), the board may approve an applicant as a qualified art therapy supervisor if the applicant demonstrates competence in supervising individuals practicing clinical art therapy by providing documentation satisfactory to the board that the applicant has:

(1) provided supervision for persons providing clinical art therapy during a period of at least 36 consecutive months as part of a master's degree program in art therapy approved by the American Art Therapy Association; or

(2) completed at least 500 hours of experience as a clinical or academic qualified art therapy supervisor under paragraph (a).

(d) Paragraph (c) expires July 1, 2030.

Sec. 12. **[148B.90] REFUSAL TO GRANT LICENSE; SUSPENSION OR REVOCATION OF LICENSE.**

Subdivision 1. **Ground for action.** The board may refuse to grant a license to, or may suspend, revoke, condition, limit, qualify, or restrict the license of, any individual who the board, after a hearing under the contested case provisions of chapter 14, determines:

(1) is incompetent to practice clinical art therapy, or is found to engage in the practice of clinical art therapy in a manner harmful or dangerous to a client or to the public;

(2) is convicted by a court of competent jurisdiction of a crime that the board determines is of a nature to render the convicted person unfit to practice clinical art therapy;

(3) has engaged in unprofessional conduct that fails to conform to minimum standards of acceptable and prevailing practice necessary for the protection of the public;

(4) has obtained or attempted to obtain a license or license renewal by bribery or fraudulent representation;

(5) has knowingly made a false statement on a form required by the board for licensing or license renewal; or

(6) has failed to obtain continuing education credits required by the board.

(b) If grounds for disciplinary action exist under paragraph (a), the board may take one or more of the following actions:

(1) refuse to grant or renew a license;

(2) revoke a license;

(3) suspend a license;

(4) impose limitations or conditions on a licensee's practice of clinical art therapy, including but not limited to limiting the scope of practice to designated competencies, imposing retraining or rehabilitation requirements, requiring the licensee to practice under supervision, or conditioning continued practice on the demonstration of knowledge or skill by appropriate examination or other review of skill and competence;

(5) censure or reprimand the licensee;

(6) refuse to permit an applicant to take the licensure examination or refuse to release an applicant's examination grade if the board finds that it is in the public interest; or

(7) impose a civil penalty not exceeding $10,000 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the applicant or licensee of any economic advantage gained by reason of the violation charged, to discourage similar violations, or to reimburse the board for the cost of the investigation and proceeding, including but not limited to fees paid for services provided by the Office of Administrative Hearings, legal and investigative services provided by the Office of the Attorney General, court reporters, witnesses, reproduction of records, board members' per diem compensation, board staff time, and travel costs and expenses incurred by board staff and board members.

(c) In lieu of or in addition to paragraph (b), the board may require, as a condition of continued licensure, termination of suspension, reinstatement of license, examination, or release of examination grades, that the applicant or licensee:

(1) submit to a quality review, as specified by the board, of the applicant's or licensee's ability, skills, or quality of work; and

(2) complete, to the satisfaction of the board, educational courses specified by the board.

(d) The board may also refer a licensee, if appropriate, to the health professionals services program described in sections 214.31 to 214.37.

Subd. 2. **Restoring a license.** For reasons the board considers sufficient and upon a vote of five of its members, the board may restore a license, reduce a period of suspension, or withdraw a reprimand.

Sec. 13. **[148B.91] COMPLAINTS; INVESTIGATION.**

Clinical art therapists licensed under sections 148B.80 to 148B.95 are subject to section 148B.371.

Sec. 14. **[148B.92] DUTY TO MAINTAIN CURRENT INFORMATION.**

All individuals licensed as clinical art therapists, all individuals with provisional licenses, and all applicants for licensure must notify the board within 30 days of the occurrence of any of the following:

(1) a change of name, address, place of employment, and home or business telephone number; and

(2) a change in any other application information.

Sec. 15. **[148B.93] NONTRANSFERABILITY OF LICENSES.**

A clinical art therapist license or a provisional clinical art therapist license is not transferable.

Sec. 16. **[148B.94] PRIVILEGED COMMUNICATION; EXCEPTIONS.**

A person licensed under sections 148B.80 to 148B.95 and employees and professional associates of the licensed person cannot be required to disclose any privileged communication that the person, employee, or associate may have acquired in rendering clinical art therapy services, unless:

(1) disclosure is required by other state laws;

(2) failure to disclose the information presents a clear and present danger to the health or safety of an individual;

(3) the person, employee, or associate is a party defendant to a civil, criminal, or disciplinary action arising from the therapy, in which case a waiver of the privilege accorded by this section is limited to that action;

(4) the patient is a defendant in a criminal proceeding and the use of the privilege would violate the defendant's right to a compulsory process or the right to present testimony and witnesses on that person's behalf; and

(5) a patient agrees to a waiver of the privilege accorded by this section, and in circumstances where more than one person in a family is receiving therapy, each family member agrees to the waiver. Absent a waiver from each family member, a licensed clinical art therapist or a provisional licensed clinical art therapist must not disclose information received by a family member.

Sec. 17. **[148B.95] FEES.**

Subdivision 1. **Fees.** All individuals licensed as clinical art therapists, all individuals with provisional licenses, and all applicants for licensure shall pay fees as follows:

(1) initial licensure and application fee for provisional licensed clinical art therapist, $100;

(2) initial licensure and application fee for licensed clinical art therapist, $250;

(3) annual renewal of provisional licensure fee, $50;

(4) annual renewal of clinical art therapist licensure fee, $200;

(5) late fee, $100 per month or portion thereof;

(6) sponsor application for approval of a continuing education course fee, $60;

(7) duplicate certificate fee, $25; and

(8) certificate of good standing or license verification, $25.

Subd. 2. **Proration of fees.** If a licensee's initial license term is less than 12 months, the board may prorate the initial license fee. All licensees must pay the full fee upon license renewal.

Subd. 3. **Nonrefundable fees.** All fees are nonrefundable.

Subd. 4. **Deposit of fees.** Fees collected by the board under this section shall be deposited in the state government special revenue fund.

Sec. 18. Minnesota Statutes 2024, section 245I.04, subdivision 2, is amended to read:

Subd. 2. **Mental health professional qualifications.** The following individuals may provide services to a client as a mental health professional:

(1) a registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a: (i) clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national certification organization; or (ii) nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization;

(2) a licensed independent clinical social worker as defined in section 148E.050, subdivision 5;

(3) a psychologist licensed by the Board of Psychology under sections 148.88 to 148.98;

(4) a physician licensed under chapter 147 if the physician is: (i) certified by the American Board of Psychiatry and Neurology; (ii) certified by the American Osteopathic Board of Neurology and Psychiatry; or (iii) eligible for board certification in psychiatry;

(5) a marriage and family therapist licensed under sections 148B.29 to 148B.392; ~~or~~

(6) a licensed professional clinical counselor licensed under section 148B.5301; or

(7) a licensed clinical art therapist licensed under sections 148B.80 to 148B.95.

Sec. 19. **APPROPRIATION.**

$..... in fiscal year 2026 and $..... in fiscal year 2027 are appropriated from the state government special revenue fund to the Board of Behavioral Health and Therapy for the implementation of Minnesota Statutes, sections 148B.80 to 148B.95.

..... moves to amend H.F. No. 2590 as follows:

Page 1, delete section 1

Page 2, after line 11, insert:

"Subd. 3. **Advisory council.** "Advisory council" means the Clinical Art Therapist Advisory Council established under section 148B.945."

Renumber the subdivisions in sequence

Page 4, line 19, delete "individual's" and insert "client's"

Page 4, delete lines 21 to 23 and insert:

"(4) identifying and assessing clients' needs in order to implement therapeutic interventions to meet developmental, behavioral, psychological, and emotional needs and provide opportunities for engagement through the creative process;"

Page 4, line 24, delete "treatment" and insert "therapeutic"

Page 4, delete lines 28 to 30 and insert:

"(6) using art media, the creative process, and the resulting artwork to enhance optimal cognitive, mental, and emotional health and development; support general wellness; and tap into clients' inner fears, conflicts, and core issues, with the goal of improving physical, psychological, and emotional functioning and well-being;"

Page 5, line 1, after "(8)" insert "incorporating"

Page 5, line 3, delete "2025" and insert "2027"

Page 6, line 19, delete "2027" and insert "2029"

Page 9, line 1, delete "illnesses and" and insert ", emotional, and behavioral"

Page 10, line 17, delete "2030" and insert "2032"

Page 10, line 20, after "board" insert ", with advice from the advisory council," and delete everything after "may" and insert "take one or more of the licensing or disciplinary actions in paragraph (b) against"

Page 10, line 21, delete everything before "any"

Page 11, line 2, after "board" insert ", with advice from the advisory council,"

Page 12, line 5, delete "section" and insert "sections"

Page 12, line 6, delete "148B.371" and insert "148B.5901 and 148B.5905"

Page 13, line 3, delete "and" and insert "or"

Page 13, after line 8, insert:

"Sec. .... **[148B.945] CLINICAL ART THERAPIST ADVISORY COUNCIL.**

Subdivision 1. **Establishment; membership.** The Clinical Art Therapist Advisory Council is created and is composed of five individuals appointed by the board. Three members must be licensed clinical art therapists, one member must be a public member as defined in section 214.02, and one member must be a qualified art therapy supervisor approved by the board.

Subd. 2. **Organization.** The advisory council shall be organized and administered under section 15.059.

Subd. 3. **Duties.** The advisory council must:

(1) advise the board regarding standards for licensure of clinical art therapists;

(2) distribute information regarding clinical art therapist licensure standards;

(3) advise the board on enforcement of sections 148B.80 to 148B.95;

(4) review applications and recommend granting or denying provisional licensure, licensure, license renewal, and approval of qualified art therapy supervisors;

(5) advise the board on issues related to receiving and investigating complaints, conducting hearings, and imposing disciplinary action regarding complaints against clinical art therapists;

(6) advise the board regarding approval of continuing education courses; and

(7) perform other duties authorized for advisory councils under chapter 214, as directed by the board."

Page 14, line 16, delete "$..... in fiscal year 2026 and $..... in fiscal year 2027 are" and insert "$..... in fiscal year 2027 is"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3348

02/17/2026 Authored by Schomacker
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health occupations; establishing licensure for certified child life specialists; permitting rulemaking; providing for civil and criminal penalties; proposing coding for new law as Minnesota Statutes, chapter 148H.

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

Section 1. **[148H.001] SCOPE; EFFECTIVE DATE.**

(a) This chapter applies to all applicants and licensees, all persons who use the title licensed certified child life specialist, and all persons in or out of Minnesota who provide licensed certified child life specialist services to clients who reside in Minnesota, unless there are specific applicable exemptions provided by law.

(b) This chapter is effective July 1, 2027.

Sec. 2. **[148H.01] DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Advisory council.** "Advisory council" means the Certified Child Life Specialist Advisory Council established in section 148H.14.

Subd. 3. **Board.** "Board" means the Board of Social Work created under section 148E.025.

Subd. 4. **Certification.** "Certification" means the formal recognition by the Child Life Certification Commission of the knowledge, skills, education, and experience demonstrated

by the achievement of standards identified by the Child Life Certification Commission and the Association of Child Life Professionals.

Subd. 5. **Certified child life specialist.** "Certified child life specialist" means an individual who holds current and valid certification as a child life specialist from the Child Life Certification Commission.

Subd. 6. **Certified child life specialist practice.** "Certified child life specialist practice" means providing developmentally appropriate interventions to mitigate the negative effects of stress and trauma on children and families within the training, professional competencies, and experience of the certified child life specialist and within the parameters of the standards established by the Child Life Certification Commission. Certified child life specialist practice includes but is not limited to:

(1) evaluating the developmental and psychosocial needs of children and families;

(2) establishing therapeutic relationships to build trust and support children and families;

(3) providing and facilitating therapeutic play opportunities to decrease distress and promote healing;

(4) creating safe, therapeutic environments that promote emotional healing and development;

(5) supporting children and families in coping with stressful events through evidence-based interventions; and

(6) providing developmentally appropriate preparation and education for potentially stressful experiences.

Subd. 7. **Direct supervision.** "Direct supervision" means one-on-one supervision by a supervisor of a supervisee that allows for personalized feedback, case review, and professional development.

Subd. 8. **Independent practice.** "Independent practice" means engaging in certified child life specialist practice without direct supervision by a licensed certified child life specialist or without being employed in a setting that provides appropriate professional oversight and supervision.

Subd. 9. **Licensed certified child life specialist.** "Licensed certified child life specialist" means an individual who holds a valid license under this chapter to engage in independent certified child life specialist practice.

Subd. 10. **Supervision or supervised practice.** "Supervision" or "supervised practice" means a professional relationship between a supervisor and a supervisee in which the supervisor oversees and evaluates a supervisee's postdegree certified child life specialist practice.

Subd. 11. **Supervisor.** "Supervisor" means an individual who meets the requirements under section 148H.09, subdivision 1.

Sec. 3. **[148H.02] DUTIES OF THE BOARD OF SOCIAL WORK.**

Subdivision 1. **General.** The board, in consultation with the advisory council, must:

(1) issue licenses to qualified individuals under this chapter;

(2) adopt and enforce standards for licensure, licensure renewal, continuing education, and regulation of certified child life specialists;

(3) monitor compliance with licensing standards;

(4) carry out disciplinary actions against licensees; and

(5) collect nonrefundable license fees for licensed certified child life specialists.

Subd. 2. **Rulemaking.** The board, in consultation with the advisory council, may adopt rules necessary to implement the duties under subdivision 1.

Sec. 4. **[148H.025] LICENSING IMPLEMENTATION.**

(a) By January 1, 2028, the board must establish the Certified Child Life Specialist Advisory Council according to section 148H.14.

(b) By July 1, 2028, the board must approve initial licensees as specified in section 148H.09, subdivision 2.

(c) By July 1, 2029, the board must begin accepting applications for certified child life specialist licensure from all applicants and granting licenses under this chapter.

Sec. 5. **[148H.03] REQUIREMENTS FOR LICENSURE.**

Subdivision 1. **General.** (a) Effective July 1, 2029, an individual seeking licensure as a certified child life specialist must submit a completed application on forms provided by the board and all fees required under section 148H.13. The application must include:

(1) the applicant's name;

(2) the applicant's business address, if applicable;

(3) the applicant's business telephone number, if applicable;

(4) the applicant's home address;

(5) the applicant's home telephone number;

(6) a description of the applicant's education, training, and professional experience, including employment or internship history for the five years immediately preceding the application date;

(7) a signed statement that the information in the application is true and correct to the best of the applicant's knowledge and belief;

(8) a signed waiver authorizing the board to obtain access to the applicant's records in Minnesota or any other state in which the applicant has worked as a certified child life specialist; and

(9) consent to a fingerprint-based criminal history records check pursuant to section 214.075.

(b) The board may request additional information from an applicant to clarify information submitted in the application.

Subd. 2. **Requirements for licensure.** An applicant for licensure as a certified child life specialist under this section must submit to the board evidence and documentation satisfactory to the board that the applicant:

(1) holds current and valid certification as a child life specialist from the Child Life Certification Commission;

(2) has obtained a bachelor's or master's degree in child life or a related field;

(3) has completed a clinical internship determined to be eligible for certification by the Association of Child Life Professionals and the Child Life Certification Commission;

(4) has passed the child life professional certification examination; and

(5) has completed one of the following:

(i) at least 6,000 hours of paid postdegree professional experience as a certified child life specialist, followed by 50 hours of supervised practice under a licensed certified child life specialist, at least 25 hours of which must be provided through direct supervision; or

(ii) at least 4,000 hours but fewer than 6,000 hours of paid postdegree professional practice, followed by 100 hours of supervised practice by a licensed certified child life specialist, at least 50 hours of which must be provided through direct supervision.

Subd. 3. **Criminal background check.** An applicant under this section must complete a background check pursuant to section 214.075 and pay the required fees.

Sec. 6. **[148H.04] LICENSURE BY RECIPROCITY AND ENDORSEMENT.**

Subdivision 1. **Licensure by reciprocity.** (a) An applicant who applies for licensure as a certified child life specialist by reciprocity must meet the requirements of paragraphs (b) and (c).

(b) An applicant applying for licensure by reciprocity must provide evidence to the board that the applicant holds a current and unrestricted license for the practice of certified child life specialist services in another jurisdiction that has requirements equivalent to or higher than those in effect for determining whether an applicant in Minnesota is qualified to be licensed as a certified child life specialist. An applicant who provides sufficient evidence under this paragraph is exempt from meeting the requirements of section 148H.03, subdivision 2, provided that the applicant otherwise meets all other requirements of section 148H.03.

(c) An applicant for licensure by reciprocity must have maintained the appropriate and unrestricted credentials in each jurisdiction during the last five years as demonstrated by submitting letters of verification to the board. Each letter must include the applicant's name, date of birth, and credential number; the date of credential issuance; a statement regarding disciplinary actions, if any, taken against the applicant; and the terms under which the credential was issued.

Subd. 2. **Licensure by endorsement.** The board may develop procedures for licensure by endorsement for applicants from jurisdictions that do not offer a credential substantially similar to the licensed certified child life specialist credential in Minnesota but in which the applicant has demonstrated competence through experience, continuing education, or other means.

Sec. 7. **[148H.05] LICENSE RENEWAL REQUIREMENTS.**

Subdivision 1. **Biennial renewal.** A license under this chapter must be renewed every two years.

Subd. 2. **License renewal notice.** At least 60 calendar days before a licensee's renewal deadline date, the board must mail a renewal notice to the licensee's last known address on file with the board. The notice must include instructions for accessing an online application for license renewal, the renewal deadline, and notice of fees required for renewal. The

licensee's failure to receive notice does not relieve the licensee of the obligation to meet the renewal deadline and other requirements for license renewal.

Subd. 3. **Renewal requirements.** (a) To renew a license, a licensee must submit to the board:

(1) a completed and signed application for license renewal, including proof of completion of continuing education requirements under section 148H.11;

(2) the license renewal fee required under section 148H.13; and

(3) evidence satisfactory to the board that the licensee holds current and valid certification as a child life specialist from the Child Life Certification Commission or otherwise meets renewal requirements as established by the board.

(b) The application for license renewal and fee must be postmarked or received by the board by the end of the day on which the license expires or the following business day if the expiration date falls on a Saturday, Sunday, or holiday. A renewal application that is not completed and signed, or that is not accompanied by the correct fee, is void and must be returned to the licensee.

Subd. 4. **Pending renewal.** If a licensee's application for license renewal is postmarked or received by the board by the end of the business day on the expiration date of the license or the following business day if the expiration date falls on a Saturday, Sunday, or holiday, the licensee may continue to practice after the expiration date while the application for license renewal is pending with the board.

Subd. 5. **Late fee.** If the application for license renewal is postmarked or received after the expiration date of the license or the following business day if the expiration date falls on a Saturday, Sunday, or holiday, the licensee must pay a renewal late fee as specified by section 148H.13, in addition to the renewal fee, before the board considers the licensee's application for license renewal.

Sec. 8. **[148H.06] LICENSE EXPIRATION.**

(a) Within 30 days after the renewal date, the board must notify a licensee who has not renewed their license by letter, sent to the last known address of the licensee in the board's file, that the renewal is overdue and that failure to pay the current fee and current biennial renewal late fee within 60 days after the renewal date will result in termination of the license.

(b) The board must 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 paragraph (a). Failure

of a licensee to receive notification is not grounds for later challenge of the termination. The board must notify the former licensee of the termination by letter within seven days after board action, in the same manner as provided in paragraph (a).

(c) Notwithstanding paragraph (b), the board retains jurisdiction over a former licensee for complaints received after termination of a license regarding conduct that occurred during licensure.

Sec. 9. **[148H.07] EXCEPTION TO LICENSURE REQUIREMENT.**

Licensure under this chapter is not required for a certified child life specialist to engage in certified child life specialist practice in Minnesota if the certified child life specialist practices exclusively under the supervision of a licensed certified child life specialist or within a professional setting that provides appropriate oversight and supervision.

Sec. 10. **[148H.08] PROHIBITED PRACTICE OR USE OF TITLES; PENALTY.**

Subdivision 1. **Practice.** (a) Effective July 1, 2029, except as provided under section 148H.09, subdivision 2, an individual must not engage in unsupervised certified child life specialist practice in Minnesota unless the individual is licensed under this chapter.

(b) An individual licensed under this chapter must practice according to the standards of clinical practice as outlined by the Child Life Certification Commission, including the commission's code of ethics and competencies and standards.

Subd. 2. **Use of titles.** (a) An individual must not use a title incorporating the words "licensed certified child life specialist" or "L-CCLS" or use any other title or description stating or implying that the individual is licensed to engage in unsupervised certified child life specialist practice in Minnesota, unless that individual holds a valid license under this chapter.

(b) Nothing in this section prohibits the use of the title "certified child life specialist" or "CCLS" by an individual who has been certified by the Child Life Certification Commission but who is not licensed under this chapter provided that the individual does not represent that they are licensed under this chapter.

Subd. 3. **Penalty.** (a) An individual who violates this section before being licensed but after applying for a license under this chapter must pay a penalty fee in the amount of the application fee under section 148H.13 for any part of the first month of unauthorized practice, plus the application fee for any part of any subsequent month of unauthorized practice, up to 36 months.

(b) An individual who violates this section after the individual's license has expired and before it is renewed must pay a penalty fee in the amount of the license renewal fee under section 148H.13 for any part of the first month of unauthorized practice, plus the license renewal fee for any part of any subsequent month of unauthorized practice, up to 36 months.

(c) An individual who violates this section and to whom paragraphs (a) and (b) do not apply is guilty of a misdemeanor. An individual engaging in unauthorized practice under paragraphs (a) and (b) for more than 36 months is guilty of a misdemeanor.

Sec. 11. **[148H.09] SUPERVISION; INITIAL LICENSURE.**

Subdivision 1. **Supervisor requirements.** To be approved by the board as a supervisor for purposes of supervised practice under this chapter, an individual must:

(1) hold a current license under this chapter;

(2) have at least four years and 4,000 hours of professional postdegree practice experience as a certified child life specialist; and

(3) provide evidence satisfactory to the board of training in supervision through:

(i) completion of a board-approved supervisor training course of 30 hours or equivalent to three semester hours from a regionally accredited educational institution; or

(ii) completion of 30 hours of coursework in a board-approved supervision education program.

Subd. 2. **Initial licensees and supervision; facilitation.** (a) Effective July 1, 2028, an individual may apply for initial licensure if the individual:

(1) is a certified child life specialist and holds a current and valid license in Minnesota to practice psychology, social work, marriage and family therapy, professional counseling, or professional clinical counseling; or

(2) is a certified child life specialist with at least 6,000 hours of paid professional experience and has completed board-approved supervisor training as described in subdivision 1, clause (3).

(b) All initial licensees must agree to facilitate supervision for certified child life specialists and to teach supervision training classes to prepare board-approved supervisors in the first year of licensure.

(c) By January 1, 2028, the board shall:

(1) develop an application process for initial licensees;

(2) publicize the opportunity to become an initial licensee through the board's website, relevant professional organizations, and direct communication to certified child life specialists in Minnesota; and

(3) select initial licensees based on qualifications, geographic distribution, and commitment to developing the child life specialist profession in Minnesota.

(d) After completing required training under subdivision 1, clause (3), an initial board-approved supervisor under paragraph (a) may apply for licensure and the board may grant the supervisor a license under this chapter.

(e) Once licensed under this chapter, a board-approved supervisor may begin supervising certified child life specialists. A board-approved supervisor must not supervise more than two certified child life specialists at a time.

(f) Paragraphs (a) to (d) expire July 1, 2029.

Sec. 12. **[148H.11] CONTINUING EDUCATION.**

(a) A licensee must complete 30 hours of continuing education every two years, including at least three hours in ethics. At the time of license renewal, a licensee must provide evidence satisfactory to the board that the licensee completed the continuing education hours during the previous renewal term as required under section 148H.05.

(b) Continuing education hours completed under this section must provide education on competency domains as specified by the Child Life Certification Commission.

Sec. 13. **[148H.12] DISCIPLINARY ACTIONS.**

Subdivision 1. **Grounds listed.** The board may impose disciplinary action as described in subdivision 2 against an applicant or licensee whom the board, by a preponderance of the evidence, determines has:

(1) intentionally submitted false or misleading information to the board;

(2) failed to provide information in response to a written request by the board within 30 days;

(3) engaged in certified child life specialist practice or provided services in an incompetent or negligent manner;

(4) failed to comply with any other provision in this chapter;

(5) failed to perform services with reasonable judgment, skill, or safety due to the individual's use of alcohol or drugs, or other physical or mental impairment;

(6) violated any state or federal law, rule, or regulation, and the violation is a felony or misdemeanor, an essential element of which is dishonesty, or which relates directly or indirectly to the practice of certified child life services. Conviction for violating any state or federal law that relates to certified child life services constitutes a violation, except as provided in chapter 364;

(7) knowingly aided or abetted another person in violating any provision of this chapter;

(8) been disciplined or is in the process of being disciplined by another jurisdiction, if the grounds for the disciplinary action in another jurisdiction are the same or substantially equivalent to those under this chapter;

(9) failed to cooperate with an investigation of the board as required under subdivision 3;

(10) advertised in a false or misleading manner;

(11) engaged in conduct likely to deceive, defraud, or harm the public, or demonstrated a willful or careless disregard for the health, welfare, or safety of a client;

(12) failed to disclose to a client any fee splitting or any promise to pay a portion of a fee to any other professional other than a fee for services rendered by the other professional to the client;

(13) engaged in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws, Food and Drug Administration regulations, or state medical assistance laws;

(14) obtained money, property, or services from a client through the use of undue influence, high-pressure sales tactics, harassment, duress, deception, or fraud;

(15) performed services for a client who would not benefit from the services; or

(16) failed to refer a client for medical evaluation or to other health care professionals when appropriate or when a client indicated symptoms associated with conditions that could be medically or surgically treated.

Subd. 2. **Disciplinary actions.** When the board determines an applicant or a licensee has violated a provision of subdivision 1, the board may:

(1) deny an application;

(2) refuse to renew a license;

(3) revoke a license;

(4) indefinitely or temporarily suspend a license;

(5) impose limitations or conditions on the licensee's certified child life specialist practice, including but not limited to limiting the licensee's scope of practice to designated areas, imposing retraining or rehabilitation requirements, requiring the licensee to practice under supervision, or conditioning the licensee's continued practice on demonstration of knowledge or skills by appropriate examination, monitoring, or other review of skill and competence;

(6) censure or reprimand the licensee;

(7) impose a civil penalty not exceeding $7,500 for each separate violation, the amount of the civil penalty to be fixed so as to deprive the applicant or licensee of any economic advantage gained by reason of the violation charged, to discourage repeated violations, or to recover the cost of the investigation and proceeding, including but not limited to attorney fees; or

(8) take any other action justified by facts of the case.

Subd. 3. **Cooperation of applicants or licensees with investigations.** An applicant or licensee of the board who is the subject of an investigation or who is questioned in connection with an investigation by or on behalf of the board shall cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation; executing all releases requested by the board; providing copies of client records, as reasonably requested by the board to assist in the board's investigation; and appearing at conferences or hearings scheduled by the board or board staff.

Sec. 14. **[148H.13] FEES.**

Subdivision 1. **Fees.** All applicants and licensees must pay fees as follows:

(1) application fee, $.....;

(2) initial license fee, $.....;

(3) license renewal fee, $.....;

(4) license renewal late fee, $.....; and

(5) licensure by reciprocity or endorsement fee, $.....

Subd. 2. **Nonrefundable fees.** All fees in this section are nonrefundable.

Subd. 3. **Deposit of fees.** Fees collected by the board under this section must be deposited in the state government special revenue fund.

Sec. 15. **[148H.14] CERTIFIED CHILD LIFE SPECIALIST ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The Certified Child Life Specialist Advisory Council is created and composed of five members appointed by the board. The advisory council consists of:

(1) one public member as defined in section 214.02;

(2) three members who are:

(i) effective July 1, 2027, certified child life specialists and who have the required qualifications to be initial licensees under section 148H.09; or

(ii) effective July 1, 2029, licensed certified child specialists under this chapter; and

(3) one member who meets the requirements to be a supervisor under section 148H.09, subdivision 1.

Subd. 2. **Administration.** The advisory council is established and administered under section 15.059, except that the advisory council does not expire.

Subd. 3. **Duties.** The advisory council must:

(1) advise the board regarding standards for licensed certified child life specialists;

(2) assist with the distribution of information regarding licensed certified child life standards;

(3) advise the board on enforcement of this chapter;

(4) review license applications and license renewal applications and make recommendations to the board;

(5) review complaints and complaint investigation reports and make recommendations to the board on whether disciplinary action should be taken and, if applicable, what type;

(6) advise the board regarding certified child life specialist practice protocols; and

(7) perform other duties authorized for advisory councils under chapter 214 as directed by the board to ensure effective oversight of licensed certified child life specialists.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2998

04/01/2025 Authored by Freiberg, Elkins, Gottfried, Bahner, Hill and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health; establishing an end-of-life option for terminally ill adults with a prognosis of six months or less; providing criminal penalties; classifying certain data; requiring reports; providing immunity for certain acts; authorizing enforcement; amending Minnesota Statutes 2024, sections 61A.031; 144.99, subdivision 1; 609.215, subdivision 3; proposing coding for new law as Minnesota Statutes, chapter 145E.

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

ARTICLE 1

END-OF-LIFE OPTION ACT

Section 1. **[145E.01] CITATION.**

This chapter may be cited as the "End-of-Life Option Act."

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 2. **[145E.02] DEFINITIONS.**

Subdivision 1. **Application.** For purposes of this chapter, the following terms have the meanings given.

Subd. 2. **Attending provider.** "Attending provider" means the provider who has primary responsibility for the medical care of the individual and treatment of the individual's terminal disease.

Subd. 3. **Consulting provider.** "Consulting provider" means a provider, other than an individual's attending provider, who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the individual's terminal disease.

Subd. 4. **Health care facility.** "Health care facility" means a hospital, nursing home, hospice facility, assisted living facility, medical clinic, or any other facility governed by chapter 144 or 144A. Health care facility does not include an individual provider.

Subd. 5. **Health plan.** "Health plan" has the meaning given in section 62A.011, subdivision 3.

Subd. 6. **Informed decision.** "Informed decision" means a decision by a qualified individual to request and obtain a prescription for medical aid in dying medication pursuant to this chapter, after being fully informed by the attending provider and consulting provider as required under section 145E.15.

Subd. 7. **Intentionally.** "Intentionally" has the meaning given in section 609.02, subdivision 9, clause (3).

Subd. 8. **Licensed mental health consultant.** "Licensed mental health consultant" means an individual who:

(1) is licensed by the profession's licensing board as a:

(i) psychiatrist;

(ii) psychologist;

(iii) licensed independent clinical social worker; or

(iv) registered nurse who is certified as:

(A) a clinical nurse specialist in child or adolescent, family, or adult psychiatric and mental health nursing by a national nurse certification organization; or

(B) a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization; and

(2) is competent, according to the laws governing the practice of their profession, to determine the mental capability of individuals with a terminal disease.

Subd. 9. **Medical aid in dying.** "Medical aid in dying" means the process in which a provider evaluates an individual's request, determines if the individual meets the criteria of a qualified individual, provides the qualified individual with a prescription for medical aid in dying medication, and, when permissible, dispenses the medication.

Subd. 10. **Medical aid in dying medication.** "Medical aid in dying medication" means a medication prescribed and dispensed pursuant to this chapter that a qualified individual may self-administer to bring about the qualified individual's peaceful death.

Subd. 11. **Mentally capable.** "Mentally capable" means the individual requesting medical aid in dying medication has the ability to make an informed decision.

Subd. 12. **Prognosis of six months or less.** "Prognosis of six months or less" means that a terminal disease will, within reasonable medical judgment, result in death within six months.

Subd. 13. **Provider.** (a) "Provider" means:

(1) a doctor of medicine or osteopathy licensed by the Minnesota Board of Medical Practice pursuant to chapter 147;

(2) an advanced practice registered nurse licensed by the Minnesota Board of Nursing and certified by a national nurse certification organization acceptable to the board to practice as a clinical nurse specialist or nurse practitioner pursuant to sections 148.171 to 148.285; or

(3) a physician assistant licensed by the Minnesota Board of Medical Practice pursuant to chapter 147A.

(b) Provider does not include a health care facility.

Subd. 14. **Qualified individual.** "Qualified individual" means an individual who meets the criteria in section 145E.10, subdivision 1.

Subd. 15. **Self-administer.** "Self-administer" means the performance of an affirmative, conscious, voluntary act to ingest medical aid in dying medication, including by means of enteral administration. Self-administration does not include administration by intravenous or other parenteral injection or by infusion.

Subd. 16. **Terminal disease.** "Terminal disease" means an incurable and irreversible disease that will, within reasonable medical judgment, result in death within six months.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 3. **[145E.05] INFORMED CONSENT; MEDICAL STANDARD OF CARE.**

Subdivision 1. **No limitation on provision of information.** Nothing in this chapter limits the information a provider must provide to an individual to comply with Minnesota informed consent laws and the medical standard of care.

Subd. 2. **Medical standard of care.** (a) Medical care that complies with the requirements of this chapter meets the medical standard of care.

(b) Nothing in this chapter exempts a provider or other medical personnel from meeting medical standards of care for the treatment of an individual with a terminal disease.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 4. **[145E.10] MEDICAL AID IN DYING MEDICATION; QUALIFICATION; REQUEST.**

Subdivision 1. **Qualified individual.** (a) Any individual may request medical aid in dying medication. In order to obtain a prescription for medical aid in dying medication, the individual must:

(1) be 18 years of age or older;

(2) be mentally capable, as determined according to section 145E.15;

(3) have a terminal disease with a prognosis of six months or less;

(4) not be subject to guardianship or conservatorship; and

(5) request a prescription for medical aid in dying medication in accordance with subdivision 2 from an attending provider meeting the requirements in section 145E.15, subdivision 1, and a consulting provider meeting the requirements in section 145E.15, subdivision 2.

(b) No individual is a qualified individual solely because of advanced age or disability.

Subd. 2. **Request process.** (a) An individual seeking medical aid in dying medication must make one oral request and one written request to the individual's attending provider. The written request must be in substantially the form specified in subdivision 4 and witnessed by an individual meeting the requirements of subdivision 3.

(b) Oral and written requests for medical aid in dying medication may be made only by the individual who will self-administer the medication. A request for medical aid in dying medication shall not be made by the individual's guardian, conservator, health care agent, living will proxy, attorney-in-fact named in a power of attorney, or surrogate decision-maker, or by an advance health care directive.

(c) For an individual seeking medical aid in dying medication who has difficulty with oral communication, the following may qualify as an oral request:

(1) use of written materials;

(2) use of technology-assisted communication;

(3) use of an interpreter; or

(4) use of other assistance with communication consistent with Title III of the Americans with Disabilities Act.

Subd. 3. **Witness.** A witness to a written request for medical aid in dying medication must be 18 years of age or older and at the time the request is signed must not be:

(1) a relative by blood, marriage, or adoption of the requesting individual;

(2) entitled to any portion of the estate of the requesting individual upon the requesting individual's death under any will or by operation of law;

(3) an owner, operator, or employee of a health care facility or provider where the requesting individual is receiving medical treatment or is a resident;

(4) the requesting individual's attending provider; or

(5) serving as an interpreter for the requesting individual.

Subd. 4. **Written request.** In order to be valid, a written request for medical aid in dying medication must be in substantially the form in this subdivision, must be signed and dated by the individual seeking medical aid in dying medication, and must be witnessed by at least one individual meeting the requirements in subdivision 3 who, in the presence of the individual seeking medical aid in dying medication, attests that to the best of the witness's knowledge and belief the individual seeking medical aid in dying medication is mentally capable, acting voluntarily, and not being coerced or unduly influenced to sign the request.

Request for Medication to End My Life in a Peaceful Manner

I, ... (name), am an adult of sound mind. I have been diagnosed with ..... (terminal illness) and given a prognosis of six months or less to live. I have been fully informed of the feasible alternative, concurrent, or additional treatment opportunities for my terminal disease, including but not limited to comfort care, palliative care, hospice care, or pain control, and of the potential risks and benefits of each. I have been offered and received resources or referrals to pursue these alternative, concurrent, or additional treatment opportunities for my terminal disease.

I have been fully informed of the nature, risks, and benefits of the medication to be prescribed, including that the likely outcome of self-administering the medication is death. I understand that I can rescind this request at any time and that I am under no obligation to fill the prescription once written, or to self-administer the medication if I obtain it.

I request that my attending provider furnish a prescription for medication that will end my life in a peaceful manner if I choose to self-administer it, and I authorize my attending provider to contact a pharmacist to dispense the prescription.

I make this request voluntarily, free from coercion or undue influence, and attest that no one has attempted, by deception, intimidation, or other means, to cause me to request this prescription.

....

Requestor Signature Date

Witness:

(i) In my presence on ..... (date), ... (name) acknowledged his/her signature on this document.

(ii) To the best of my knowledge and belief the person named above is mentally capable, is acting voluntarily, and is not being coerced or unduly influenced to sign this request for medical aid in dying medication.

(iii) I am at least 18 years of age.

(iv) I am not a relative of the person named above by blood, marriage, or adoption.

(v) I am not entitled to any portion of the estate of the person named above upon that person's death under any will or by operation of law.

(vi) I am not an owner, operator, or employee of a health care facility or provider where the person named above is receiving medical treatment or is a resident.

(vii) I am not currently the attending provider of the person named above.

(viii) I am not currently serving as an interpreter for the person named above.

I certify that the information in (i) through (viii) is true and correct.

.....

Witness Signature

.....

Address

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 5. **[145E.15] RESPONSIBILITIES OF ATTENDING PROVIDER, CONSULTING PROVIDER, LICENSED MENTAL HEALTH CONSULTANT, AND PHARMACIST.**

Subdivision 1. **Attending provider responsibilities.** (a) If an individual requests a prescription for medical aid in dying medication from the individual's attending provider, the attending provider must:

(1) determine whether the individual has a terminal disease with a prognosis of six months or less;

(2) determine whether the individual is mentally capable or refer the individual for confirmation of mental capability in accordance with subdivision 3;

(3) confirm that the individual's request does not arise from coercion or undue influence by asking the individual outside the presence of other persons, except for an interpreter as necessary, whether anyone has attempted, by deception, intimidation, or other means, to cause the individual to request this prescription;

(4) inform the individual of:

(i) the individual's diagnosis;

(ii) the individual's prognosis;

(iii) the potential risks and benefits and the probable result of self-administering medical aid in dying medication;

(iv) feasible end-of-life care and treatment options for the individual's terminal disease, including but not limited to alternative, concurrent, or additional treatment options, comfort care, palliative care, hospice care, and pain control, and the potential risks and benefits of each; and

(v) the individual's right to rescind the request for medical aid in dying medication, or consent for any other treatment, at any time and in any manner;

(5) inform the individual that there is no obligation to fill the prescription or self-administer the medical aid in dying medication if the medication is obtained;

(6) offer the individual the opportunity to rescind the individual's request for medical aid in dying medication;

(7) provide the individual with a referral for comfort care, palliative care, hospice care, pain control, or other end-of-life treatment options as requested or as clinically indicated;

(8) refer the individual to a consulting provider to complete the requirements in subdivision 2;

(9) inform the individual of the benefits of notifying the individual's next of kin or other important person of the individual's decision to request medical aid in dying medication;

(10) educate the individual on:

(i) the recommended procedure for self-administering the medical aid in dying medication to be prescribed;

(ii) proper safekeeping and disposal of the medical aid in dying medication in accordance with federal and Minnesota law;

(iii) the importance of having another person present when the individual self-administers the medical aid in dying medication; and

(iv) not self-administering the medical aid in dying medication in a public place. For purposes of this item, a health care facility is not considered a public place;

(11) document in the individual's medical record the individual's diagnosis and prognosis, the attending provider's determination of mental capability or referral for confirmation of mental capability by a licensed mental health consultant, the date of the oral request, a copy of the written request, and a notation that the requirements under this subdivision have been met; and

(12) include in the individual's medical record the consulting provider's written confirmation that the requirements in subdivision 2 have been met and, if applicable, the licensed mental health consultant's written determination.

(b) After the attending provider completes the steps in paragraph (a); the consulting provider completes the steps in subdivision 2; and, if applicable, the licensed mental health consultant completes the steps in subdivision 3, the attending provider may prescribe medical aid in dying medication and any ancillary medications for the qualified individual. The attending provider must:

(1) deliver the prescription to a licensed pharmacist personally, by mail, or as an electronic order; or

(2) if authorized by the Drug Enforcement Administration, dispense medical aid in dying medication and any ancillary medications to the qualified individual or to an individual expressly designated in person by the qualified individual to receive the medications.

(c) Upon prescribing medical aid in dying medication and any ancillary medications for the qualified individual, the attending provider must identify the prescribed medications in the qualified individual's medical record.

Subd. 2. **Consulting provider qualifications and responsibilities.** (a) If the attending provider is not a doctor of medicine or osteopathy licensed by the Minnesota Board of Medical Practice pursuant to chapter 147, the consulting provider must be a doctor of medicine or osteopathy licensed by the Minnesota Board of Medical Practice pursuant to chapter 147.

(b) After receiving a referral from an attending provider of an individual requesting medical aid in dying medication, a consulting provider must:

(1) medically evaluate the individual and the individual's relevant medical records;

(2) determine whether the individual is mentally capable or refer the individual for confirmation of mental capability in accordance with subdivision 3;

(3) confirm that the individual's request does not arise from coercion or undue influence by asking the individual outside the presence of other persons, except for an interpreter as necessary, whether anyone has attempted, by deception, intimidation, or other means, to cause the individual to request this prescription;

(4) inform the individual of:

(i) the individual's diagnosis and prognosis;

(ii) feasible end-of-life care and treatment options for the individual's terminal disease, including but not limited to alternative, concurrent, or additional treatment options, comfort care, palliative care, hospice care, and pain control, and the risks and benefits of each;

(iii) the potential risk associated with taking medical aid in dying medication;

(iv) the probable result of taking medical aid in dying medication; and

(v) the individual's right to rescind a request for medical aid in dying medication, or consent for any other treatment, at any time;

(5) if determined by the consulting provider, submit written confirmation to the attending provider that:

(i) the individual has a terminal disease with a prognosis of six months or less;

(ii) the individual is mentally capable or provide documentation that the consulting provider has referred the individual for further evaluation in accordance with subdivision 3; and

(iii) the individual's request for medical aid in dying medication does not arise from coercion or undue influence; and

(6) offer the individual an opportunity to rescind the request.

Subd. 3. **Referral for confirmation of mental capability.** (a) If the attending provider or the consulting provider is unable to confirm that the individual requesting medical aid in dying medication is mentally capable, the attending provider or consulting provider who cannot determine mental capability must refer the individual to a licensed mental health consultant for a determination of mental capability.

(b) The licensed mental health consultant who evaluates the individual under this subdivision must submit to the requesting provider a written determination of whether the individual is mentally capable.

(c) If the licensed mental health consultant determines that the individual is not mentally capable, the individual is not a qualified individual and the attending provider must not prescribe medical aid in dying medication to the individual.

Subd. 4. **Pharmacist responsibilities.** A pharmacist who receives a prescription for medical aid in dying medication may dispense the medication and any ancillary medications to the attending provider, to the qualified individual, or to an individual expressly designated in person by the qualified individual. When dispensed, the medical aid in dying medication and any ancillary medications must be dispensed in person or, with a signature required on delivery, by mail service, common carrier, or messenger service.

Subd. 5. **No duty to provide medical aid in dying.** (a) A provider must provide sufficient information to an individual with a terminal disease regarding available options, the alternatives, and the foreseeable risks and benefits of each so that the individual is able to make informed decisions regarding the individual's end-of-life health care.

(b) A provider may choose whether or not to practice medical aid in dying.

(c) If a provider is unable or unwilling to fulfill an individual's request for medical aid in dying medication or to provide related information or services requested by the individual, the provider must, upon request, transfer the individual's care and medical records to a new provider consistent with federal and Minnesota law. The provider must transfer the

individual's medical records to a new provider within two business days after the provider receives the individual's transfer request.

(d) Consistent with section 147.091, subdivision 1, paragraph (v); 147A.13, subdivision 1, clause (20); or 148.261, subdivision 1, clause (19), a provider must not engage in false, misleading, or deceptive practices relating to the provider's willingness to qualify an individual or to provide a prescription to a qualified individual for medical aid in dying medication.

Subd. 6. **No duty to fill a medical aid in dying medication prescription.** (a) A pharmacist may choose whether or not to fill a prescription for medical aid in dying medication.

(b) Consistent with Minnesota Rules, part 6800.2250, a pharmacist must not engage in false, misleading, or deceptive practices relating to the pharmacist's willingness to fill a prescription for medical aid in dying medication.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 6. **[145E.20] SAFE DISPOSAL OF UNUSED MEDICATIONS.**

After a qualified individual's death, any individual, facility, or staff member in possession, custody, or control of medical aid in dying medications must ensure disposal of the medication in accordance with federal and Minnesota law and guidelines.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 7. **[145E.25] HEALTH CARE FACILITIES; PERMISSIBLE PROHIBITIONS AND DUTIES.**

Subdivision 1. **Facility policies.** (a) A health care facility may prohibit providers or pharmacists from determining an individual's qualification for medical aid in dying or prescribing or dispensing medical aid in dying medication while performing duties for the facility. A prohibiting health care facility must give providers and pharmacists advance written notice of this policy at the time of hiring, contracting with, or privileging the provider or pharmacist.

(b) A health care facility that fails to provide advance written notice of the policy as required under paragraph (a) waives the right to enforce any prohibitions authorized under paragraph (a).

(c) No health care facility shall prohibit a provider or pharmacist from fulfilling the requirements of informed consent and meeting the medical standard of care by:

(1) providing information to an individual regarding the individual's health status, including but not limited to diagnosis, prognosis, recommended treatment, treatment alternatives, and any potential risks to the individual's health; or

(2) providing information regarding health care services available under this chapter, information about relevant community resources, and information about how to access those resources to obtain the individual's care of choice.

Subd. 2. **Timely transfer.** If an individual requests to transfer care to another health care facility, the facility currently providing care to the individual shall cooperate with a timely transfer to the new facility, including transfer of the individual's medical records within two business days after the facility receives the individual's transfer request, in a manner consistent with applicable federal and Minnesota laws.

Subd. 3. **False, misleading, or deceptive practices prohibited.** In accordance with section 144.651, a health care facility shall not engage in false, misleading, or deceptive practices relating to the facility's policy with respect to medical aid in dying, including:

(1) whether the facility has a policy that prohibits affiliated providers or pharmacists from determining an individual's qualification for medical aid in dying or from prescribing or dispensing medical aid in dying medication to a qualified individual; or

(2) intentionally denying an individual access to medical aid in dying medication by failing to transfer the individual to another provider or health care facility in a timely manner or failing to transfer the individual's medical records to another provider or health care facility within two business days after the facility receives the individual's transfer request.

Subd. 4. **Conflict.** If any provision of this section is found to conflict with federal requirements necessary for a health care facility or the state to receive federal funds, the conflicting provision of this section is inoperative solely to the extent of the conflict as it applies to the directly affected facility, and the finding or determination shall not affect the operation of the remainder of this chapter.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 8. **[145E.30] IMMUNITY FOR ACTIONS IN GOOD FAITH; PROHIBITION AGAINST REPRISALS.**

(a) An individual, including a provider, pharmacist, licensed mental health consultant, or hospice provider employee, shall not be subject to criminal liability or professional disciplinary action, including censure, suspension, loss of license, loss of privileges, or any other penalty for engaging in good faith compliance with this chapter.

(b) No provider or health care facility shall subject a provider, pharmacist, or licensed mental health consultant to discharge, demotion, censure, discipline, suspension, loss of license, loss of privileges, discrimination, or any other penalty for:

(1) providing medical aid in dying in accordance with the standard of care and in good faith under this chapter while engaged in the outside practice of the individual's profession and off the facility premises;

(2) providing scientific and accurate information about medical aid in dying to an individual when discussing end-of-life care options; or

(3) choosing not to practice or participate in medical aid in dying.

(c) No individual shall be subject to civil or criminal liability or professional disciplinary action if, at the request of the qualified individual, the individual is present outside the scope of their employment contract and off the facility premises when the qualified individual self-administers medical aid in dying medication or at the time of death. An individual who is present may, without civil or criminal liability, assist the qualified individual by preparing the medical aid in dying medication, including opening medication containers, measuring the medication, or preparing an enteral dispenser containing the medication. The assisting individual is not permitted to assist the qualified individual by administering a prepared enteral dispenser to the qualified individual.

(d) The following acts do not constitute neglect or elder abuse and are not a basis for appointment of a guardian or conservator:

(1) a request by an individual for medical aid in dying medication; or

(2) the provision of medical aid in dying medication.

(e) A failure by a provider or a licensed mental health consultant to confirm that an individual requesting medical aid in dying medication is mentally capable is not a basis for appointment of a guardian or conservator.

(f) This section does not limit civil liability for intentional or negligent misconduct.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 9. **[145E.35] REPORTING REQUIREMENTS.**

Subdivision 1. **Forms.** The commissioner of health must develop and maintain an attending provider checklist form and attending provider follow-up form to facilitate collection of the information required in this section. The commissioner must post the forms on the Department of Health website. Failure by the commissioner to develop the attending provider checklist form and attending provider follow-up form shall not delay the effective date of this chapter and shall not relieve an attending provider of the responsibility to submit the information in subdivision 2 or 3, as applicable, to the commissioner of health.

Subd. 2. **Attending provider checklist form; submission requirements.** Within 30 calendar days after providing a prescription for medical aid in dying medication, the attending provider must submit to the Department of Health an attending provider checklist form with the following information:

(1) the qualified individual's name and date of birth;

(2) the qualified individual's terminal diagnosis and prognosis;

(3) confirmation that the requirements of section 145E.15 were met; and

(4) notice that the attending provider prescribed medical aid in dying medication to the qualified individual.

Subd. 3. **Attending provider follow-up form; submission requirements.** Within 60 calendar days after receiving notice of a qualified individual's death from self-administration of medical aid in dying medication prescribed by the attending provider, the attending provider must submit to the Department of Health an attending provider follow-up form with the following information:

(1) the qualified individual's name and date of birth;

(2) the date of the qualified individual's death; and

(3) an annotation of whether or not the qualified individual was enrolled in hospice services at the time of the qualified individual's death.

Subd. 4. **Review of forms; annual report.** (a) Effective August 1, 2025, through July 31, 2029, the commissioner of health must annually review all of the forms submitted under this section to ensure completeness, timeliness, and accuracy of submitted forms. Effective August 1, 2029, the commissioner of health must annually review a sample of the forms

submitted under this section to ensure completeness, timeliness, and accuracy of submitted forms.

(b) The commissioner of health must annually issue a public report with summary data for the most recent reporting period on the number of:

(1) prescriptions for medical aid in dying medication provided;

(2) providers who provided prescriptions for medical aid in dying medication; and

(3) qualified individuals who died following self-administration of medical aid in dying medication.

(c) For purposes of this subdivision, "summary data" has the meaning given in section 13.02, subdivision 19.

Subd. 5. **Data practices.** Information submitted to the commissioner of health under subdivision 2 or 3 is classified as private data on individuals as defined in section 13.02, subdivision 12.

Subd. 6. **Enforcement.** The commissioner of health may enforce this section under the powers and authority in sections 144.989 to 144.993.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 10. **[145E.40] EFFECT ON CONSTRUCTION OF WILLS AND CONTRACTS.**

(a) No provision in a contract, will, or other agreement, whether written or oral, that would determine whether an individual may make or rescind a request for medical aid in dying medication is valid.

(b) No obligation owing under any currently existing contract shall be conditioned on or affected by an individual's act of making or rescinding a request for medical aid in dying medication.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 11. **[145E.45] INSURANCE OR ANNUITY POLICIES.**

(a) The sale, procurement, or issuance of a life, health, or accident insurance or annuity policy or the rate charged for a policy shall not be conditioned on or affected by an individual's act of making or rescinding a request for medical aid in dying medication.

(b) A qualified individual's act of self-administering medical aid in dying medication does not invalidate any part of a life, health, or accident insurance or annuity policy.

(c) An insurer, or the commissioner of human services when delivering services under medical assistance or MinnesotaCare through managed care or fee-for-service, must not deny or alter health care benefits otherwise available to an individual with a terminal disease who is an enrollee of the health plan based on the availability of medical aid in dying, the individual's request for medical aid in dying medication, or the absence of a request for medical aid in dying medication.

(d) An insurer must not attempt to coerce an individual with a terminal disease to request medical aid in dying medication.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 12. **[145E.50] DEATH RECORD.**

(a) Notwithstanding any other provision of law, the attending provider may sign the death record of a qualified individual who obtained and self-administered medical aid in dying medication.

(b) When a qualified individual dies after self-administering medical aid in dying medication:

(1) the cause of death on the qualified individual's death record shall be attributed to the qualified individual's underlying terminal disease; and

(2) the death shall not be designated on the death record as a suicide or homicide.

(c) Death of a qualified individual after self-administration of medical aid in dying medication does not constitute grounds for postmortem inquiry by a coroner or medical examiner. A coroner or medical examiner notified of a qualified individual's death after self-administration of medical aid in dying medication shall decline jurisdiction over the death record and refer the death record to the attending provider according to paragraph (a).

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 13. **[145E.55] OFFENSES, PENALTIES, AND CLAIMS FOR COSTS INCURRED.**

Subdivision 1. **Offenses.** A person who commits any of the following acts is guilty of a felony and may be sentenced as provided in subdivision 2:

(1) intentionally alters or falsifies a request for medical aid in dying medication for another individual;

(2) without authority of law, intentionally destroys, mutilates, or conceals another individual's rescission of a request for medical aid in dying medication;

(3) compels another individual to request medical aid in dying medication through the use of coercion, undue influence, harassment, duress, compulsion, or other enticement; or

(4) compels another individual to self-administer medical aid in dying medication through the use of coercion, undue influence, harassment, duress, compulsion, or other enticement and murder in the first or second degree was not committed as a result.

Subd. 2. **Penalties.** (a) An individual who violates subdivision 1, clause (1) or (2), may be sentenced to imprisonment for not more than five years or to payment of a fine of not more than $10,000, or both.

(b) An individual who violates subdivision 1, clause (3), may be sentenced to imprisonment for not more than ten years or to payment of a fine of not more than $20,000, or both.

(c) An individual who violates subdivision 1, clause (4), may be sentenced to:

(1) imprisonment for not more than 20 years or to payment of a fine of not more than $40,000, or both; or

(2) imprisonment for not more than 25 years or to payment of a fine of not more than $50,000, or both, if the person committed the violation through the use of force.

Subd. 3. **Venue.** Notwithstanding anything to the contrary in section 627.01, an offense committed under this section may be prosecuted in: (1) the county where any part of the offense occurred; or (2) the county of residence of the victim or one of the victims.

Subd. 4. **Civil liability; other criminal penalties.** (a) Nothing in this section limits civil liability or damages arising from negligent conduct or intentional misconduct related to the provision of medical aid in dying, including failure to obtain informed consent by any person, provider, or health care facility.

(b) The penalties in this section do not preclude criminal penalties applicable under other laws for conduct that violates this chapter.

Subd. 5. **Claims by governmental entity for costs incurred.** A governmental entity that incurs costs due to a qualified individual's self-administration in a public place of medical aid in dying medication prescribed under section 145E.15 may file a claim against the individual's estate to recover the costs and reasonable attorney fees related to enforcing the claim.

EFFECTIVE DATE. Subdivisions 1 to 3 and 4, paragraph (b), are effective August 1, 2025, and apply to crimes committed on or after that date. Subdivisions 4, paragraph (a), and 5 are effective August 1, 2025.

Sec. 14. **[145E.60] CONSTRUCTION.**

(a) Nothing in this chapter authorizes a provider or any other person, including the qualified individual, to end the qualified individual's life by lethal injection, lethal infusion, mercy killing, homicide, murder, manslaughter, euthanasia, or any other criminal act.

(b) Actions taken in accordance with this chapter do not, for any purpose, constitute suicide, assisted suicide, euthanasia, mercy killing, homicide, murder, manslaughter, elder abuse or neglect, or any other civil or criminal violation under the law.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 15. **COMMISSIONER OF HEALTH; DEVELOPMENT OF FORMS.**

By August 1, 2025, the commissioner of health must develop and post on the Department of Health website the attending provider checklist form and attending provider follow-up form required under Minnesota Statutes, section 145E.35.

EFFECTIVE DATE. This section is effective the day following final enactment.

ARTICLE 2
OTHER PROVISIONS

Section 1. Minnesota Statutes 2024, section 61A.031, is amended to read:

61A.031 SUICIDE PROVISIONS.

(a) The mental competency of a person shall not be a factor in determining whether a person completed suicide within the terms of an individual or group life insurance policy regulating the payment of benefits in the event of the insured's suicide. This paragraph shall not be construed to alter present law but is intended to clarify present law.

(b) A life insurance policy or certificate issued or delivered in this state may exclude or restrict liability for any death benefit in the event the insured dies as a result of suicide within one year from the date of the issue of the policy or certificate. Any exclusion or restriction shall be clearly stated in the policy or certificate. Any life insurance policy or certificate which contains any exclusion or restriction under this paragraph shall also provide that in the event any death benefit is denied because the insured dies as a result of suicide within one year from the date of issue of the policy or certificate, the insurer shall refund

all premiums paid for coverage providing the denied death benefit on the insured. An exclusion or restriction authorized under this paragraph shall not apply in the event the insured dies due to self-administration of medical aid in dying medication obtained in accordance with chapter 145E.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 2. Minnesota Statutes 2024, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 145E.35; 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 3. Minnesota Statutes 2024, section 609.215, subdivision 3, is amended to read:

Subd. 3. **Acts or omissions not considered aiding suicide or aiding attempted suicide.** (a) A health care provider, as defined in section 145B.02, subdivision 6, who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.

(b) A health care provider, as defined in section 145B.02, subdivision 6, who withholds or withdraws a life-sustaining procedure in compliance with chapter 145B or 145C or in accordance with reasonable medical practice does not violate this section.

(c) A provider, as defined in section 145E.02, subdivision 13, or pharmacist who prescribes or dispenses medical aid in dying medication in compliance with chapter 145E does not violate this section.

EFFECTIVE DATE. This section is effective August 1, 2025, and applies to crimes committed on or after that date.

APPENDIX
Article locations for 25-04749

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 2937

04/01/2025 Authored by McDonald, Scott and Hudson
The bill was read for the first time and referred to the Committee on Judiciary Finance and Civil Law

A bill for an act

relating to civil law; regulating the use of parenting consultants in family court cases; amending Minnesota Statutes 2024, section 518.1751, subdivision 4, by adding a subdivision.

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

Section 1. Minnesota Statutes 2024, section 518.1751, subdivision 4, is amended to read:

Subd. 4. **Other agreements.** (a) A person selected by the parties to serve as a parenting consultant must meet the qualifications in subdivision 2c for a parenting time expeditor or the qualifications of a marriage and family therapist in section 148B.33, subdivision 1. For the purposes of this section, a "parenting consultant" is a neutral third party hired by the parties to resolve parenting time disputes and other parenting conflicts.

(b) The role of a parenting consultant is to assist and guide the parties in resolving issues that arise due to implementing a custody and parenting time court order. A parenting consultant may not modify a custody order or change the percentage of the parenting time awarded to either party.

(c) Any party may discharge a parenting consultant by providing written notice to the consultant. The party must also file the notice with the court and serve all parties with the notice. The court may discharge a parenting consultant when the court finds that the consultant is not serving the best interest of the child.

(d) This section does not preclude the parties from voluntarily agreeing to submit their parenting time dispute to a neutral third party or from otherwise resolving parenting time disputes on a voluntary basis.

Sec. 2. Minnesota Statutes 2024, section 518.1751, is amended by adding a subdivision to read:

Subd. 8. **Decisions of parenting consultants.** The decisions of a parenting consultant must not be binding on the parties to an action under this chapter. The court must not be bound by the decisions of a parenting time consultant. The court must treat evidence of a parenting consultant's determination as inadmissible in proceedings commenced under this chapter. Any evidence, evaluations, or recommendations made by a parenting consultant must not be admissible in court.

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 936

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

A bill for an act

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

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

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

14.002 STATE REGULATORY POLICY.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.131 STATEMENT OF NEED AND REASONABLENESS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.386 PROCEDURE FOR ADOPTING EXEMPT RULES; DURATION.

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

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

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

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

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

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

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

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

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

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

(d) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14.44 DETERMINATION OF VALIDITY OF RULE.

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

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

14.45 RULE DECLARED INVALID.

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

Sec. 16. **EFFECTIVE DATE.**

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

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 3978

03/05/2026 Authored by Reyer and Virnig
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health occupations; providing protections to participants in and employees and operators of a health care provider wellness program; amending Minnesota Statutes 2024, section 214.41.

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

Section 1. Minnesota Statutes 2024, section 214.41, is amended to read:

214.41 ~~PHYSICIAN~~ HEALTH CARE PROVIDER WELLNESS PROGRAM.

Subdivision 1. ~~**Definition**~~ **Definitions.** (a) For the purposes of this section, the following terms have the meanings given.

(b) "Health care provider" or "provider" means an individual who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law.

(c) "~~physician~~ Health care provider wellness program" means a program for health care providers of evaluation, counseling, or other modality to address an issue related to career fatigue or wellness related to work stress ~~for physicians licensed under chapter 147~~ that is administered by a statewide association that is exempt from taxation under United States Code, title 26, section 501(c)(6), and that primarily represents physicians and osteopaths of multiple specialties. ~~Physician~~ Health care provider wellness program does not include the provision of services intended to monitor for impairment under the authority of section 214.31.

Subd. 2. **Confidentiality.** Any record of a ~~person's~~ health care provider's participation in a ~~physician~~ health care provider wellness program is confidential and not subject to

discovery, subpoena, or a reporting requirement to the applicable health-related licensing board or to the commissioner of health, unless the ~~person~~ provider voluntarily provides for written release of the information or the disclosure is required to meet the ~~licensee's~~ provider's obligation to report certain information to the applicable health-related licensing board or the commissioner of health according to ~~section 147.111~~ law governing the practice of the provider's profession.

Subd. 3. **Civil liability.** Any person, agency, institution, facility, or organization employed by, contracting with, or operating a ~~physician~~ health care provider wellness program is immune from civil liability for any action related to their duties in connection with a ~~physician~~ health care provider wellness program when acting in good faith.

MINNESOTA
BOARD OF PSYCHOLOGY

Minnesota Board of Psychology Executive Director Report
March 20, 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. As of this week, the Board has issued 977 Behavior Analyst Licenses. The numbers of applications we receive with payment have stayed the same as has the average time to review and issue a license. Since the last Board meeting as reported on the Consent Agenda, the team has issued 33 behavior analyst licenses. Of that number, 13 report an address in Minnesota and the other 20 list states that, all but three, do not border Minnesota. Overall, of the 977 licenses issued thus far, 554 licensees report addresses in Minnesota, which is 57%.

The team continues to correspond with all Psychology and Behavior Analyst applicants that have not had movement on their applications. Of this effort we have issued four Behavior Analyst licenses since the last Board meeting. The team has completed work on a checklist for applicants trained in an educational institution outside of the United States or Canada as well.

II. Executive Director's Report

a. Move to PEAKAgenda

Board meeting operations will move to PEAKAgenda in May. The Executive Director and Assistant Executive Director will finish training on the system by the end of March.

b. Board Presentation to the Minnesota Psychological Association

The Application Review Committee is preparing to present at the Minnesota Psychological Association Annual Meeting on April 24th. The ARC will be presenting on its process of reviewing post-doctoral supervision.

c. Executive Director Presentation at Minnesota Association of Medical Staff Services
The Executive Director is preparing to present to MAMSS about the Board's licensing process, who can provide services in Minnesota, and different pathways to licensure. The Board is presenting along with the Boards of Behavioral Health and Therapy, Marriage and Family Therapy, and Social Work. MAMSS is an association of over 200 members of medical staff and provider credentialing professionals.

d. Poster Presentation at CLEAR
The Executive Director is preparing to present a poster at the Council on Licensure Enforcement and Regulation. The topic is the importance of accreditation in the state licensing process.

e. ASPPB Meetings
The Executive Director is preparing for the ASPPB Model Act and Rules Committee meeting at the end of March. The MARC Committee plans to finalize master's level licensure act and rules. The Executive Director and the Assistant Executive Director are attending the midyear meeting in April.

f. Board Policy: A Board policy on expense and per diem reimbursement has been provided for your review. This policy establishes a consistent process that illustrates how the Board reviews, approves, and issues Board member expenses.

g. Legislative Updates:
A number of bills have been provided that are moving through the Legislature that relate to the practice of psychology and other mental health professions. Of particular interest is a bill focused on AI regulation, psilocybin regulation, and art therapists.

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

SUBMITTED BY: Licensure Specialist

TITLE: CE Variance Request

INTRODUCTION TO THE TOPIC:

Licensee is requesting a second CE Variance to complete CEU's that were not completed during her first CE Variance.

Reasons for variance or waiver requested	From April 2024 until 12/24/25, I was recovering from serious injuries that impaired my ability to work and take care of daily activities. I was able to return to work December 2025. I have approximately 20 CEUs. On Wednesday 3/11/26, I was involved in an accident that totaled my car. I was on my way to the MSSA workshop. Unfortunately I was unable to make it, consequently missing out on 18.5 credits. I possibly can make up the remaining credits before 3/31, however, if I am unable to, My license would be in jeopardy as well as my job. I am a therapist at REH Crisis Stabilization program. REH Crisis is a 3-10 day program that allows individuals opportunity to stabilize with Mental Health. These individuals are often faced with homelessness as well as substance abuse. This would place an undue burden on my co-workers and on the people we serve.
Not adversely affect the public welfare	REH Crisis is under Radias Health. As an employee I have obligation to not only follow MN laws and rules of ethical conduct with Board of Psychology, I have obligation to keep up to date with trainings that enhance efficacy serving this population. I take rules of conduct and laws seriously, as I have for the past 33 years.
Written plan of alternative practices	I am taking PESI Online course, "Mastering Polyvagal Theory for Trauma Professionals" 22 hours and 43 mn. "Grief Counseling Specialist" 26hours and 50 mn. In addition to approximately 20 hours already accumulated.
Rationale for the rule	I'm not sure I understand this, I apologize. I am not sure how I can meet CEU requirements by other means.

BOARD ACTION REQUESTED:

Approve or Deny the request

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 3/20/2026

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:

LP#	Name	Expiration
LP1519	Wendy Johnson	11/30/2025
LP5171	Rachel Allyn	11/30/2025
LP5175	Marian Eckhardt	11/30/2025
LP2986	Terryl Raddatz	11/30/2025
LP0244	Mark Meyer	11/30/2025
LP3846	Steve Maurer	11/30/2025
LP2974	Michael Kogan-White	11/30/2025
LP0238	Linda Vest Klein	11/30/2025