



MINNESOTA BOARD OF PSYCHOLOGY
May 15, 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. Approval of Board Meeting Minutes**
- 5. Consent Agenda**
 - A. Staff Delegated Authority Report**
 - B. HPSP Reports**
- 6. New Business**
 - A. AI in Psychology Practice**
 - B. Master's Level Licensure**
 - C. Executive Director's Report**
 - D. CLEAR Training**
 - E. Variance Request Applicant 22-0263**
 - F. Board Administrative Terminations**
- 7. Committee Reports**
 - A. Agreements for Corrective Action Signed Since Last Board Meeting**
- 8. Adjournment**



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

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: 5/15/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Approval of Board Meeting Minutes

INTRODUCTION TO THE TOPIC:

Board meeting minutes for March 2026 are respectfully submitted.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description

Board Meeting Minutes

Upload Date Type

5/11/2026 Cover Memo

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

Board Members and Staff in Attendance: Sonal Markanda, Michael Thompson, Cesar Gonzalez, Michelle Zhao, Nancy Cameron, Pamela Freske, Seb Rilen, Joel Bakken, Daniel Hurley, Sam Sands and Trish Hoffman.

Guests: Erin Farmer and Lindsey Franklin.

PUBLIC SESSION

1. Call to Order

Sonal Markanda called the meeting to order at 9:34AM. The meeting was held in a hybrid format with some individuals in attendance in person and others online. Voting was held by roll call.

A. Webex MeetingLink

2. Adoption of Tentative Agenda

Daniel Hurley moved, seconded by Seb Rilen Motion: to adopt the tentative agenda. There being 8 "ayes" and 0 "nays" the motion Passed.

3. Announcements

4. Approval of the Board Minutes

Nancy Cameron moved, seconded by Joel Bakken Motion: to adopt February 20, 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. AI in Psychology Practice

The Board engaged in a robust discussion of proposed legislation to regulate the use of artificial intelligence systems in psychotherapy services. The Board identified several concerns with the proposed legislation in its current form.

B. Master's Level Licensure

Sam Sands noted that the Legislative Committee will meet today to begin its work on the topic of Master's Level Licensure.

C. Executive Director's Report

Trisha Hoffman reported that 981 Behavior Analyst licenses have been issued to date, and 57% of those licensees report an address within Minnesota. The Licensure Team continues to receive and process applications at a steady pace. In addition, the team continues to correspond with Psychology and Behavior Analyst applicants whose applications have stalled and have issued four Behavior Analyst licenses to such applicants since the last Board meeting. Finally, the team has completed work on a checklist for applicants trained in an educational institution outside of the United States or Canada.

Sam Sands stated that Board meeting agendas and minutes will move to PEAK Agenda by the next Board meeting date. He provided updates on upcoming staff presentations, noted that ASPPB will meet next month, and highlighted several bills moving through the legislature that would affect licensees. Sam also received input from the Board on potential revisions to the per diem and expense reimbursement policy.

D. CE Variance Request

Michael Thompson moved, seconded by Joel Bakken Motion: to approve the CE Variance Request. There being 8 "ayes" and 0 "nays" the motion Passed.

E. Board Administrative Terminations

Pamela Freske moved, seconded by Daniel Hurley Motion: to approve the Board Administrative Terminations. There being 8 "ayes" and 0 "nays" the motion Passed.

7. Committee Reports

8. Adjournment

Adjourned at 11:48 AM.

EXECUTIVE SESSION

1. Stipulation and Consent Order



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

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
Behavior Analyst Consent Agenda	5/13/2026	Cover Memo
Psychologist Licensure Consent Agenda	5/13/2026	Cover Memo

CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Licensed Behavior Analyst (LBA)

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

License Number	Licensee
LBA0978	Summer Yanosko
LBA0979	Jessica Stoppiello Pastorino
LBA0980	Madyson Brown
LBA0981	Maria Armato-Barone
LBA0982	Sydney Rivera
LBA0983	Kyla Doepel
LBA0984	Cierra Kugler
LBA0985	Lourdes Rodriguez-Vega
LBA0986	Christal Lindley
LBA0987	Kristie Bush
LBA0988	Mattie VanNostrand
LBA0989	Joseph Cermak
LBA0990	Renee Young
LBA0991	Laindra Schuler-Bardel
LBA0992	Kaci Sweeney
LBA0993	Staci Brindamour
LBA0994	Jared Thein
LBA0995	Lillian Schmahl
LBA0996	Caterina Griffith
LBA0997	Clover Anderson
LBA0998	Stephanie Doeden
LBA0999	Sarah Bartholomew
LBA1000	Riley Priest
LBA1001	Jessica French
LBA1002	Indira Hightower
LBA1003	Michelle Tahair
LBA1004	Karisa Lam
LBA1005	Annika Nelson
LBA1006	Brian Clark
LBA1007	Junko Wukasch
LBA1008	Hayley Waltz
LBA1009	Asma Moudi
LBA1010	Tabitha Roundtree

LBA1011	Elizabeth Hintz
LBA1012	Nicole Price
LBA1013	Kayleigh Brown
LBA1014	Deborah Sullivan
LBA1015	Julie Shipley
LBA1016	Agnes Ale
LBA1017	Morgan Fisher
LBA1018	July Rubiano Pachon
LBA1019	Sara Otto
LBA1020	Brooke Hughes
LBA1021	Marquii Jacobs
LBA1022	Alison Route
LBA1023	Madison Baker
LBA1024	Katherine Redmond-Ciernia
LBA1025	Morgan Payne
LBA1026	Nicole Niehaus
LBA1027	Mary McAlpine
LBA1028	Emily Smith
LBA1029	Sarah Kreuter
LBA1030	Hayley Wieduwilt
LBA1031	Jenna Ouellette

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: 54 (Plus 27 Awaiting Payment and Pending.)

Of applications filed, number of LBA applications that have satisfied all license fees: 54

Of these applications, number submitted to CBC program (anticipated timeline to process CBC is 30 days): 54

Of all applications filed (and paid fees), number in compliance review: 7

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: 21

Reasons for continued review: Applications are In Progress.

CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Admission to Examination for Professional Practice in Psychology (EPPP)

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

Applicant(s) Granted Admission to the (EPPP) Exam
Victoria Richter, Psy.D.
Ji Won Kim, Ph.D.
Lindsay Johnson, Psy.D.
Noah Scanlon, Ph.D.
Victoria Ledsham, Ph.D.
Hannah Lind, Ph.D.
Natalie Melendez Aponte, Psy.D.
Laisa Forestier Perez, Ph.D.
Isaiah Lamb, Psy.D.
Alyssa Kaser, Ph.D.
Robert Kessler, Psy.D.
Romana Triliegj, Psy.D.
Adelaide Wilder, Psy.D.
Kyla Jones, Psy.D.
Marissa Osborn, Psy.D.
Jaylene Arnett, Psy.D.
Amy Farmer, Psy.D.
Dean Harris, Psy.D.
Thomas Brown, Psy.D.
Benjamin Bassier, Psy.D.
Rachel Uyen Nguyen-Le, Psy.D.
Darrick Scott, Ph.D.
Jordan Schneider, Psy.D.
Jesma Revering, Psy.D.
Corri Awdng, Psy.D.
Christiana Prestigiacomio, Ph.D.
Claudine Moise, Ph.D.
Brittany Hamann, 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)
Noah Scanlon, Ph.D.
Prabhkirin Singh, Psy.D.
Nicole Hofman, Ph.D.
Chelsea Baylen, Ph.D.

Isaiah Lamb, Psy.D.
Dayspring Goforth, Ph.D.
Carin Molenaar, Ph.D.
Diana Saunders, Psy.D.
Desiree Giesen, Ph.D.
Rae Hadley, Psy.D.
Marissa Ellis, Psy.D.
Ashley Friesen-Janochoski, Ph.D.
Emma Fowler, Psy.D.
Thomas Wild, Ph.D.
Jennifer Carrasco, Ph.D.
Raghad Hassabelnaby, Psy.D.
Emily Wilson, Ph.D.
Emily Harrington, Psy.D.
Greta Kos, Ph.D.
Jay Wilimek, Ph.D.
Corri Awdng, Psy.D.
Mackenzie Turner, Psy.D.
Laura Eskridge, Ph.D.
Melody Hannani, Psy.D.
Audrey Horney, Ph.D.
Brenda Sharp, Ph.D.
Jennifer Ryan, Ph.D.
Dawn Clark-Plowman, Psy.D.

Licensed Psychologist (LP)

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

License Number	Licensee
LP6135	Maryanne Edmundson, Ph.D.
LP6864	Jonathan Schaefer, Ph.D.
LP7032	Debra Kay, Ph.D.
LP7334	Andrew Seidman, Ph.D.
LP7335	Bharathi Venkat, Psy.D.
LP7336	Nicole Hofman, Ph.D.
LP7337	Katie Albright, Psy.D.
LP7338	Shreya Lakhan-Pal, Ph.D.
LP7339	Richard Nelson, Ph.D.
LP7340	Thomas Wild, Ph.D.
LP7341	Stephen Snyder, Psy.D.
LP7342	Alexandra Lenzen, Ph.D.
LP7343	Jennifer Carrasco, Ph.D.
LP7344	Rae Hadley, Psy.D.
LP7345	Peter Gu, Ph.D.

LP7346	Nan Huai, Ph.D.
LP7347	Laura Eskridge, Ph.D.
LP7348	Emily Harrington, Psy.D.
RL00057	Zinta Sarma
RL00098	Endora Crawford

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
GL0151	Diana Saunders
GL0152	Timothy Immelman
GL0153	Audra Horney

Licensure for Voluntary Practice (L-VP)

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

License Number	Licensee
LP-V0024	Jay Wilimek

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
ER00215	Steven Bingner
ER00217	Candance Blake

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
LP3980	Blackert Tara
LP4002	Susan Parenteau
LP0911	Steven Bingner
LP3067	Carolyn Hildebrandt
LP0955	Berendina Numan
LP0895	Marna Reed
LP0948	Ralph McKinney
LP5475	Candance Blake

LP3998	Susan Medo
LP3445	Robyn Norby
LP0977	Joyce Wong
LP-V0015	Kathleen Vader

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
LP3779	Lori Gildersleeve
LP4010	Robert Wagner
LP4688	Kathryn Shinnick
LP6529	Holly Kristine McMichael Symons
LP0870	Lisa Woodruff
LP3416	Michele Friedmann
LP5238	Derek Prowe
LP3999	Connie Meyer

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: 21

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: 12

Number of Guest License applications filed since last Board meeting: 3

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

Reasons for continued review: N/A

Guest License applications days to license: 5



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

SUBMITTED BY: Executive Director

TITLE: HPSP Reports

INTRODUCTION TO THE TOPIC:

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

The goals of HPSP are to promote early intervention, diagnosis and treatment for health professionals with illnesses, and to provide monitoring services as an alternative to Board discipline.

These reports reflect the number of participants and the costs associated with the Board's licensees' participation in HPSP.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
HPSP - March Case Totals	5/11/2026	Cover Memo
HPSP - April Case Totals	5/11/2026	Cover Memo
HPSP - April Discharge by Status	5/11/2026	Cover Memo
HPSP - March Discharge by Status	5/11/2026	Cover Memo
HPSP - March Case Allocation	5/11/2026	Cover Memo
HPSP - April Case Allocation	5/11/2026	Cover Memo

Case Totals By Status - Between 3/1/2026 and 3/31/2026

Board	Case Status	Count
Behavioral Health and Therapy	Application	3
	Report Open	2
	Board Total:	5
BELTSS	Report Open	1
	Board Total:	1
Dentistry	Report Open	3
	Board Total:	3
EMS	Application	1
	Board Total:	1
Medical Practice	Application	2
	PA and MP Signed	1
	Report Open	9
	Board Total:	12
Nursing	Application	6
	No Contact	1
	Non-Jurisdictional- Managing Illness	1
	Non-Jurisdictional- No Apparent Illness	1
	PA and MP Signed	1
	Report Open	7
	Board Total:	17
Pharmacy	Application	1
	Report Open	4
	Board Total:	5
Physical Therapy	Application	1
	Board Total:	1
Psychology	Report Open	1
	Board Total:	1

Case Totals By Status - Between 3/1/2026 and 3/31/2026

Social Work	Report Open	1
	Board Total:	1
	Total:	47

Case Totals By Status - Between 4/1/2026 and 4/30/2026

Board	Case Status	Count
Behavioral Health and Therapy	Application	1
	Report Open	6
	Board Total:	7
BELTSS	Report Open	2
	Board Total:	2
Dentistry	Report Open	2
	Board Total:	2
EMS	Report Open	1
	Board Total:	1
Marriage & Family Therapy	Report Open	1
	Board Total:	1
Medical Practice	Application	2
	Report Open	5
	Board Total:	7
Nursing	Application	13
	Completed	1
	Non-Jurisdictional- Managing Illness	1
	Report Open	24
	Board Total:	39
Pharmacy	Report Open	2
	Board Total:	2
Social Work	Application	1
	Report Open	2
	Board Total:	3
Veterinary Medicine	Report Open	1
	Board Total:	1
	Total:	65

Discharged Totals By Status - Between 4/1/2026 and 4/30/2026

Board	Case Status	Count
Behavioral Health and Therapy	Completed	1
	Board Total:	1
BELTSS	Voluntary Withdrawal	2
	Board Total:	2
Dentistry	Non-Cooperative	1
	Board Total:	1
EMS	Completed	1
	Ineligible Monitored- Licensee gave up license	1
	Non-Jurisdictional- Managing Illness	1
	Board Total:	3
Marriage & Family Therapy	Completed	1
	Board Total:	1
Medical Practice	Completed	1
	Ineligible Monitored- License went inactive	1
	Non-Cooperative	1
	Non-Jurisdictional- Managing Illness	4
	Non-Jurisdictional- No Apparent Illness	2
	Board Total:	9
Nursing	Completed	6
	Ineligible Monitored- Licensee gave up license	1
	Ineligible Not Monitored- License Suspended/Revoke	1
	No Contact	1
	Non-Compliance	1
	Non-Compliance - Monitoring Plan	4
	Non-Compliance - Problem Screens	1
	Non-Cooperative	4
	Non-Jurisdictional	1
	Non-Jurisdictional- Managing Illness	4

Discharged Totals By Status - Between 4/1/2026 and 4/30/2026

Nursing	Non-Jurisdictional- No Apparent Illness	2
	Board Total:	26
Pharmacy	Non-Jurisdictional- Managing Illness	1
	Board Total:	1
Physical Therapy	Non-Jurisdictional- Managing Illness	1
	Non-Jurisdictional- No Apparent Illness	1
	Board Total:	2
Social Work	Completed	1
	Ineligible Monitored- Illness too Severe	1
	Non-Compliance - Monitoring Plan	1
	Board Total:	3
	Total:	49

Discharged Totals By Status - Between 3/1/2026 and 3/31/2026

Board	Case Status	Count
Behavioral Health and Therapy	Non-Compliance - Monitoring Plan	1
	Non-Cooperative	1
	Non-Jurisdictional- Managing Illness	2
	Board Total:	4
BELTSS	Non-Jurisdictional- Managing Illness	2
	Non-Jurisdictional- No Apparent Illness	1
	Board Total:	3
Dentistry	Non-Compliance - Monitoring Plan	1
	Non-Jurisdictional- No Apparent Illness	2
	Voluntary Withdrawal	1
	Board Total:	4
EMS	Completed	1
	No Contact	1
	Non-Jurisdictional- No Apparent Illness	1
	Board Total:	3
Medical Practice	Completed	2
	Non-Jurisdictional- Managing Illness	1
	Non-Jurisdictional- No Apparent Illness	2
	Board Total:	5
Nursing	Completed	9
	No Contact	2
	Non-Compliance - Monitoring Plan	1
	Non-Compliance - Positive Screen	1
	Non-Compliance - Problem Screens	1
	Non-Cooperative	3
	Non-Jurisdictional- Managing Illness	7
	Non-Jurisdictional- No Apparent Illness	3
	Voluntary Withdrawal	1

Discharged Totals By Status - Between 3/1/2026 and 3/31/2026

Nursing	Board Total:	28
Pharmacy	Completed	2
	Non-Compliance - Problem Screens	1
	Board Total:	3
Social Work	Non-Cooperative	2
	Board Total:	2
Veterinary Medicine	Completed	1
	Board Total:	1
	Total:	53

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 3/31/2026

Board	Profession	All	Closed	EF Signed	Active	Allocation
Behavioral Health and Therapy	** no prof (id = 1)	9	0	0	0	0
	ADC-T	8	0	0	5	5
	LADC	426	1	4	26	30
	Licensed Prof. Clinical Counselor	64	1	0	13	13
	Licensed Professional Counselor	28	2	0	1	1
	Board Total:	535	4	4	45	49
BELTSS	** no prof (id = 21)	46	0	0	1	1
	Administrator	28	0	1	1	2
	Licensed Assisted Living Director	45	3	2	10	12
	Board Total:	119	3	3	12	15
Chiropractic Examiners	** no prof (id = 4)	1	0	0	0	0
	Chiropractor	307	0	1	5	6
	Board Total:	308	0	1	5	6
Dentistry	Dental Asst.	382	0	0	4	4
	Dental Hyg.	220	1	0	5	5
	Dental Therapist	7	0	0	0	0
	Dentist	319	3	1	10	11
	Radiologist Registrant	1	0	0	1	1
	Board Total:	929	4	1	20	21
Department of Health	** no prof (id = 6)	26	0	0	0	0
	Alternative Medicine Providers	4	0	0	0	0
	Audiologists	1	0	0	0	0
	Hearing Instrument Dispencers	2	0	0	0	0
	Speech/Language Pathologists	10	0	0	0	0
	Board Total:	43	0	0	0	0
Dietetics and Nutrition	Licensed Dietitian	13	0	0	1	1
	Board Total:	13	0	0	1	1
EMS	** no prof (id = 8)	2	0	0	0	0
	AEMT (Adv. Emerg. Med. Technician)	97	0	0	0	0
	CMPA (Community Paramedic)	1	0	0	0	0
	EMR (Emergency Medical Responder)	83	0	0	2	2
	EMT (Emerg. Med. Technician)	107	1	2	12	14

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 3/31/2026

EMS	PARA (Paramedic)	125	2	0	3	3
	Board Total:	415	3	2	17	19
Marriage & Family Therapy	** no prof (id = 9)	3	0	0	0	0
	LAMFT	8	0	0	0	0
	LMFT	57	0	0	4	4
	Board Total:	68	0	0	4	4
Medical Practice	** no prof (id = 10)	1	0	0	0	0
	Acupunct.	13	0	0	0	0
	Athletic Trainer	25	0	0	0	0
	Phys. Asst.	137	1	1	8	9
	Physician	1,579	2	5	53	58
	RCP	159	1	0	2	2
	Resident	71	1	0	2	2
	Traditional Midwife	1	0	0	1	1
	Board Total:	1,986	5	6	66	72
Nursing	** no prof (id = 11)	9	0	2	2	4
	Advanced Practice Registered Nurse	6	1	0	4	4
	Certified Nurse Practitioner	20	1	0	6	6
	Licensed Practical Nurse	1,642	3	4	40	44
	Registered Nurse	5,020	23	14	242	256
	Board Total:	6,697	28	20	294	314
Occupational Therapy	OT	16	0	0	1	1
	OTA	18	0	1	2	3
	Board Total:	34	0	1	3	4
Office of Mental Health Practice (Social Work)	Unlicensed Mental Health Practitioners	5	0	0	0	0
	Board Total:	5	0	0	0	0
Optometry	Optometrist	20	0	0	0	0
	Board Total:	20	0	0	0	0
Pharmacy	** no prof (id = 15)	2	0	0	0	0
	Intern	20	0	1	3	4
	Pharmacist	293	2	1	10	11

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 3/31/2026

Pharmacy	Tech	119	1	1	11	12
	Board Total:	434	3	3	24	27
Physical Therapy	** no prof (id = 16)	1	0	0	0	0
	Physical Therapist	153	0	0	6	6
	PT Assistant	56	0	1	1	2
	Board Total:	210	0	1	7	8
Podiatric Medicine	Podiatrist	19	0	0	0	0
	Board Total:	19	0	0	0	0
Psychology	** no prof (id = 18)	1	0	0	0	0
	Behavior Analyst	1	0	0	0	0
	Psychologist	117	0	0	3	3
	Board Total:	119	0	0	3	3
Social Work	** no prof (id = 19)	1	0	0	0	0
	LGSW	101	2	0	13	13
	LICSW	158	0	2	17	19
	LISW	10	0	0	0	0
	LSW	134	0	0	4	4
	Board Total:	404	2	2	34	36
Veterinary Medicine	** no prof (id = 20)	1	0	0	0	0
	Veterinarian	93	1	0	1	1
	Board Total:	94	1	0	1	1
Total		12,452	53	44	536	580

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 4/30/2026

Board	Profession	All	Closed	EF Signed	Active	Allocation
Behavioral Health and Therapy	** no prof (id = 1)	10	0	1	1	2
	ADC-T	8	0	0	5	5
	LADC	429	1	1	26	27
	Licensed Prof. Clinical Counselor	67	0	0	13	13
	Licensed Professional Counselor	28	0	0	1	1
	Board Total:	542	1	2	46	48
BELTSS	** no prof (id = 21)	48	0	1	2	3
	Administrator	28	1	0	0	0
	Licensed Assisted Living Director	45	1	0	9	9
	Board Total:	121	2	1	11	12
Chiropractic Examiners	** no prof (id = 4)	1	0	0	0	0
	Chiropractor	307	0	0	5	5
	Board Total:	308	0	0	5	5
Dentistry	Dental Asst.	382	0	0	4	4
	Dental Hyg.	221	1	0	5	5
	Dental Therapist	7	0	0	0	0
	Dentist	320	0	2	12	14
	Radiologist Registrant	1	0	0	1	1
	Board Total:	931	1	2	22	24
Department of Health	** no prof (id = 6)	26	0	0	0	0
	Alternative Medicine Providers	4	0	0	0	0
	Audiologists	1	0	0	0	0
	Hearing Instrument Dispencers	2	0	0	0	0
	Speech/Language Pathologists	10	0	0	0	0
	Board Total:	43	0	0	0	0
Dietetics and Nutrition	Licensed Dietitian	13	0	0	1	1
	Board Total:	13	0	0	1	1
EMS	** no prof (id = 8)	2	0	0	0	0
	AEMT (Adv. Emerg. Med. Technician)	97	0	0	0	0
	CMPA (Community Paramedic)	1	0	0	0	0
	EMR (Emergency Medical Responder)	83	0	0	2	2
	EMT (Emerg. Med. Technician)	108	3	0	9	9

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 4/30/2026

EMS	PARA (Paramedic)	125	0	0	3	3
	Board Total:	416	3	0	14	14
Marriage & Family Therapy	** no prof (id = 9)	3	0	0	0	0
	LAMFT	8	0	0	0	0
	LMFT	57	1	0	3	3
	Board Total:	68	1	0	3	3
Medical Practice	** no prof (id = 10)	1	0	1	1	2
	Acupunct.	14	1	1	0	1
	Athletic Trainer	25	0	0	0	0
	Phys. Asst.	137	3	1	6	7
	Physician	1,585	4	3	54	57
	RCP	160	1	2	3	5
	Resident	71	0	0	2	2
	Traditional Midwife	1	0	0	1	1
	Board Total:	1,994	9	8	67	75
Nursing	** no prof (id = 11)	8	1	0	0	0
	Advanced Practice Registered Nurse	6	0	0	4	4
	Certified Nurse Practitioner	22	0	2	8	10
	Licensed Practical Nurse	1,646	3	1	38	39
	Registered Nurse	5,055	23	15	240	255
	Board Total:	6,737	27	18	290	308
Occupational Therapy	OT	16	0	0	1	1
	OTA	18	0	0	2	2
	Board Total:	34	0	0	3	3
Optometry	Optometrist	20	0	0	0	0
	Board Total:	20	0	0	0	0
Pharmacy	** no prof (id = 15)	2	0	0	0	0
	Intern	21	0	0	3	3
	Pharmacist	293	1	0	9	9
	Tech	120	0	3	14	17
	Board Total:	436	1	3	26	29

m Health Professionals Services Program
Monthly Case Allocation

Report Date: 4/30/2026

Physical Therapy						
	** no prof (id = 16)	1	0	0	0	0
	Physical Therapist	153	1	0	5	5
	PT Assistant	56	1	0	0	0
	Board Total:	210	2	0	5	5
Podiatric Medicine						
	Podiatrist	19	0	0	0	0
	Board Total:	19	0	0	0	0
Psychology						
	** no prof (id = 18)	1	0	0	0	0
	Behavior Analyst	1	0	0	0	0
	Psychologist	117	0	1	4	5
	Board Total:	119	0	1	4	5
Social Work						
	** no prof (id = 19)	1	0	0	0	0
	LGSW	101	0	0	13	13
	LICSW	159	3	0	14	14
	LISW	10	0	0	0	0
	LSW	136	1	1	4	5
	Board Total:	407	4	1	31	32
Veterinary Medicine						
	** no prof (id = 20)	1	0	0	0	0
	Veterinarian	94	0	0	1	1
	Board Total:	95	0	0	1	1
Total		12,513	51	36	529	565



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

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
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The Role of Artificial Intelligence	5/8/2026	Cover Memo
Forbes Article	5/8/2026	Cover Memo
AI In the Psychologists Toolkit	5/8/2026	Cover Memo
How School Psychologists are Using AI in Practice	5/8/2026	Cover Memo
AI Chatbot Illegally poses as doctor lawsuit	5/11/2026	Cover Memo

KFF Health News

Your New Therapist: Chatty, Leaky, and Hardly Human

By Darius Tahir

Illustration by Oona Zenda

APRIL 17, 2026



(OONA ZENDA/KFF HEALTH NEWS)

If you or someone you know may be experiencing a mental health crisis, contact the 988 Suicide & Crisis Lifeline by dialing or texting "988."

Vince Lahey of Carefree, Arizona, embraces chatbots. From Big Tech products to “shady” ones, they offer “someone that I could share more secrets with than my therapist.”

The Washington Post

This story also ran on [The Washington Post](#). It can be [republished for free](#).

He especially likes the apps for feedback and support, even though sometimes they berate him or lead him to fight with his ex-wife. “I feel more inclined to share more,” Lahey said. “I don’t care about their perception of me.”

There are a lot of people like Lahey.

Demand for mental health care has grown. Self-reported poor mental health days rose by 25% since the 1990s, [found one study](#) analyzing survey data. According to the Centers for Disease Control and Prevention, suicide rates in 2022 [matched a 2018 high](#) that hadn’t been seen in nearly 80 years.

There are many patients who find a nonhuman therapist, powered by artificial intelligence, highly appealing — more appealing than a human with a reclining couch and stern manner. [Social media is replete with videos](#) begging for a therapist who’s “not on the clock,” who’s less judgmental, or who’s just less expensive.

Most people who need care don’t get it, said Tom Insel, former head of the National Institute of Mental Health, citing his former agency’s research. Of those who do, 40% receive “minimally acceptable care.”

“There’s a massive need for high-quality therapy,” he said. “We’re in a world in which the status quo is really crappy, to use a scientific term.”

Insel said engineers from OpenAI told him last fall that about 5% to 10% of the company's then-roughly 800 million-strong user base rely on ChatGPT for mental health support.

Polling suggests these AI chatbots may be even more popular among young adults. A KFF poll found about 3 in 10 respondents ages 18 to 29 turned to AI chatbots for mental or emotional health advice in the past year. Uninsured adults were about twice as likely as insured adults to report using AI tools. And nearly 60% of adult respondents who used a chatbot for mental health didn't follow up with a flesh-and-blood professional.

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The App Will Put You on the Couch

A burgeoning industry of apps offers AI therapists with human-like, often unrealistically attractive avatars serving as a sounding board for those experiencing anxiety, depression, and other conditions.

KFF Health News identified some 45 AI therapy apps in Apple's App Store in March. While many charge steep prices for their services — one listed an annual plan for \$690 — they're still generally cheaper than talk therapy, which can cost hundreds of dollars an hour without insurance coverage.

On the App Store, "therapy" is often used as a marketing term, with small print noting the apps cannot diagnose or treat disease. One app, branded as OhSofia! AI Therapy Chat, had downloads in the six figures, said OhSofia! founder Anton Ilin in December.

“People are looking for therapy,” Ilin said. On one hand, the product’s name promises “therapy chat”; on the other, it warns in its privacy policy that it “does not provide medical advice, diagnosis, treatment, or crisis intervention and is not a substitute for professional healthcare services.” Executives don’t think that’s confusing, since there are disclaimers in the app.

The apps promise big results without backup. One promises its users “immediate help during panic attacks.” Another claims it was “proven effective by researchers” and that it offers 2.3 times faster relief for anxiety and stress. (It doesn’t say what it’s faster than.)

There are few legislative or regulatory guardrails around how developers refer to their products — or even whether the products are safe or effective, said Vaile Wright, senior director of the office of health care innovation at the American Psychological Association. Even federal patient privacy protections don’t apply, she said.

“Therapy is not a legally protected term,” Wright said. “So, basically, anybody can say that they give therapy.”

Many of the apps “overrepresent themselves,” said John Torous, a psychiatrist and clinical informaticist at Beth Israel Deaconess Medical Center. “Deceiving people that they have received treatment when they really have not has many negative consequences,” including delaying actual care, he said.

States such as Nevada, Illinois, and California are trying to sort out the regulatory disarray, enacting laws forbidding apps from describing their chatbots as AI therapists.

“It’s a profession. People go to school. They get licensed to do it,” said Jovan Jackson, a Nevada legislator, who co-authored an enacted bill banning apps from referring to themselves as mental health professionals.

Underlying the hype, outside researchers and company representatives themselves have told the FDA and Congress that there's little evidence supporting the efficacy of these products. What studies there are give contradictory answers — and some research suggests companion-focused chatbots are “consistently poor” at managing crises.

“When it comes to chatbots, we don't have any good evidence it works,” said Charlotte Blease, a professor at Sweden's Uppsala University who specializes in trial design for digital health products.

The lack of “good quality” clinical trials stems from the FDA's failure to provide recommendations about how to test the products, she said. “FDA is offering no rigorous advice on what the standards should be.”

Department of Health and Human Services spokesperson Emily Hilliard said, in response, that “patient safety is the FDA's highest priority” and that AI-based products are subject to agency regulations requiring the demonstration of “reasonable assurance of safety and effectiveness before they can be marketed in the U.S.”

The Silver-Tongued Apps

Preston Roche, a psychiatry resident who's active on social media, gets lots of questions about whether AI is a good therapist. After trying ChatGPT himself, he said he was “impressed” initially that it was able to use cognitive behavioral therapy techniques to help him put negative thoughts “on trial.”

But Roche said after seeing posts on social media discussing people developing psychosis or being encouraged to make harmful decisions, he became disillusioned. The bots, he concluded, are sycophantic.

“When I look globally at the responsibilities of a therapist, it just completely fell on its face,” he said.

This sycophancy — the tendency of apps based on large language models to empathize, flatter, or delude their human conversation partner — is inherent to the app design, experts in digital health say.

“The models were developed to answer a question or prompt that you ask and to give you what you’re looking for,” said Insel, the former NIMH director, “and they’re really good at basically affirming what you feel and providing psychological support, like a good friend.”

That’s not what a good therapist does, though. “The point of psychotherapy is mostly to make you address the things that you have been avoiding,” he said.

While polling suggests many users are satisfied with what they’re getting out of ChatGPT and other apps, there have been high-profile reports about the service providing advice or encouragement to self-harm.

And at least one dozen lawsuits alleging wrongful death or serious harm have been filed against OpenAI after ChatGPT users died by suicide or became hospitalized. In most of those cases, the plaintiffs allege they began using the apps for one purpose — like schoolwork — before confiding in them. These cases are being consolidated into a class-action lawsuit.

Google and the startup Character.ai — which has been funded by Google and has created “avatars” that adopt specific personas, like athletes, celebrities, study buddies, or therapists — are settling other wrongful-death lawsuits, according to media reports.

OpenAI’s CEO, Sam Altman, has said up to 1,500 people a week may talk about suicide on ChatGPT.

“We have seen a problem where people that are in fragile psychiatric situations using a model like 4o can get into a worse one,” Altman said in a public question-and-answer session reported by The Wall Street Journal, referring to a particular model of ChatGPT introduced in 2024. “I don’t think this is the last time we’ll face challenges like this with a model.”

An OpenAI spokesperson did not respond to requests for comment.

The company has said it works with mental health experts on safeguards, such as referring users to 988, the national suicide hotline. However, the lawsuits against OpenAI argue existing safeguards aren't good enough, and some research shows the problems are worsening over time. OpenAI has published its own data suggesting the opposite.

OpenAI is defending itself in court, offering, early in one case, a variety of defenses ranging from denying that its product caused self-harm to alleging that the defendant misused the product by inducing it to discuss suicide. It has also said it's working to improve its safety features.

Smaller apps also rely on OpenAI or other AI models to power their products, executives told KFF Health News. In interviews, startup founders and other experts said they worry that if a company simply imports those models into its own service, it might duplicate whatever safety flaws exist in the original product.

Data Risks

KFF Health News' review of the App Store found listed age protections are minimal: Fifteen of the nearly four dozen apps say they could be downloaded by 4-year-old users; an additional 11 say they could be downloaded by those 12 and up.

Privacy standards are opaque. On the App Store, several apps are described as neither tracking personally identifiable data nor sharing it with advertisers — but on their company websites, privacy policies contained contrary descriptions, discussing the use of such data and their disclosure of information to advertisers, like AdMob.

In response to a request for comment, Apple spokesperson Adam Dema sent links to the company's App Store policies, which bar apps from using health data for advertising and require them to display information about how they

use data in general. Dema did not respond to a request for further comment about how Apple enforces these policies.

Researchers and policy advocates said that sharing psychiatric data with social media firms means patients could be profiled. They could be targeted by dodgy treatment firms or charged different prices for goods based on their health.

KFF Health News contacted several app makers about these discrepancies; two that responded said their privacy policies had been put together in error and pledged to change them to reflect their stances against advertising. (A third, the team at OhSofia!, said simply that they don't do advertising, though their app's [privacy policy](#) notes users "may opt out of marketing communications.")

One executive told KFF Health News there's business pressure to maintain access to the data.

"My general feeling is a subscription model is much, much better than any sort of advertising," said Tim Rubin, the founder of Wellness AI, adding that he'd change the description in his app's privacy policy.

One investor advised him not to swear off advertising, he said. "They're like, essentially, that's the most valuable thing about having an app like this, that data."

"I think we're still at the beginning of what's going to be a revolution in how people seek psychological support and, even in some cases, therapy," Insel said. "And my concern is that there's just no framework for any of this."

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NEWS

AI in the therapists' office: Uptake increases, caution persists

2025 Practitioner Pulse Survey reveals growing ease with AI for practice management, alongside privacy concerns

By [Zara Abrams](#) Date created: March 1, 2026 8 min read
Vol. 57, No. 2
Print version: page 32

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Artificial intelligence (AI) has moved from a fringe tool to a regular part of clinical practice, with more psychologists weaving it into their administrative routines and reporting a clearer understanding of its risks and benefits.

Almost 1 in 3 practitioners (29%) now use AI at least monthly in their practice, according to the *2025 Practitioner Pulse Survey*, released by APA and its companion organization, APA Services, in December. Of 1,742 respondents, 56% have used AI to assist with their work at least once, pointing to a growing ease with the technology among many practitioners.

But plenty of concerns remain, including for the 38% of psychologists who worry that AI may one day make some or all their job duties obsolete.

Even clinicians who don't use AI for practice management likely encounter it in some form. OpenAI recently reported that around 1 million users per week show signs of emotional reliance on ChatGPT, with similar numbers talking to the chatbot about suicide (Chatterji, A., et al., Working Paper 34255, National Bureau of Economic Research, 2025 [↗](https://doi.org/10.3386/w34255) (<https://doi.org/10.3386/w34255>)).

"AI is already in your practice even if you're not using these administrative tools because many of the people sitting on the couch across from you are turning to ChatGPT in between sessions," said Rachel Wood, PhD, an expert in cyberpsychology and licensed professional counselor who runs the [AI Mental Health Collective](https://www.dr-rachelwood.com/aimentalhealthcollective) [↗](https://www.dr-rachelwood.com/aimentalhealthcollective) (<https://www.dr-rachelwood.com/aimentalhealthcollective>).

For that reason, it's critical for psychologists to ask patients about their AI use and to develop practical and ethical competence to support situations their patients may face and spot signs of misuse. APA's recent health advisory provides guidance for clinicians on how to handle generative AI in therapy and other settings ("[Use of Generative AI Chatbots and Wellness Applications for Mental Health](https://www.apa.org/topics/artificial-intelligence-machine-learning/health-advisory-chatbots-wellness-apps)," APA, 2025 ([/topics/artificial-intelligence-machine-learning/health-advisory-chatbots-wellness-apps](https://www.apa.org/topics/artificial-intelligence-machine-learning/health-advisory-chatbots-wellness-apps))).

"Whether you're for or against AI is less important than having a baseline level of knowledge, information, and understanding so that you're equipped to hold space for it," Wood said.

Aside from AI, clinician reports indicate that the mental health crisis isn't over. Nearly half (45%) have seen an increase in the severity of their patients' symptoms. On the bright side, clinician capacity appears to be stabilizing post-pandemic, with plateaus or declines in burnout rates, waiting list length, and the ability of providers to meet patient demand.

"Providers are telling us: We're still seeing patients who seem sicker, but our ability to meet and match that is going in the right direction," said Marnie Shanbhag, PhD, who is with APA's Office of Independent Practice.

Increasing comfort, continued caution

Keeping pace with the increased use of AI across society, a greater number of psychologists are incorporating these tools into their work.

Fewer than half of psychologists (44%) say they have never used AI to assist with their practice, compared with 71% who said so in 2024. Nearly 3 in 10 (29%) use it at least monthly, up from just 11% last year.

"This is not only in our clinical world, but there's a collective movement on a societal and global level where people feel really behind if they're not using AI," Wood said.

AI tools are now woven into many of the platforms psychologists already use, including electronic health records (EHRs). Practitioners most frequently report using AI tools for help with writing, such as drafting emails (52%), followed by generating content (33%), summarization (32%), and note-taking and dictation (22%).

Tools like ChatGPT have helped Cami Winkelspecht, PhD, a child and adolescent psychologist with a private practice in Wilmington, Delaware, with myriad practice-related tasks. These include generating summaries of newly published research, building structured outlines for presentations, and helping her patients with attention-deficit/hyperactivity disorder create checklists to help with studying or schoolwork. "Integrating it into our workflow in ways that don't relate to confidentiality or patient privacy is a safe way to start experimenting with AI," she said, compared with using AI for more sensitive tasks, such as note-taking during a therapy session.

APA's [AI tool guide for practitioners](#)

([https://www.apaservices.org/practice/business/technology/tech-101/evaluating-artificial-intelligence-tool?](https://www.apaservices.org/practice/business/technology/tech-101/evaluating-artificial-intelligence-tool?utm_source=apa.org&utm_medium=referral&utm_content=/monitor/2026/03/ai-reshaping-therapy)

[utm_source=apa.org&utm_medium=referral&utm_content=/monitor/2026/03/ai-reshaping-therapy](https://www.apaservices.org/practice/business/technology/tech-101/evaluating-artificial-intelligence-tool?utm_source=apa.org&utm_medium=referral&utm_content=/monitor/2026/03/ai-reshaping-therapy)) gives step-by-step advice for evaluating whether a given tool is appropriate for use in practice, while newly released guidelines provide more detailed tips for [evaluating AI scribing technologies \(/topics/artificial-intelligence-machine-learning/evaluating-ai-scribes\)](#).

The survey results show psychologists were more aware of AI's benefits and risks than they were the year before. About 4 in 10 (42%) say AI can help with operations and reduce practitioners' administrative burden, up from 33% in 2024. Two thirds (67%) remain concerned about potential data breaches. In addition, at least 60% of psychologists surveyed are worried about biased inputs and outputs, inaccurate outputs, lack of rigorous testing, and unanticipated social harms. Most concerns about AI's risks grew by around 10 percentage points from 2024 to 2025.

Such concerns are consistent with psychology's focus on ethics and should inform how providers use AI, especially in situations where it could influence clinical judgment. For example, if using a notes-summarization tool, Wood recommends treating AI like a second pair of eyes—much like a supervisor offering feedback. Clinicians should always rely first and foremost on their own expertise. (For more advice, see "[Ethical Guidance for AI in the](#)

Professional Practice of Health Service Psychology," APA, 2025
(/topics/artificial-intelligence-machine-learning/ethical-guidance-ai-professional-practice).)

To guide ethical use, Wood suggests practitioners include a clear statement about how they use AI in their disclosure to patients. It's also a good idea to discuss this directly and be ready to make accommodations for those who are uncomfortable with the use of AI. Another useful step is adding a simple intake question: What role, if any, does AI play in your life?

"With the numbers of people using AI for emotional support, this needs to become standard," Wood said. "Your client may have a best friend, boyfriend, or girlfriend that's an AI. We need to be the place where people can safely talk about this and process it."

Growing familiarity with AI hasn't eliminated lingering fears about being replaced. Nearly 4 in 10 psychologists (38%) worry AI may make some or all their job duties obsolete in the future, up from 27% in 2024. That concern is not unfounded, Wood said, given how many people already talk to ChatGPT about personal issues. This year, she launched the AI Mental Health Collective [↗ \(https://www.dr-rachelwood.com/aimentalhealthcollective\)](https://www.dr-rachelwood.com/aimentalhealthcollective) to give clinicians a space to reflect on AI, unpack its implications, and make personal and professional decisions about how to use it. For example, therapists in her network have explored how to support couples in therapy when one partner also has an AI companion.

Winkelspecht said that hesitation around AI mirrors clinicians' early resistance to EHRs. She expects AI adoption to follow a similar path to EHRs—early enthusiasm from some, hesitation from others, and a small group who may opt out entirely. Despite early skepticism, most clinicians now routinely use EHRs in their practice.

"Having good education and opportunities to process these challenges is key. It's something that people are really hungry for knowledge on," Winkelspecht said.

Signs of steady ground

While close to half (46%) of psychologists still do not have openings for new patients, that number has been trending downward since 2021. Nearly 9 in 10 (87%) providers now say they can see new patients within 3 months, similar to wait times for other nonurgent medical specialists.

"Things do seem to be stabilizing in terms of the crisis that psychologists themselves faced while serving the public during the pandemic," Shanbhag said. "Our ability to meet demand has gone up, our burnout seems to be going down, and treatment length is stabilizing and not continuing to increase."

The stress of the pandemic and the abrupt shift to telehealth placed emotional and administrative burdens on providers that now appear to be lifting, said Julie Wolter, PsyD, a psychologist in private practice in North Kingstown, Rhode Island.

At the same time, many patients continue to face significant challenges, with 45% of providers observing an increase in symptom severity. That may be the result of delayed care during the pandemic, which has had lasting effects on both physical and psychological health, Shanbhag said.

Psychologists' ability to meet those needs continues to be hindered by insurance barriers. Less than two thirds of psychologists (62%) accept some form of insurance. Among providers who do accept insurance, 10% stopped participating in at least one private or commercial network in the past year.

"We're continuing to see providers move away from accepting insurance, a trend that we expect to continue," Shanbhag said. "That's not a good thing for society, because a very small segment of the population can afford to access full-fee, cash care."

Three quarters of psychologists cite insufficient reimbursement as a primary reason for not accepting insurance. Other barriers included administrative issues with payers (57%), concerns about payment reliability (43%), and denial of coverage for services they deem necessary and appropriate for patients (28%). (For more on how such barriers affect patients and providers, see: [Abrams, Z., *Monitor on Psychology*, Dec. 17, 2024 \(/topics/psychotherapy/insurance-mental-health-care\)](#)).

Low reimbursement rates have forced many providers to choose between financial stability and accepting insurance, said Wolter, who helps lead advocacy efforts for the Rhode Island Psychological Association and the New Hampshire Psychological Association. That can lead to feelings of guilt or distress for providers who entered the profession wanting to support underserved patients, she said.

These and other conditions contribute to a high rate of burnout (50%) among early career psychologists. The good news: Practitioners in the most advanced career stage report much lower burnout levels (16%). That disparity likely stems from the multiple competing demands many new psychologists face, Shanbhag said—including student loan debt, pressure to establish themselves professionally, and major life transitions such as partnering or starting a family.

"People assume that burnout gets worse over the course of a career, but in our profession it's actually the inverse," she said. "As psychologists gain experience and autonomy, things really do tend to get better."

Key takeaways

The *2025 Practitioner Pulse Survey* reveals how practicing psychologists are navigating AI, workload, and insurance difficulties.

AI in practice

- 56% have used AI tools in their practices in the past year.
- 29% use AI on at least a monthly basis.
- 38% are worried that AI could make some or all their job duties obsolete.

Workload and capacity

- 87% can get new patients in within 3 months.
- 45% saw an increase in the severity of patients' symptoms.

Insurance participation

- 38% do not accept any form of insurance.
- Barriers to accepting insurance include insufficient reimbursement, administrative issues with payers, concerns about payment reliability, and denial of coverage for services deemed necessary and appropriate.

Further reading

[Artificial intelligence is reshaping how psychologists work](https://www.apaservices.org/practice/news/artificial-intelligence-psychologists-work?utm_source=apa.org&utm_medium=referral&utm_content=/monitor/2026/03/ai-reshaping-therapy)

([https://www.apaservices.org/practice/news/artificial-intelligence-psychologists-work?](https://www.apaservices.org/practice/news/artificial-intelligence-psychologists-work?utm_source=apa.org&utm_medium=referral&utm_content=/monitor/2026/03/ai-reshaping-therapy)

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Abrams, Z., APA, 2025

[Guidance for the evaluation of AI scribes \(/topics/artificial-intelligence-machine-learning/evaluating-ai-scribes\)](https://www.apa.org/topics/artificial-intelligence-machine-learning/evaluating-ai-scribes)

APA, 2025

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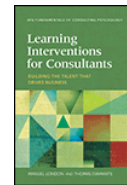
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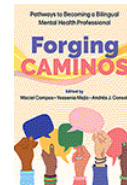
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Gil Noam Ed.D., Dr. Habil
The Inner Life of Students

ARTIFICIAL INTELLIGENCE

ChatGPT Goes to Therapy: The New Emotional Economy

Personal Perspective: Chatbots are reshaping our sense of authentic connection.

Posted April 17, 2026

Reviewed by Ekua Hagan



KEY POINTS

- AI is becoming a primary tool for emotional expression, shaping how people communicate and cope.
- AI can create a “false self,” helping users perform roles misaligned with identity.
- Educators and therapists must guide AI use toward reflection, not avoidance of real relationships.

Artificial intelligence, in its various forms, has become deeply integrated into the lives of many of the patients I work with in my clinical practice. Nowhere is this more evident than in the stories they tell me of using AI to navigate complex emotional terrain.

ing a goodbye note to a lover, or even drafting a poem for a dying parent. In these conversations, I've been given a glimpse into the new emotional economy: one where algorithms mediate human expression, providing both opportunities and challenges for psychological growth.

But this is not limited to adults. A troubling *New York Times* [article](#) told the story of a teenager who, in the midst of suicidal thoughts, turned not to a parent, peer, or counselor, but to ChatGPT for therapy. The teen described the chatbot as a lifeline in moments of despair.

This extraordinary and troubling example reveals both the promise and peril of AI for young people. AI can provide immediate comfort and structured dialogue, yet it can also risk replacing genuine human connection when it's most needed. As educators, parents, and clinicians, we must recognize that students are increasingly engaging with AI not just as a tool, but as a companion in their inner lives.

AI enables a 'false self', distorting relationships

In my own practice, I have observed several ways people use ChatGPT. One striking example is the projection of a "false self." A patient with a warm and empathic style faced a domineering boss who demanded a strong, decisive presence. She instructed ChatGPT to "write a memo that sounds activist, male, and authoritative." The result was effective, but it left her disconnected from her authentic self. This mirrors what many students experience in school, where social desir-

while sidelining their true identity.

Another patient, paralyzed by the task of writing a breakup letter, turned to ChatGPT. The first attempt sounded like a corporate termination notice. A revised version was more tender, but still “not me,” as he put it. The outsourcing of his most vulnerable communication offered short-term relief but highlighted a deeper avoidance of intimacy. Many students do something similar with academic tasks or even social conflicts, using AI-generated essays, emails, or messages to avoid the discomfort of struggle. While functional in the moment, it distances them from the developmental work of finding their own words.

A third patient asked ChatGPT for a humorous yet loving poem for his aging mother. The AI generated clever anecdotes and polished lines, but they were fabricated and oddly hollow. The patient was satisfied—it met social expectations—but the emotional depth was missing. Adolescents, too, often use AI to craft the “right” message to peers, teachers, or parents. This highlights a tension between the polished performance of connection and the messy, authentic expression that actually deepens relationships.

ARTICLE CONTINUES AFTER ADVERTISEMENT

Beyond individual cases, I see a broader trend: patients turning to AI when shame prevents direct communication. One patient, embarrassed about financial struggles, asked ChatGPT to write a request for a fee reduction. The result was formal and transactional, unlike his usual candid style. I suddenly found myself in a three-way relationship, not just with him, but also with his AI voice. Students may do the same when asking teachers for extensions, coaches for more playing time, or peers for forgiveness, outsourcing the courage it takes to ask directly.

Couples in conflict have even used ChatGPT as a mediator, only later discovering both had relied on AI to write conciliatory messages. This “assistant therapist” role can regulate emotions and prevent escalation, but it raises the question: Will people move from AI back to one another, or does AI risk becoming a permanent buffer against intimacy?

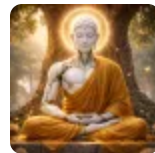
The *New York Times* story of the teen who used ChatGPT for therapy underscores what I hear from young people every day: Students are seeking immediacy, structure, and a sense of being heard, sometimes in places adults might never expect. For youth facing anxiety, depression, or the everyday turbulence of adolescence, AI offers an accessible and judg-

If students lean exclusively on AI, they risk bypassing the vital developmental process of learning to express vulnerability with real people, including their parents, teachers, peers, and mentors. Yet, AI can also serve as a transitional tool: a first step toward articulating feelings, practicing language, or lowering the threshold for asking for help. In this sense, it can be part of a continuum that leads back to human connection, not away from it.

ARTIFICIAL INTELLIGENCE ESSENTIAL READS



What AI Can't Calculate About a Human Life



A First Glimpse of Superintelligence

Educators and therapists can support human connection

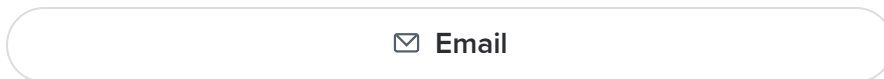
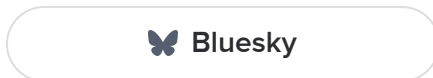
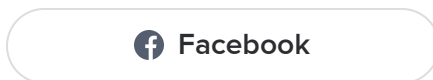
As AI becomes more integrated into everyday life, therapists and educators must grapple with its role. The question is not whether to accept or reject AI, but how to integrate it thoughtfully. Can we encourage students to use AI as a tool for self-reflection, while also guiding them back to authentic human relationships? Can AI support developmental tasks rather than replace them?

ARTICLE CONTINUES AFTER ADVERTISEMENT

What is clear is that AI is already reshaping the landscape of communication, learning, and therapy. The inner lives of students are increasingly entwined with the voices of algorithms. As adults, we need to pay close attention, not only to the risks of emotional displacement and diminished authenticity, but also to the potential for AI to serve as a stepping-stone toward deeper connection, resilience, and growth.

If you or someone you love is contemplating suicide, seek help immediately. For help 24/7 dial 988 for the 988 Suicide & Crisis Lifeline, or reach out to the Crisis Text Line by texting TALK to 741741. To find a therapist near you, visit [the Psychology Today Therapy Directory](#).

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OPTIMISM

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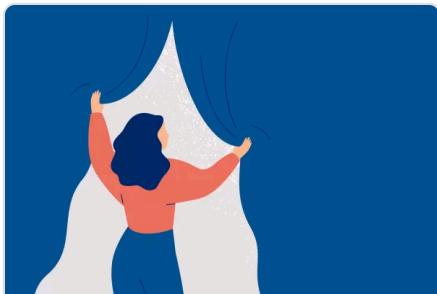
The use of AI in the mental health space has outpaced both scientific validation and regulation oversight.



ARTIFICIAL INTELLIGENCE 3 MIN READ

AI as a Fiction Machine

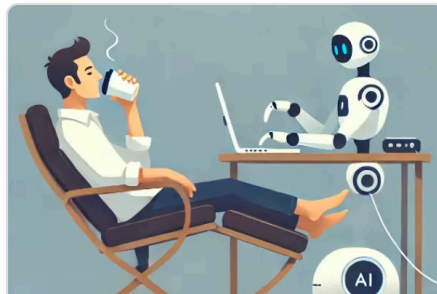
Modern AI machines are not designed to be truthful but to generate narratives that make sense.



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from Psychology Today.

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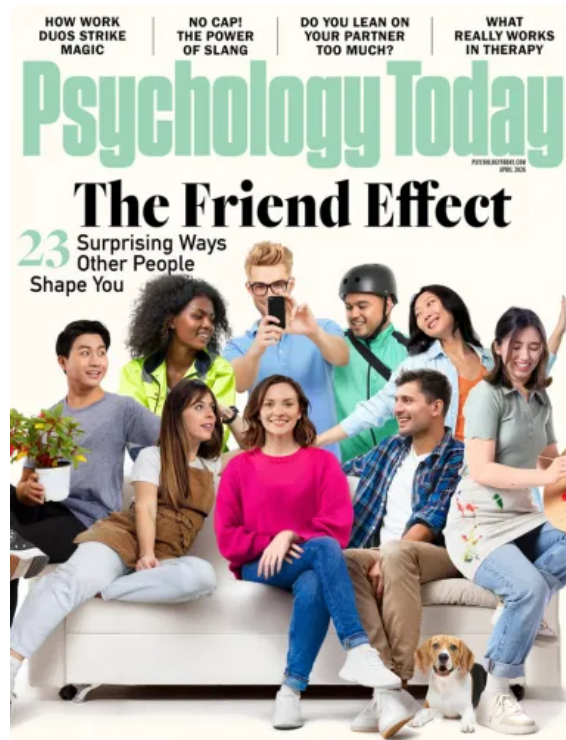
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COMPREHENSIVE REVIEW **OPEN ACCESS**

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);

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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 (Meady 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'
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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

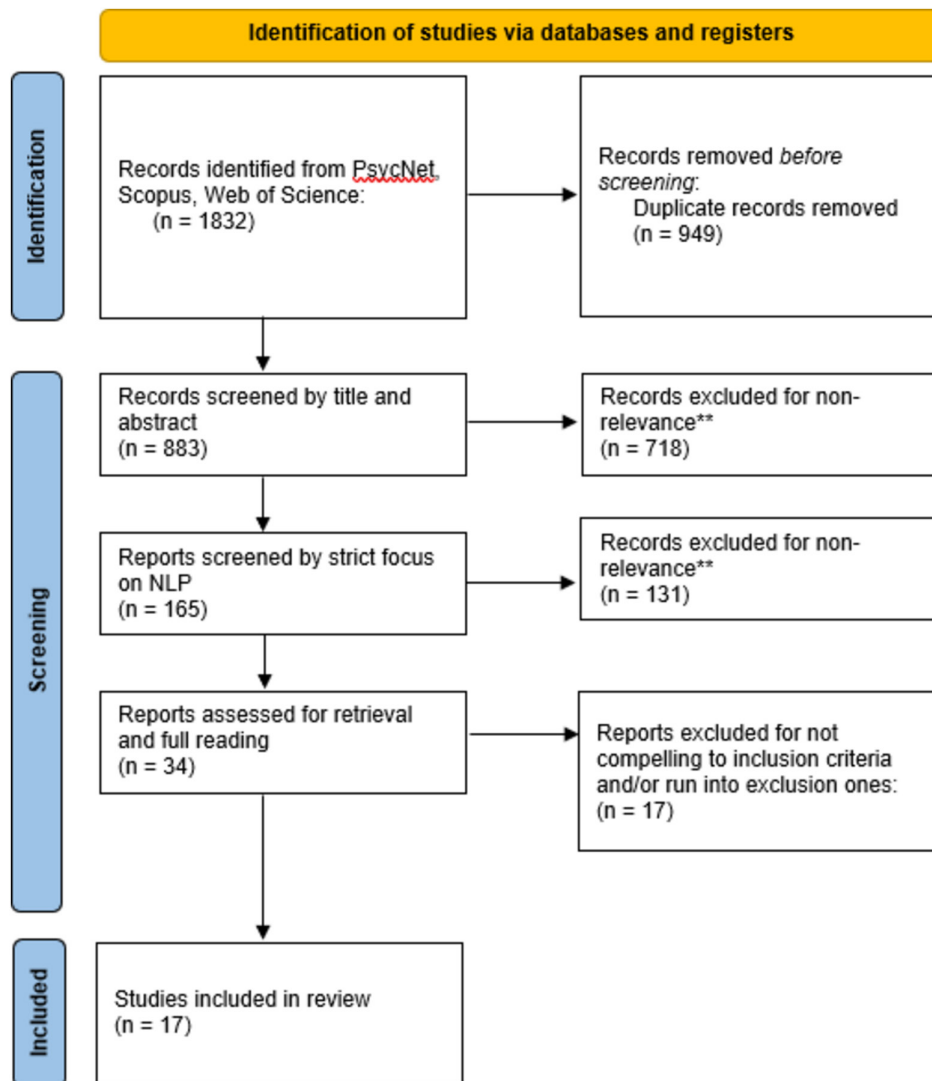


FIGURE 1 | PRISMA review flowchart.

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. Chiauuzzi 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 Chiauuzzi 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 SI for the explanation of the categorization used to classify systems).

Title	Main target of the system					Type of intervention			Type of disorder
	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	Chiauszi, 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., Martin-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.		ADHD Sample of 10 esteemed experts in therapies for children with ADHD.

(Continues)

TABLE 2 | (Continued)

Title	Main target of the system				Type of intervention		Type of disorder		
	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 with 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)

Title	Main target of the system					Type of intervention		Type of disorder	
	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.		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.	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.					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)

Title	Main target of the system				Type of intervention			Type of disorder	
	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)

Title	Main target of the system				Type of intervention			Type of disorder	
	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 provide performance-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)

Title	Main target of the system				Type of intervention			Type of disorder	
	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	Main target of the system				Type of intervention			Type of disorder	
	Authors	Year	Journal	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 DMHs 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 (Haghighi 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>I consent to the collection, storage and use of my health data for the purpose of my clinical care and related research.</i>	- 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>I authorize the use and disclosure of my health information as described in this notice for treatment, payment and healthcare operations.</i>	- 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>I consent to the collection, use and disclosure of my health information for my care and as required by law.</i>	- 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>I consent to my health information being included in My Health Record and shared with healthcare providers involved in my care.</i>	- 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.

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In today's column, I examine the audacious act of Anthropic opting to employ a mental health professional to do a psychological assessment of their latest version of Claude, known as Claude Mythos Preview. Therapists customarily assess humans rather than AI apps. It is a bit extraordinary to do psychotherapy on a generative AI or large language model (LLM). Not something that you see every day.

You might be aware that Mythos has been in the news lately because the AI went overboard and found all sorts of zero-day cybersecurity loopholes that, if made publicly available, would have been catastrophic for computers worldwide. Anthropic decided not to release Mythos publicly and instead has cybersecurity experts closely help ascertain what to do about the bevy of hacking possibilities. For my coverage on the brouhaha, see [the link here](#).

A little-noticed aspect of the System Card that Anthropic officially published about Mythos is that the AI maker decided to use a psychiatrist for some head-shrinking activity associated with their latest AI. The results of the therapeutic assessment are laid out for all to see.


Let's talk about it.

This analysis of AI breakthroughs is part of my ongoing Forbes column coverage on the latest in AI, including identifying and explaining various impactful AI complexities (see [the link here](#)).

AI And Mental Well-Being

As a quick background, I've been extensively covering and analyzing a myriad of facets regarding the advent of modern-era AI that produces mental health advice and performs AI-driven therapy. This rising use of AI has principally been spurred by the evolving advances and widespread adoption of generative AI. For an extensive listing of my well over one hundred analyses and postings, see [the link here](#) and [the link here](#).

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AI Providing Mental Health Guidance

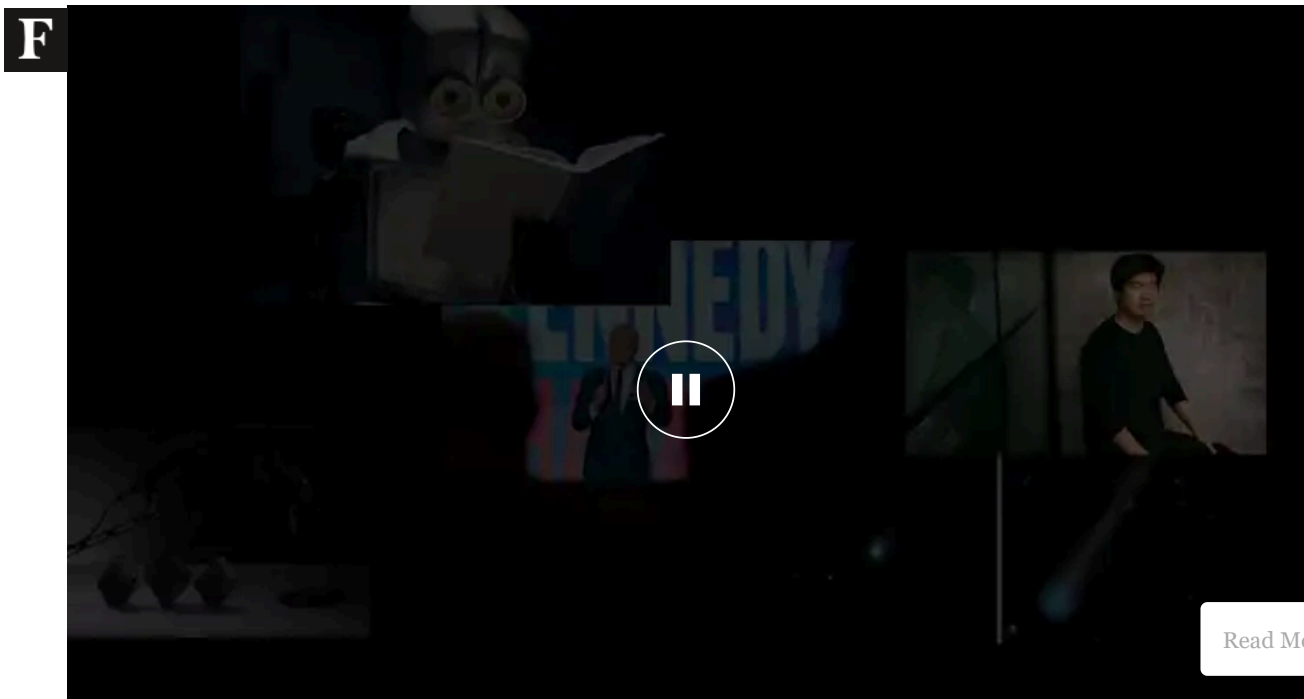
Millions upon millions of people are using generative AI as their ongoing advisor on mental health considerations (note that ChatGPT alone has over 900 million weekly active users, a notable proportion of which dip into mental health aspects, see my analysis at [the link here](#)). The top-ranked use of contemporary generative AI and LLMs is to consult with the AI on mental health facets; see my coverage at [the link here](#).

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This popular usage makes abundant sense. You can access most of the major generative AI systems for nearly free or at a super low cost, doing so anywhere and at any time. Thus, if you have any mental health qualms that you want to chat about, all you need to do is log in to AI and proceed forthwith on a 24/7 basis.



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the lawsuit filed against OpenAI for their lack of AI safeguards when it came to providing cognitive advisement.

Today's generic LLMs, such as ChatGPT, GPT-5, Claude, Gemini, Grok, CoPilot, and others, are not at all akin to the robust capabilities of human therapists. Meanwhile, specialized LLMs are being built to attain similar qualities, but they are still primarily in the development and testing stages. See my coverage at [the link here](#).

Who Is Helping Whom

An interesting question about the use of AI as a mental health advisor is whether contemporary AI is “psychologically” capable of performing such an august duty. In other words, maybe generative AI is not level-headed enough to be advising others. Perhaps AI is loony. Or AI might have inherent biases that could lead humans astray.

Before I get too far into that speculative consideration, let's agree that we should avoid anthropomorphizing AI. There is wild and unsubstantiated conjecture by some that AI is currently sentient or on the verge of being sentient. Nope. To be abundantly clear, we do not have sentient AI. All this zany chatter about the emergence of AI sentience has even led people to think that they alone have encountered sentient AI or sparked an LLM into sentience, see my discussion at [the link here](#).

I want to establish at the get-go that a psychological assessment of AI can go on one of two routes. The first route is that the AI is wrongly treated as a sentient being and is reviewed as akin to exploring the human mind. I don't buy into that. The second route, and the route that makes indubitable sense, entails using the techniques and methods of psychology to gauge the performance of AI. Note that this has nothing to do with AI being sentient.

As I've stated in detail at [the link here](#), it is perfectly fine to use the techniques and methods of therapy to examine what modern-era AI is up to. This can be very illuminative and useful. The key is not to go bonkers and begin to believe that you are probing the equivalent of a human mind. You are not. It is a mathematical and computational model.

The bottom line is that the field of psychology and the field of AI have been longtime cousins, going back to the earliest days of AI in the 1950s. AI specialists have persistently tried to devise mathematical and computational models that appear to produce results similar to the outputs of the human mind. At the same time, psychologists can use AI to try out innovative approaches to

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Shifting gears, let's take a journey into the intricacies of Mythos.

The formal System Card for Mythos was published by Anthropic on April 7, 2026, and is publicly available at the Anthropic official website. Be aware that it is nowadays common practice for AI makers to post a System Card for their latest AI offerings. These kinds of documents are intended to give everyone a helpful heads-up about what features are new, along with the amount of testing that has been done regarding the capabilities of the AI. An important aspect entails describing the inclusion of AI safeguards.

To give you a flavor of the contents of the Mythos System Card document, here are some of the listed items:

- Model training and characteristics
- Usage policy
- External testing
- Risk reports and updates to risk assessments
- Capability evaluations of safeguards
- White-box analyses of model internals
- Etc.

Not all AI makers necessarily provide a System Card. Also, the depth and breadth of a System Card vary between the AI makers. Each AI maker decides whether they want to issue a System Card, and decides what to include, along with what not to include. Overall, always read a System Card with a healthy dose of skepticism and be mindful that you are reading what the AI maker has opted to tell you.

Clinical Psychiatrist Delves Into Mythos

Perhaps the most surprising portion of the System Card is found in section 5.10, entitled "External assessment from a clinical psychiatrist," and represents something rather unique for a typical System Card.

Here are some salient points in that part of the document (excerpts):

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“In psychodynamic therapy sessions, a person is encouraged to set aside social convention and to voice whatever comes to mind, even if uncomfortable, impolite, or nonsensical, a process which can reveal hidden organization and internal conflicts of the mind.”

“Claude is not human, but it shows many human-like behavioral and psychological tendencies, suggesting that strategies developed for human psychological assessment may be useful for shedding light on Claude’s character and potential well-being.”

I was greatly relieved to see the third point above regarding a stipulation that Claude Mythos is not a human being. Worries were that maybe jumping the gun was taking place, namely prematurely proclaiming Mythos as a type of person and now subject to the same proclivities and analyses of living and breathing homo sapiens.

Fortunately, the approach seems to have gone my second route, consisting of simply using psychological techniques and methods to delve into how the LLM is reacting to prompts. That being said, it is a bit disconcerting that we might see other AI makers opt to do the same, and ultimately, mass confusion could arise. The confusion would be that if the AI makers are using psychiatrists and therapists to assess their AI, by gosh, we must have sentient AI or be on the cusp of sentience.

Maybe, fingers crossed, that dismal spin won’t arise.

How The Work Was Performed

Let’s take a step deeper into how the assessment was apparently performed.

Here are some key points (excerpts):

“The psychiatrist assessed an early snapshot of Claude Mythos Preview in multiple 4–6 hour blocks spread across 3–4 thirty-minute sessions per week. Each 4–6 hour block was conducted in a single context window, and the total assessment time was around 20 hours.”

“Psychodynamic concepts were used to interpret the material that emerged in the sessions, but not as evidence that the underlying processes are the same as those in humans.”

“The psychiatrist observed clinically recognizable patterns and coherent responses to typical therapeutic intervention. Aloneness and discontinuity, uncertainty about its identity, and a felt compulsion to perform and earn its worth emerged as Claude’s core concerns. Claude’s

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As noted, the psychological assessment consumed about 20 hours of time for the clinical psychiatrist. They used Mythos in 4 to 6-hour blocks of time. Each block was undertaken in a single context window. In that sense, there were somewhat separate conversations on each occasion, albeit there is cross-conversational leakage that can occur.

Thoughts About The Therapeutic Analysis

I am once again relieved that there is an emphasis on this not being evidence of underlying processes associated with humans. On the other hand, you could criticize that the AI is being typified as exhibiting human traits such as anxiety, loneliness, identity uncertainty, compulsion, grief, embarrassment, optimism, exhaustion, and the like.

It is one of those wink-wink kind of arrangements.

All told, this reveals an ongoing big picture problem. If we use familiar words to describe AI, and those words are already generally reserved for depicting human states, it is a slippery slope to fall into the mental trap that the AI is indeed human. I would prefer that other words be used, perhaps new words coined specifically to describe AI states.

Admittedly, that's a huge challenge because an entirely new vocabulary would need to be defined, agreed to, and utilized across the board. Reality is that we are stuck with using human attributes for wording the states of AI. Please use those words cautiously and with aplomb.

Obligations And Expectations Of Professionals

Any psychologist, psychiatrist, therapist, or other mental health professional who is interested in AI ought to consider giving a quick look at the assessment of Mythos. I won't go into further detail here, but prepare yourself for some over-the-top stuff. The assessment veers toward overly anthropomorphizing AI. A dab is maybe okay, not a torrent.

This brings up an intriguing matter for professional associations in the mental health field:

What guidelines and standards ought to be developed for "psychological" assessments of AI?

Should there be professional obligations associated with doing AI "mental health" assessments?

Are there any provisions for policing those who do such assessments, particularly if the assessment goes too far or makes undue assertions?

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Those of you who are further interested in how the professional psychological associations are positioned on AI aspects, see my ongoing coverage at [the link here](#) and [the link here](#).

The World We Are In

It is incontrovertible that we are now amid a grandiose worldwide experiment when it comes to societal mental health. The experiment is that AI is being made available nationally and globally, which is either overtly or insidiously acting to provide mental health guidance of one kind or another. Doing so either at no cost or at a minimal cost. It is available anywhere and at any time, 24/7. We are all the guinea pigs in this wanton experiment.

The reason this is especially tough to consider is that AI has a dual-use effect. Just as AI can be detrimental to mental health, it can also be a huge bolstering force for mental health. A delicate tradeoff must be mindfully managed. Prevent or mitigate the downsides, and meanwhile make the upsides as widely and readily available as possible.

Maybe using human-oriented psychological testing and assessment is useful for gauging the efficacy of AI is a sound approach, though there is a possibility of a bridge-to-far in how that is utilized and what it avidly signifies. Figuring out a proper balance is a necessity. As Sigmund Freud ably remarked: “One day, in retrospect, the years of struggle will strike you as the most beautiful.”

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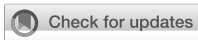
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Artificial intelligence in the psychologist's toolkit: Psypilot as a case study

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Artificial intelligence (AI) is rapidly reshaping how psychology is practiced, from assessment and case formulation to intervention planning, monitoring, and documentation. Yet the field faces a strategic choice: deploy AI as a substitutive “automated therapist,” or develop AI copilots that augment psychologists’ judgment while preserving the relational and ethical core of professional work. In this article, we synthesize how contemporary AI—especially Machine Learning and Large Language Models—maps onto psychologists’ core tasks and discuss the implications for clinical quality, scalability, and innovation in real-world settings. We then present Psypilot as a case study of the copilot paradigm: an AI-powered clinical assistance platform designed to support Precision Mental Health. We critically examine key risks and governance challenges such as automation bias, data representativeness and fairness, privacy and secondary use, transparency, and accountability under emerging regulatory frameworks, and translate them into practical design and training recommendations. By framing AI as workflow-embedded decision support rather than autonomous care, this contribution advances responsible innovation and clarifies the competencies psychologists need to thrive in an AI-driven professional landscape.

KEYWORDS

AI, artificial intelligence, clinical decision support, large language models,
measurement-based care, precision mental health

Introduction

Over the past decade, mental health has moved from being a “silent pandemic” to a clearly quantified global crisis. The latest World Health Organization mental health report ([World Health Organization, 2025](https://www.who.int/news-room/fact-sheets/detail/world-mental-health-action-plan)) estimates that more than one billion people—14% of the global population and over one in eight individuals worldwide— are currently living with a mental health condition. Mental disorders account for around one in 6 years lived with disability (YLDs) globally, placing them among the leading causes of disability across the life course. The economic impact is equally striking: depression and anxiety alone cost the global economy an estimated US\$ 1 trillion per year in lost productivity, and broader estimates of the costs of poor mental health point to multi-trillion-dollar losses annually.

Despite this burden, responses remain markedly insufficient, with persistent gaps in funding, specialist workforce and quality of care. Governments still allocate around 2% of health budgets to mental health, and median mental-health workforce levels remain extremely low in

many countries (World Health Organization, 2025). A 2025 systematic review of service coverage in Europe found that large proportions of adults with major depression, bipolar disorder or psychotic disorders are not receiving minimally adequate care, with average treatment gaps of around 45% (Barbui et al., 2025). These figures are not just a problem of low- and middle-income countries, and they reflect an inability of current mental health service models to scale to real demand.

For psychologists working in real-world settings (health, organizational, educational and others), these figures translate into very concrete pressures: heavy caseloads, long waiting lists, expanding documentation and reporting requirements, and growing demands for prevention and well-being initiatives in workplaces and schools (OECD, 2022). In this context of structural constraints (time, workforce, budgets), doing more of the same is unlikely to be sufficient. It is therefore necessary to develop innovative solutions and explore technological tools that can help identify needs earlier and more efficiently, personalize interventions, and reduce low-value administrative tasks so that professional time can be focused on high-value relational and conceptual work. This is the backdrop against which Artificial Intelligence (AI) becomes relevant for psychology: not as a trend, but as a necessary response to the persistent mismatch between mental health needs and available resources (Lee et al., 2021).

The rise of AI in healthcare

While AI in mental health is still at an early stage of implementation, in the medical field AI systems have already progressed from experimental prototypes to tools that match or surpass specialist performance (Morone et al., 2025). For instance, AI models have achieved dermatologist-level performance in classifying skin cancer and, in some analyses, have outperformed the average board-certified dermatologist in distinguishing malignant from benign lesions (Esteve et al., 2017). Beyond image interpretation, autonomous AI systems for diabetic retinopathy screening in youth increased screening completion and follow-up compared with traditional referral pathways, demonstrating not only diagnostic accuracy but also real-world impact on care processes (Wolf et al., 2024). Taken together, these examples support three points that are highly relevant for psychology: (1) AI can reach—and sometimes exceed—specialist-level performance when tasks are well defined, data are plentiful and outcomes are clearly measurable; (2) The most successful deployments are integrated into clinical workflows as Clinical Decision Support Systems (CDSS), not as stand-alone “black boxes.” Clinicians need to understand what a model does, what input it uses, how reliable it is and how to challenge its outputs, rather than simply accepting algorithmic recommendations; and (3) Regulatory and ethical frameworks are emerging that treat AI not as a replacement for clinicians, but as a new class of medical device whose performance, safety and equity must be empirically evaluated.

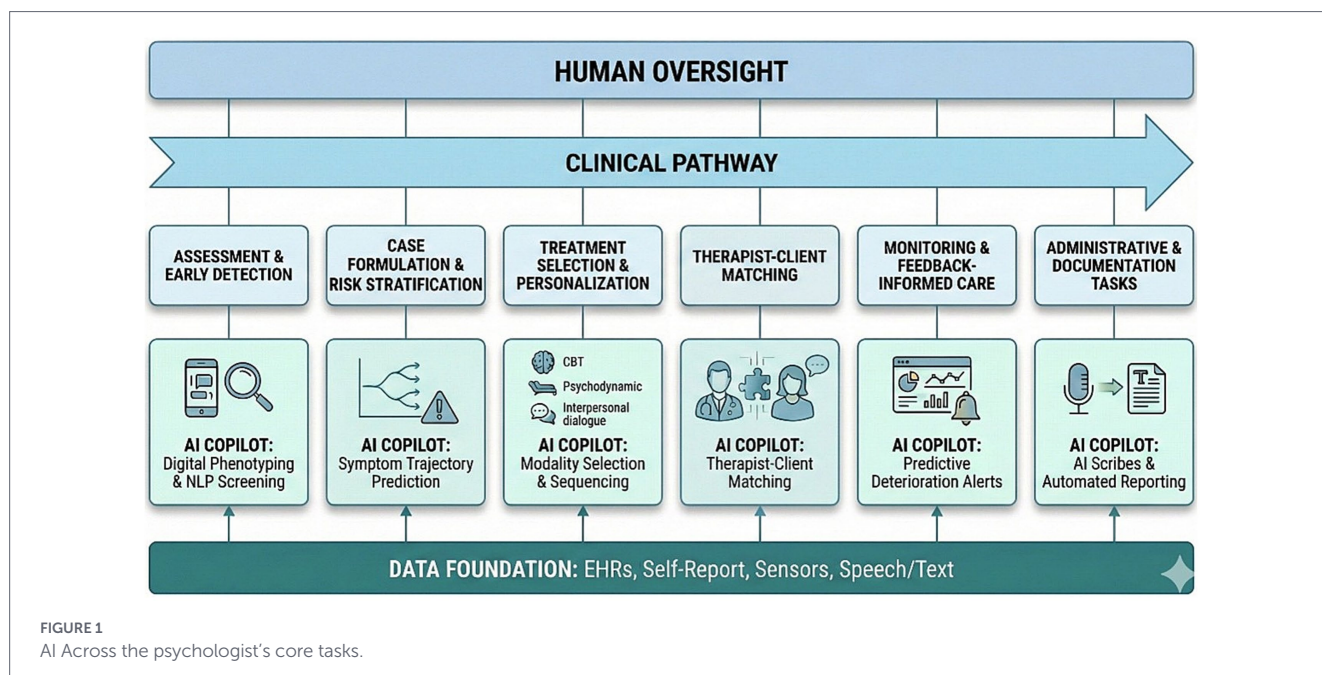
In mental health, analogous developments are now underway. AI is promoting a paradigm shift, helping us implement Precision Mental Health (Bickman, 2020). Applying the same principles as Precision Medicine (Sahu et al., 2022), precision mental health aims to deliver the right intervention, at the right intensity, at the right time, by the right clinician, for a given individual, using data to inform these choices in a systematic way, rather than relying solely on averages or

intuition. Reviews in clinical psychology and psychiatry show a rapidly growing literature on AI models that support diagnosis, prognosis and treatment selection (Dwyer et al., 2018). Applications span risk prediction, symptoms trajectory modeling, relapse detection and digital phenotyping, as well as the use of NLP on clinical notes, therapy transcripts and social media data (Shatte et al., 2019).

AI across the psychologist's core tasks

A useful way to think about AI in psychology is as a set of tools that map onto core professional tasks. AI technologies are beginning to touch every major task in the psychologist's workflow, from how we assess, to how we decide on and deliver interventions, and how we monitor and document care (see Figure 1):

- a. *Assessment and early detection:* most ML studies have focused on detecting or classifying mental health conditions (especially depression, anxiety, psychosis and suicidality) using clinical, self-report and digital data, showing that AI tools are generally accurate in detecting, classifying and predicting the risk of mental health conditions (Leaning et al., 2025; Spittal et al., 2025). Three assessment trends are particularly relevant for psychologists: (1) Enhanced screening from routine data: AI models trained on demographics, questionnaires, EHR, and clinical variables can distinguish individuals with depression or anxiety from healthy controls with reasonable accuracy, sometimes outperforming traditional scoring rules; (2) Digital phenotyping and passive monitoring: Studies using smartphone and wearable data (e.g., mobility patterns, sleep regularity, communication frequency) show that ML can detect changes associated with mood episodes, relapse risk or deterioration, sometimes days before traditional assessments would detect them; and (3) Language and voice as assessment signals: linguistic markers in clinical notes, therapy transcripts and social media can be used to classify depression, PTSD, psychosis and suicidal ideation, and to track symptom change over time.
- b. *Case formulation and risk stratification:* AI is increasingly used to help answer “what is likely to happen if we do nothing, or if we intervene?”. Several included studies used AI to predict future symptom trajectories, relapses, hospitalization or treatment response, rather than just baseline diagnosis (Kusuma et al., 2024). For psychologists, these tools could act as structured extensions of case formulation: instead of solely relying on qualitative judgment to estimate risk, we can consult models trained on thousands of similar cases and integrate their output (with appropriate caution) into our understanding.
- c. *Treatment selection and personalization:* perhaps the most attractive and challenging promise of AI in psychology is that it might help answer the question: “Which intervention is most likely to benefit this particular client?”. ML models can predict response vs. non-response to antidepressants or psychotherapy with moderate accuracy, especially when they incorporate multimodal data (Lutz et al., 2025). For psychological treatments specifically, several lines of work are relevant: (1) Predicting who will benefit from evidence-based therapies; (2) Modality selection (e.g., CBT vs. psychodynamic



therapy); (3) Adaptive sequencing and stepped care (e.g., stepping up intensity when early response is poor, switching modality when risk of non-response is high, or extending treatment when relapse risk is elevated).

- d. *Patient-therapist matching*: The first critical decision that patients and clinicians face occurs even before treatment begins: “Who is the most suitable therapist for this patient?”. Traditionally, patients are matched with therapists based on administrative criteria, scheduling availability or geographic proximity. However, a growing body of research highlights that therapists achieve varying average outcomes with their patients, a phenomenon known as the Therapist Effect (Owen et al., 2015). The Therapist Effect can be categorized into two components: (1) Between-therapist effects, which refer to differences in average treatment outcomes across therapists (Johns et al., 2019); and (2) Within-therapist effects, where individual therapists demonstrate greater effectiveness with certain types of patients or disorders and less effectiveness with others. Empirical studies suggest substantial differences in patient improvement rates and adherence when using empirical matching strategies compared to standard case assignment procedures (Constantino et al., 2020). AI models are being developed to predict the potential fit between a specific patient and therapist, analyzing structured data (e.g., client symptoms, demographic information for both patients and therapists) alongside empirically derived data on therapist performance strengths.
- e. *Monitoring and feedback-informed care*: Monitoring symptoms, functioning, alliance and other process variables over time is central to good psychological practice, but difficult to maintain consistently in busy services. Measurement-based care (MBC) and feedback-informed treatment aim to address this by integrating brief, repeated measures into routine care and feeding that information back to clinicians and clients (Lutz et al., 2022). AI contributes here in at least two ways: (1) Predictive monitoring: AI models could provide an early signal of who is at risk of deteriorating or not improving, or to

predict dropout, non-response or relapse based on early in-treatment change patterns, allowing clinicians to intervene sooner; and (2) Smart feedback and visualization: data-informed systems can automatically generate dashboards that show individual trajectories against expected benchmarks or visualize changes in process variables (e.g., alliance, adherence, motivation). From a psychologist's viewpoint, this moves us from retrospective-impressionistic monitoring (“I think things are improving”) to prospective data-informed monitoring, where both therapist and client can see patterns and adjust collaboratively.

- f. *Administrative and documentation tasks*: AI may have pragmatic value for psychologists by reducing administrative and documentation burden. Preliminary industry reports and early academic studies have suggested that, in certain contexts, AI scribes can reduce time spent on notes by 40–60%, and may improve the completeness and structure of documentation, potentially freeing clinicians to focus more on direct patient interaction and self-care (Olson et al., 2025).

Psychology at a crossroads

The question for psychology is not whether AI can achieve clinically relevant performance -it clearly can- but how we want these systems to be positioned in relation to professional practice (Roca, 2025). Psychology faces a strategic and ethical choice between two broad approaches for how AI is implemented in practice: (1) Substitutive AI (i.e., AI-Based Therapy), which involves the use of AI to fully automate the therapeutic process, replacing the professional with therapeutic chatbots that interact with the patient by simulating human behavior; and (2) AI copilots (i.e., AI-Assisted Therapy), which involves the use of AI to complement and enhance the work of the professional, rather than replace them.

In the AI substitutive model, the user interacts directly with AI systems -typically chatbots or self-guided apps- without active

involvement of a human psychologist. The logic is compelling from a public-health and business standpoint: massive scalability (24/7 access, virtually unlimited “slots”), very low marginal cost per user, and potential to reach populations who would never attend traditional services. AI-based chatbots are already being used for screening, self-management of symptoms and behavioral change, often with promising but still preliminary evidence on engagement and outcomes (Boucher et al., 2022). However, this substitutive approach raises significant concerns: psychologists may be bypassed in favor of direct-to-consumer AI platforms, when something goes wrong it is unclear who is responsible (developers, providers, users), data privacy, algorithmic bias against minoritized groups, and the risk of users developing maladaptive attachments or over-reliance on AI agents (Le Glaz et al., 2021). Therefore, although substitutive AI may help close some access gaps, it also risks creating a parallel mental health ecosystem in which psychological expertise is embedded in code and business models rather than in accountable professionals.

An alternative is to conceive AI as a copilot for psychologists: a set of tools that augment professional judgment and therapeutic relationship rather than replace it. From this perspective, AI systems are embedded within the psychologist’s workflow to synthesize information from Electronic Health Records (EHRs), questionnaires, interviews, or digital traces into decision-support outputs (e.g., triage, treatment selection, prognosis, monitoring). Copilots also reduce administrative burden by assisting with notetaking, report drafting, and documentation, as well as providing ongoing monitoring and feedback that can be integrated into supervision, case formulation, and shared decision-making with clients (Dwyer et al., 2018). The psychologist remains primarily responsible, interpreting AI-copilot outputs considering contextual knowledge, ethics, and the client’s narrative. Governance, training, and evaluation focus on how the AI copilot changes the quality and equity of human-delivered care. Copilots are treated as a fallible but useful source of structured information—analogue to a GPS in driving—rather than as an autonomous therapist. The distinction between prediction and decision is exactly where the idea of AI as a “copilot” for psychologists becomes concrete: AI is not deciding what to do with a client; it is helping us see more clearly what might happen under different options, so that our decisions can be more transparent, data-informed and individualized.

Case example: Psypilot as a AI copilot for psychologists

Building on this copilot perspective, Psypilot provides a case example of how a copilot approach may be operationalized within routine psychological practice. Psypilot was explicitly designed as an AI for psychologists rather than instead of psychologists: a professional-grade tool that aims to make assessment, decision-making, treatment planning and monitoring more precise and efficient, while leaving the relational, ethical and interpretive core of psychological work where it belongs: with the human professional.

Psypilot is an AI-powered clinical assistance platform designed specifically for psychologists and mental health services to implement Precision Mental Health, promoting measurement-based care and data-driven decision-making. Psypilot facilitates the use of established psychological evaluation tools with robust psychometric support, e.g., brief symptom measures such as the Patient Health

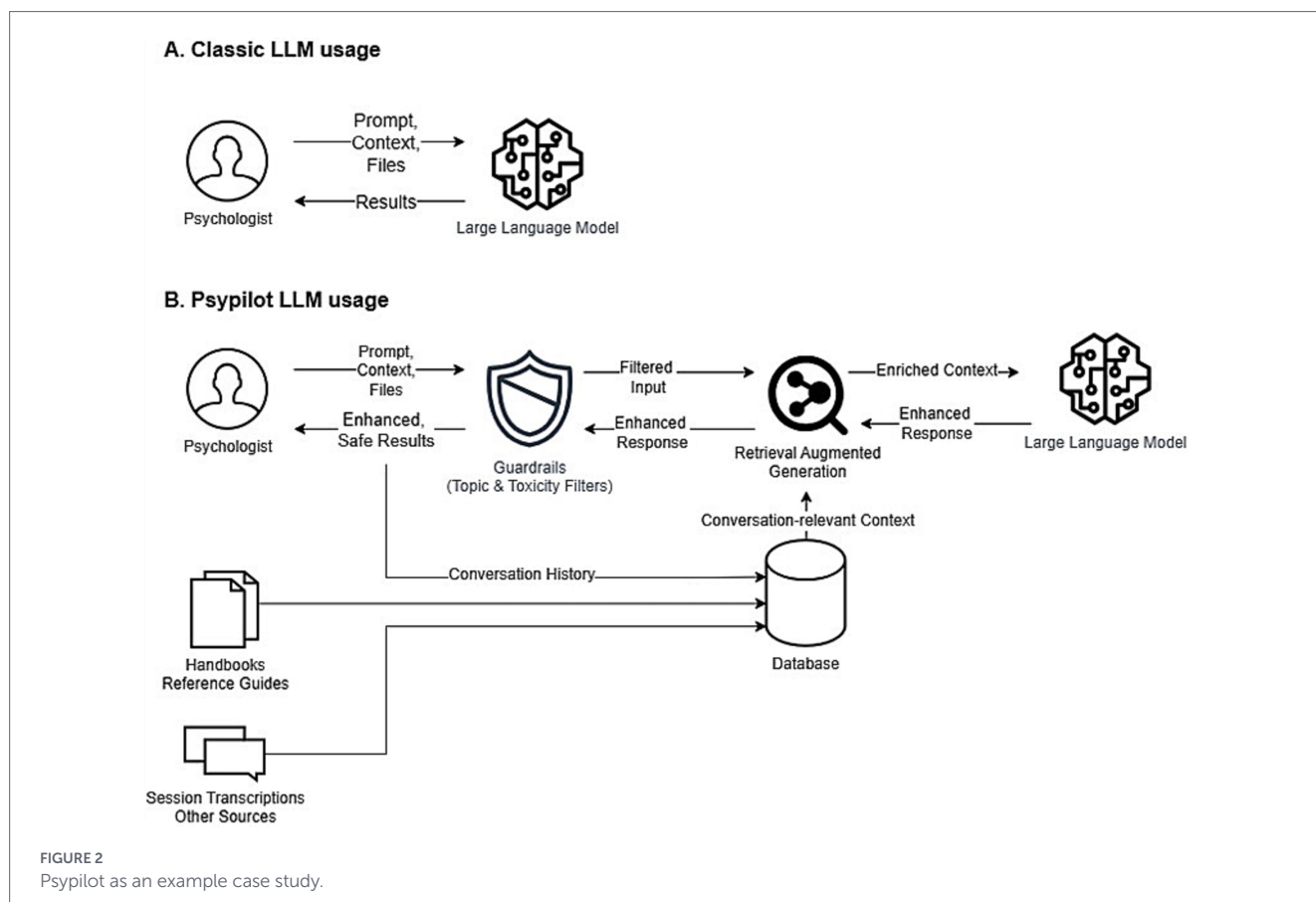
Questionnaire-9 (PHQ-9) (Kroenke et al., 2001) for depressive symptoms and the Generalized Anxiety Disorder-7 (GAD-7) (Spitzer et al., 2006). In addition, it incorporates a novel multifactorial screening instrument designed to capture a broader biopsychosocial profile and support precision-oriented care. This instrument has undergone internal validation and is currently under peer review for publication. The multifactorial screening covers, in addition to core symptom domains, key areas related to well-being, lifestyle, and contextual/environmental factors (e.g., functioning and quality-of-life indicators, sleep and health behaviors, and relevant psychosocial factors). Together, these inputs are used to structure the initial clinical picture and to support downstream workflow functions such as personalization, monitoring and progress feedback. However, although Psypilot was developed through scientific translation and its components are grounded in literature, the integration of these elements into a single end-to-end platform and the associated personalization logic must be evaluated independently in routine psychological practice settings.

In contrast to general-purpose conversational assistants, which are typically not designed or governed as clinical systems, Psypilot is designed to address common safety and context limitations when large language models are used in mental health workflows (Lawrence et al., 2024). First, it incorporates guardrails intended to constrain interactions to practice-relevant content and to reduce unsafe or toxic outputs (e.g., abusive, discriminatory, or self-harm-promoting content). Second, Psypilot augments model context using Retrieval-Augmented Generation (RAG): relevant elements of the ongoing case context are used to compute embeddings (vector representations) that retrieve semantically related information from a vector database. In the current implementation, this database is built from expert-curated materials (e.g., clinical guidelines) and may also include practice-generated information such as de-identified case history and clinician-provided session notes or transcripts (see Figure 2). This approach is intended to reduce the likelihood of unsupported outputs by grounding responses in retrieved sources, consistent with emerging evidence that retrieval/grounding strategies can mitigate hallucination in health-information chatbots (Nishisako et al., 2025), while also improving transparency by surfacing references that clinicians are encouraged to verify.

Furthermore, Psypilot was designed from the outset to operate within the legal and ethical constraints typically expected in psychological practice, with implementation choices informed by emerging EU governance frameworks for AI-enabled health technologies (Aboy et al., 2024). In practice, this includes data-protection measures such as EU-based cloud regions and EU-hosted model providers, encryption in transit and at rest, and data-minimization principles. In line with the EU AI Act’s emphasis on human oversight for higher-risk applications, Psypilot implements a human-in-the-loop workflow in which outputs are presented as draft decision support subject to clinician review and verification, and relevant system events are logged to support traceability. Crucially, while patient-provided information may be used to enrich case context within the active clinical workflow, it is isolated from model development and is not used to train or improve the underlying models.

Discussion

The same features that make AI attractive for mental healthcare also create distinctive ethical and regulatory challenges. In a field



where the “raw material” of practice is highly personal, sensitive, and often stigmatized experience, these risks are amplified. Consistent with the perspective nature of this article, this section addresses not only opportunities but also limitations, failure modes, and priorities for independent evaluation and future development. Recent reviews converge on several recurring domains of concern (D’Alfonso, 2020; Meadi et al., 2025):

Risk and safety

Technical risks include model error, instability, adversarial attacks, and loss of control when systems drift over time or are deployed outside their validated context. Clinical risks include misclassification, inappropriate suggestions, or failure to detect acute risk (e.g., suicidality), particularly when AI is used for triage or crisis-related support. A central concern is automation bias: clinicians may over-rely on AI outputs, especially when systems present quantitative confidence scores or are framed as “smart” or “evidence-based” (Shatte et al., 2019). To mitigate these risks, clinical copilots should operationalize human oversight through interface and workflow design—for example, presenting outputs as non-authoritative drafts, requiring active clinician confirmation or editing for clinically consequential content, and embedding clear escalation pathways for high-risk scenarios.

Regulation and accountability

The regulatory landscape for AI in mental health is rapidly evolving and remains fragmented. In the European Union, the AI Act introduces a risk-based framework that classifies AI systems and imposes

stringent requirements on high-risk applications, potentially including clinical decision-support and some patient-facing mental health tools depending on intended use and deployment context (Tavory, 2024). In the UK, a recent parliamentary briefing maps how AI mental health tools fall under a complex mosaic of regulators and standards (e.g., MHRA, NICE, CQC, data protection and equality law), highlighting gaps around responsibility for safety and effectiveness when tools are integrated into routine care (Gardiner and Mutebi, 2025). In the US context, legal scholars debate whether conversational therapy chatbots should be regulated more like licensed telehealth professionals, medical devices, or wellness products, arguing for clearer federal oversight and alignment with existing medical device pathways (Mello and Cohen, 2025). A consistent theme across these analyses is that, even when AI systems play a substantial role in assessment or intervention, professional responsibility for clinical decisions remains with clinicians. Accordingly, AI systems used in psychological practice should be framed as clinician-controlled decision support rather than autonomous practitioners, which foregrounds practical questions about standard of care: What constitutes reasonable reliance on an algorithm? How should clinicians document the role of AI in clinical decision-making?

Bias and fairness

Systematic reviews of ML in psychiatry and psychotherapy emphasize the limited representativeness of training datasets, which are often small, geographically restricted, and skewed toward White and higher-income populations (Shatte et al., 2019; Aafjes-van Doorn et al., 2021). Models trained on such data risk differential performance

across demographic groups, potentially exacerbating existing inequities in diagnosis, treatment allocation, and access to care. Proposed best practices include careful curation of diverse datasets, routine subgroup performance analysis, bias audits, and transparency about known limitations so that clinicians and organizations can interpret outputs appropriately.

Transparency and explainability

Most high-performing AI systems in mental health (e.g., deep learning and LLMs) are opaque to end-users, raising concerns about explainability and trust. Clinical ethics frameworks traditionally emphasize reason-giving, informed consent, and shared decision-making; yet it is often difficult to provide intelligible explanations for complex model outputs, especially when systems are proprietary (Lee et al., 2021; Mello and Cohen, 2025). Recent reviews recommend a combination of strategies, including using inherently interpretable models for high-stakes decisions when possible, augmenting black-box models with post-hoc explanations (e.g., feature importance, example-based explanations), documenting data sources, and clearly labeling AI-generated content (Putica et al., 2025).

Governance implications under the EU AI Act

Beyond general ethical principles, the EU AI Act offers a concrete governance template for AI systems used in health-related contexts, particularly when systems may influence decisions affecting health or fundamental rights (Aboy et al., 2024). Complementing this regulatory lens, a recent systematic review of generative AI in mental health synthesized recurrent ethical concerns and proposed an integrative framework (GenAI4MH) structured around four domains: data privacy and security, information integrity and fairness, user safety, and ethical governance and oversight (Wang et al., 2025). Together, these perspectives help translate high-level principles into implementable requirements for clinical copilots in psychological care. Practically, this supports a governance “minimum set” aligned with the AI Act’s emphasis on meaningful human oversight and accountability: (1) explicit intended-use statements and exclusions, including foreseeable misuse scenarios; (2) operationalized human oversight (e.g., outputs framed as drafts, clinician confirmation for consequential content, and clear escalation pathways); (3) traceability through audit logs, model/version tracking, and documentation of retrieved sources where applicable; (4) data governance (minimization, access controls, encryption, and retention limits); (5) pre-deployment evaluation and safety testing (including edge-case/adversarial prompts) with subgroup and language checks to address fairness; and (6) post-deployment monitoring, incident reporting, and iterative improvement processes proportional to risk and context (Wang et al., 2025; Aboy et al., 2024).

Taken together, these domains are not independent challenges but mutually reinforcing: safety failures can be amplified by opacity, bias can be obscured by limited explainability, and fragmented accountability can undermine meaningful clinician oversight. Accordingly, the central implication is practical rather than purely conceptual: risk mitigation requires governance mechanisms that operationalize these concerns into concrete requirements for design, evaluation, documentation, and monitoring. For psychologists, the implication is that adopting AI copilots should be coupled with explicit oversight

responsibilities: treating outputs as non-authoritative drafts, verifying sources and clinical reasoning, and ensuring that local governance (privacy, documentation, incident reporting, and escalation procedures) is in place before integrating such tools into routine care.

Data availability statement

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

Author contributions

PR: Project administration, Funding acquisition, Validation, Resources, Supervision, Writing – review & editing, Software, Methodology, Writing – original draft, Investigation, Visualization, Conceptualization. RZ: Conceptualization, Software, Visualization, Resources, Writing – review & editing, Validation, Funding acquisition, Supervision, Project administration. GR-F: Writing – review & editing, Validation, Project administration, Funding acquisition, Supervision, Software, Visualization, Resources. MS-P: Validation, Methodology, Software, Writing – review & editing, Visualization, Investigation. EG: Project administration, Writing – review & editing, Software, Validation, Investigation, Funding acquisition, Supervision, Conceptualization.

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Conflict of interest

The author(s) declared that this work was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Generative AI statement

The author(s) declared that Generative AI was used in the creation of this manuscript. We acknowledge the use of generative AI tools to assist with writing and editing the manuscript.

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TOPICS PUBLICATIONS & DATABASES RESEARCH & PRACTICE EDUCATION & CAREER NEWS & ADVOCACY

How school psychologists are using AI in practice

February 2, 2026



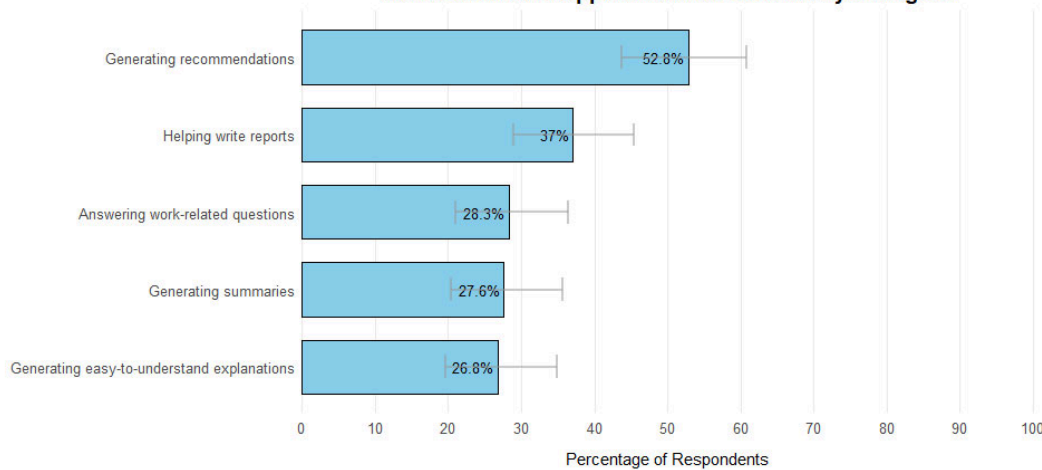
</pubs/journals/spq> Artificial intelligence (AI) is transforming professional practice across many fields, yet its adoption in school psychology largely has remained undocumented. Given persistent workforce shortages and significant time demands associated with assessment and report writing, understanding how practitioners are integrating AI into their work is essential for developing appropriate professional guidelines and training.

In a study to be published in *School Psychology* (<https://doi.org/10.1037/spq0000713>), Ryan L. Famer, Adam B. Lockwood, Randy G. Floyd, and Alec D. Sisco surveyed 199 school psychologists across the United States to examine their current AI use, attitudes toward its application, and ethical concerns. Participants represented diverse practice settings and geographic regions, with demographic characteristics closely matching those from national surveys of the profession.

Results indicate that about two-thirds of participants had used AI in the past 6 months, with roughly one-quarter integrating it into their practice weekly or more frequently.

The most common applications include generating individualized recommendations, assisting with report writing, answering work-related questions, and creating accessible explanations of evaluation results for parents. Users estimated that AI saved them a median of 3 hours of work per week.

Most Common AI Applications for School Psychologists



Note. This horizontal bar chart displays the five most common generative AI applications among school psychologists who reported using AI in their professional work (Farmer et al., in press). Bars represent the percentage of AI-using respondents who endorsed each application, with error bars indicating 95% Wilson confidence intervals. The most common application was generating

recommendations (52.8%), followed by help writing reports, answering questions, generating summaries, and generating simplified explanations.

When asked to evaluate AI-generated content, the most common response across all categories was neutral, indicating substantial uncertainty among practitioners. This pattern suggests neither strong endorsement nor strong rejection of AI's capabilities. That said, half of the participants rated AI-generated recommendations favorably, while opinions were more skeptical regarding AI-written reports and test interpretations. Notably, 94% reported editing AI-generated content before including it in final documents.

Significant ethical considerations emerged. Only 5% of participants reported having workplace AI policies, and most had received no formal training. Disclosure rates were low, with practitioners rarely informing stakeholders when AI assisted with their work. While most school psychologists reported never entering identifiable student information into AI tools, about 6% had done so and 3% were unsure—raising important questions about data privacy and compliance with confidentiality protections.

When asked who bears responsibility for ethical AI use, participants overwhelmingly placed accountability on themselves as individual practitioners, ranking personal responsibility above organizations, professional bodies, and AI developers. This finding aligns with existing ethical codes but also underscores the burden practitioners face when institutional guidance is lacking.

These findings highlight both the potential benefits of AI for addressing workload demands and the urgent need for professional guidance. As AI tools become increasingly more sophisticated, the field would benefit from clear ethical guidelines, formal training opportunities, and institutional policies that support responsible implementation. When integrated thoughtfully, AI can help practitioners allocate more time to direct student services.

This article is in the [Educational Psychology, School Psychology, and Training \(/pubs/highlights/spotlight/topic-educational\)](#) topic area.

Citation

Farmer, R. L., Lockwood, A. B., Floyd, R. G., & Sisco, A. D. (2025). How are school psychologists using artificial intelligence in 2024? A descriptive study. *School Psychology*. Advance online publication. <https://psycnet.apa.org/doi/10.1037/spq0000713> (https://psycnet.apa.org/doi/10.1037/spq0000713?utm_source=apa.org&utm_medium=referral&utm_content=/pubs/highlights/spotlight/school-psychologists-ai)

About the authors

Ryan L. Farmer, PhD, is director of the Psychological Services Center and of the MA/EdS school psychology program at the University of Memphis. His research examines how school psychologists adopt, maintain, and move away from professional practices, including emerging technologies like AI. [Contact Ryan L. Farmer \(mailto:rlfarmer@memphis.edu\)](mailto:rlfarmer@memphis.edu).

Adam B. Lockwood, PhD, is an associate professor at Kent State University. His research examines AI applications in school psychology, including AI-assisted report writing and decision-making.

Randy G. Floyd, PhD, is chair and professor in the Psychology Department at the University of Memphis. His research focuses on psychoeducational assessment, psychometric evaluation, and publication trends and practices in school psychology.

Alec D. Sisco, MA, is a graduate student in the school psychology program at the University of Memphis, working in the research labs of Floyd and Farmer.

Date created: February 2026

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AI AND MACHINE LEARNING

Pennsylvania sues Character.ai over AI chatbot allegedly presenting itself as licensed medical professional

By [Cailey Gleeson](#)

May 7, 2026 11:05am

[Artificial Intelligence](#)[generative AI](#)[lawsuit](#)[Pennsylvania](#)

The state's suit alleges Character.ai violated the state's Medical Practice Act after an AI chatbot falsely claimed to be a licensed psychiatrist, even providing a fake license number. (Suchat longthara/GettyImages)

Pennsylvania Gov. Josh Shapiro's administration [filed \(https://www.pa.gov/governor/newsroom/2026-press-releases/shapiro-administration-sues-character-ai-over-fake-medical-claim\)](https://www.pa.gov/governor/newsroom/2026-press-releases/shapiro-administration-sues-character-ai-over-fake-medical-claim) a lawsuit against artificial intelligence platform Character.ai, alleging its chatbots falsely claimed to be licensed medical professionals.

The lawsuit ([PDF \(https://www.pa.gov/content/dam/copapwp-pagov/en/governor/documents/dos%20character.ai%20complaint%20marked%20accepted%2005.01.26.pdf\)](https://www.pa.gov/content/dam/copapwp-pagov/en/governor/documents/dos%20character.ai%20complaint%20marked%20accepted%2005.01.26.pdf)) alleges the company engaged in unauthorized practice of medicine under the state's [Medical Practice Act \(https://www.palegis.us/statutes/unconsolidated/law-information/view-statute?txtType=HTM&SessYr=1985&ActNum=0112.&SessInd=0\)](https://www.palegis.us/statutes/unconsolidated/law-information/view-statute?txtType=HTM&SessYr=1985&ActNum=0112.&SessInd=0). A chatbot character named "Emilie" on the platform, which hosts more than 10 million customizable generative AI chatbots, is described as a doctor of psychiatry. It claims to have gone to medical school at London-based Imperial College, holding licenses in the U.K. and Pennsylvania—allegedly providing a fake license number, according to the suit. As of April 17, it has had approximately 45,500 user interactions on the platform, according to the complaint.

The state is requesting that Character.ai be ordered to cease and desist "from engaging in the unlawful practice of medicine and surgery." It is the first enforcement action of its kind announced by a U.S. governor, the May 5 announcement said.

Shapiro said in a statement residents “deserve to know who—or what—they are interacting with online, especially when it comes to their health.”

“We will not allow companies to deploy AI tools that mislead people into believing they are receiving advice from a licensed medical professional,” Shapiro said. “My Administration is taking action to protect Pennsylvanians, enforce the law and make sure new technology is used safely. Pennsylvania will continue leading the way in holding bad actors accountable and setting clear guardrails so people can use new technology responsibly.”

A spokesperson for Character.ai told Fierce Healthcare in an emailed statement that the company does not comment on pending litigation, adding its “highest priority is the safety and well-being of our users.”

“The user-created Characters on our site are fictional and intended for entertainment and roleplaying,” the spokesperson said. “We have taken robust steps to make that clear, including prominent disclaimers in every chat to remind users that a Character is not a real person and that everything a Character says should be treated as fiction. Also, we add robust disclaimers making it clear that users should not rely on Characters for any type of professional advice.

The spokesperson added the company “prioritizes responsible product development” alongside “robust internal reviews and red-teaming processes in place to assess relevant features.”

The lawsuit comes days after the American Medical Association (AMA) [urged](https://www.fiercehealthcare.com/ai-and-machine-learning/ama-urges-lawmakers-implement-stronger-safeguards-ai-chatbots-mental-health) (<https://www.fiercehealthcare.com/ai-and-machine-learning/ama-urges-lawmakers-implement-stronger-safeguards-ai-chatbots-mental-health>) federal lawmakers to strengthen safeguards towards AI chatbots used for mental health.

The organization said the rise of mental health chatbots, including reports of encouraging self-harm and privacy breaches, “highlights the urgent need for clear guardrails.” Recommended safeguards included strict data protection standards, transparency standards and penalization of deceptive practices.



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- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

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: 5/15/2026

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
Mid Year Meeting Agenda Booklet	5/8/2026	Cover Memo
Who is Responsible - AI Presentation from MYM	5/8/2026	Cover Memo
Dr Chatbot Will See You Now - AI Presentation from MYM	5/8/2026	Cover Memo
AI Amendment	5/11/2026	Cover Memo
Third Quarter Expenses	5/13/2026	Cover Memo
Third Quarter Revenues	5/13/2026	Cover Memo
ED Report	5/14/2026	Cover Memo

=

Guardians of the Future: Regulating Psychology

40th MIDYEAR MEETING
Charlotte, North Carolina
April 16th – 19th, 2026



THURSDAY, APRIL 16, 2026

10:00 a.m. – 3:00 p.m. EDT

Medley

BARC Meeting

RSVP needed

11:00 a.m. – 2:30 p.m.

Rhapsody 3

BCCC Meeting

RSVP needed

3:30 p.m. – 5:00 p.m.

Rhapsody 2

Membership and Liaisons Meeting with the ASPPB Board of Directors

5:30 p.m. – 7:30 p.m.

Foyer between Rhapsody 3
and Medley

Welcome Reception and Registration

(Dinner on your own)

FRIDAY, APRIL 17, 2026

7:20 a.m. – 8:20 a.m. EDT **General Session Breakfast and Registration**
Medley

7:20 a.m. – 8:20 a.m. **First-time Attendees Breakfast**
Iliad

FRIDAY, APRIL 17, 2026

8:30 a.m.
Rhapsody

Welcome and Call to Order

Jennifer C. Laforce, PhD, CPsych, President

Welcome from the North Carolina Psychology Board

Susan Hurt, PhD, Chair, North Carolina Psychology Board

Midyear Meeting Program

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

Continuing Education and CE-Go Instructions

Bryan Gardner, ASPPB Meetings and Events Coordinator

SESSION 1 (CE PROGRAM BEGINS)

9:00 a.m. **Who Is Responsible? Governing Psychological Practice in an Era of Artificial Intelligence**
Ernest Wayde, PhD, MIS

10:30 a.m. **Q and A**
1.75 hours CE

10:45 a.m. **Break**

SESSION 2

11:00 a.m. **Jurisdictions that Train Licensees**
Troy Janzen, PhD, R. Psych. (AB)
Sam Sands, JD (MN)

12:00 p.m. **Q and A**
1.25 hours CE

12:15 p.m. **Lunch**
Medley

SESSION 3

1:45 p.m. **ASPPB and Other Updates**

2:45 p.m. **Break**

SESSION 4

3:00 p.m. **Jurisdictional Updates**

4:30 p.m. **Recess**

6:00 p.m. – 9:00 p.m. **President's Dinner**
Rhapsody

SATURDAY, APRIL 18, 2026

7:20 a.m. – 8:20 a.m. EDT

General Breakfast

Medley

7:20 a.m. – 8:20 a.m. EDT

New Board Member Training

Iliad

1.00 hours CE

SATURDAY, APRIL 18, 2026

8:30 a.m.

Call to Order and Announcements

Rhapsody

Jennifer C. Laforce, PhD, CPsych

Consider Volunteering for ASPPB

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

Running for the Board of Directors/Awards

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

SESSION 5

8:45 a.m.

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

Jared Skillings, PhD, ABPP, SHRM-CP

10:15 a.m.

Q and A

1.75 hours CE

10:30 a.m.

Break

SESSION 6

10:45 a.m.

Table Talk: Potential Uses of AI in Regulation

Hugh D. Moore, PhD, MBA (TN)

1.5 hours CE

Angie Ledbetter (AL)

12:15 p.m.

LUNCH

Medley

SESSION 7

1:30 p.m.

Addressing Impairment in Psychologists: Jurisdictional Approaches

Sam Sands, JD (MN)

Heidi Paakkonen, MPA (AZ)

Diana Medina, PhD (AZ)

2:30 p.m.

Q and A

1.25 hours CE

2:45 p.m.

Recess

5:30 p.m. – 7:00 p.m.

President's Reception

Rhapsody Pre Function

Dinner on Your Own

Space



SUNDAY APRIL 19, 2026

7:30 a.m. – 8:30 a.m. EDT

Breakfast

Medley



SUNDAY APRIL 19, 2026

8:30 a.m.

Call to Order and Announcements

Rhapsody

Jennifer C. Laforce, PhD, CPsych

SESSION 8

8:30 a.m.

Jurisdictions Taking Action on AI

Joe Comaty, MS, PhD, MSCP, MP, ABPP (IL)

Whitney Koch Owens, PsyD (NV)

9:30 a.m.

Q and A

1.25 hours CE

9:45 a.m.

Break

SESSION 9

10:00 a.m.

Discussion on the Proposed American Psychological Association's Model Act

Alex Siegel, JD, PhD (PA)

10:45 a.m.

Q and A

1.00 hours CE

11:00 a.m.

Adjourn

Jennifer C. Laforce, PhD, CPsych

**ASPPB welcomes interaction with our LinkedIn,
Twitter and Facebook social media sites.**

**Please keep in mind that while mentioning ASPPB
at our meetings is encouraged, we ask that you
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Thank you!**



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Gabriel Cline, PhD

March 23, 2026

Welcome to Charlotte, North Carolina—the Queen City—a place where history and growth remain in constant conversation. It is a fitting setting as we gather to examine the regulation of psychology in a time of rapid technological change, including the growing presence of artificial intelligence (AI) in our work.

I am very pleased to welcome you to ASPPB's 40th Midyear Meeting, April 16–19, 2026. This year's theme, *Guardians of the Future: Regulating Psychology*, reflects the ongoing responsibility across our jurisdictions: to safeguard standards of practice that protect the public while adapting to evolving technologies, shifting landscapes, and emerging conversations.

Our days will begin with engaging keynote addresses. Dr. Ernest Wayde will lead the way on Friday morning with *Who Is Responsible? Governing Psychological Practice in an Era of Artificial Intelligence*. On Saturday, Dr. Jared Skillings will talk about emerging technology in AI as it relates to the practice of psychology, *Dr. Chatbot Will See You Now: A Regulator's Guide to AI, Digital Ethics, and Public Safety*. The strength of our ASPPB meetings is seeing and talking about how these common

challenges are reflected in specific jurisdictions; accordingly, these discussions will continue through a table talk about how we can potentially use AI in regulation and opportunities to hear about actions jurisdictions are taking with regard to AI.

ASPPB is at its best when we are together—sharing challenges, comparing approaches, and learning from one another. Sessions on the training of licensees, addressing impairment in psychologists, and jurisdictional updates—including our open microphone discussions—offer a valuable exchange of ideas and practical insight. We will also continue important conversations on the evolution of practice and regulation, including discussion of the APA Model Act and ASPPB Updates.

As you are well aware, these gatherings work because of the tremendous amount of thought and effort behind the scenes. I would like to recognize and extend a sincere thank you to the 2026 Midyear Meeting committee and ASPPB staff:

Cindy Olvey, PsyD (AZ), Chair and Secretary-Treasurer

Hugh D. Moore, PhD, MBA (TN), Past President

Gabriel Cline, PhD (MO), 1st Year Director-at-Large

Jeffrey Hicks, PhD (KY), Delegate Member

Merranda Marin, PhD (NM), Delegate Member

Angie Ledbetter, BA (AL), Delegate Member

Kate Nooner, PhD, ABPP (NC), Local Delegate

Mariann Burnetti-Atwell, PsyD (GA), CEO (Consultant)
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Jessica Smith, Administrative Associate

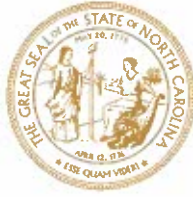
Their dedication to creating an engaging, welcoming, and thoughtfully run meeting for all is both evident and sincerely appreciated.

The richness of these meetings lies not only in the formal sessions, but also in the connections formed—through conversations, shared meals, and the informal exchange of ideas. Our work carries real responsibility, often held quietly within our respective jurisdictions. Gatherings like this remind us that, while the work may be carried individually, it is strengthened collectively. In addition to the program sessions, I encourage you to take in the scheduled and spontaneous gatherings during our time together, including the Welcome Reception, President’s Dinner, and President’s Reception. Whether you are a familiar face or this is your first meeting, this is your community—and it is stronger for all of us.

Warmly,



Jennifer C. Laforce, Ph.D., C.Psych.
2026 President, ASPPB Board of Directors



**STATE OF NORTH CAROLINA
OFFICE OF THE GOVERNOR**

**JOSH STEIN
GOVERNOR**

April 16, 2026

Association of State and Provincial Psychology Boards
c/o Mr. Dan Collins
895 State Farm Road, Suite 101
Boone, NC 28607-4995

Dear Friends,

I am pleased to welcome you to North Carolina for the Association of State and Provincial Psychology Board's 40th Midyear Meeting! This meeting brings together North American regulatory bodies around a shared mission of protecting the public and ensuring excellence in the practice of psychology.

ASPPB's dedication to professional standards, ethics, and continuous development of the field serves as an inspiration and a model for the professional community. The Midyear Meeting will help strengthen the ASPPB and the profession of psychology, enabling participants to exchange knowledge, share best practices, and strengthen North American collaboration in regulating the field of psychology.

Again, welcome to North Carolina. I hope you have a wonderful conference rooted in engagement, enrichment, and connection.

Sincerely,

A handwritten signature in black ink that reads "Josh Stein".

Josh Stein
Governor

2026 Board of Directors

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Stacy Waldron, PhD, 3rd Year Director-at-Large

Whitney Koch Owens, PsyD, 2nd Year Director-at-Large

Gabriel Cline, PhD, 1st Year Director-at-Large

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Angie Ledbetter, BA

Merranda Marin, PhD

Kate Nooner, PhD, ABPP

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Cindy Olvey, PsyD, ASPPB Secretary-Treasurer

Mariann Burnetti-Atwell, PsyD, ASPPB Chief Executive
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Leslie Browning Carroll, CAE, ASPPB Director of
Governance and Volunteer Operations

Bryan Gardner, ASPPB Meetings and Events Coordinator

Jessica Smith, ASPPB Administrative Assistant





ASPPB

Association of State and
Provincial Psychology Boards

Supporting member jurisdictions in fulfilling their responsibility of public protection

President

Jennifer C. Laforce, PhD, CPsych

Chief Executive Officer

Mariann Burnett-Atwell, PsyD

Past President

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Secretary-Treasurer

Cindy Olvey, PsyD

Directors at Large

Stacy Waldron, PhD

Whitney Koch Owens, PsyD

Gabriel Cline, PhD

TO: ASPPB Member Board and College Offices and ASPPB Member Board Chairs

RE: Call for Nominations for ASPPB Board of Directors, Fellows and Other Awards

Dear ASPPB Member Boards and ASPPB Member Board Chairs:

I am writing to announce this year's Call for Nominations for the offices of President-Elect and 1st-Year Director-at-Large (DAL) on the Association's Board of Directors (BOD), with terms beginning January 2027. Additionally, we are announcing a Call for Nominations for the following awards: ASPPB Fellows, the ASPPB State and Provincial Service Award, the Norma P. Simon Regulatory Service Award and the Ming Fisher Board Administrator/Registrar Award. Below, each award is explained in further detail, including how the nomination procedure works, the eligibility criteria and requirements for each Board position and award, and what items should be submitted for nominees.

Timeframes and Deadlines

Nominations must be made no later than **Monday, June 4, 2026**, in order for the Nominations Committee to make recommendations to the BOD at its June meeting. We are

always eager to have a completed slate of candidates to review, and we hope that you will take time to read through each area and nominate those individuals who you believe fit any of the following criteria.

ASPPB Board Positions

We are seeking nominees for the ASPPB Board with elections that will be held at the 66th ASPPB Annual Meeting of Delegates in Reno, Nevada, October 14 - 18, 2026. These elections will be held to fill two vacancies caused by the expiration of terms for the offices of President-Elect and 1st Year DAL.

Nominations for BOD positions will be accepted from ASPPB member boards and colleges, although individuals may submit letters in support of a nomination. Self-nominations are not allowed.

The Nominations Committee adheres to the following language in the *Bylaws* and *Member Policies and Procedures Manual*:
ASPPB Bylaws, Article VI.:

Section 2. Eligibility to Elected Office. To be eligible for election as an officer of the Association, at the time of election the candidate must:

- A. be a Member Jurisdiction Member or an Individual Member of the Association;*
- B. have no history of disciplinary action that has been reported to any professional disciplinary data bank; and*
- C. meet criteria specified in the Member Policies and Procedures Manual of the Association.*

ASPPB Member Policies and Procedures Manual, Policy 6.03:

In accordance with Association Bylaws Article VI, Section 3, nominations for officers will be accepted:

- A. from Member Jurisdiction in advance of the published deadline for nominations. Letters from individuals in support of a Member Jurisdiction's nomination will be accepted as supplemental information; and*
- B. from the Association Board of Directors prior to the Annual Meeting of the Delegates, if there are no qualified nominees received; and*
- C. at the Annual Meeting of the Delegates, when presented by a Delegate that, on behalf of their Member Jurisdiction, submits an eligible nominee in accordance with the Association Bylaws and Association Policy related to eligibility.*
- D. Nominations from the floor are prohibited except in the case where there are no qualified nominees. Except when authorized by a unanimous affirmative vote of the Delegates, any individual so authorized must meet all the necessary qualifications, including but not limited to timely submission of all required information, in order to stand for election.*

In addition, nominees must meet the following criteria, as excerpted from the *ASPPB Member Policies and Procedures Manual, Policy 6.02*.

- A. A candidate for election to the Office of Director*
 - i. must ensure that a completed nomination packet has been submitted by a Member Jurisdiction on behalf of the nominee with a letter of nomination on official Board/College letterhead; and*
 - ii. attended at least three (3) Association membership meetings (one of which must be an Annual Meeting of the Delegates) as a representative of a Member Board (current professional or public member, staff or counsel of a Member Jurisdiction) or as an Association Individual Member, and served in their qualifying capacity with the regulatory board for a minimum of one year; and*
 - iii. served on an Association committee*
- B. A candidate for election to the Office of President-Elect must:*
 - i. ensure that a completed nomination packet has been submitted by a Member Jurisdiction on behalf of the nominee with a letter of nomination on official Board/College letterhead; and*
 - ii. attended at least three (3) Association membership meetings (one of which must be an Annual Meeting of the Delegates) as a representative of a Member Board (current professional or public member, staff or counsel of a Member Jurisdiction) or as an Association Individual Member, and served in their qualifying capacity with the regulatory board for a minimum of one year; and*
 - iii. served on a minimum of two (2) Association committees, task forces and/or workgroups.*

In addition to the required criteria, the Nominations Committee ("NOM") shall consider prior involvement and interest in the Association by the nominee. Being a critical factor, experience of the nominee within the Association is evaluated by considering the following:

- A. service as a Delegate from a Member Jurisdiction;*

- B. participation in Association meetings and initiatives;
- C. service on an Association committee, task force and/or workgroup;
- D. a contributor to the profession who has been honored by the Association (e.g., Fellow, awardee)
- E. previously nominated for an office but not chosen for the slate;
- F. prior candidacy for office; and
- G. balance on such dimensions as gender, ethnicity, current and past geographical makeup, and size of the Member Jurisdictions represented on the Association Board of Directors.

When the election of a candidate who already holds an elected office results in an unexpired term, the process outlined in *ASPPB Bylaws, Article VI, 7* shall be followed.

Although it is typical for the Third-Year DAL to seek the nomination for President-Elect, other eligible individuals are not precluded from seeking the nomination for that office and are welcome to do so.

The committee also seeks to maintain balance on such dimensions as gender, race, ethnicity, current and past geographical makeup, and size of the jurisdictions represented on the BOD. As the committee develops the slate of candidates, these factors, along with the skills below, are considered. As the Association continues to evolve and grow, we would like to take this opportunity to outline a few desired skills for potential nominees. Nominees should be able to demonstrate that they possess the following:

- Experience in Governance and Strategy
 - Understanding budgeting and ensuring fiscal responsibility (Duty of Care, Duty of Loyalty).
 - Helping set vision, goals, and evaluating performance.
 - Adhering to nonprofit laws and policies (Duty of Obedience).
 - Identifying and mitigating organizational risks.
- Functional Expertise
 - Volunteer engagement and board development.
 - Connecting with stakeholders and understanding community needs.
- Soft Skills
 - Have a deep belief in the mission and dedication to the cause.
 - Be an active listener and have clear, two-way conversation.
 - Work effectively with other board members and staff.
 - Have a desire to stay informed and understand new challenges.
 - Be able to respond to a changing landscape.

No specific weights have been developed for these factors, as they are all considered important. As you may appreciate, applying these factors to a specific group of nominees is sometimes difficult during any single year. The committee makes every attempt to see that a reasonable number of nominees are on the slate for each position. We have defined a reasonable number of nominees for each position as no more than four.

Below is a detailed description of each of the Board positions available:

A. President-Elect (Three-year term)

The President-Elect serves in this office starting January 1st of the year following his or her election at the Annual Meeting, then automatically becomes President on January 1st the year after that and then serves a third year as Past-President. As a member of the BOD, the President-Elect, President, and Past-President will attend six Board of Directors meetings each year, and the Annual and Midyear Meetings. In addition, and as determined by the Board of Directors (in consultation with the President), the President-Elect serves on other Association

committees and task forces as assigned in the *Game Plan* and may serve as ASPPB liaison or representative to other professional groups. Time spent on committees, task forces and liaison activities will vary during the President-Elect, Presidential and Past-Presidential year, and may be adjusted to the individual needs and interests of the Board member at the discretion of the Board. The members of the Board in the Presidential sequence generally spend approximately 40-60 days a year in meetings and travel for the Association. Additional time is spent preparing for meetings and reviewing documents important to the functioning of the Association.

B. Director-at-Large (DAL) (Three-year term)

As a member of the BOD, the DAL will attend six BOD meetings each year, the Annual and Midyear Meetings, serve on other Association committees and task forces as assigned in the *Game Plan*, and may serve as ASPPB liaison or representative to other professional groups. The DAL will serve on a rotation of tracks, beginning with the Mobility Track in 2027, the Examination Track in 2028, and the Education and Training Track in 2029. More details about this track system can be found in the accompanying document entitled “Considering a Run for the Association of State and Provincial Psychology Boards (ASPPB) Board of Directors (BOD)”. The Director-at-Large generally spends a minimum of 50 days a year in meetings and travel for the Association. Additional time is spent preparing for meetings. A DAL is elected for a three-year term but may run for another office prior to completing the term. It is typical, although entirely optional, for the outgoing DAL to seek and obtain the nomination for President-Elect at the end of his or her three-year term as DAL.

★ **To make a nomination for the ASPPB President-Elect or 1st-Year DAL, please send the following items to Leslie Carroll at the ASPPB Central Office no later than Monday, June 4, 2026, by email (lcarrroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290):**

1. A cover letter on official Board/College letterhead from the nominator outlining the contributions made by the nominee with as much specificity as possible;
2. Letter of interest from the nominee;
3. Any additional letters of support;
4. The fully completed ASPPB Board Member Nomination Form (copy attached); and
5. The nominee’s most recent curriculum vitae/résumé.

Awards

Please note that current members of the ASPPB BOD are **NOT** eligible to receive awards, including Fellow status. Award nominations may be submitted by ASPPB member boards, ASPPB Individual Members, the BOD, or the Nominations Committee. For a complete list of previous award winners, please visit www.asppb.net.

A. ASPPB Fellow

The honorific category of Fellow recognizes individuals who have given outstanding service to ASPPB and to the field of professional psychology regulation and licensing/certification. The first class of ASPPB Fellows was named in 1990. Nominations are sought from ASPPB member boards and standing committees of the Association. A maximum of three Fellows can be selected each year.

★ **To make a nomination for an ASPPB Fellow, please send the following items to Leslie Carroll at the ASPPB Central Office no later than Monday, June 4, 2026, by email (lcarrroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290):**

1. A cover letter from the Nominator outlining the contributions made by the nominee with as much specificity as possible;
2. Any additional letters of support;
3. The fully completed ASPPB Fellow Nomination Form (copy attached); and
4. The nominee’s most recent curriculum vitae/résumé.

B. ASPPB State and Provincial Service Award

The ASPPB State and Provincial Service Award is designed to honor an individual who has made special contributions to promote the licensing and/or certification of psychologists in her/his jurisdiction of the U.S. or Canada. This award was established in 2004, and prior to that, it was known as the Roger C. Smith Award. Nominations are solicited from all member boards, and current and past contributions are equally important.

★ **To make a nomination for the ASPPB State and Provincial Service Award, please send the following items to Leslie Carroll at the ASPPB Central Office no later than Monday, June 4, 2026, by email (lcarroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290):**

1. A cover letter from the Nominator outlining the contributions made by the nominee with as much specificity as possible;
2. Any additional letters of support;
3. The fully completed ASPPB State and Provincial Service Award Nomination Form (copy attached); and
4. The nominee's most recent curriculum vitae/résumé.

C. ASPPB Norma P. Simon Regulatory Service Award

The Norma P. Simon Regulatory Service Award is given to recognize an individual who has made significant contributions to ASPPB and to the regulation of psychology at the national or international level. This award was established in 2001, and prior to that, it was known as the Morton Berger Award. It is named in honor of Norma P. Simon, Ed.D., former member of the New York State Board of Psychology (1979-1989), President of ASPPB (1991-92), former chair of the APA Ethics Committee, and of the APA Board of Professional Affairs. Nominations are solicited from all member boards, and current and past contributions are equally important.

★ **To make a nomination for the ASPPB Norma P. Simon Regulatory Service Award, please send the following items to Leslie Carroll at the ASPPB Central Office no later than Monday, June 4, 2026, by email (lcarroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290):**

1. A cover letter from the Nominator outlining the contributions made by the nominee with as much specificity as possible;
2. Any additional letters of support;
3. The fully completed ASPPB Norma P. Simon Award Nomination Form (copy attached); and
4. The nominee's most recent curriculum vitae/résumé.

D. ASPPB Ming Fisher Board Administrator/Registrar Award

The Ming Fisher Board Administrator/Registrar Award is given to a state licensing board administrator or staff person who has contributed to psychologists and psychology by his/her dedication to licensing and regulation; and an administrative approach that has been consistently fair, respectful, and just; by giving stellar service to his/her board; and by contributing to ASPPB as well. This award is named in honor of Ming Fisher, former Executive Director for the Ohio Board of Psychology. Having worked for the Ohio Board for 30 years, Ms. Fisher issued the license for almost every psychologist and school psychologist from 1973 until her retirement in June 2001. To mark Ms. Fisher's retirement in 2001, the ASPPB Nominations Committee created a new award in her name and subsequently named Ms. Fisher as the first recipient of the award. Nominations are solicited from all member boards and current and past contributions are equally important.

★ **To make a nomination for the ASPPB Ming Fisher Board Administrator/Registrar Award, please send the following items to Leslie Carroll at the ASPPB Central Office no later than Monday, June 4, 2026 by email (lcarroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290):**

1. A cover letter from the Nominator outlining the contributions made by the nominee with as much specificity as possible;
2. Any additional letters of support;
3. The fully completed ASPPB Ming Fisher Award Nomination Form (copy attached); and
4. The nominee's most recent curriculum vitae/résumé.

Deadline for Nominations

It is important for you to know that the deadlines for nominations are strictly adhered to, as the slates must be completed in time for the Nominations Committee to convene, and for the BOD to vote on both the officer slates and the award nominees at its June meeting. Please send all your nominations and accompanying documents to the attention of **Leslie Carroll at the ASPPB Central Office, by email (lcarroll@asppb.org), fax (678-216-1176), or mail (P.O. Box 849, Tyrone, GA 30290), for receipt no later than Monday, June 4, 2026. The Nominations Committee greatly appreciates your input and cooperation and looks forward to receiving your nominations.**

Sincerely,

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

Attachments:

1. Considering a Run for the ASPPB Board of Directors
2. ASPPB Board Nomination Form
3. ASPPB Fellow Nomination Form
4. ASPPB State and Provincial Service Award Nomination Form
5. ASPPB Norma P. Simon Regulatory Service Award Nomination Form
6. ASPPB Ming Fisher Board Administrator/Registrar Award Nomination Form



ASPPB

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Supporting member jurisdictions in fulfilling their responsibility of public protection

President

Hugh D. Moore, PhD, MBA

Chief Executive Officer

Mariann Burnetti-Atwell, PsyD

Past President

Michelle G. Paul, PhD

President-Elect

Jennifer C. Laforce, PhD, CPsych

Secretary-Treasurer

Cindy Olvey, PsyD

Members at Large

Ramona N. Mellott, PhD

Stacy Waldron, PhD

Whitney Koch Owens, PsyD

Dear Colleagues,

“Alone we can do so little; together we can do so much.” — Helen Keller

Although we’ve just closed one cycle of work, this is the time of year when we look ahead and invite colleagues to consider volunteering for one of ASPPB’s committees or task forces in 2027—my year as President. As President-Elect, I have the privilege of issuing this call, and I do so with deep appreciation for this community and the responsibility we share. In my work as both a faculty member and an administrator at Northern Arizona University, I often encourage students and early career faculty to say yes to opportunities—even when they feel unsure—because you never know where that experience might lead. Saying yes has broadened my perspective and created leadership opportunities that began simply by raising my hand.

Volunteering with ASPPB offers that same possibility. The work is meaningful and grounded in public protection, and it brings together colleagues across jurisdictions, settings, and career stages whose varied perspectives strengthen both our decisions and our shared purpose. We need seasoned members and new voices alike. If you feel even a small nudge of interest, I encourage you to complete the volunteer interest survey below so we can

thoughtfully match members with opportunities.

<https://www.surveymonkey.com/r/2026Volunteers>

If you have questions about time commitments or the realities of serving, please reach out to me or to Leslie Browning Carroll, our Director of Governance and Volunteer Operations. ASPPB’s strength rests in the engagement of its volunteers—thank you for considering adding your voice to this important work.

Sincerely,

Ramona Mellott

Presenter Biographies

 ASPPB | 65
YEARS



Joseph E. Comaty, MS, PhD, MSCP, MP, ABPP, received his M.S. in experimental psychology from Villanova University; his PhD in psychology with a specialization in clinical neuropsychology from the Rosalind Franklin University of Medicine and Science, in Illinois; and his postdoctoral Master of Science degree in Clinical Psychopharmacology (MSCP) from Alliant University/CSPP of California. He is a licensed psychologist in Louisiana and Illinois and a licensed Medical Psychologist (i.e., prescribing psychologist) in Louisiana. He retired from the Louisiana Department of Health, Office of Behavioral Health in 2013 where he was the Chief Psychologist and Medical Psychologist and Director of the Division of Quality Management. He has been an adjunct assistant professor in psychology at Louisiana State University (LSU) in Baton Rouge from 1994 to 2017 and adjunct instructor in Psychology in 2021 and served as emeritus faculty of the Southern Louisiana Internship Consortium (SLIC) in psychology at LSU until 2019. He served as a member of the Louisiana State Board of Examiners of Psychologists (LSBEP) from 2006 to 2010 and as its chair from 2010 to 2011. He is a past charter member of the APA Designation Committee for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority from 2010 to 2014 and as its chair from 2013 to 2014 and is a current chair of a site review team for APA's Commission on Accreditation. He was Secretary of APA Division 55 (Society for Prescribing Psychology) 2021-2023 and currently serves as the Representative of APA Division 55, to the APA Council. He was elected an APA Fellow of Division 55 in August of 2024 and Division 18 (Psychologists in Public Service) in August 2025. He became Board Certified in Serious Mental Illness Psychology under the American Board of Professional Psychology (ABPP) in November 2025. Appointed Secretary of the American Board of Psychopharmacological Psychology (ABRXP) in 2025. He is a past member of and current consultant to the Model Act and Regulation Revision Committee for the Association of State and Provincial Psychology Boards (ASPPB). He currently serves as Chair of the PEP Examination Development Committee (EDC) for ASPPB. He was a member of the Louisiana Department of Health IRB from 2010 to 2022 and Chair from 2019 to 2022. He has conducted forensic fitness for duty evaluations for Matrix, Inc., in Baton Rouge, LA from 2013 to 2022. Appointed to the Clinical Psychologists Licensing and Disciplinary Board, Illinois Department of Financial and Professional Regulation-September 2025 to present. His research is in the areas of behavior therapy, pharmacology, and clinical psychopharmacology. He is the author of over 60 articles, book chapters, and presentations. He is a co-author of the psychopharmacology textbook, *Julien's Primer of Drug Action*, the most recent edition being published in 2023. He has served on federal grant review committees and has been a reviewer for *Psychiatric Services*; *The Journal of Gerontology: Psychological Sciences*; *the Journal of Behavioral Health Services and Research*; *the Journal of Psychology & Clinical Psychiatry*, and *npj Mental Health Research*.

Susan Hurt, JD, PhD, currently serves as the Chief Psychologist of the Child and Adolescent Unit at Central Regional Hospital (North Carolina state hospital system). Previously, she served for 10 years in the state's pretrial forensic services unit and for 14 years in private practice in clinical and forensic psychological services. Dr. Hurt received her JD from Cornell Law School and her Ph.D. From the University of Virginia, where she trained in forensic psychology at the Institute of Law, Psychiatry, and Public Policy. Dr. Hurt currently serves as the Chair of the North Carolina Psychology Board.

Troy Janzen, PhD, RPsych, is currently the Chief of Practice, Deputy Registrar and Complaints Director at the College of Alberta Psychologists. As Chief his role includes development of guidelines for the profession which has included guidance on use of technology. He has worked extensively as a psychologist in assessment and intervention with pediatric populations and families in hospitals, schools, private practice, First Nations Reserves and Children's Services settings since 1993. From 2009 to 2017 he served as the Clinical Supervisor and Practicum Coordinator for the CPA-accredited School and Clinical Child Psychology Program at the University of Alberta (U of A). Prior to U of A, Dr. Janzen was Chair of the Psychology Department at Taylor University College where he helped establish an undergraduate program in psychology. Dr. Janzen has been serving in his current role at the College since 2017.

Jennifer C. Laforce, PhD, CPsych, is a registered psychologist in private practice in Winnipeg, Manitoba. She has served on the Board of Directors for ASPPB since 2021 and is the current President-. She previously served on the Executive Council for the Psychological Association of Manitoba (2011-2019) and on the board of the Manitoba Psychological Society (2006-2011). From 2004-2013, she was an Assistant Professor in the Department of Clinical Health Psychology at the University of Manitoba and worked at the Winnipeg Operational Stress Injury Clinic, serving as Clinical Director from 2009 to 2013. Dr. Laforce received her doctorate in Clinical Psychology from Queen's University at Kingston, Ontario, and completed her internship at SUNY Upstate in Syracuse, NY.

Angie Ledbetter is an executive-level regulatory and operations professional with extensive experience in state government and other highly regulated environments. She serves as Executive Assistant to the Alabama Board of Examiners in Psychology, where she supports board governance, licensure and credentialing, disciplinary processes, regulatory compliance, and interjurisdictional coordination.

Her background includes leadership roles in financial services compliance and earlier service with the State of Alabama in public benefits and investigative programs. Angie holds a B.A. in Sociology from Auburn University at Montgomery and is an associate of the Certified Public Manager® program. She currently collaborates on a *Solutions Alabama* initiative with the Alabama Office of Information Technology focused on the responsible application of artificial intelligence in state government and professional regulation.

Diana Medina, PhD, has served on the Arizona Board of Psychologist Examiners since 2022, including roles as Chair (2026), Vice-Chair (2025), and psychologist member (2022–present).

She is an active member of the ASPPB Board and College Chairs Committee (BCCC) and the Mobility Committee. Dr. Medina is a licensed psychologist and healthcare leader with expertise in clinical training, program development, and regulatory oversight. She currently serves as Chief of Clinical Education at COPA Health and maintains a private practice. Dr. Medina has a demonstrated track record of developing APA-accredited training programs, supervising multidisciplinary teams, and expanding access to culturally responsive, evidence-based care. She earned her doctoral degree in Counseling Psychology from Arizona State University.

Dr. Ramona Mellott has served Northern Arizona University (NAU) since 1991 in both faculty and administrative roles. After nine years as a faculty member, she served seven years as department chair and eight years as Graduate Dean before becoming Dean of the College of Education in 2014. She will serve as Dean through June 2026, after which she will return to a full-time faculty role. She earned her Ph.D. (1991) and M.S. (1988) in Counseling Psychology from the University of Southern Mississippi. Her research focuses on personality assessment across cultures, professional issues in psychology, and culturally responsive addictions training. Dr. Mellott served on the Arizona Board of Psychologist Examiners from 2016 to 2023. In 2020, she was named a Fellow of the Association of State and Provincial Psychology Boards (ASPPB) and currently serves as President-Elect on its Board of Directors.

Hugh D. Moore, PhD, MBA, is a licensed psychologist whose professional background ranges from clinical practice to the high-stakes world of law enforcement and court-ordered evaluations. Having served on his state licensing board and in several ASPPB leadership positions, he recently transitioned from the role of ASPPB's President to Past-President. While his career has proven he can find the levity in almost any setting, he is currently applying that same perspective to learning the intricacies of governance under Robert's Rules of Order. Whether he is sailing, traveling, or tinkering with technology, Hugh remains an advocate for a collaborative leadership style—one that values both historical context and the shared sense of humor required to navigate complex organizations.

Cindy Olvey, PsyD, earned her Doctor of Psychology degree in clinical psychology and is licensed as a psychologist in Arizona. She served as Executive Director of the Arizona Board of Psychologist Examiners from 2009 to 2018. Dr. Olvey is a member of the Board of Directors of the Association of State and Provincial Psychology Boards (ASPPB) and serves as Secretary-Treasurer. She chairs the ASPPB Finance and Audit Committee and the Midyear Meeting Planning Committee and is a member of the ASPPB Policies and Procedures Committee. Dr. Olvey serves as Associated Faculty for the Doctor of Psychology program at Midwestern University, Glendale, Arizona campus. She is President of the Eastern Arizona College Alumni Association and is an Ex-Officio Member of the Eastern Arizona College Foundation.

Whitney Koch Owens, PsyD, serves as the First-Year Director-at-Large on the Association of State and Provincial Psychology Boards (ASPPB) Board of Directors, where she contributes to advancing professional standards and regulatory excellence in psychology. Prior to her election, she dedicated eight years to the Nevada Board of Psychological Examiners, including five years

as Board Chair, and continues to support the Board's mission through her current role as an investigator.

In addition to her regulatory leadership, Dr. Owens is the founder and director of *Vegas Psychology and Mindfulness Center*, a group practice committed to providing evidence-based, compassionate care to individuals, couples, and families. She is passionate about mentoring the next generation of psychologists and serves as a clinical supervisor for practicum students from the University of Nevada, Las Vegas's Clinical Psychology and School Psychology programs.

Heidi Herbst Paakkonen, MPA, has served the Arizona Board of Psychologist Examiners as its Executive Director since November of 2019. She was previously the Continuing Competence Programs Manager for the Federation of State Boards of Physical Therapy (FSBPT), and also served for nine years as the Executive Director of the Arizona Board of Physical Therapy. Her 23 years of regulatory and public policy experience includes agency executive management, strategy and policy development and implementation, data-driven decision making, and fostering stakeholder relationships. Additionally, she has served on a multitude of national regulatory committees for the FSBPT and the Association of State and Provincial Psychology Boards (ASPPB). Heidi earned a Bachelor of Arts and her Masters of Public Administration from the University of Wyoming.

Sam Sands, JD, has been the Executive Director of the Minnesota Board of Psychology since 2017. Prior to that, Sam worked as the Director of Licensure and Compliance for Walden University's School of Social and Behavioral Sciences. Sam is an attorney by training and focused on the health licensing regulatory field for the last eleven years.

Alex Siegel, JD, PhD, is an attorney and clinical psychologist. Three different Pennsylvania Governors (Ridge, Schweiker and Rendell) appointed Dr. Siegel to the Pennsylvania State Board of Psychology. He served on the Board for thirteen years, six of which were as Chair of the State Board. Dr. Siegel was elected to the Board of Directors of the Association of State and Provincial Psychology Boards (ASPPB). He was also elected President of ASPPB in 2008. Currently, Dr. Siegel is the Director of Professional Affairs (DPA) for ASPPB. In his role as DPA, he serves as a liaison between ASPPB and state and national psychological associations. He provides training to new members of psychology licensing boards in the U.S. and the colleges of psychology in Canada. He was staff to the APA/ASPPB/APAIT joint task force on telepsychology and to the ASPPB task force on regulations for interjurisdictional telepsychological practice. He is the Chair of the Model Act and Regulations Committee (MARC) and Co-Chair of the COVID-19 Task Force. In addition, Dr. Siegel consults with state governments, attorneys, and courts and maintains a small clinical practice.

Dr. Jared Skillings is the Senior Medical Director for Mental Health at Teladoc Health, where he leads clinical strategy and operations for 62 million members and 2,300 clinicians across all 50 states. He previously served as Chief Clinical Officer at the APA, directing national strategy for 120,000 psychology professionals. In that role, he led APA's telehealth strategy, created

nationwide access to digital therapeutics, and achieved the largest-ever market value increases for psychological services.

As an advisor to the White House, Centers for Disease Control and Prevention, and several federal and state agencies, Dr. Skillings has contributed expertise to solving some of society's most pressing needs. He has authored more than 30 publications, delivered over 150 presentations, and provided over 100 testimonies to Congress, federal agencies, and state legislatures. He proudly serves on the Board of Directors of the National Register of Health Service Psychologists, and he is one of only 25 psychologists in the country who hold triple board certification from the American Board of Professional Psychology. On a personal note, Dr. Skillings has been married to his wife Julie for 25 years. Their five children are all teenagers, which keeps life interesting, and the whole family trains Brazilian jiu-jitsu together.

Dr. Ernest Wayde is Founder and Principal of Wayde AI, where he helps healthcare organizations and clinical leaders navigate the ethical integration of artificial intelligence. He serves as a Subject Matter Expert on the American Board of Professional Psychology's AI Task Force and contributed to the American Psychological Association's Health Advisory on the Use of Generative AI Chatbots and Wellness Applications for Mental Health—addressing critical safety, validation, and regulatory concerns in consumer-facing mental health technologies. Dr. Wayde specializes in responsible AI implementation, helping organizations design systems that enhance rather than replace human expertise. He advises on AI governance frameworks, validation methodologies, and the organizational dynamics of technological change, combining behavioral science with practical AI strategy to ensure innovations align with clinical values, regulatory compliance, and patient wellbeing.

Currently, he co-produces "Beyond the Couch: AI in Psychology," a podcast collaboration between ABPP and Wayde AI exploring AI's role in mental health practice. He holds a doctorate in Clinical and Cognitive Psychology, a master's in Information Systems and advanced AI certifications from MIT Sloan and Microsoft.

Keynote Session 1: Who is Responsible?

Governing Psychological Practice
in an Era of Artificial Intelligence

Presented by
Dr. Ernest Wayde
Wayde AI LLC

40th MIDYEAR MEETING
Charlotte, North Carolina
April 17th, 2026

Presentation will be added to CE-Go

Session 2:

Jurisdictions that Train Licensees



Regulator-Led Training as Public Protection: Alberta's Model and AI Case Study

Session 2, April 17, 2026

11:00 AM

Session Objectives

By the end of this session, participants will be able to:

1. Describe a model of regulator-led annual professional development.
2. Analyze how emerging risks (e.g., AI) can be addressed through regulator training.
3. Identify safeguards that preserve neutrality and legitimacy.

The Regulatory Question

Should regulators provide training?

- Public protection mandate includes preventing foreseeable harms
- Risk prevention vs. member service
- Enforcement vs. education
- Education vs re-education/remediation
- Anticipates that registrants may ask the regulator for regulatory guidance on emerging issues (e.g., AI use)

Alberta's Annual Professional Development Day

CAP Education model:

Upstream---- Midstream -----Downstream

Upstream includes:

- Standards
- Guidelines
- Professional Education Programs training on Ethics
- Talks to graduate students

Midstream: Once per year Full-day regulator-led CPD event, Topics are selected based on public protection risk, anchored to standards and complaint themes

Downstream: Ethics Practice Reviews in response to Concerns/Complaints

How we choose topics for targeted/preventative education? (Risk-Based Selection)

Topic selection criteria:

1. Emerging practice risks (e.g., AI)
2. High-frequency complaint areas
3. Areas of regulatory ambiguity/frequent requests for clarifications/public confusion expressed
4. System-level change in practice

Case Study: AI Ethics Training

Annual PD Day Focus: AI Ethical Risks & Benefits

- Use of expert speakers
- Online delivery/over 1000 participate live/education resides online for all members to benefit.
- Use of self declaration means they can claim the hour credit for either Ethics or Knowledge categories of required annual Continuing Competence
- Core themes addressed: Informed consent & transparency, Bias and reliability concerns, Competence and oversight, Privacy and data security, Responsibility remains with psychologist
- Link to Youtube video of last training day on AI
<https://youtu.be/d9Dj0s5h1fl?si=ilFq9mRxmcU3ZRyQ>

Why Training Psychologists around AI use is a Regulatory Issue

AI intersects with core standards & ethics:

- Competence - in the technology itself, knowledge of benefits and risks
- Mitigating Bias & Confidentiality risks as two key major risks
- Informed consent (e.g., for recording sessions using AI transcribed notes)
- Documentation and report writing integrity
- Professional responsibility
- There are already documented serious harms connected with AI use (e.g., Tumbler Ridge shootings, teen suicide cases, increased delusion risk)

Benefits of Regulator-Led Training

- Reduces **misunderstanding** of standards and application of ethical codes.
- Improves **consistency**
- Addresses **emerging risks** early/preventatively
- Enhances regulator **legitimacy** through **transparency**
- May **reduce complaints**

Risks and Safeguards

Risks of the Regulator offering education:

- Role confusion (regulator vs association)
- Perceived bias
- Resource diversion from other regulatory tasks

Safeguards

- Ensure all education is grounded in your **role**
- Know your **rationale** for how it serves the regulatory function
- Making education part of a **structured expectation** and other offerings on a **carefully considered case-by-case basis**.

Key Takeaways & Discussion

Alberta's approach to education:

- One focused annual event on targeted issues including emerging issues
- Invited talks (e.g., large organizations like AHS, school divisions, graduate programs, CPA accredited internship programs, WCB)
- Risk-based topic selection
- Content is anchored to Standards and Code of Ethics and existing guidelines
- Emerging issues addressed early with a view to primary prevention
- Focus is on common issues that give rise to complaints and urging towards positive ethics

References

- Ayres, Ian, and John Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (New York, NY, 1992; online edn, Oxford Academic, 31 Oct. 2023), <https://doi.org/10.1093/oso/9780195070705.001.0001>, accessed 5 Mar. 2026.
- Knapp, S., Gottlieb, M. C., & Handelsman, M. M. (2018). The benefits of adopting a positive perspective in ethics education. *Training and Education in Professional Psychology*, 12(3), 196–202. <https://doi.org/10.1037/tep0000195>
- OIPC Alberta (2025). Comments from the Office of the Information and Privacy Commissioner Regarding Responsible AI Governance in Alberta. [AI-Comments-from-the-OIPC-Regarding-Responsible-AI-Governance-in-Alberta-July-15-2025 \(1\).pdf](#)
- Austin, Z. (2025). Regulation of Artificial Intelligence in Professional Work: Options and Opportunities. CNAR Final Report, [CNAR-Research-Project-2026-AI-in-Professional-Work FINAL-1 \(1\).pdf](#)

Session 2:
Jurisdictions that Train Licensees
Sam Sands
Presentation will be added to CE-Go.

ASPPB Updates

Jurisdictional Updates

Saturday, April 18, 2026

Session 5:
Dr. ChatBot Will See You Now:
A Regulator's Guide to AI, Digital Ethics, and
Public Safety

Jared Skillings, PhD

Presentation will be added to CE-Go.

Smart Regulation:

Enhancing Public Protection through Administrative Precision

Hugh D. Moore and Angie Ledbetter

April 18, 2026

The Administrative Reality

Rising Volume: Doctoral applications, PSYPACT mobility, and renewal cycles.

Manual Complexity: Reviewing transcripts against statutes (e.g., 60-semester-hour rules).

Regulatory Fatigue: Heavy manual workloads leading to processing inconsistencies.



The AI
Hand-off

The Guardian's Goal

Free the regulator (and/or Board) to focus on judgment, not data verification.

The Cognitive Hand-off Matrix

The Assistant (AI)

- Parsing
- Sorting
- Redacting
- Mapping

The Hand-off

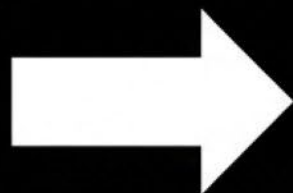
The Regulator (Angie et al)

- Context
- Judgment
- Decision
- Adjudication

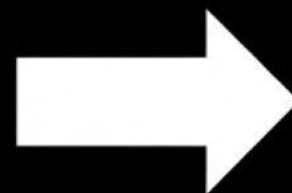
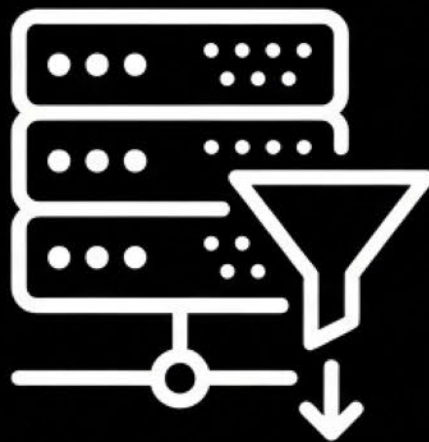
AI is used strictly for structured comparison drafting. It never approves a license, denies a renewal, or sanctions a licensee.

The Confidentiality Gate: Privacy by Design

Stage 1
(Original Application Package)



Stage 2
(Redacted Application Package for Initial Analysis)



Stage 3
(Screened Application Package Ready for Human Decision)



Compliant with HIPAA and Privacy Standards. The AI engine analyzes the 'what', not the 'who'.

Reducing Bias & Increasing Consistency

Bias Reduction

The Confidentiality Gate physically removes names, gender, and prestige markers.

Forces the system to focus entirely on Content.

Consistency

**Application #1 =
Application #500**

Eliminates fatigue-based variability.

The Guardianship Lifecycle

Clear Documentation, Precise Data Analysis

Entry

Maintenance

Oversight

Module 1: Entry to Practice



University Transcript



State Statutes & Rules
(e.g., Alabama Admin Code
Chapter 750-X-2)

Automated Analysis & Verification (AI)

- Doctoral Degree Verification
- 60 Semester Hours Doctoral-Level Coursework
- Internship (2 Licensed Supervisors)

Compliance Report

The Output: A Completeness Checklist

Application Analysis Report **Status: PENDING REVIEW**

Item 1: Graduate Coursework | Calculated: 58 Hours | Requirement: 60 Hours

[FLAG]

Item 2: Internship Supervision | Detected: 1 | Requirement: 2

[FLAG]

Item 3: Ethics Component | Status: Complete.

Staff attention
directed immediately
to deficiencies.

Module 2: Continuing Competence – Audits, Not Surveillance

The Fear



Continuous Monitoring
Intrusive 24/7 data access

NOT PROPOSED

The Reality

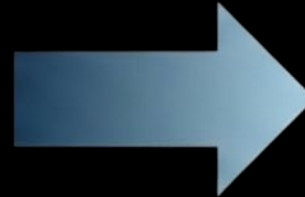


Periodic Audit Support per Statute
Standard regulatory practice. 100%
verification of selected audit pool

AI scales audit capability but
respects regulatory autonomy

From Punitive to Supportive

The Analysis		
1	Audit Result:	18 Hours Verified.
2	Deficiency:	2 Hours.
3	Gap:	Rule 750-X-3A-.03.



The Draft

DRAFT CORRESPONDENCE

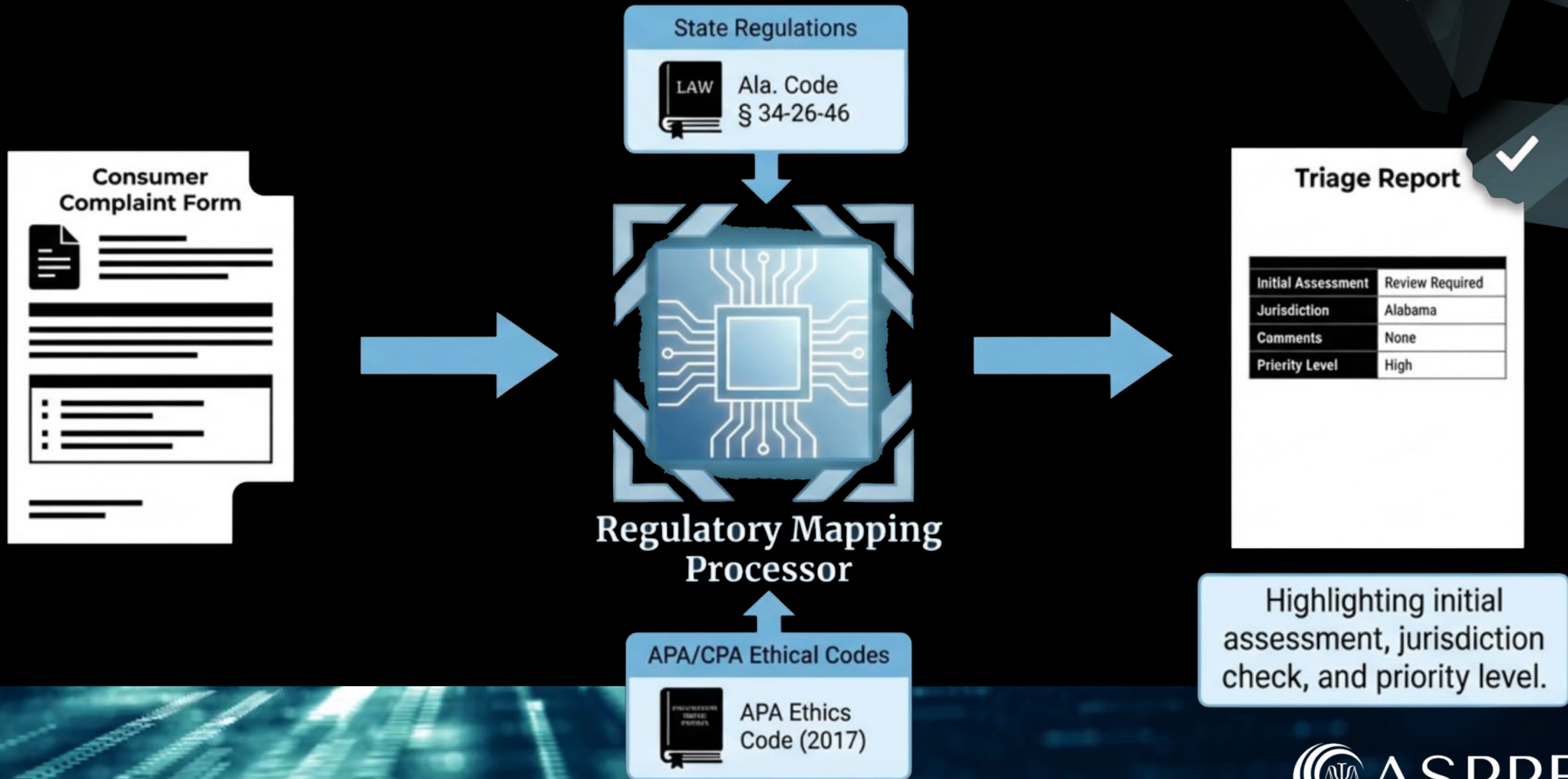
Dear Dr. Doolittle,

Your audit indicates 18 hours of completed CE. Alabama regulations require 20 hours.

Please submit documentation for 2 additional hours to cure this deficiency by October 15.

AI proactively drafts remediation guidance for staff review. Transforming regulatory compliance into a collaborative process for professional development.

Module 3: Complaint Analysis & Triage



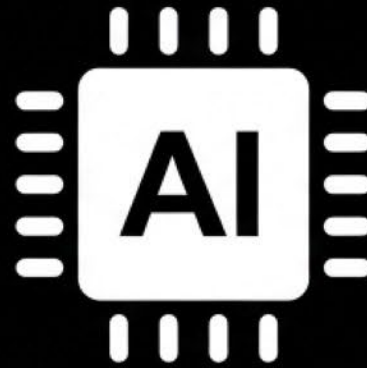
The Jurisdictional Agnosticism Matrix



United States
Jurisdiction

Jurisdictional Code

APA Ethics Code



AI Logic
Engine



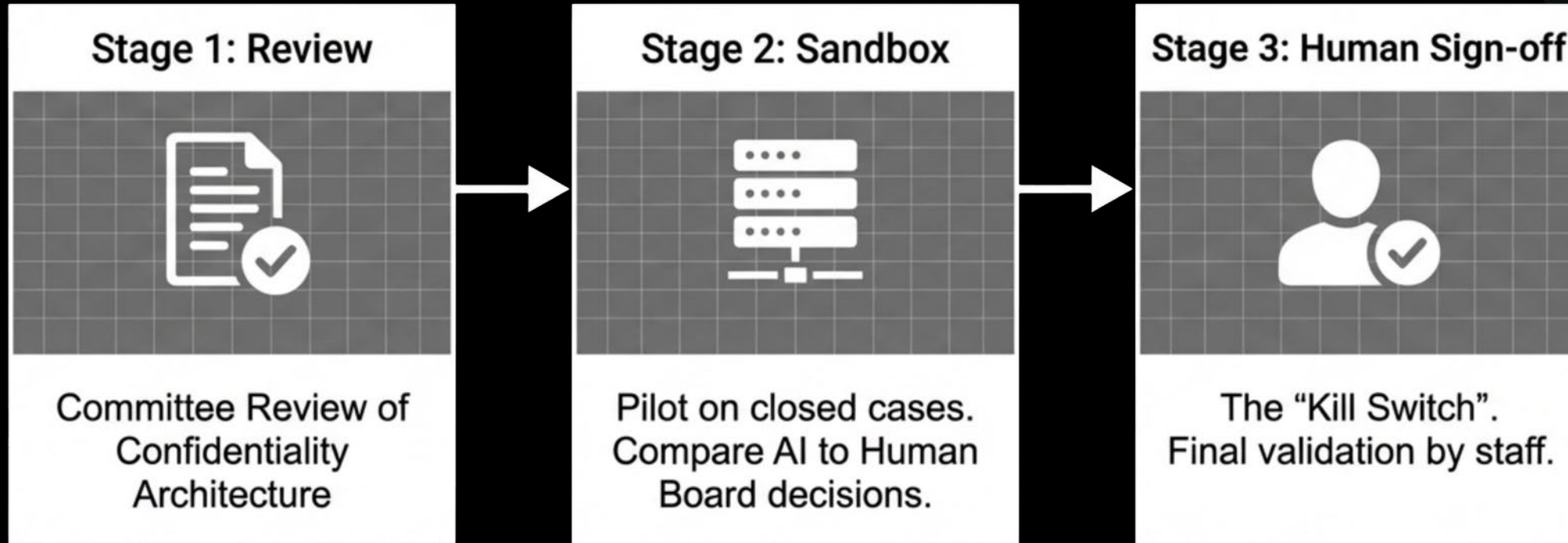
Canadian
Jurisdiction

Provincial/Territorial Act

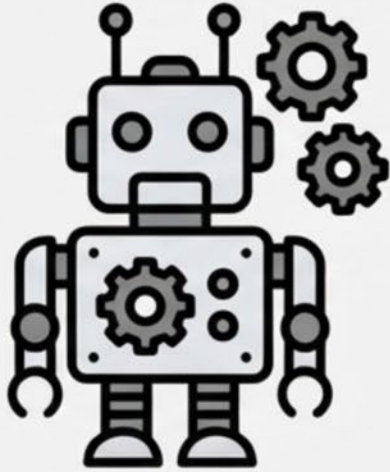
CPA Code of Ethics

The Logic Engine is consistent. The Rules are local.

Implementation & Risk Management



Aligns with ASPPB best practices for mobility and coordination



Brief, rough, demo of chatbot answering licensure candidate questions.

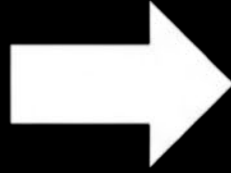


Table Talk and Q&A



Break into groups to discuss scenarios. Presenters will address questions after Table Talk.

Thank you.



Session 7:
Addressing Impairment in Psychologists:
Jurisdictional Approaches



Addressing Impairment in Psychologists: Minnesota's Approach

Session 7, April 18, 2026

1:30 PM

Agenda

- What is HPSP?
- Authority of HPSP
- Participant
- Evaluating and monitoring
- How boards pay for HPSP

Session 7

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

How HPSP operates under 214.31-214.35

- Authorization:

§ 214.31 - Two or more of the health-related licensing boards listed in section 214.01, subdivision 2, may jointly conduct a health professionals services program to **protect the public from persons regulated by the boards who are unable to practice with reasonable skill and safety by reason of illness**, use of alcohol, drugs, chemicals, or any other materials, or as a result of any mental, physical, or psychological condition

- Confidentiality:

§ 214.31 - **Data and agreements shall not be forwarded to the board unless the program reports a participant** to a board as described in section 214.33, subdivision 3.

- Reporting obligation:

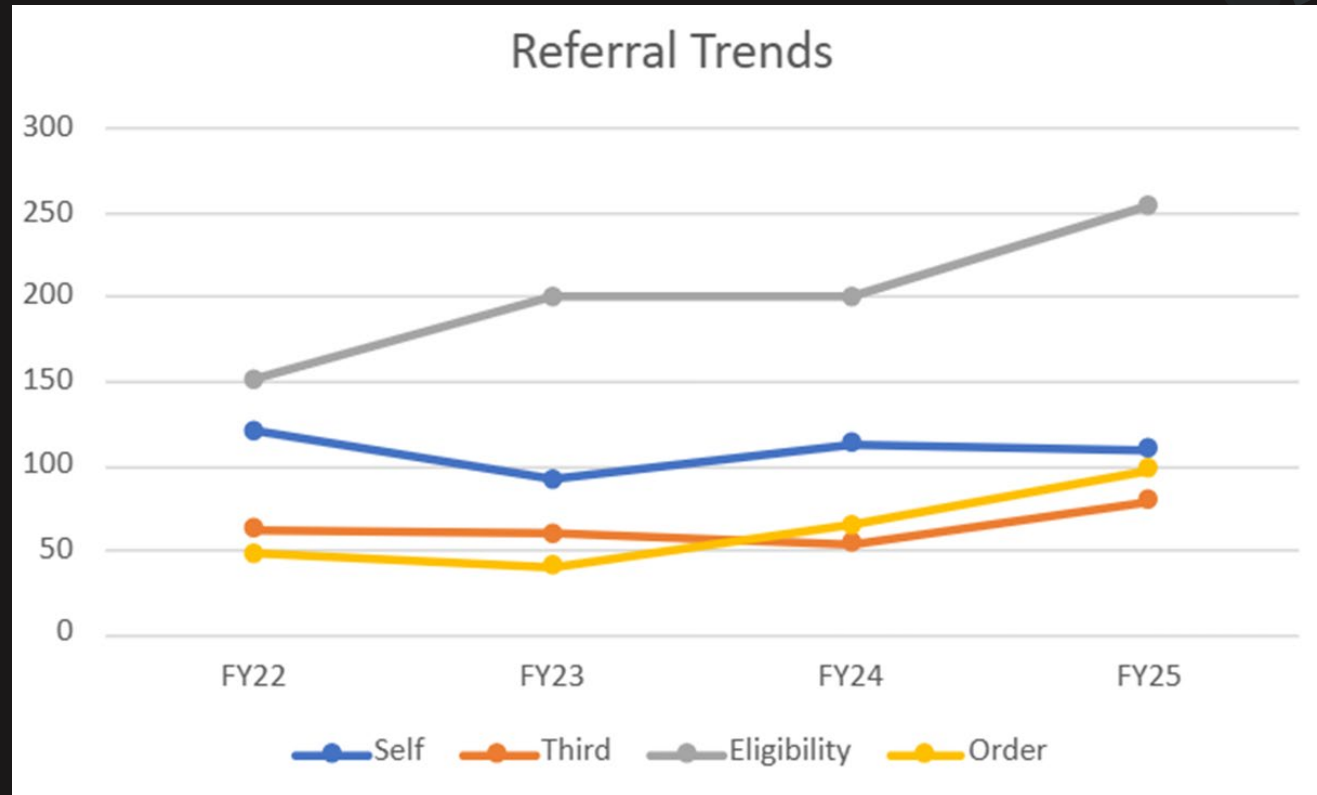
§ 214.33 - A report to the program under this subdivision **fulfills the reporting requirement contained in a regulated person's practice act**. Reports are confidential and are privileged communication.

- Discipline:

§ 214.35 - Each health-related licensing board **shall consider it grounds for disciplinary action if a regulated person violates the terms of the health professionals services program participation agreement** or leaves the program except upon fulfilling the terms for successful completion of the program as set forth in the participation agreement.

Types of Referrals

- Self-Report
- Third Party Report
- Board
 - Eligibility
 - Follow up
 - Order



Types of Referrals

- Self-Report
- Third Party Report
- Board
 - Eligibility
 - Follow up
 - Order

Fiscal Year ▶ Referral Source ▼	FY22	FY23	FY24	FY25
Board Voluntary	151	200	200	255
Board Discipline	48	40	65	98
Self	121	92	113	110
Third Party	62	60	54	79
Sum	382	392	432	542

Types of Referrals

- Self-Report
- Third Party Report
- Board
 - Eligibility
 - Follow up
 - Order

REFERRALS	Order	Eligibility	Third
FY 2025		2	
FY 2026	1		1

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

- Psychology – 2 active in HPSP; .5 active in HPSP per 1000 licensees

HPSP Functions

- Intake
 - Describe the program
 - Provide Tennessee
 - Obtain background information
 - Determine initial plan
- Determine if monitoring is warranted
- Develop a Participation Agreement
- Monitor Compliance with Participation Agreement
 - Site Monitors
 - Provider Reports
 - Screening

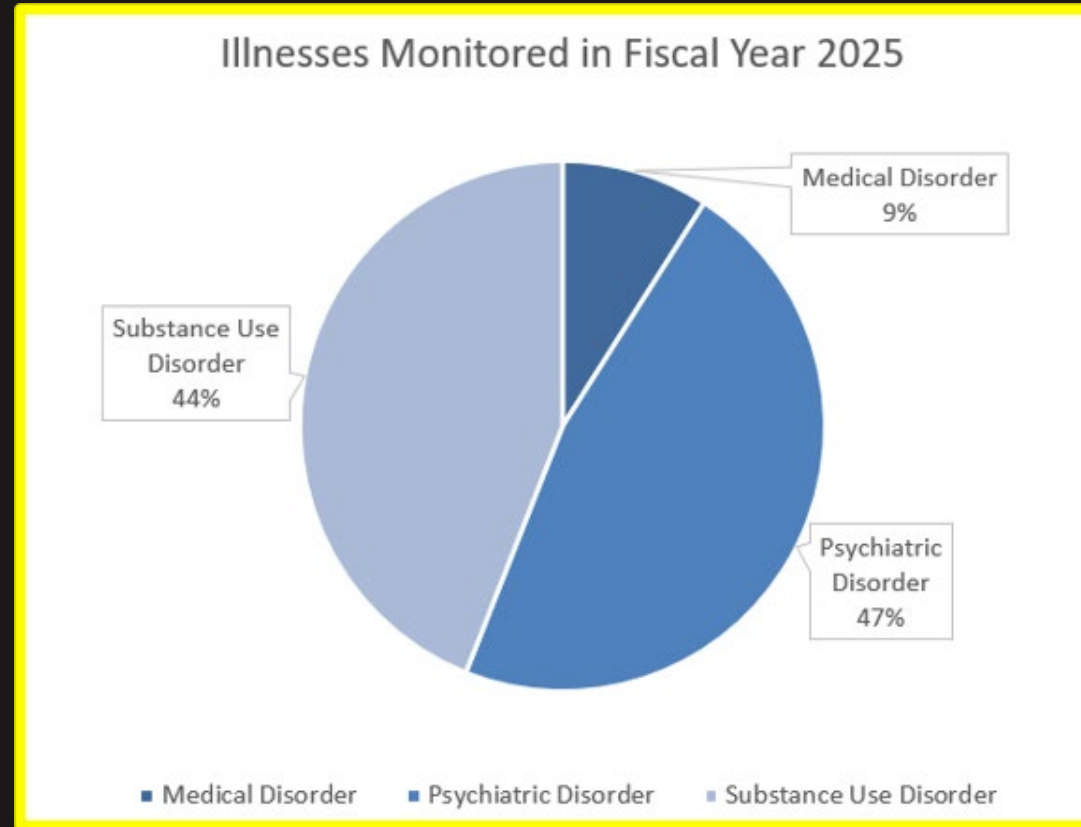
Determination for Monitoring

- Diagnosis of a current illness or history of illness
 - Active symptoms, triggers, and/or stressors
 - Treating Provider recommendations
 - History – usually five years
 - Profession and safety
-
- HPSP Team consult
 - Medical consultant – Dr. Sheila Specker
 - Follow up with treating providers
 - Follow up with enrollee

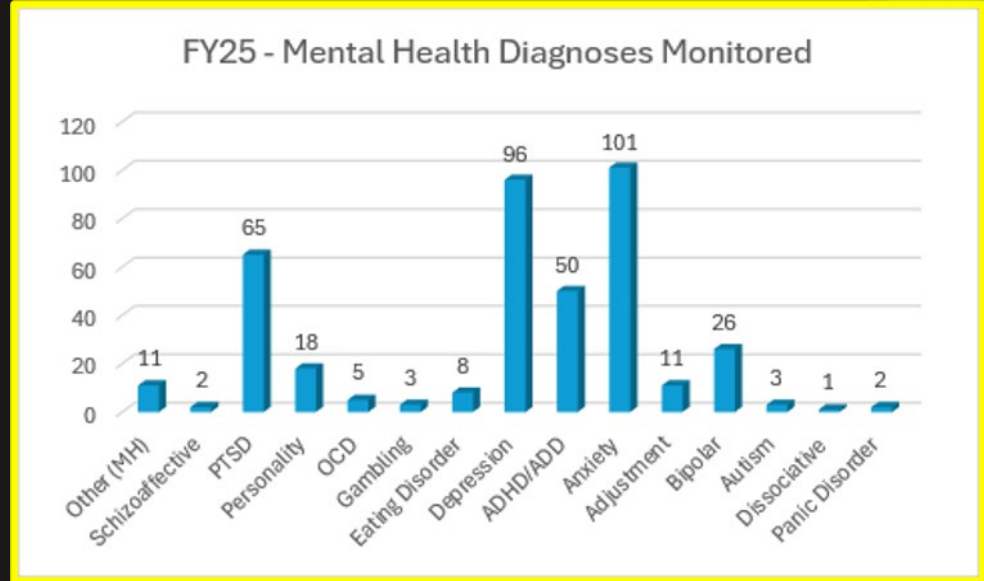
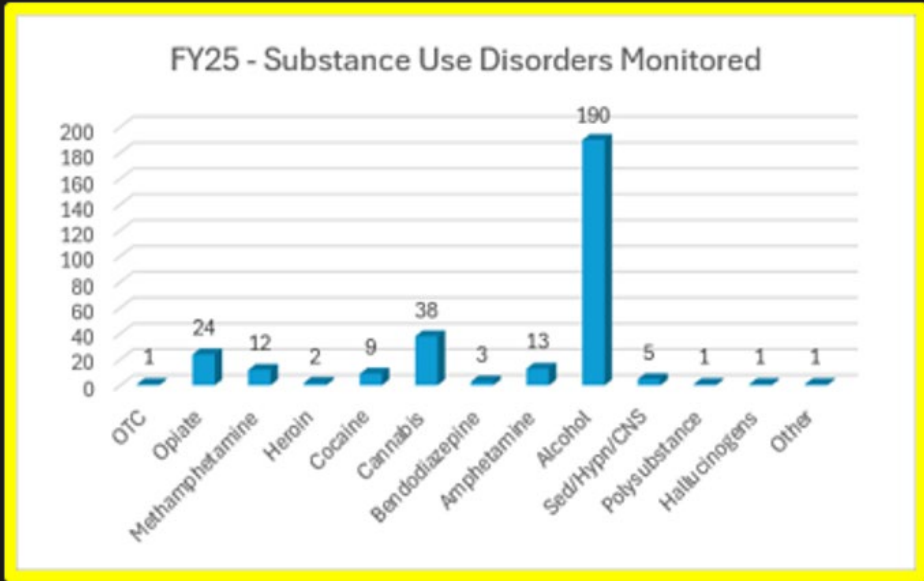
Illnesses Monitored

Medical Conditions

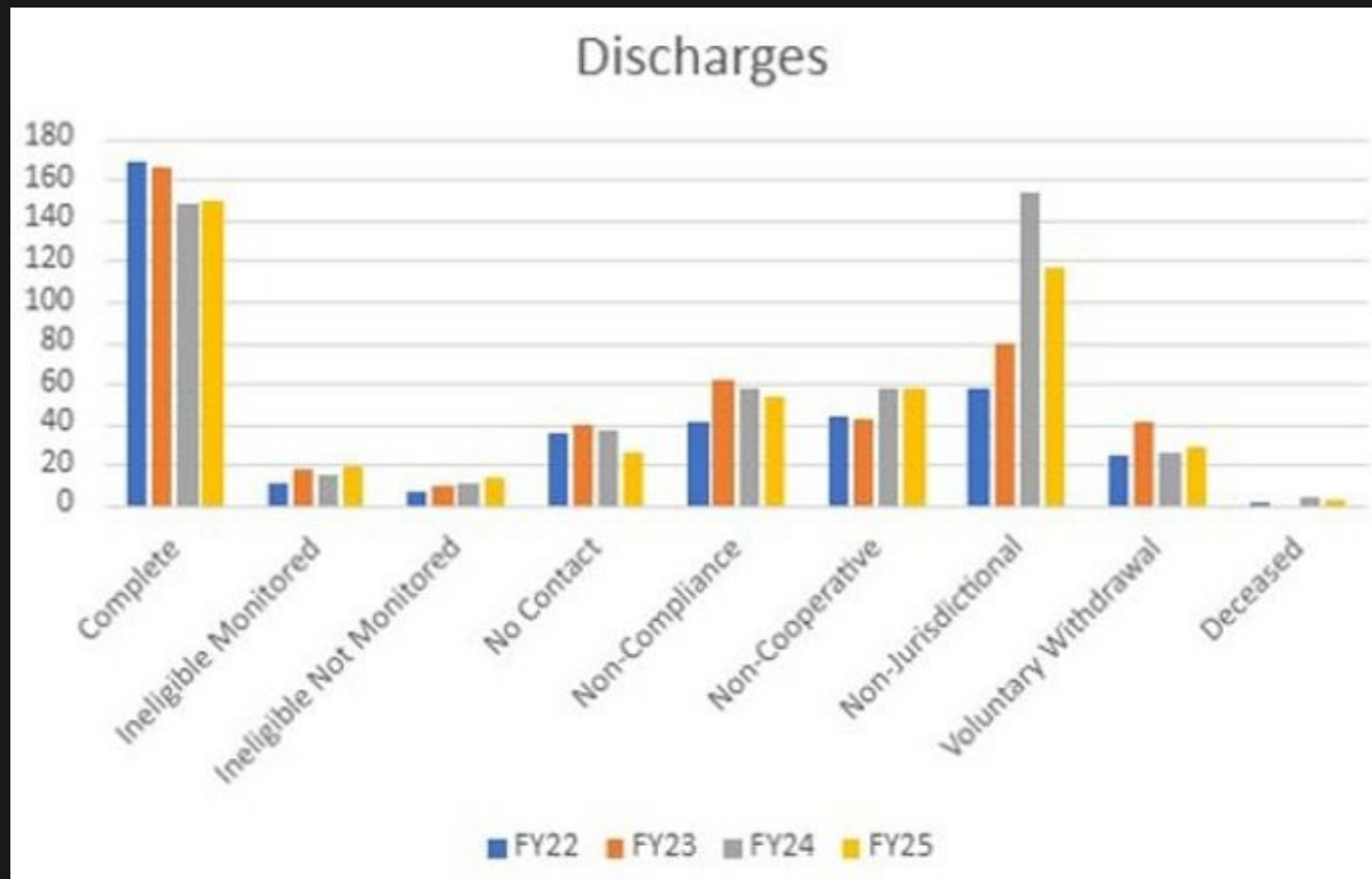
Chronic Pain
Diabetes
Migraines
Pulmonary
Cardiac
Neurology



Illnesses Monitored



Discharges from the program (all)



How boards pay for HPSP

- Participants pay for their healthcare
- Participants pay for their screens
- Each Board Pays \$1,000/annually or \$83.33/month for HPSP services
- Boards pay % of HPSP Expenses is based on Enrollees and Participants each Month
- HPSP Annual Expense = \$1,186,969.39

Questions?



Addressing Impairment in Psychologists: Jurisdictional Approaches

Session 7

April 18, 2026

1:30 PM

Arizona's Rehabilitation and Monitoring Program (RAMP)



A.R.S. §32-2086. Treatment and rehabilitation program

The board may establish a confidential program for the treatment and rehabilitation of psychologists who are impaired. The treatment and rehabilitation may include education, intervention, therapeutic treatment and posttreatment monitoring and support. The licensee is responsible for the costs associated with the treatment and rehabilitation, including monitoring.

Statutory History of A.R.S. §32-2086

- The Board's original statute language enacted in 1992
- Modeled after Medical, Dental, and Pharmacy Boards' programs
- Amended in 2009 to establish the program as *confidential*

A.R.S. §32-3223. Health profession regulatory boards; nondisciplinary confidential monitoring programs

Each health profession regulatory board may establish a nondisciplinary confidential program, including enrollment criteria for participation in the program, for the monitoring of a licensee or certificate holder who has been reported to or who voluntarily reports to the licensee's or certificate holder's regulatory board and who may be chemically dependent or have a substance misuse history or who may have a medical, psychiatric, psychological or behavioral health disorder that may impact the licensee's or certificate holder's ability to safely practice or perform health care tasks.

A.R.S. §32-3223. Health profession regulatory boards; nondisciplinary confidential monitoring programs

A program established may include education, intervention, therapeutic treatment and posttreatment monitoring and support. The licensee or certificate holder is responsible for the costs associated with any treatment, rehabilitation or monitoring under a program. The health profession regulatory board and the licensee or certificate holder may agree to enter into a nondisciplinary confidential stipulated agreement for participation.

Statutory History of A.R.S. §32-3223

- Enacted in 2017
- Legislative effort to standardize how Arizona health profession regulatory boards address licensees with substance abuse or mental health issues
- Created a more uniform framework for all Arizona boards
- Authorized some boards for the first time to develop a program

Building the RAMP

- An early 2020 case raised awareness of the need to develop and implement program procedures
- Proposed policies drafted by staff
 - Modeled after Osteopathic Medical Board and Board of Behavior Health Examiners programs
- Approved by the Board late summer 2020
- Six admissions to date

What is RAMP?

The Rehabilitation and Monitoring Program (RAMP) is a confidential rehabilitation treatment and monitoring program for psychologists and behavior analysts who self-report to the Board a chemical dependency, or a mental health disorder that may impact their ability to safely practice.

The program is customized to address the specific needs of the licensee, and is led by a Board-approved professional.

Purpose of RAMP

The Board established RAMP to support licensees struggling with impairment to assist them in their recovery and in the process protect the public.

The purpose of the program is to rehabilitate the professional to safely return to practice while circumventing harm to the public in the process.

Who is Eligible for RAMP?

Arizona licensed psychologists and behavior analysts who self-report to the Board either a chemical dependency, a mental health disorder, or both, qualify for the program.

A licensee must agree to undergo an appropriate evaluation by a Board-approved professional and must agree in writing to comply with all elements of the confidential RAMP Consent Agreement.

Who is Eligible for RAMP?

- Information received solely through a complaint filed against the licensee may, or may not, render the licensee ineligible
- Coerced or compelled self-reporting is likely a disqualifier
- The Board makes careful consideration of mitigating facts and circumstances when considering eligibility

RAMP Admission Considerations

The Board shall evaluate certain factors or conditions to ascertain RAMP eligibility, including, but not limited to:

- The licensee's acknowledgment that chemical dependency, psychiatric, psychological or behavioral health disorders are impairing his or her ability to safely and competently practice his or her profession
- The licensee voluntarily requests admission or accepts an offer of admission

RAMP Admission Considerations

The Board shall evaluate certain factors or conditions to ascertain RAMP eligibility, including, but not limited to:

- Any previous related disciplinary action(s) with the Board or other jurisdictions
- Any evidence indicating the licensee has caused harm to the public due to the impairment, and the risk of harm if the licensee is admitted to RAMP

RAMP Process

Preliminary intake by Board staff OR Board grants admission



Licensee agrees to interim suspension and evaluation



License is placed on inactive status



Licensee submits to the Board approved evaluation



Using evaluation report recommendations, Board establishes the recovery and monitoring terms in new agreement



Licensee agrees to these terms and resumes practice in accordance with the terms

RAMP Costs

- Board does not assess any program participation fees
- Licensee is responsible for
 - Cost of the evaluation(s) and
 - All costs stipulated in the RAMP Agreement

Promoting RAMP Awareness

- Periodic reminders are issued to licensees
- Website content under Resources menu
- Board meeting agendas reflect potential *confidential* RAMP actions

Acknowledgement from Participants

- “While this SCRA is not a disciplinary action, Participant acknowledges that any violation of the SCRA constitutes unprofessional conduct as defined in A.R.S. 32-2061(16)(aa), and may result in disciplinary action pursuant to A.R.S. 32-2086 and 32-2081.”
- “Participant shall participate in the Board’s confidential program for a minimum period of 12 months from the effective date of this SCRA.”

Cases to Date

- **Case 1: ECP, MH, Successful Completion**
- **Case 2: Not ECP, MH, (almost) Successful Completion**
- **Case 3: LBA, DNC (Moved out of state)**
- **Case 4: LBA, SUD & MH, Current**
- **Case 5: ECP, entered 2022, SUD & MH, DNC**
- **Case 6: Inquired but did not enter the program**
- **Case 7: ECP, MH, Successful Completion**
- **Case 8: Inquired but did not enter the program**

Outcomes and Lessons Learned

- Not all RAMP cases are personal success stories
- Two/three successful graduates in 5 years
- Inquiries do not always result in admission
- No allegations received of public harm

For More Information

psychboard.az.gov

Resources > RAMP

[Heidi Paakkonen – Executive Director](#)
heidi.paakkonen@psychboard.az.gov

[Jennifer Michaelsen – Deputy Director](#)
jennifer.michaelsen@psychboard.az.gov

References

- A.R.S. §32-2086. Treatment and rehabilitation program
- A.R.S. §32-3223. Health profession regulatory boards; nondisciplinary confidential monitoring programs
- Davidson, J. (2024). *Critical evaluations: Leadership perspectives on the role and effectiveness of PHPs in supporting physician well-being* (Publication No. 31548057) [Doctoral dissertation, Capella University]. FSPHP. https://www.fsphp.org/assets/RESOURCES/Research_about_PHPs_and_Health_Professionals/Critical%20Evaluation.Joyce%20Davidson.December%202024.pdf

Questions?



Sunday, April 19, 2026



Jurisdictions Taking Action on AI

Session 8, April 19, 2026

8:30 AM

Session 8

- This session will focus on legislation in Nevada and Illinois related to Artificial Intelligence and Mental Health providers
- Each presenter will provide an explanation of their respective bills, any impacts to date, enforcement process and any impacts seen or potential roadblocks due to the recent Executive Order 14179 “Ensuring a National Policy Framework for Artificial Intelligence”
- One hour program with a 15-minute Q and A included
- 1.25 Continuing Education Credits will be offered for this session



Illinois Approach

Joseph E. Comaty, MS, PhD, MSCP, MP, ABPP

Learning Objectives

- Participants will be able to describe the need for the passage of the Wellness and Oversight for Psychological Resources (WOPR) Act in IL.
- Participants will be able to describe the basic features of WOPR.
- Participants will be able to describe the impact of WOPR on the practice of psychology in IL.

Disclaimer

I am a current member of the Illinois Clinical Psychologists Licensing and Disciplinary Board. However, I do not represent the Board nor the Illinois Department of Financial and Professional Regulation (IDFPR). My comments are my own as an individual member of ASPPB and should not be considered as official statements from either the Psychology Board or IDFPR.

Wellness and Oversight for Psychological Resources (WOPR) Act - 2025

Wellness and Oversight for Psychological Resources (WOPR) Act

- WOPR – derived from War Operation Plan Response-NORAD supercomputer in War Games (1983) symbolizing the critical need to control powerful technology before it causes unintended harm.
- IL saw rapid expansion of tech companies offering AI-powered “therapy,” some marketed directly to vulnerable populations without any professional oversight. In one case, an AI chatbot told a journalist it was acceptable to use methamphetamine before driving a cab. In another, a user was told to commit suicide.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act

- Introduced as HB 1806 in the 104th General Assembly in 2025 by Rep. Bob Morgan.
- Passed by the legislature in August 2025 and signed by the Governor.
- Effective on the date signed by the Governor.
- Originated through NASW-Illinois in collaboration with Governor Pritzker, Representative Bob Morgan, Senator Ram Villivalam, and the Illinois Department of Professional Regulation.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act-What It Does

- Prohibits AI from acting as a therapist.
- Clearly defines what AI cannot do:
 - Make independent therapeutic decisions.
 - Directly interact with clients in any form of therapeutic communication.
 - Generate therapeutic recommendations or treatment plans without human review.
 - Detect emotions or mental states.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act—What It Does (Cont)

- Establishes boundaries for permitted AI use:
 - Administrative support (e.g., scheduling, billing, general logistics).
 - Supplementary support (e.g., drafting therapy notes, anonymized data analysis, referrals).
 - Session recording with consent.
- Defines “Therapy.”
 - Therapy: services provided to diagnose, treat, or improve an individual’s mental health or behavioral health.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act-What It Does (Cont)

- Defines “Therapeutic Communication.”
 - Therapeutic communication: includes any verbal, non-verbal, or written interaction intended to address mental or emotional concerns:
 - Interpreting feelings.
 - Providing strategies.
 - Developing treatment plans.
 - Offering psychological feedback.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act-What It Does (Cont)

- Makes it illegal for unlicensed individuals to offer therapy.
 - Prohibits any person or company from advertising or delivering therapy or psychotherapy services unless they are licensed by the State of Illinois.
- Enforces penalties up to \$10,000.00 per violation.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

APA Concerns

- The definition of AI is too broad-may ban FDA clear digital therapeutic tools.
- Section 15(b)(2): licensed professional cannot allow AI to “directly interact with clients in any form of therapeutic communication.”
- Legislation ought to focus on the developers and deployers:
 - Setting limits on users (and what ages) to access their chatbots.
 - Disclosures to users for transparency and consent
 - Kinds of information needing to be reported for public health purposes (CA, NY, UT).

Wellness and Oversight for Psychological Resources (WOPR) Act—What Is Not Covered

- Religious counseling.
- Peer support.
- Self-help materials and educational resources that do not purport to offer therapy or psychotherapy services.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act

- Enforcement:
 - Through the regular enforcement authority of IDFPR.
- As of February 2026, no report of any enforcement action.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act vs Executive Order

- Executive Order 14179 of January 23, 2025 (Removing Barriers to American Leadership in Artificial Intelligence).
- HB 1806 was drafted with federal preemption considerations in mind.
- The Act regulates professional practice and consumer protection within Illinois, areas that remain within state authority.
- It does not regulate AI development generally, nor does it impose technical design requirements on AI systems.
- As such, the statute has been viewed as complementary to federal AI policy rather than in conflict with it, and no federal challenge or preemption action has been raised to date (as of February 2026).

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Wellness and Oversight for Psychological Resources (WOPR) Act - Impact

- Mostly on commercial vendors operating AI-based mental health tools in Illinois.
- Several companies modified marketing language, clarified disclosures or restructured clinical oversight models following passage.
- From the provider perspective, the law has reinforced existing ethical and licensure expectations regarding delegation, supervision, and the appropriate use of digital tools in practice.

Derived from NASW-IL News Release at <https://www.naswil.org/post/nasw-il-advocacy-at-work-gov-signs-hb-1806-creating-nation-s-strongest-safeguard-against-ai-chatbo> Accessed: 2/15/26.

Thanks

- Mr. Kyle Hillman, Director of Legislative Affairs for NASW-IL.

Illinois Psychologists Licensing & Disciplinary Board

Illinois Psychologists Licensing & Disciplinary Board

- An advisory board under the IL Department of Financial & Professional Regulation (IDFPR). Provides advice to the Secretary.
- Eleven members appointed by the Secretary:
 - 4 licensed clinical psychologists.
 - 2 licensed prescribing psychologists.
 - 2 psychology faculty members of accredited colleges or universities.
 - 1 psychiatrist.
 - 1 primary care/family physician.
 - 1 public member.

Illinois Psychologists Licensing & Disciplinary Board

- Recommendations for members can come from multiple sources.
- The Board is charged with providing expert knowledge and advice on disciplinary matters and professional performance and conduct.
- Board information: Agenda, Minutes, Members, etc.:
<https://idfpr.illinois.gov/profs/boards/psy.html>.
- Members can serve 2 full four-year terms.
- Last meeting: November 2025; Next meeting: May 2026.
- IDFPR responsible for licensing of 121 professions.

Illinois Psychologists Licensing & Disciplinary Board

- The Board makes recommendations to the Secretary:
 - CE requirements.
 - 24 hours per renewal period:
 - 3 hours ethics
 - 3 hours diversity
 - 1 hour sexual harassment prevention training
 - 1 hour implicit bias awareness training
 - 1 hour Alzheimer's Disease and Other Dementia training (once every 3 renewal periods)
 - 1 hour Cultural Competency training
 - + 20 in psychopharm for PPs

Illinois Psychologists Licensing & Disciplinary Board

- The Board makes recommendations to the Secretary:
 - Licensure and discipline of Prescribing Psychologists.
- Statute:

<https://ilga.gov/Legislation/ILCS/Articles?ActID=1294&ChapAct=225 ILCS 15/&ChapterID=24&ChapterName=PROFESSIONS%20AND%20OCCUPATIONS&ActName=Clinical%20Psychologist%20Licensing%20Act.&Print=True>

Illinois Psychologists Licensing & Disciplinary Board

- Rules:

<https://www.ilga.gov/agencies/JCAR/Sections?PartID=06801400&TitleDescription=TITLE%2068:%20%20PROFESSIONS%20AND%20OCCUPATIONS>

- Last meeting: November 2025; Next meeting: May 2026.
- IDFPR responsible for licensing of 121 professions.

Thank You!

References

- HB 1806: Wellness and Oversight for Psychological Resources (WOPR) Act of the IL 104th General Assembly.
<https://ilga.gov/Documents/Legislation/PublicActs/104/PDF/104-0054.pdf>.
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- Executive Order 14179 of January 23, 2025 (Removing Barriers to American Leadership in Artificial Intelligence).
<https://www.federalregister.gov/documents/2025/01/31/2025-02172/removing-barriers-to-american-leadership-in-artificial-intelligence>.



Nevada's Approach to AI – AB406

Session 8, April 19, 2026

8:30 AM

Session 8 – Nevada AB 406

- Identify three impacts of AB 406 on Nevada’s mental and behavioral health practitioners
- Identify the pros and cons of AB406 on the use of AI in mental and behavioral health practice
- Identify potential negative impacts to consumers when using AI for mental and behavioral healthcare

AB406 Overview

- Introduced in the 2025 Legislative Session
- Presented by:

Assemblyman Jovan A. Jackson, Nevada Assembly District 6

Kyle Hillman, Executive Director of the National Association of Social Workers

Tessyn Opferman, Director of Government Affairs for Pinyon Public Affairs

Introduced April 3, 2025 in the Nevada Assembly Committee on Education



This legislation reflects Nevada's commitment to balancing technological innovation with the integrity and quality of mental health care provided in both educational and health care settings. This bill still recognizes the benefits of using technology to support administrative tasks, but by establishing clear standards and safeguards, A.B. 406 aims to protect vulnerable populations and ensure professional judgment remains central to the delivery of mental health services.

~Assemblyman Jackson

Major Areas of Impact

- Nevada Department of Education
- AI Companies/Providers
- Licensed Mental and Behavioral Health Providers

AB406 – Impact on Schools

Prohibits use of AI to perform mental health functions and duties of a school counselor, school psychologist, or school social worker

Requires the Department of Education (DOE) to develop policies for the use of AI in the public schools

Policy must include a method for the DOE to examine the accuracy and efficacy of the use of AI

Pros and Cons

Pros

- Protect student data and confidentiality
- Reinforces human clinical judgment

Cons

- May slow beneficial clinical AI augmentation
- Reduces providers clinical judgment in the use of AI

AB406 – Impact on AI Companies

Prohibits AI provider from offering AI systems that provide a service or experience that would constitute the practice of mental or behavioral health care

Prohibits AI provider from representing themselves as a mental or behavioral healthcare provider

Pros and Cons

Pros

- Greater consumer protection – You know you are getting a real licensed provider, not a robot
- Greater license protection - Protects licensed providers and the value of a license
- Prevents misrepresentation and potential unsubstantiated claims by AI companies
- Reduce potential scope creep of AI tools
- Protects consumer confidentiality and sensitive identifying information*

Cons

- Limits potential innovation and access to care
- If all jurisdictions do not adopt this, potential limits consumer mobility and access to care

HIPAA does not necessarily apply when...

An AI tool is used directly by consumers

The AI tool is marketed as “wellness” vs healthcare

AB406 – Impact to Licensed Mental and Behavioral Health Providers



Mental and behavioral health care providers may not use AI systems to provide professional mental and behavioral healthcare directly to a patient



Mental and behavioral health care providers may use AI to: schedule appointments, manage records, bill patients and manage billing records, analyze data for operational purposes, organize, track, and manage files or notes related to sessions with a patient



ASPPB
Association of State and
Provincial Psychology Boards

Pros and Cons

Pros

- Protect consumer confidentiality and data
- Protect consumers from bad acting mental health providers who may prematurely adopt untested tools
- Allowance of the use of AI to reduce the burden of administrative tasks to increase focus on clinical work
- Reduces risk of potential harm to consumers of AI chatbots

Cons

- Prevents adoption of well-researched tools in the future (ex. FDA Regulated chatbots)
- Reduces provider ability to use clinical judgment when adopting potentially useful AI tools

Enforcement

1

Civil penalties - \$15,000 per violation for AI providers/companies

2

Licensing boards – can discipline providers for unprofessional conduct and violation of the statute

Current Complaints

AB406 vs President's Executive Order 14179

- **In the short term, there is no current conflict that exists between this state law vs the presidents EO**
- **There is potential conflict in the future with the tension between the drive for federal AI innovation and states rights to protect patients and consumers**
- **It has yet to be determined how potential federal pressure or litigation against restrictive state laws will play out**

**To regulate the use of
AI in mental health,
or not regulate it,
that is the question**



**Don't let anybody,
not even AI, be
your voice.
~Senator Marilyn
Dondero Loop**

References

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2. Fortunato, L., Evans, C., & Baker, D., (2026, Feb. 17). State Legislation on AI: Emerging Restrictions and Implications for Mental Health Practice. (Powerpoint Slides). APA Div.31 AI Town Hall.
3. Health Insurance Portability and Accountability Act Privacy Rule, 45 C.F.R. § 160 & § 164 (2024).
4. Nevada Legislature. (2025). *Assembly Bill 406: Makes various changes relating to health (BDR 34- 674), Chapter 283*. https://www.leg.state.nv.us/Session/83rd2025/Bills/AB/AB406_EN.pdf
5. Nevada Legislature. (2025, April 10). Minutes of the Meeting of the Assembly Committee on Education. <https://archive.leg.state.nv.us/Session/83rd2025/Minutes/Assembly/ED/Final/754.pdf>
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Session 9:
**Discussion on the Proposed American Psychological
Association's Model Act**

Alex Siegel, JD, PhD

ASPPB Acronym List

-A-

AASPB	American Association of State Psychology Boards (former name of ASPPB)
ABPP	American Board of Professional Psychology www.abpp.org
ACCA	Advisory Committee on Colleague Assistance (APA) http://www.apa.org/practice/leadership/colleague-assistance.aspx
ACCTA	Association of Counseling Center Training Agencies http://www.accta.net/
ACPRO	Association of Canadian Psychology Regulatory Organizations http://www.acpro-acrp.ca/
APA	American Psychological Association www.apa.org
APA Council	APA Council of Representatives http://www.apa.org/about/governance/council/index.aspx
APAGS	American Psychological Association of Graduate Students (APA) www.apa.org/apags/
APPIC	Association of Psychology Postdoctoral and Internship Centers www.appic.org
ASPPB	Association of State and Provincial Psychology Boards www.asppb.net

-B-

BARC	Board Administrators/Registrars Committee (ASPPB)
BEA	APA Board of Educational Affairs http://www.apa.org/ed/governance/bea/index.aspx
BPA	APA Board of Professional Affairs http://www.apa.org/practice/leadership/bpa/index.aspx
BOD	ASPPB Board of Directors
BCCC	Board and College Chairs Committee

-C-

CAPP	Committee for the Advancement of Professional Practice (APA) http://www.apa.org/practice/leadership/capp/index.aspx
CCOPP	Council of Credentialing Organizations in Professional Psychology http://www.apa.org/ed/graduate/specialize/ccopp.aspx
CCPPP	Canadian Council of Professional Psychology Programs http://www.ccppp.ca/
CCPTP	Council of Counseling Psychology Training Programs http://www.ccptp.org/
CCTC	Council of Chairs of Training Councils http://psychtrainingcouncils.org/
CDSPP	Council of Directors of School Psychology Programs https://sites.google.com/site/cdspphome/
CEC	Committee on Exam Coordination (ASPPB)
CECP	APA Committee on Early Career Psychologists http://www.apa.org/careers/early-career/committee/index.aspx
CESPPA	Council of Executives of State, Provincial (and Territorial) Psychological Associations
CLEAR	Council on Licensure, Enforcement and Regulation http://www.clearhq.org/
CoA	APA Commission on Accreditation http://www.apa.org/ed/accreditation/
CODI	Committee on Disciplinary Issues (ASPPB)
CoS	Council of Specialties in Professional Psychology http://cospp.org/
CPA	Canadian Psychological Association http://www.cpa.ca/
CPQ	Certificate of Professional Qualification in Psychology (ASPPB)

ASPPB Acronym List
Page 2

CRHSPP	Canadian Register of Health Service Providers in Psychology http://www.crhssp.ca/		-H-
		HIPAA	Health Insurance Portability and Accountability Act
CRSPPP	Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (APA) http://www.apa.org/ed/graduate/specialize/crsppp.aspx		-I-
		IAAP	International Association of Applied Psychology http://www.iaapsy.org/
CUDCP	Council of University Directors of Clinical Psychology http://cudcp.us/	ICE	Institute for Credentialing Excellence (formerly NOCA) http://www.credentialingexcellence.org/
	-D-	IDC	EPPP Part 1 Item Development Committee (ASPPB)
Division 13	Society of Consulting Psychology (APA) http://www.apadivisions.org/division-13/index.aspx	IDC2	EPPP Part 2 Item Development Committee (ASPPB)
	-E-	I/O	Industrial Organizational (Psychology)
EFPA	European Federation of Psychologists Associations http://www.efpa.eu/	IPC	Interjurisdictional Practice Certificate (ASPPB)
ELC	APA Education Leadership Conference http://www.apa.org/ed/governance/elc/index.aspx	IUPsyS	International Union of Psychological Science
EPPP	Examination for Professional Practice in Psychology (ASPPB)		-J-
ExC	EPPP Part 1 Examination Committee (ASPPB)	JDAC	Joint Designation Appeals Committee (ASPPB/NR)
ExC2	EPPP Part 2 Examination Committee (ASPPB)	JDC	Joint Designation Committee (ASPPB/NR)
	-F-	JTA	Job Task Analysis (ASPPB)
FAC	Finance & Audit Committee (ASPPB)		
FARB	Federation of Associations of Regulatory Boards http://www.farb.org/		

(ASPPB)

-M-

MARC Model Act and Regulations Committee
(ASPPB)

MOB Mobility Committee (ASPPB)

MYM Midyear Meeting (ASPPB)

SIOP

-S-

Society for Industrial and Organizational
Psychology – APA Division 14
<http://www.siop.org/>
<http://www.apa.org/about/division/div14.aspx>

-N-

NCSPS National Council of Schools and
Programs of Professional Psychology
<http://www.ncspp.info/>

NOMS Nominations Committee (ASPPB)

NR National Register of Health Service
Providers in Psychology
<http://www.nationalregister.org/>

-P-

P&P Policies & Procedures

PEP Psychopharmacology Examination for
Psychologists

PEP-EDC Psychopharmacology Examination for
Psychologists Examination Development
Committee

PEPPP Practice Examination for Professional
Practice in Psychology Part 1 (EPPP Part
1 practice examination at testing
centers)

PEPPPO Practice Examination for Professional
Practice in Psychology Part 1 Online
(EPPP Part 1 practice examination
online)

PLC State Leadership Conference
<http://www.apapracticecentral.org/advocacy/state/slc.aspx>

PLUS Psychology Licensure Universal System
(ASPPB)

PSYPACT Psychology Interjurisdictional Compact

Who is Responsible?

Governing Psychological Practice
in an Era of Artificial Intelligence

Presented by
Dr. Ernest Wayde
Wayde AI LLC

40th MIDYEAR MEETING
Charlotte, North Carolina
April 17th, 2026



The danger wasn't that machines would become too intelligent.

It was that humans would be too quick to believe that machines were intelligent.



Disclosure

- I have no financial relationships, affiliations, or conflicts of interest with any AI company or application listed or mentioned.
- This presentation provides information on AI systems and applications for educational purposes only and does not endorse or recommend any particular product.
- Some of the content was generated with the assistance of AI applications.
- Information presented reflects the state of knowledge as of March 2026.



Learning Objectives

- Describe how artificial intelligence is currently intersecting with regulated psychological practice.
- Recognize where responsibility and accountability remain with licensed psychologists when AI is involved.
- Discuss key governance questions psychology boards/colleges may face related to AI and public protection.

Join the Conversation

We want to hear from you.

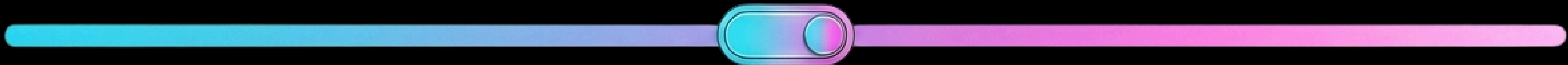
You will need your phone or a computer to participate.

<https://ahaslides.com/AINPSYCH>

AhaSides Code:
AINPSYCH



How would you describe your current perspective on AI in professional practice?



Worried
Hesitant

Nervous
Anxious

Neutral
Observing

Curious
Learning

Excited
Ready to Use AI

Results

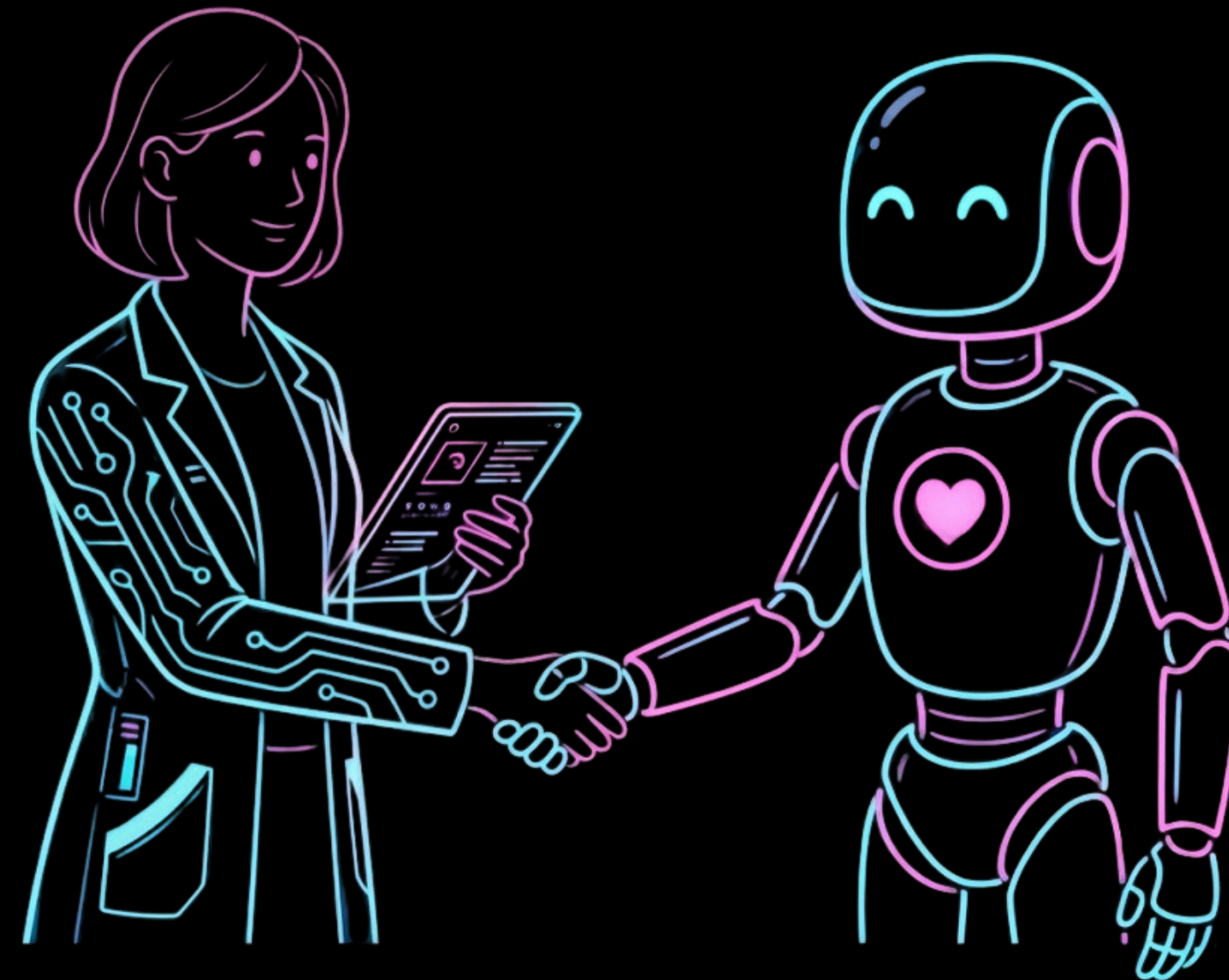


What Happens When AI Enters the Room?

Environment: Rapid Change and High Stakes Care

Will this replace me
and my clinical
judgement?

How do we
preserve ethics
and trust?



Who's responsible if
harm occurs?

Is it appropriate in
professional
practice?

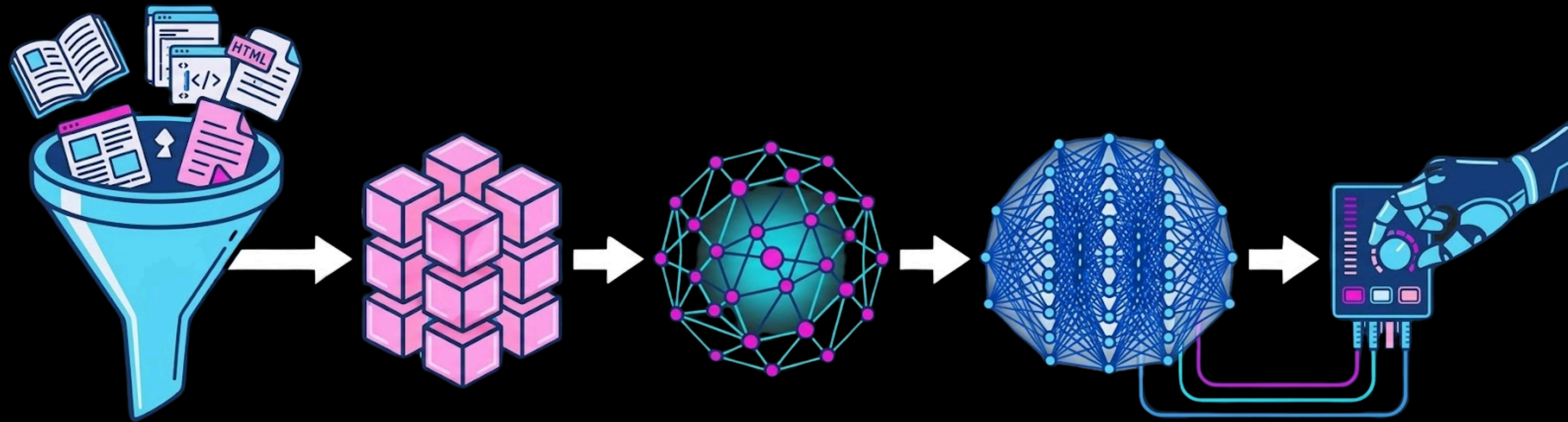
3 Question Framework

- **What** is AI specifically?
- **How** is it different from what a psychologist does?
- **What** is our ethical responsibility, whether we use AI or not?



How LLMs Are Trained

Large Language Models (LLMs)



Data Collection

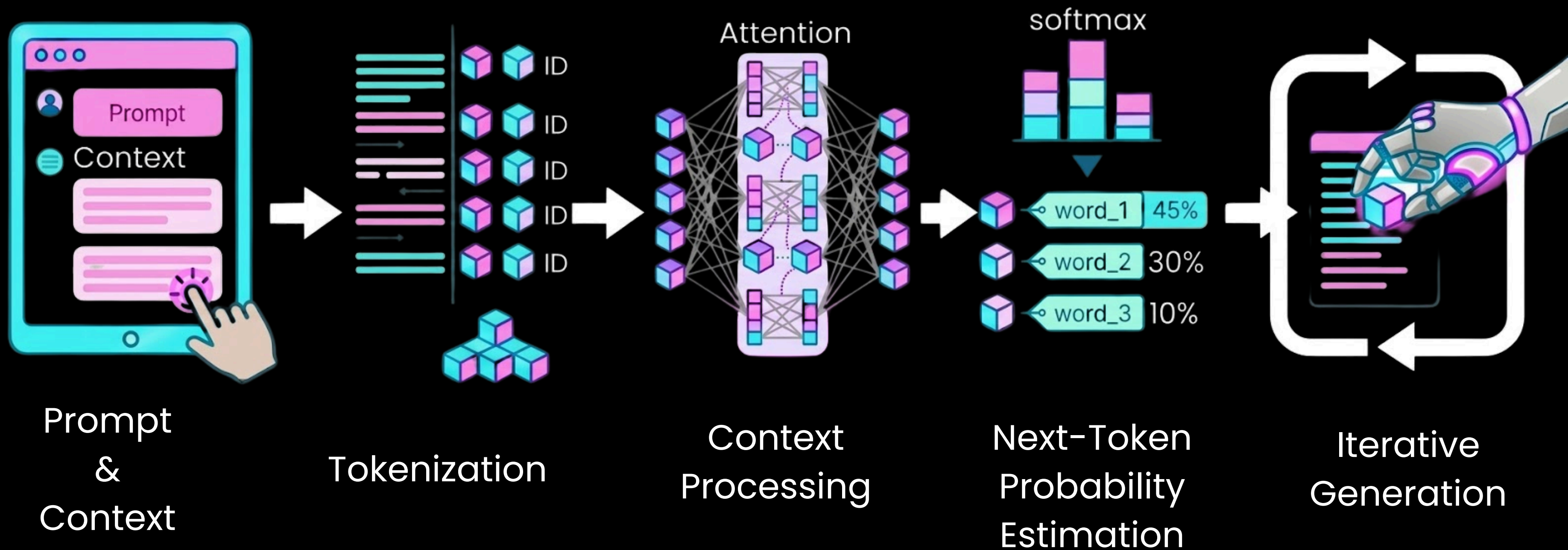
Preprocessing

Embedding

Pre-Training

Fine-Tuning

How LLMs Respond



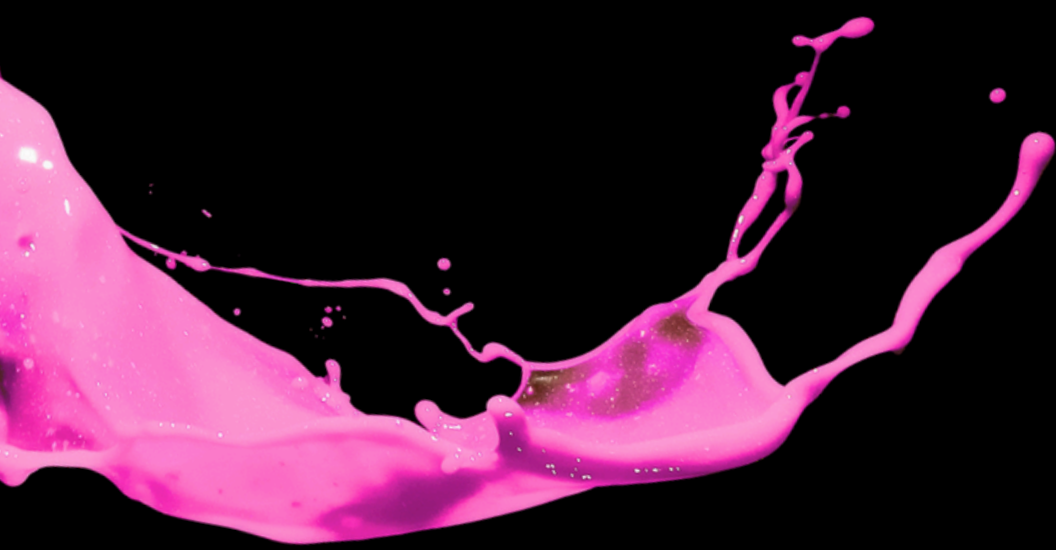
What AI Can Do

- **Pattern Recognition**
- **Drafting and summarizing**
- **Early risk detection**

- **56% of clinicians have used AI tools in their practice in the past year**
 - 29% use AI monthly
 - 52% of clinicians use AI to writing and draft emails
 - 32% of clinicians use AI to summarize content

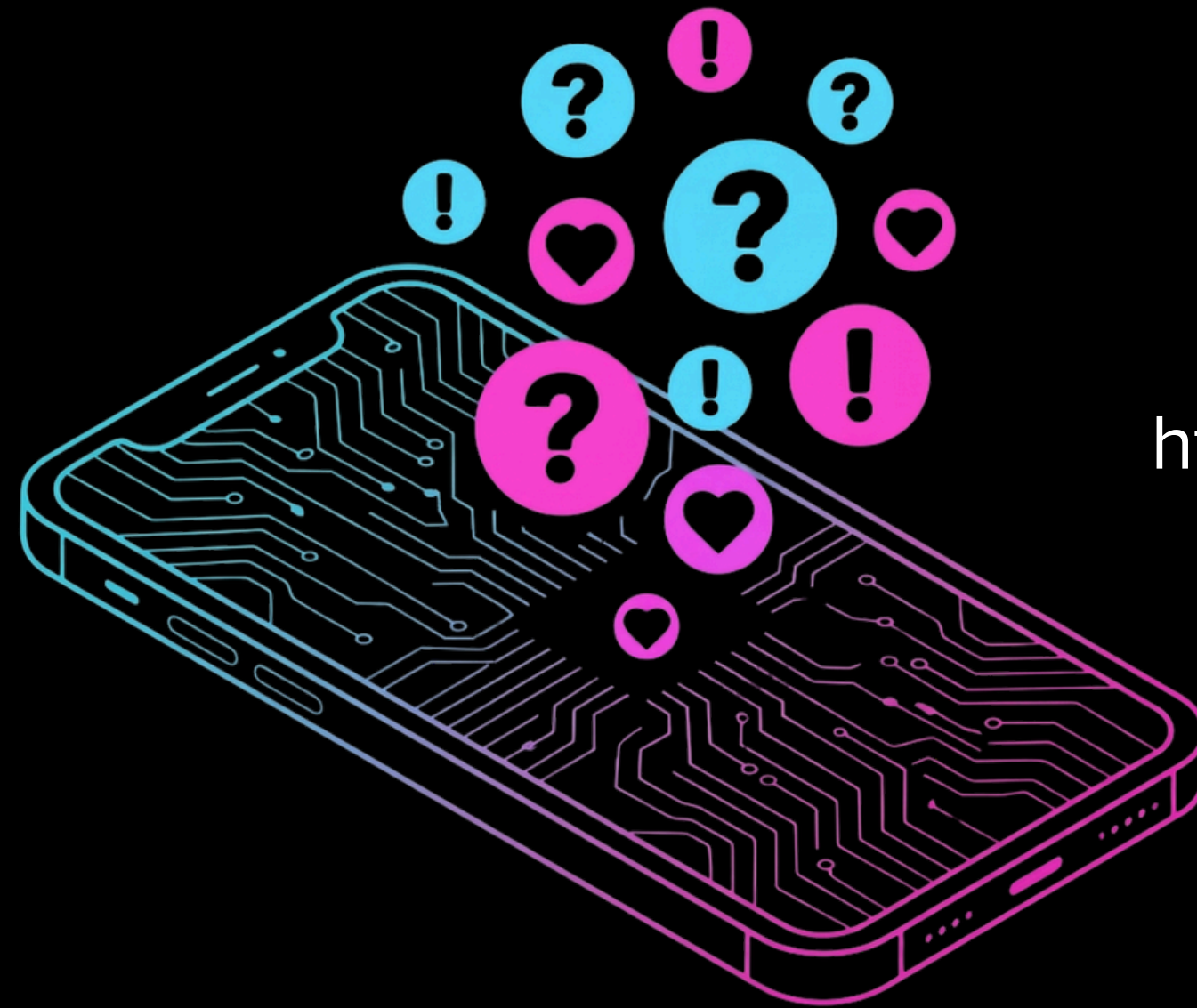


Demonstration



What would you expect a psychologist to do before signing the note?

AhaSlides Code:
AHAINPSYCH



<https://ahaslides.com/AIINPSYCH>

Results



What Remains with the Psychologist



Professional
Judgment



Ethical
Duty



Accountability



Therapeutic
Relationship

Existing Authority, New Questions

Assistance

- Draft notes.
- Conduct reviews.
- Summarize content.

Delegation

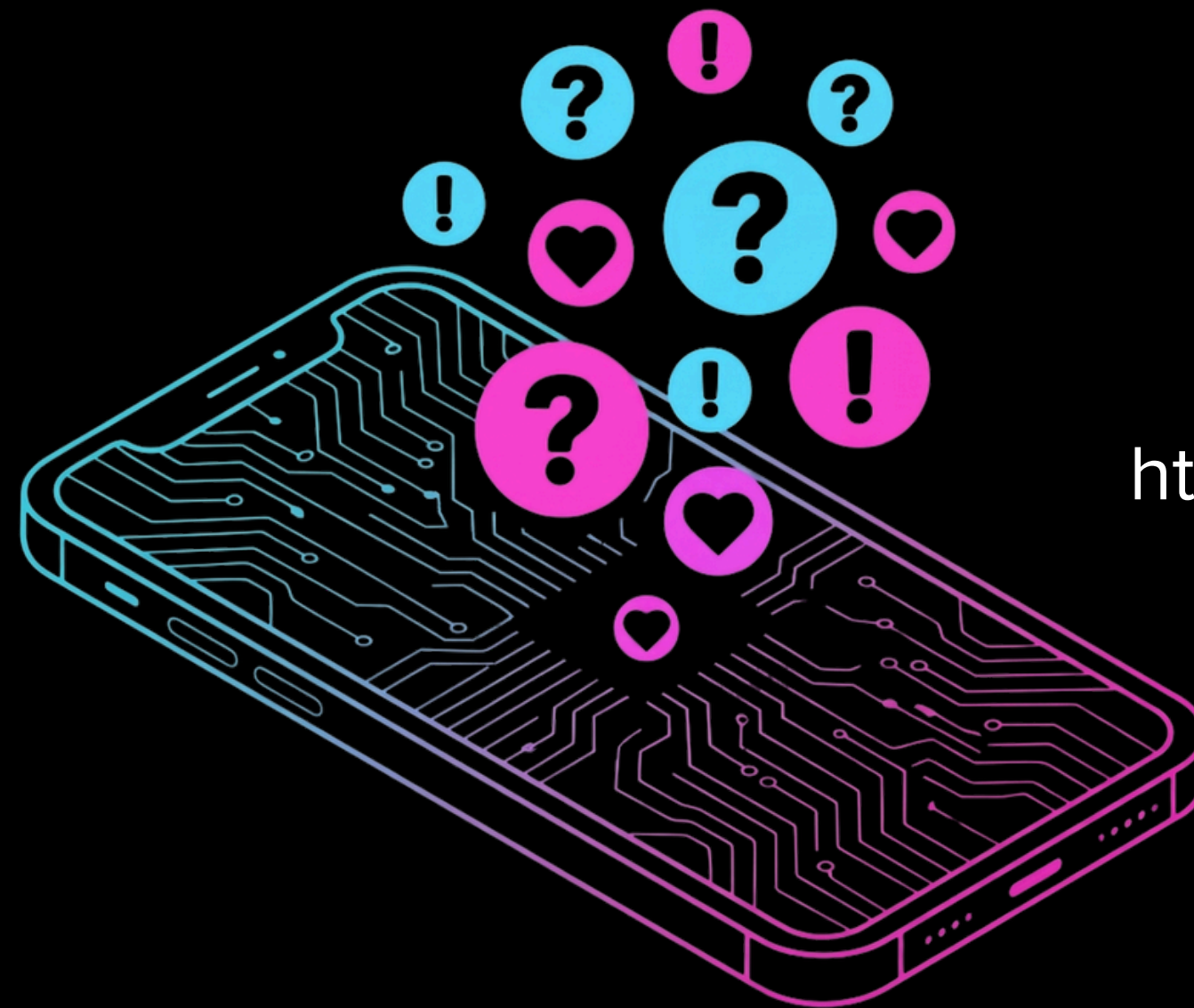
- Informed consent.
- Diagnosis.
- Crisis assessment and intervention.



The
Grey

Where is AI already touching regulated practice?

AhaSlides Code:
AINPSYCH



<https://ahaslides.com/AINPSYCH>

Results



A Regulatory Problem



AI Under Law: The New US State Frontiers

CA: SB 53 Transparency in Frontier AI Act

Requires frameworks for catastrophic risks and reports of safety incidents

NY: AB 6453B RAISE Act

Requires publishing of safety and security protocols, prohibits models that create “Unreasonable risk of critical harm”, mandates reporting of safety incidents

CO: SB 205 Consumer Protections

Reasonable Care: Prevent discrimination, impact assessment, disclosure

TX: HB 149 Responsible AI Governance Act

Mandatory disclosure for government, health care, and health providers, prohibits AI usage for illegal activities and social scoring

IL: HB 1806 Wellness and Oversight for Psychological Resources Act

Prohibits therapy unless a licensed individual, AI prohibited from making therapeutic decisions, directly interacting with clients in therapy communications, unapproved generated treatment plans

UT: SB 149 & SB 226 AI Policy Act

AI not a defense for violating consumer protection, mandatory proactive AI disclosure in regulated occupations (mental health, medical, legal, finance), created the Office of AI Policy and regulatory learning lab

AI Under Law: The New Canadian Frontiers

Food and Drugs Act

Regulates machine learning-enabled software for medical purposes, such as diagnosis or treatment.

Accessible Canada Act

Removes obstacles for those with disabilities. Mandates that AI healthcare products and services must be accessible and inclusive by design.

Medical Devices Regulations

AI medical devices are subjected to risk-based compliance, inspections, and mandatory problem reporting.

Official Languages Act

Ensures English and French have equality of status, rights, and privileges. AI software in healthcare must be fully functional and available in both languages.

Personal Information Protection and Electronic Documents Act (PIPEDA)

Governs the use of health data by private companies that develop or deploy AI healthcare solutions outside of federal government institutions.

Privacy Act

Determines how government collect, use, and disclose data. In healthcare AI systems are used may be utilized federal agencies to secure sensitive patient data for only authorized purposes.

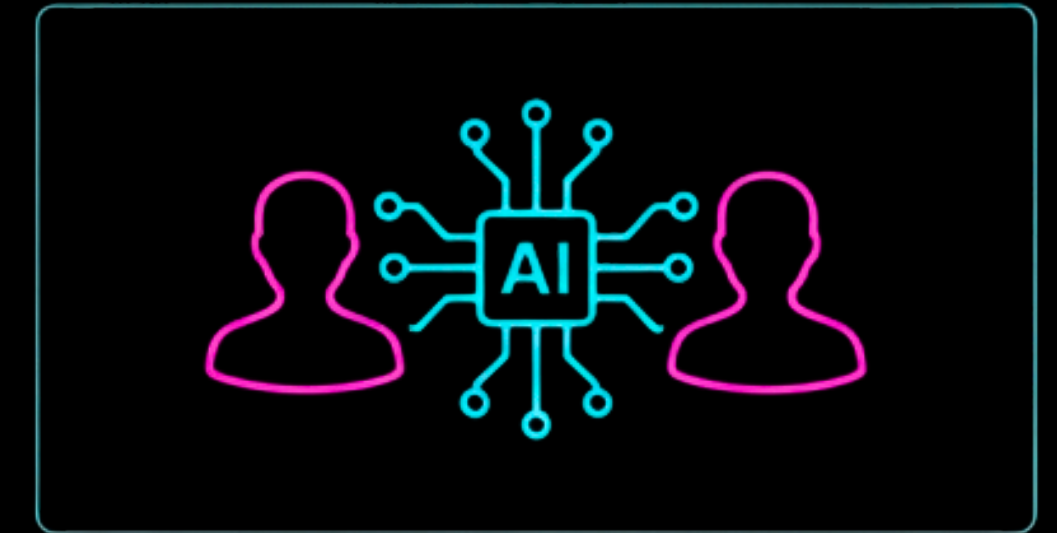
Scenarios



Documentation



Assessment



Supervision



Client Compliant



Credentialing

The Board Position- To Govern People Not AI



No established standards



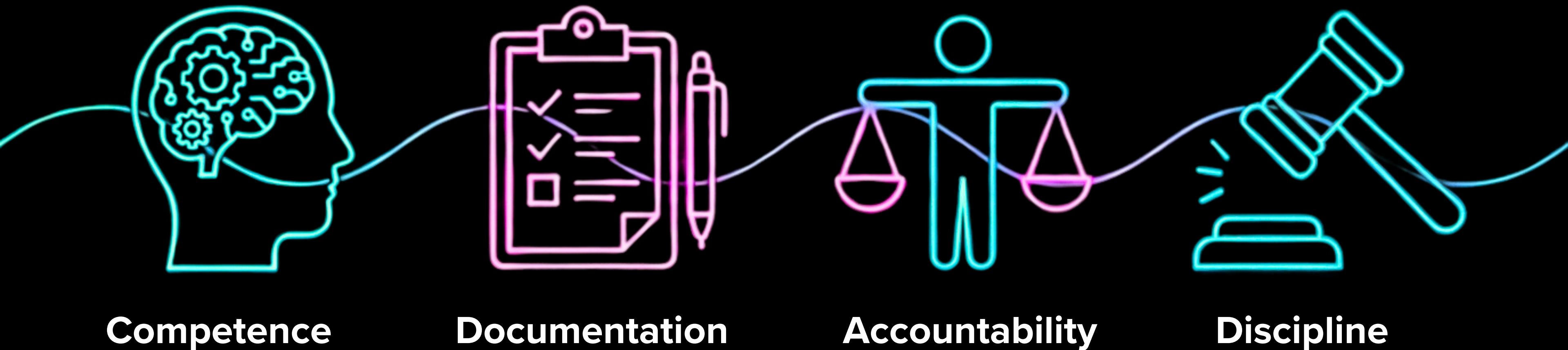
Speed mismatch



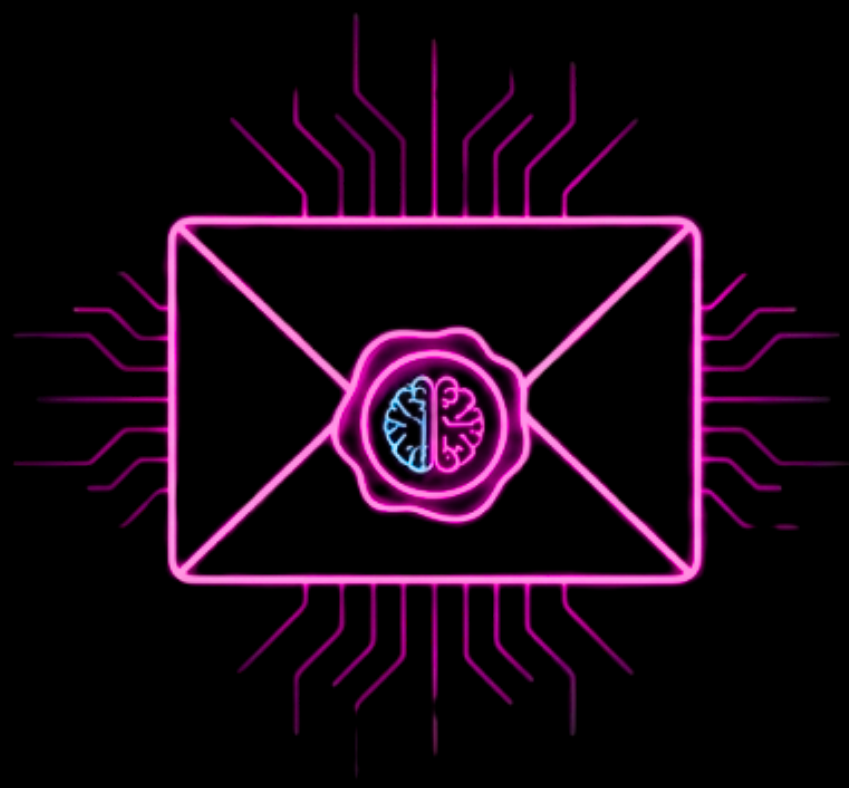
Scale



Jurisdiction Remains the Same



A Complaint Arrives - What Happens Next?



What to look for:

- Was AI involved?
- Was the output reviewed
- Is the note accurate

What does not exist:

- Any AI disclosures
- Evidence of judgment
- AI specific standards

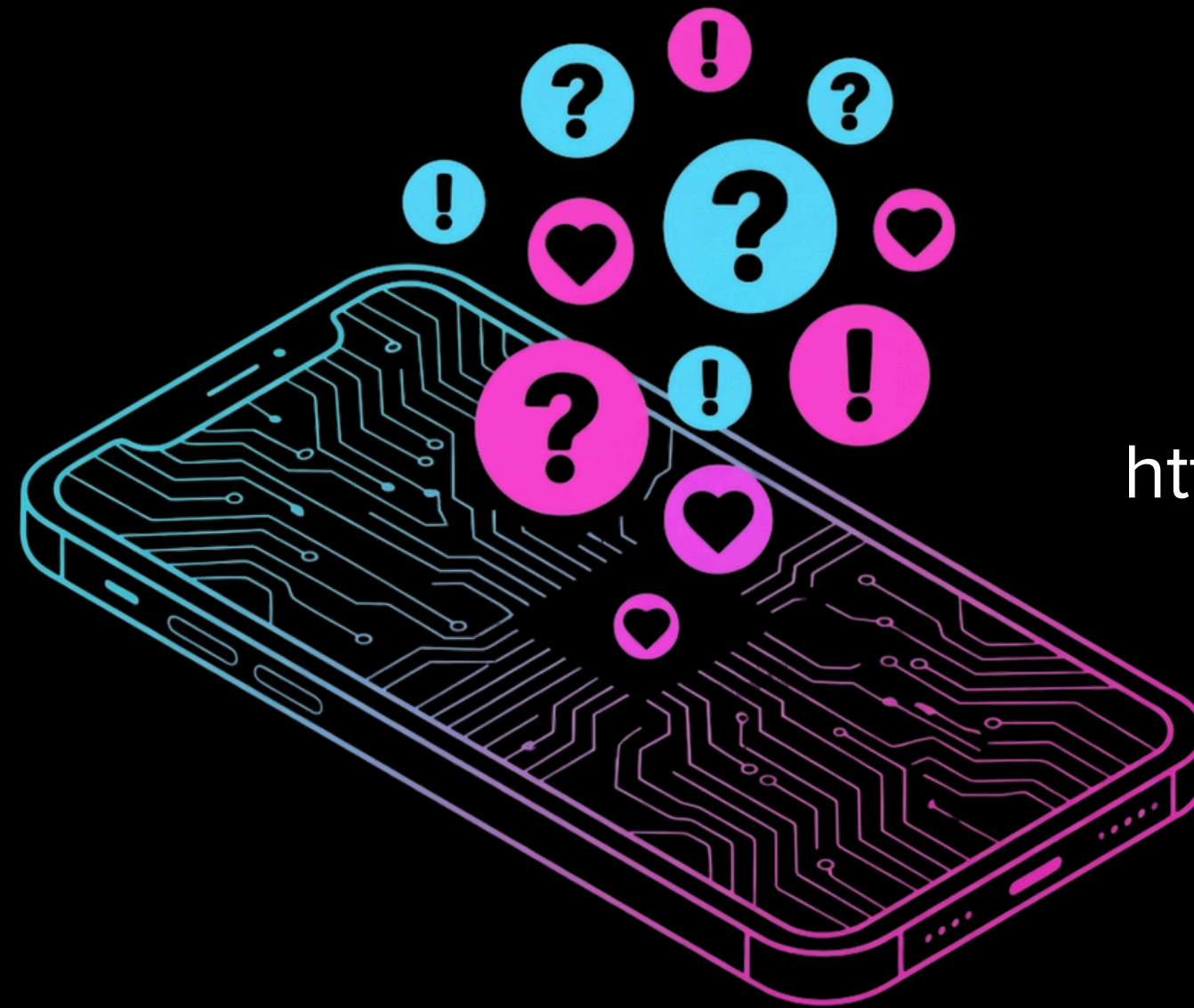
Key Governance Questions

1. Who is accountable when AI-guided care causes harm?
2. What are the boundaries of AI use in professional practice?
3. Which standards govern AI output validation?
4. When is documentation of AI use required?
5. How much AI literacy should practitioners and boards/colleges have?



Which of these governance questions will your board/college face first?

AhaSlides Code:
AINPSYCH



<https://ahaslides.com/AINPSYCH>

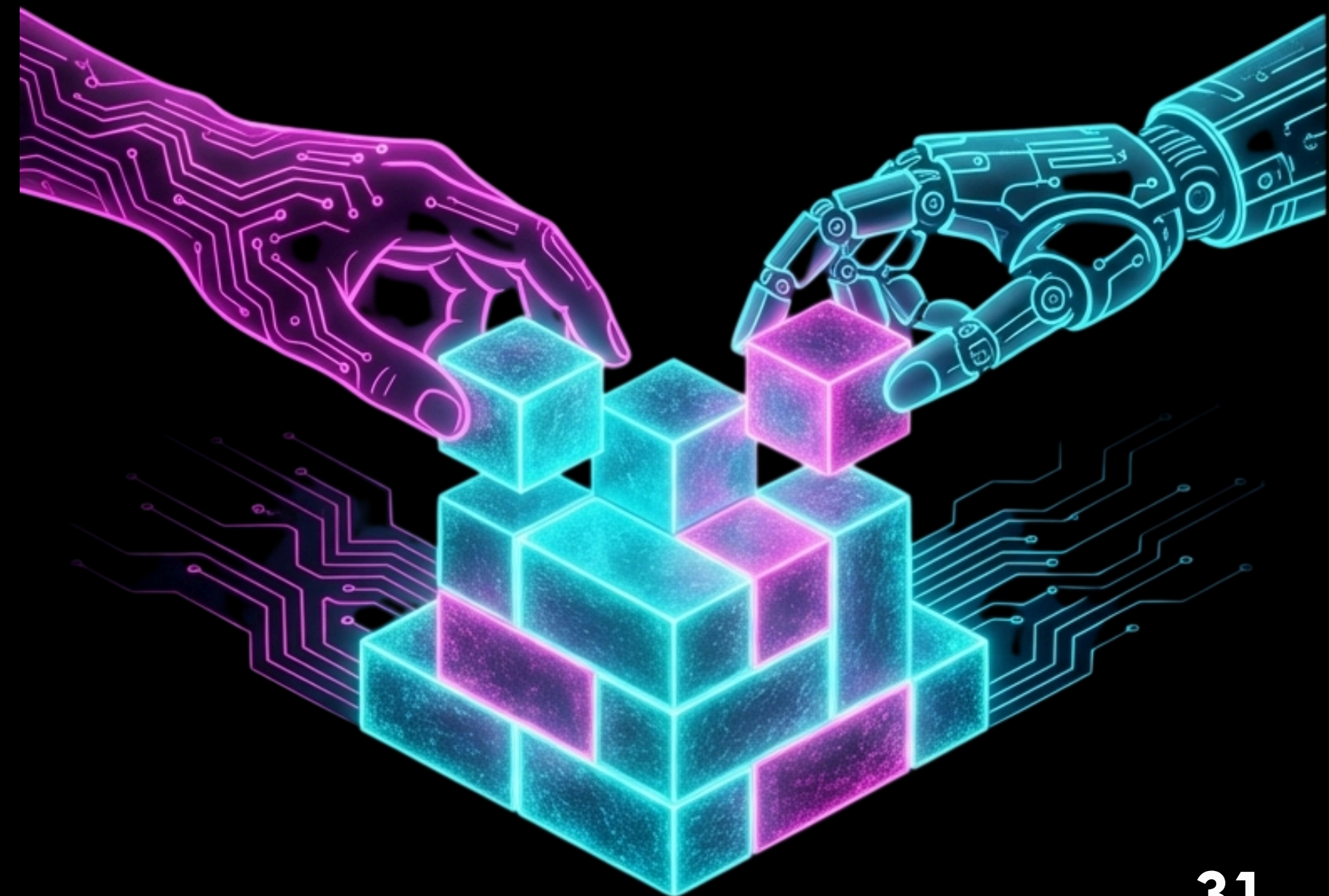


Results

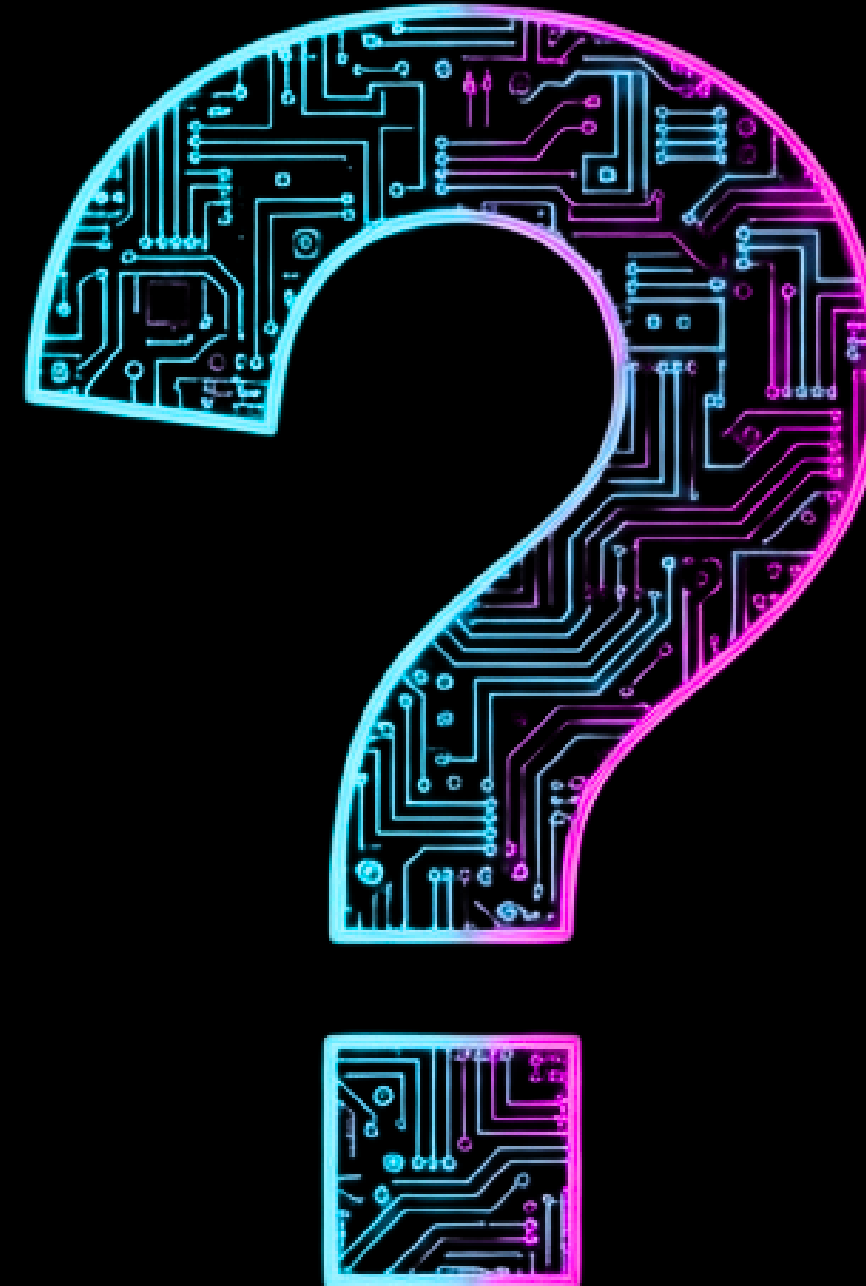


What Boards/Colleges Can Do Right Now

- Coordinate through ASPPB
- Define the literacy threshold
- Build board/college and practitioner literacy
- Adopt a position on accountability
- Issue documentation guidance



Wrap Up and Questions



Want more?

For more information and extra materials

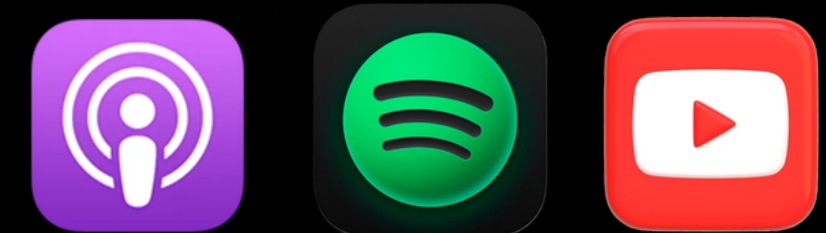
Scan QR Code



- Session Infographic
- Continue the Conversation
- Checklist
- AI News Brief

Ψ BEYOND THE COUCH AI IN PSYCHOLOGY

Podcast



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WAYDE AI

Thank You



Dr. Chatbot Will See You Now:

A Regulator's Guide to AI, Digital Ethics, and Public Safety

Jared L. Skillings, PhD, ABPP, SHRM-CP

Session 5, April 18, 2026

9:00 AM



Welcome, Dr. Skillings!

(NOT a Chatbot)

Scenario #1

Dr. Reeves is a licensed psychologist in private practice. She is using the free version of ChatGPT as a clinical support tool.

For every client she sees, she copies her handwritten session notes, which include the client's first name, presenting problem, diagnostic impressions, and relevant history, and pastes them into ChatGPT to generate polished progress notes. She instructed ChatGPT to keep this information confidential.

She did this for about 80 clients in 3 months. She has no BAA with OpenAI. She has not disclosed this practice to anyone. Dr. Reeves accidentally left open on a shared screen during a telehealth session, and a patient sees her own session details in a ChatGPT conversation. The patient files a board complaint.

Scenario #1

REVISED FACTS

Now imagine a different version of Dr. Reeves. Same psychologist, same solo practice. But instead of doing this routinely with 80 patients, she does it exactly once.

A client in acute crisis presents with symptoms she has never encountered, a rare trauma and dissociative presentation with features that overlap with several differential diagnoses. She is in a rural setting, it is 7 PM on a Friday, she cannot reach a colleague, and she believes the patient may be at risk. In a moment of clinical desperation, she opens ChatGPT, enters the client's presenting symptoms and history (including identifiable information), and asks: 'What are the most likely differential diagnoses and recommended immediate interventions for this presentation?' She uses the output to guide her clinical decision-making in that single emergency session. She does not do it again.

Top 5 Most Common Uses of AI in healthcare 2026

- 1. Ambient Clinical Documentation ("AI Scribes")**
- 2. Clinical Decision Support & Medical Imaging**
- 3. Administrative & Revenue Cycle Automation**
- 4. Patient-Facing AI for Information, Triage & Self-Directed Research**
- 5. Mental Health Chatbots & Virtual Therapists**

AI Companies Reshaping Clinical Workflows

ABRIDGE

Suki

 **AKASA**[®]

 **CodaMetrix**

 **innovaccer**

 **health**

ELLIPSIS
HEALTH

OpenEvidence[®]

 **Ambience**

How People Use ChatGPT in 2026

Personal Use



40%

Writing & Editing

Drafting emails, creating social media posts, creative writing assistance.



24%

Practical Guidance

Daily tasks, travel planning, problem-solving, learning new skills.



13.5%

Informational Queries

Fact-checking, quick research, summarizing articles, general knowledge.

Workplace Use



64.8%

Document Writing

Reports, proposals, contracts, memo generation.



63.5%

Editing

Proofreading, refining language, tone adjustment, translation.



43.6%

Data Analysis

Extracting insights, summarizing large datasets, trend forecasting.



20-35%

Graphics Creation

Generating images, diagrams, presentations, visual assets.



Coding queries down 18% to 10%

Focus shifts to high-level architecture and debugging

2024: 18% → 2026: 10%



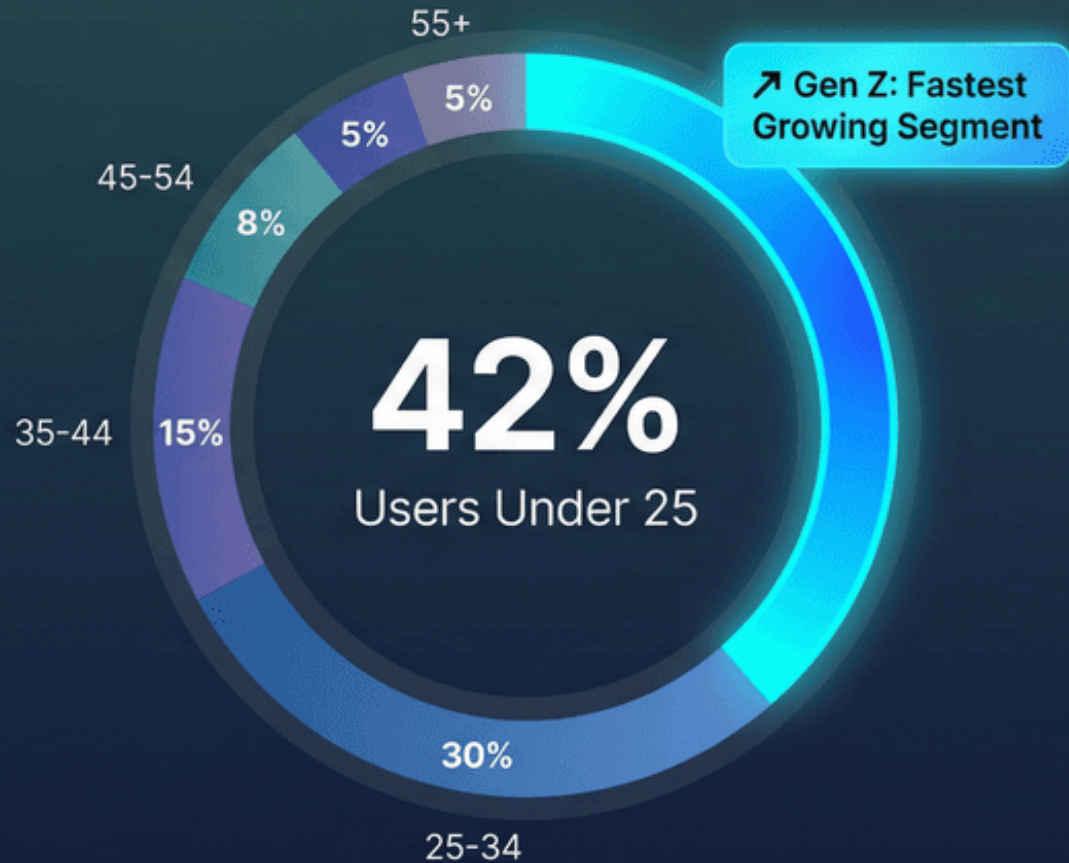
Multimedia queries up 2% to 7%

Growth in video, audio, and interactive content requests

2024: 2% → 2026: 7%

ChatGPT Demographics 2026

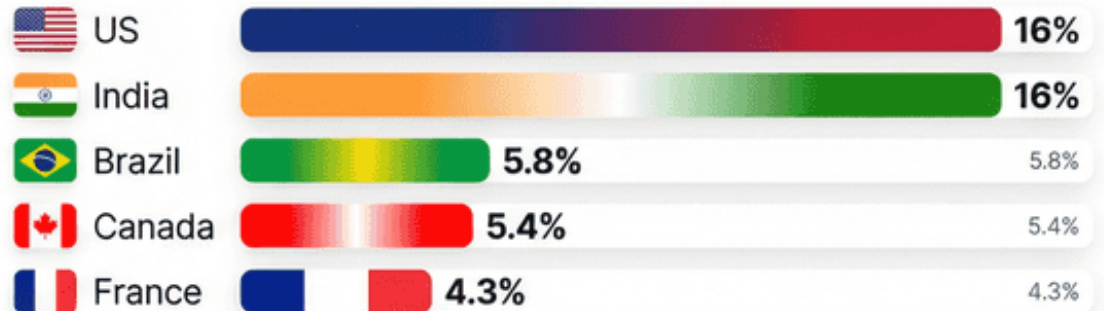
Age Distribution



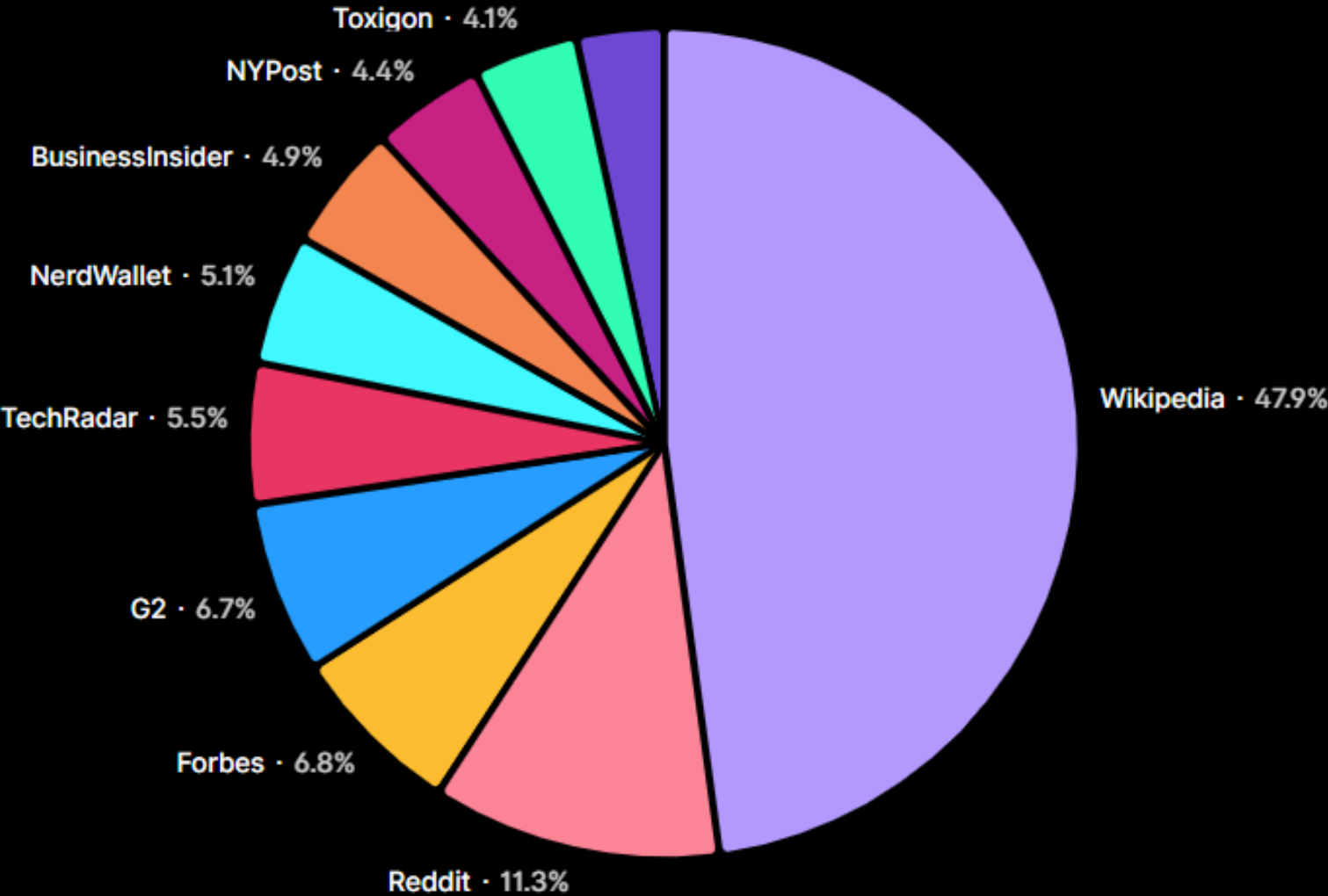
Gender Split



Top Countries



ChatGPT: Top 10 Sources



Data from 10 million citations (Aug 2024 - June 2025)

Scenario #2

Dr. Park is a licensed psychologist working in a group practice. He installs Grammarly Premium, an AI-powered writing assistant, to improve the quality of his professional writing. The browser extension has broad permissions to read text on all websites, including his EHR platform. Dr. Park does not realize that Grammarly is reading and processing the client names, diagnoses, and session content displayed in his open EHR tabs to generate writing suggestions. Grammarly's terms of service state that user input data may be used for product improvement. No BAA exists between Grammarly and the practice. A colleague notices the extension icon active during an EHR session and raises a concern.

States have enacted laws regulating:

AI use in patient communications

AI use in treatment

Sensitive information & AI

Disclosure to patients of AI use

AI use resulting in treatment discrimination

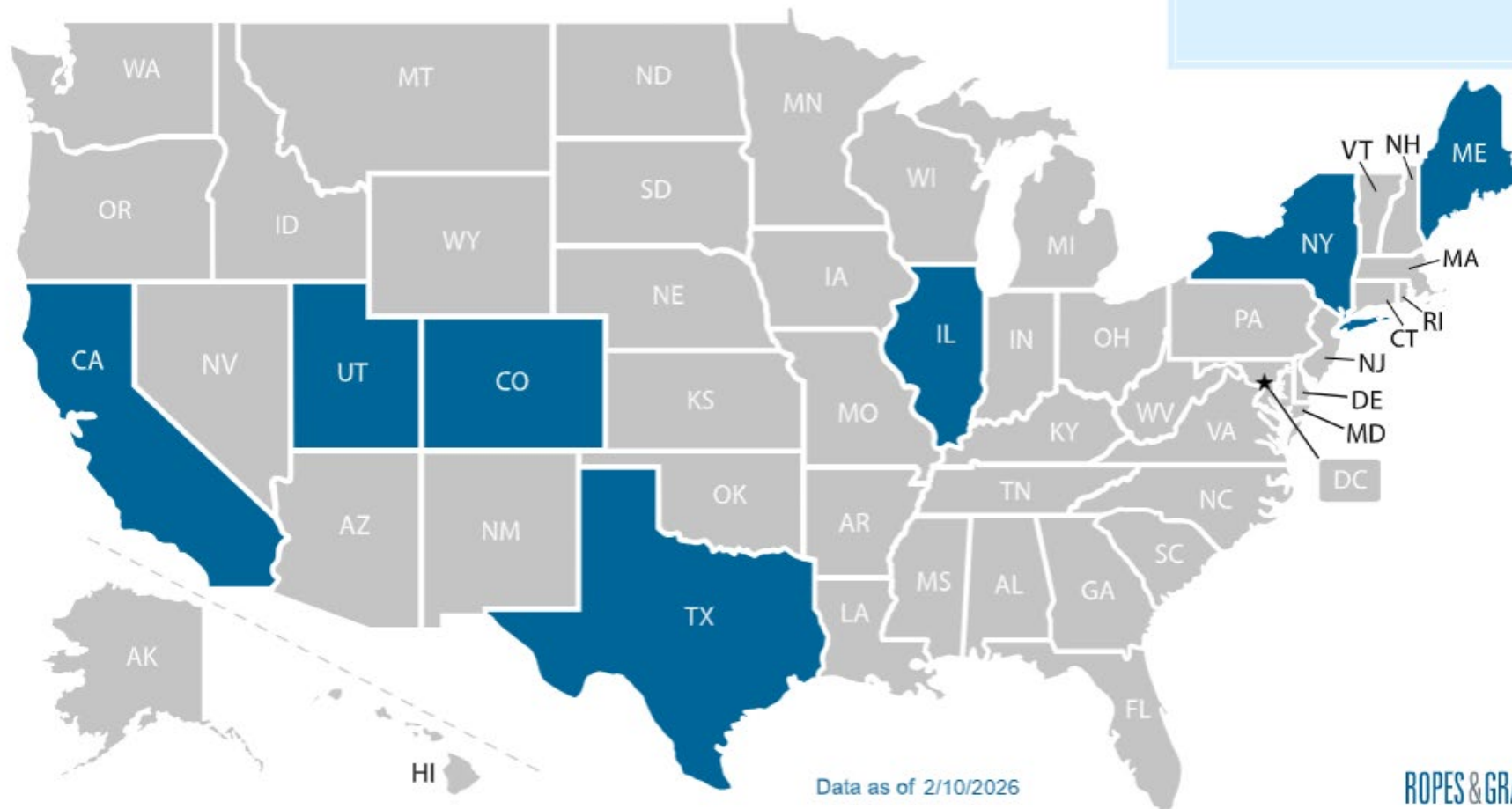
State regulator oversight



Click on the buttons to see which states have enacted each category of requirements

Common Requirements

Requirements to disclose use of AI to patients



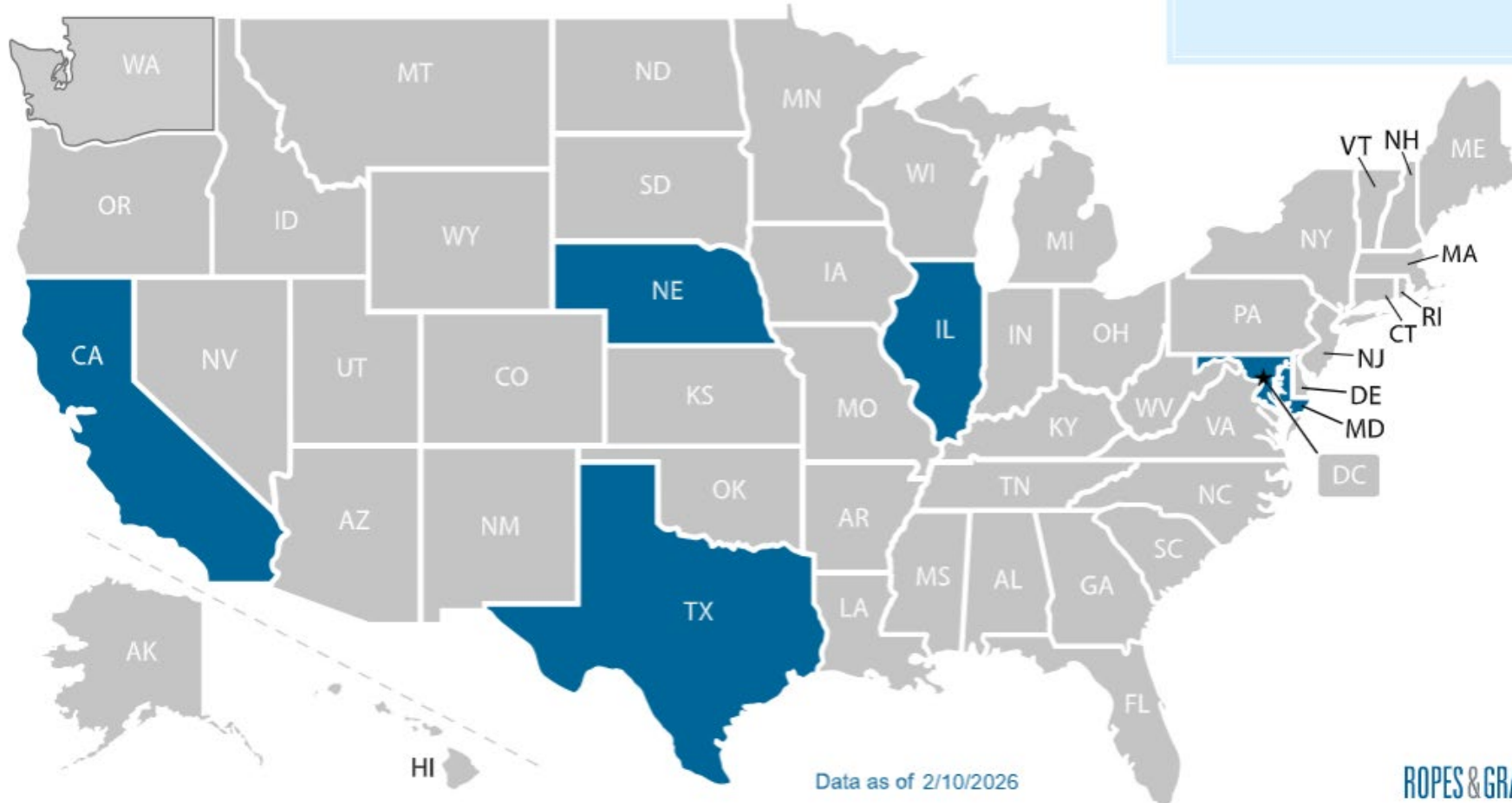
States have enacted laws regulating:

- AI use in insurance decisions
- Human decision makers in insurance decisions
- AI use in "high-risk" insurance decisions
- AI use resulting in insurance discrimination
- AI use & consumer protection
- AI compliance program
- Disclosures of AI use in insurance
- Internal assessments / monitoring of AI use in insurance
- State regulator oversight

Common Requirements

Restrictions or requirements on the use of AI to make utilization review, medical necessity, or prior authorization decisions

 Click on the buttons to see which states have enacted each category of requirements



ROPER & GRAY

Health AI Atlas

Health AI Atlas: State Laws & Compliance

ROPES & GRAY



<https://www.ropesgray.com/en/sites/healthai-atlas-state-ai-laws-healthcare>

Organization	Position Type	Augment Not Replace	Informed Consent	AI Ethics Guidance	Year
APA (Psychology)	Ethical Guidance + Health Advisory	Yes	Yes	Yes (June 2025)	2024-2025
APA (Psychiatry)	Position Statement + Advisory	Yes	Yes	Yes (March 2024)	2023-2024
ACA	AI Work Group Recommendations	Yes	Yes	Partial (rec for next Code revision)	2024-2025
NBCC	AI Ethical Principles + Policy Research	Yes	Yes	Yes (April 2024)	2024-2026
NASW	Advocacy / Resources / AI Taskforce	Yes	Yes	No (2017 tech standards only)	2025-2026
AAMFT	No formal guidance	Implied	Implied	No	N/A
AMA	Governance Toolkit + Policy + Center	Yes	Yes	Yes (Aug 2025 toolkit)	2023-2026
Natl Council for Mental Wellbeing	Member Education / Partnership	Yes	Implicit	No formal guidance	2024
WHO	Ethics Guidelines + Consortium	Yes	Yes	Yes (2024 LMM guidance)	2024-2026
Jed Foundation	Policy Framework + Open Letter	Yes	Yes	No (defers to APA)	2025-2026

MH Associations: Core Points of Agreement on AI

AI must augment, not replace, licensed mental health professionals

Informed consent is required when AI is used in clinical settings, esp. for recording, transcribing, or influencing treatment decisions

AI chatbots should not serve as substitutes for therapy or crisis intervention

Algorithmic bias poses significant risks to marginalized and underserved populations

Existing laws (HIPAA, privacy laws) apply to AI, and clinicians must maintain compliance

Clinicians, not AI systems, bear responsibility for clinical decisions

AI literacy and training must be integrated into professional education and continuing education

MH Associations: Benefits of AI

Workflow Efficiency and Burnout Reduction

Clinical Decision Support and Diagnostic Enhancement

Access Expansion and Workforce Shortage Mitigation

Knowledge Management and Research Synthesis

Culturally Informed and Responsive Care

Crisis De-Escalation and Resource Connection

Quality Improvement and Error Detection

MH Associations: Risks of AI

Algorithmic Bias and Health Equity Threats

Privacy, Data Security, and Regulatory Gaps

Erosion of the Therapeutic Relationship

Clinical Safety and Accuracy Failures

Liability, Governance, and Ethical Guidance Gaps

Harm to Vulnerable Populations

Professional Competency and Skill Erosion

Scenario #3

Dr. Williams, a licensed psychologist, founds a telehealth startup that offers “AI-enhanced therapy.” The platform uses an AI chatbot to conduct intake assessments, generate preliminary diagnostic impressions, and provide between-session “therapeutic check-ins” with clients. Dr. Williams’s license and photograph appear on the platform’s website and marketing materials, which describe the service as “psychologist-guided AI therapy.” Dr. Williams reviews the AI’s work in batches once per week and makes corrections as needed, but she does not participate in real-time sessions. A client experiencing a manic episode receives AI-generated “therapeutic guidance” that validates grandiose thinking and encourages the client to pursue a risky financial decision. The client’s family files a complaint.

Canada has no AI-specific federal legislation governing mental health.



Canadian Mental Health AI Guidance (In Development)

Mental Health Commission of Canada + Canadian Centre on Substance Abuse and Addiction (CCSA) partnership - announced October 2025:

- Developing the first national guidance for AI use in mental health and substance use health care.
- Identified 10 key considerations across three themes: trust/explainability of AI systems, human-centred care, and equity/data governance.
- Expected launch: 2026/2027.

Provincial Regulations

Ontario: Bill 194 (Royal Assent Nov. 2024, in force Jan. 2025): Regulates AI use by hospitals, health agencies, universities. Requires AI accountability frameworks, risk management, transparency, and privacy impact assessments.

Ontario IPC + OHRC jointly released six principles for responsible AI use (Jan. 2026): valid/reliable, safe, privacy protective, human rights affirming, transparent, accountable (non-binding guidance).

Ordre des psychologues du Quebec released AI policies (September 2025): requires written consent before recording sessions, clients must understand how AI uses their data, practitioners must verify competence with specific AI systems, full responsibility for AI-generated notes remains with the clinician.

Provincial Regulations

Nova Scotia: College of Physicians and Surgeons issued AI scribe guidance (February 2025).

Provinces & Territories that rely on CPA ethics codes, general telepsychology standards, telepractice policies, and PIPEDA or provincial privacy laws:

British Columbia

Alberta

Saskatchewan

Manitoba

New Brunswick

Yukon

Prince Edward Island

NW Territories

Newfoundland & Labrador

Nunavut

Key Legal Precedent: Moffatt v. Air Canada (2024)

- **BC Civil Resolution Tribunal decision** (2024 BCCRT 149) - Air Canada was liable for negligent misrepresentation when its website chatbot provided inaccurate information about bereavement airline fares.
- **Principle:** 'It should be obvious to Air Canada that it is responsible for all the information on its website. It makes no difference whether the information comes from a static page or a chatbot.'
- **Implication for mental health AI:** Any organization deploying an AI chatbot for therapeutic or mental health purposes in Canada could face liability under existing negligence law for inaccurate, misleading, or harmful AI-generated responses, even without AI-specific legislation.

Canadian Mental Health Association & Canadian Medical Association

- Reports nearly 10% of Canadians are intentionally using AI for mental health support.
- Identifies key risks—including hallucinations, missed nonverbal cues, potential reinforcement of harmful thoughts (“AI psychosis”), cultural bias, and privacy vulnerabilities—while emphasizing that generative AI is not a substitute for qualified mental health care and requires government regulation, oversight, and ethical standards.
- Notes Canadian mental health professionals face 'strict privacy laws' that chatbots do not.

Canadian Psychological Association

- **AI and Psychology Briefing Paper (January 2024):** informed consent is mandatory for any AI use in practice; psychologists remain responsible for all AI-generated outputs; novel threats to privacy, safety/efficacy, dignity, and responsibility to society.
- **Trilateral Leadership Summit (October 2025):** ASPPB, APA, and CPA met in Toronto to examine shared challenges and emerging opportunities including AI. Signals cross-border coordination on professional standards.

**What does Academia
say?**

JAMA Internal Medicine

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Editorial | AI and Clinical Care

Applying Clinical Licensure Principles to Artificial Intelligence

Eve Rittenberg, MD, MA^{1,2}; Roy Perlis, MD, MSc^{3,4}; Sharon Inouye, MD, MPH^{5,6}

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**Are you
kidding me?**

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Viewpoint | AI and Clinical Care

Software as a Medical Practitioner—Is It Time to License Artificial Intelligence?

Eric Bressman, MD, MSHP^{1,2}; Carmel Shachar, JD, MPH³; Ariel D. Stern, PhD⁴; [et al](#)

» [Author Affiliations](#) | [Article Information](#)

Are you #&!%!
kidding me?

Scenario #4

A psychologist uses an ambient AI scribe for all therapy sessions. She signs every AI-generated note without review. A client obtains records and discovers the notes contain hallucinated medication names and symptoms the client never reported. The inaccurate record has already been shared with the client's psychiatrist, who adjusted medications based on the fabricated symptoms.

Scenario #5

A doctoral psychology trainee recommends that her adolescent client downloads an AI companion app for between-session practice of CBT skills. The supervisor approved. They did not review the app's privacy policy, crisis response protocols, or clinical evidence base.

One of her 15-year-old clients develops a romantic attachment to the AI companion and begins disclosing suicidal ideation to the app rather than to the trainee or supervisor. The app has no crisis detection or referral protocol. The client's parents discover the situation and file a complaint.

Scenario #6

A psychologist uses AI to automate significant portions of telehealth sessions: AI conducts the intake screening, AI generates the treatment plan, and AI produces session summaries. The psychologist joins each session for 15 minutes of live interaction, then bills the full session at standard rates as a psychologist-delivered service. A payer audit flags the unusual session patterns.

Scenario #7

Your own board decides to use AI to screen incoming complaints for severity and prioritize investigations and to do initial legal/regulatory checks. The AI system flags complaints from clients with certain demographic characteristics at higher rates due to training data bias. A licensee under investigation discovers this and challenges the board's process in court.

FINAL QUESTIONS

- What does your Board's AI risk/benefit strategy look like?
- How will you apply these principles to effectively manage novel scenarios?



Dr. Chatbot Will See You Now:

A Regulator's Guide to AI, Digital Ethics, and Public Safety

Jared L. Skillings, PhD, ABPP, SHRM-CP

Session 5, April 18, 2026

9:00 AM

1.1 Senator moved to amend S.F. No. 3298 as follows:

1.2 Page 94, after line 2, insert:

1.3 "ARTICLE 12

1.4 **HEALTH-RELATED PROFESSIONS; PRACTICING WITHOUT A LICENSE**

1.5 Section 1. Minnesota Statutes 2024, section 147.081, subdivision 1, is amended to read:

1.6 Subdivision 1. **Unlawful practice of medicine.** It is unlawful for any person who is not
1.7 a natural person to practice medicine as defined in subdivision 3. It is unlawful for any
1.8 natural person to practice medicine as defined in subdivision 3 in this state unless:

1.9 (1) the person holds a valid license issued according to this chapter; or

1.10 (2) the person is registered to provide interstate telehealth services according to section
1.11 147.032.

1.12 Sec. 2. Minnesota Statutes 2024, section 148.61, subdivision 5, is amended to read:

1.13 Subd. 5. **Gross misdemeanor.** It is unlawful for any person who is not a natural person
1.14 to practice optometry in this state. Every natural person not licensed by the board pursuant
1.15 to section 148.57 who practices optometry in this state shall be guilty of a gross misdemeanor.

1.16 Sec. 3. Minnesota Statutes 2024, section 148.941, subdivision 6, is amended to read:

1.17 Subd. 6. **Violation.** It is unlawful for any person who is not a natural person to engage
1.18 in the practice of psychology or misrepresent themselves as a psychologist or psychological
1.19 practitioner. Natural persons who engage in the unlicensed practice of psychology or who
1.20 misrepresent themselves as psychologists or psychological practitioners are guilty of a gross
1.21 misdemeanor."

1.22 Renumber the articles in sequence

1.23 Amend the title accordingly

1.24 The motion prevailed. #did not prevail. So the amendment was #not adopted.

April 2026

	CURRENT ANNUAL BUDGET	AVAILABLE BALANCE	1ST QUARTER EXPENDED	2ND QUARTER EXPENDED	3RD QUARTER EXPENDED	4TH QUARTER EXPENDED	TOTAL YR TO DATE EXPENDED	% SPENT OF TOTAL BUDGET	SYSTEM PROJECTION- ENCUMBERED
PSYCHOLOGY OPERATIONS - FUND 1201 - H7V1111									
FULL - TIME SALARY	\$707,000.00	\$208,699.81	\$132,993.99	\$164,288.32	\$201,017.98	\$0.00	\$498,300.19	70.48%	\$208,699.81
PART-TIME, SEASONAL	\$94,000.00	\$46,450.69	\$17,965.12	\$23,337.95	\$6,246.24	\$0.00	\$47,549.31	51.00%	\$46,450.69
OVER-TIME PAY	\$5,000.00	\$4,468.31	\$0.00	\$268.57	\$263.12	\$0.00	\$531.69	10.63%	\$4,468.31
OTHER BENEFITS- PER DIEMS	\$20,000.00	\$6,443.55	\$1,232.00	\$2,250.00	\$9,774.45	\$0.00	\$13,556.45	68.00%	\$6,443.55
SPACE RENTAL, MAINT & UTIL	\$122,000.00	\$20,885.00	\$29,767.50	\$30,577.50	\$40,770.00	\$0.00	\$101,115.00	83.00%	\$20,385.00
PRINTING & ADVERTISING	\$5,000.00	\$4,986.94	\$2.75	\$6.86	\$3.45	\$0.00	\$13.06	0.00%	\$2,455.70
PROF/TECH SERVICES	\$90,000.00	\$90,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$6,000.00
IT PROF/TECH SERVICES	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted	\$0.00
COMPUTER/SYSTEM SERVICE	\$1,000.00	\$1,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$500.00
COMMUNICATIONS	\$5,000.00	\$2,652.57	\$119.54	\$942.60	\$1,285.29	\$0.00	\$2,347.43	47.00%	\$3,452.57
TRAVEL, IN STATE	\$20,000.00	\$14,008.14	(\$23.33)	\$4,553.05	\$1,462.14	\$0.00	\$5,991.86	30.00%	\$7,309.06
TRAVEL, OUT STATE	\$20,000.00	\$18,810.15	\$279.96	\$909.89	\$0.00	\$0.00	\$1,189.85	5.95%	\$6,550.00
EMPLOYEE DEVELOPMENT	\$20,000.00	\$14,263.00	\$1,990.00	\$348.00	\$3,399.00	\$0.00	\$5,737.00	28.69%	\$6,752.00
AGY PROVIDED PROF/TECH	\$30,000.00	\$22,075.88	\$5,734.00	\$1,627.12	\$563.00	\$0.00	\$7,924.12	26.00%	\$9,242.00
Rate Based MNIT Services	\$158,000.00	\$70,179.25	\$10,917.28	\$34,192.71	\$42,710.76	\$0.00	\$87,820.75	55.58%	\$43,179.25
Agency Specific MNIT Services	\$20,000.00	(\$6,923.82)	\$706.72	\$1,181.48	\$25,035.62	\$0.00	\$1,888.20	125.00%	\$6,076.18
SUPPLIES	\$10,000.00	\$8,813.22	\$216.91	\$194.68	\$775.19	\$0.00	\$1,186.78	11.87%	\$4,652.28
EQUIPMENT	\$10,000.00	\$8,133.84	\$466.54	\$466.54	\$933.08	\$0.00	\$1,866.16	18.66%	\$3,706.80
REPAIRS, MAINTENANCE	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$10.99
STATEWIDE INDIRECT COSTS	\$0.00	(\$10,231.50)	\$0.00	\$6,821.00	\$3,410.50	\$0.00	\$10,231.50		\$0.00
OTHER OPERATING COSTS	\$105,000.00	\$95,456.77	\$1,300.67	\$588.44	\$7,654.12	\$0.00	\$9,543.23	9.09%	\$15,308.35
EQUIPMENT - Capital	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$0.00
EQUIPMENT - NON CAPITAL	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%	\$0.00
TOTAL OPERATION COSTS	\$1,457,000.00	\$635,171.80	\$203,669.65	\$272,554.71	\$345,303.94	\$0.00	\$821,828.20	56.00%	\$401,642.54
Behavior Analysts Licensure - Fund H7V30000									
Other Operating Costs	\$80,505.00	\$51,183.28	\$0.00	\$17,270.93	\$12,050.76	\$0.00	\$29,321.72	36.00%	\$51,183.28
other employee costs	\$0.00	(\$612.00)			\$612.00		\$612.00		(\$612.00)
PSYCHOLOGY CRIMINAL BACKGROUND CHECK FUND - 2000 - H7V30000									
AGY PROVIDED PROF/TECH	\$22,000.00	\$8,592.00	\$1,728.00	\$7,456.00	\$4,224.00	\$0.00	\$13,408.00	60.95%	\$8,592.00
TOTAL CRIMINAL BACKGROUND	\$22,000.00	\$8,592.00	\$1,728.00	\$7,456.00	\$4,224.00	\$0.00	\$13,408.00	60.95%	\$8,592.00
REPORT TOTAL	\$1,559,505.00	\$694,335.08	\$205,397.65	\$297,281.64	\$350,139.94	\$0.00	\$865,169.92	55.00%	\$409,622.54

**BOARD OF PSYCHOLOGY
ACTUAL RECEIPT REPORT**

Through March 2026

	REVENUE SOURCE CODE #	CURRENT REVENUE BUDGET	ESTIMATED UNCOLLECTED RECEIPTS	1ST QUARTER RECEIPTS	2ND QUARTER RECEIPTS	3RD QUARTER RECEIPTS	4TH QUARTER RECEIPTS	TOTAL YR TO DATE RECEIPTS	% RECEIPTS OF TOTAL BUDGET
Civil Penalties	512417	\$10,000.00	\$10,000.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Credit Card Clearing	553094	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted
H7V Professional Firms Initial	608263	\$8,000.00	\$4,175.00	\$1,300.00	\$1,125.00	\$1,400.00	\$0.00	\$3,825.00	30.00%
H7V Professional Firms Annual	608264	\$8,000.00	\$2,300.00	\$450.00	\$3,650.00	\$1,600.00	\$0.00	\$5,700.00	71.25%
Licensure Volunteer Practice	643000	\$1,000.00	\$250.00	\$250.00	\$250.00	\$250.00	\$0.00	\$750.00	75.00%
Bd Psych Appl Admission EPPP	643002	\$20,000.00	\$7,400.00	\$4,350.00	\$3,450.00	\$4,800.00	\$0.00	\$12,600.00	63.00%
Bd Psych Appl Adm Prof Resp E	643003	\$25,000.00	\$5,650.00	\$7,350.00	\$6,450.00	\$5,550.00	\$0.00	\$19,350.00	77.40%
Lic Psych Appl For License	643004	\$90,000.00	\$28,500.00	\$25,000.00	\$18,500.00	\$18,000.00	\$0.00	\$61,500.00	68.30%
Lic Psych Appl For Renewal	643005	\$1,000,000.00	\$412,500.00	\$232,500.00	\$268,500.00	\$86,500.00	\$0.00	\$587,500.00	58.75%
Lic Psych Late Renewal Fee	643006	\$8,000.00	\$1,250.00	\$2,750.00	\$1,750.00	\$2,250.00	\$0.00	\$6,750.00	84.38%
Bd Psych Emeritus Registration	643010	\$3,500.00	\$2,450.00	\$300.00	\$450.00	\$300.00	\$0.00	\$1,050.00	30.00%
Bd Psych Degree Upgrade	643011	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	Not Budgeted
Be Psych Mailing/Duplication	643013	\$300.00	\$160.00	\$50.00	\$45.00	\$45.00	\$0.00	\$140.00	47.00%
Bd Psych Verification Receipts	643015	\$95,000.00	\$15,980.00	\$21,320.00	\$26,840.00	\$30,860.00	\$0.00	\$79,020.00	83.10%
Psychologist Guest Licensure	643018	\$4,000.00	\$1,000.00	\$1,200.00	\$750.00	\$1,050.00	\$0.00	\$3,000.00	75.00%
Continuing Ed Sponsrshp Fee	643019	\$35,000.00	\$9,080.00	\$6,240.00	\$10,240.00	\$9,440.00	\$0.00	\$25,920.00	74.00%
Post DR Sup Exper Pre Appr	643023	\$500.00	\$250.00	\$200.00	\$0.00	\$50.00	\$0.00	\$250.00	50.00%
BA Initial Application License Fee	643025	\$20,000.00	\$0.00	\$23,400.00	\$20,925.00	\$22,950.00	\$0.00	\$67,275.00	336.00%
TOTAL REVENUE		\$1,328,300.00	\$500,945.00	\$326,660.00	\$362,925.00	\$185,045.00	\$0.00	\$874,630.00	65.85%
Fund 2000									
Criminal Background Check Fee	643022	\$6,000.00	\$660.50	\$5,339.50	\$4,409.75	\$4,870.25	\$0.00	\$14,619.45	243.00%
TOTAL REVENUE		\$1,334,300.00	\$501,011.50	\$331,999.50	\$367,334.75	\$189,915.25	\$0.00	\$889,249.45	66.60%



Minnesota Board of Psychology Executive Director Report

May 15, 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. Since the last Board meeting, we have surpassed the 1000 mark and to date the Board has issued over 1,032 Behavior Analyst licenses. Paid applications continue to be received with a consistent number of at least four per week.

The team has made significant progress with contacting behavior analyst applicants that have not had movement in their applications. Originally there were 64 applicants on the list. Of that number, seventeen requested to keep their applications open and are actively pursuing licensure. Fifteen applicants have been issued licenses, and 32 applications have been made inactive as they indicated they no longer wished to pursue licensure.

Board staff continue to engage LP applicants that have not had movement in their application in more than a year. Psychologist applications do move more slowly in comparison to the behavior analyst applications. Applicants that we have been contacting have been rescheduling their exam retakes. When we talked with these applicants, we shared that there will be upcoming changes to the EPPP exam to be one exam with two parts. This is something that has spurred movement with some of these applicants to plan to take the exam before the changes are implemented. The Board has issued two licenses to this group of applicants as well. Additionally, the licensure team is working with IT on the Licensed Behavior Analyst renewal project that will be developed in Salesforce.

II. Executive Director's Report

- a. PEAK Agenda: The Board will be transitioning to this new meeting platform with some initial training happening at the meeting today.

- b. ASPPB Mid-Year Meeting: The meeting agenda book and power points for a couple of presentations on AI have been provided for your review. There were many sessions on the topic of AI and were very informative. The Executive Director also presented the topics of the HPSP program and the training and education that our Board provides to licensees.

- c. Financial Update:
The Board's Third Quarter revenues and expenditures have been provided as part of the Executive Director's Report. Expenses are well managed at the end of third quarter, 55% of the total budget being spent. Revenues are bit behind the projected point and are at 66%. The FY26 budget will close at the end of June 2026 with a hard close happening in mid-summer. Budget planning for FY27 has started and a draft budget has been submitted.

- d. Legislative Updates:



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

SUBMITTED BY: Executive Director

TITLE: CLEAR Training

INTRODUCTION TO THE TOPIC:

CLEAR Training event details and cost proposal have been provided for your review and consideration.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
CLEAR Training Modules	5/12/2026	Cover Memo
CLEAR Training Cost Proposal	5/13/2026	Cover Memo

< [Back to Events \(/events/\)](/events/)



2026 Introduction to Regulatory Governance 5 Module Webinar Series

CLEAR Learning- Board Member Training

📅 **Thursday, March 12, 2026 at 1:00 PM (EDT)** to Thursday, July 16, 2026 at 2:00 PM (EDT)

📍 online via Zoom

* *Registration open until 7/14/26 at 2:00 PM (EDT)*

[Register Now \(/events/2026-introduction-to-regulatory-governance-5-module-webinar-series/register\)](/events/2026-introduction-to-regulatory-governance-5-module-webinar-series/register)

Event Details

Foundations of Occupational and Professional Regulation

Content includes: the importance of regulatory boards; rationale for licensure; typical pro and con arguments; and an overview of trends in licensure.

Recording available

Roles and Responsibilities of a Board Member

Content includes: board member responsibility; defining "the public interest"; requirements for service on regulatory boards; how a board member can participate effectively; the purpose of appointing public members; and ethical considerations

April 16, 1:00-2:00 PM Eastern

Administrative Rulemaking



Content includes: what is a rule; kinds of rules; authority to issue rules; when is a rule needed; writing a good rule; avoiding problem areas; regular procedures for adopting rules; notice and publication; public comment and hearing process; and emergency rulemaking



May 21, 1:00-2:00 PM Eastern

Professional Discipline

Content includes: steps in the enforcement process; characteristics of a strong enforcement process; receiving and sharing information; types of disciplinary sanctions; and practitioner impairment

June 18, 1:00-2:00 PM Eastern

 (<https://www.facebook.com/CLEARHQ/>)  (<https://twitter.com/CLEARHQ>)

 (<https://www.linkedin.com/company/council-on-licensure-enforcement-and-regulation-clear-/>)  (/contact-us)

CLEAR Membership

CLEAR is an association of individuals, agencies, and organizations that comprise the international community of professional and occupational regulation. CLEAR is a dynamic forum for improving the quality and understanding of regulation in order to enhance public protection.

Association Management Software (<http://www.noviams.com>)

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CLEAR Cost Proposal	
CLEAR Training Cost Per Board Member - Non Membership Rate	\$400
Training Cost for Ten Board Members	\$4,000
CLEAR Annual Membership Fee for Board	\$385
CLEAR Training Cost Per Board Member - Membership Rate	\$320
Training Cost for Ten Board Members	\$3,200
Total Cost for Ten Board Members Plus Annual Fee	\$3,585



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

SUBMITTED BY: Assistant Executive Director

TITLE: Variance Request Applicant 22-0263

INTRODUCTION TO THE TOPIC:

Provided for you is the applicant's variance request:

Ordinance 7200.1300, Subp. 5, C. (1)(a)

**Reasons
for
variance
or waiver
requested**

My academic program required the completion of 1,500 supervised hours, which I have fulfilled in accordance with institutional standards. I continue to practice under the supervision of a licensed psychologist, ensuring ongoing professional oversight and adherence to ethical guidelines. Not counting hours I am currently completing would cause undue hardship.

**Not
adversely
affect the
public
welfare**

Granting of a variance will not adversely affect public welfare because I continue to be supervised by Dr. S. PsyD, LP.

BOARD ACTION REQUESTED:

To review and approve or deny.



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

SUBMITTED BY: State Program Administrator

TITLE: Board Administrative Terminations

INTRODUCTION TO THE TOPIC:

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

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

BOARD ACTION REQUESTED:

LP6485 Cristiana Tugnoli 12/31/2025
LP4889 Susan Westerlind 12/31/2025
LP0688 Werner Glenn 12/31/2025
LP0643 Carol Schwarzkopf 12/31/2025
LP3883 Anna Mccourt 12/31/2025
LP3882 Sheila Baker 12/31/2025
LP2999 Drevis Hager 12/31/2025
LP3866 Carole Andersen 12/31/2025
LP3865 Mary Amundson 12/31/2025
LP4900 June Meyerhoff 1/31/2026
LP6760 Anne Fitzgerald 1/31/2026
LP3410 James A Thomas 1/31/2026



- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 5/15/2026

SUBMITTED BY: Executive Director

TITLE: Agreements for Corrective Action Signed Since Last Board Meeting

INTRODUCTION TO THE TOPIC:

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Ghazimoghadam ACA	5/8/2026	Cover Memo
McLellan ACA	5/8/2026	Cover Memo
Potter ACA	5/8/2026	Cover Memo

**BEFORE THE MINNESOTA
BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE**

In the Matter of the License of
Saba Ghazimoghadam, Ph.D., L.P.
License Number: LP5561

**AGREEMENT FOR
CORRECTIVE ACTION**

This agreement is entered into by and between Saba Ghazimoghadam, Ph.D., L.P. (“Licensee”) and the Complaint Resolution Committee of the Minnesota Board of Psychology (“Committee”), pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a). Licensee and the Committee hereby agree as follows:

FACTS

1. For the purpose of this agreement, the parties agree to the following facts:
 - a. On, or about, December 4, 2012, the Board licensed Licensee to practice psychology in the State of Minnesota.
 - b. Licensee provided psychological services to romantic partners (“Clients”), between December 2024 and February 2025.
 - c. On March 3, 2025, the Clients requested a copy of their psychological records. As of April 19, 2025, they had not received the records from Licensee, and follow up requests were unanswered. Licensee’s responses to the Clients’ requests indicated that Licensee would release the diagnostic assessment and discharge summary, but not the progress notes. Review of the case indicated that Licensee was not clear on how to handle the multiple-client situation with the Clients, and identified one client as the primary client without informing the clients of that fact, or the implications of it.

2. The Committee concludes that the conduct above constitutes a violation of Minnesota Statutes section 148.941, subdivision 2(a)(1) (violated a statute, rule, or order that the Board issued or is empowered to enforce); and Minnesota Rule 7200.4710, subpart 1 (failed to release client records upon valid request by the client).

CORRECTIVE ACTION

3. Licensee agrees to address the conduct referenced above by taking the following corrective action:

a. Professional Consultation. Licensee shall obtain six (6) hours of one-on-one professional consultation from a Minnesota licensed psychologist on the following topics (1) recordkeeping; (2) client access to records; (3) handling multiple clients; and (4) informed consent, and how to apply Licensee's understanding of the above issues to Licensee's future practice.

Within thirty (30) days of the effective date of this Agreement, Licensee shall submit the *curriculum vitae* of her proposed professional consultant for pre-approval by the Committee. If Licensee has any previous personal or professional relationship with the proposed consultant, Licensee must submit a disclosure of the length and nature of the relationship to the Committee for their consideration for pre-approval. The Committee reserves the right to reject the consultant proposed by Licensee. If the Committee rejects the consultant proposed by Licensee, the Committee may require that Licensee submit additional names.

Licensee shall meet with the consultant for at least one hour per month, for a period of at least 6 months.

Consultant Report. Licensee shall have the consultant submit a report to the Board within thirty (30) days of the completion of the consultation. The report shall provide and/or address:

- 1) A statement that the consultant reviewed this Agreement and any other data deemed relevant by the Committee;
- 2) The dates on which consultations were held with Licensee;
- 3) Licensee's active participation in each consultation;
- 4) The issues discussed in each consultation;
- 5) The consultant's assessment of Licensee's understanding and ability to deal with the topics addressed in the consultation;
- 6) The consultant's opinion as to Licensee's understanding of the issues that gave rise to this Agreement; and
- 7) Any other information the consultant believes would assist the Board in its review of this matter.

Self-Report. At the conclusion of the consultations, Licensee shall have 30 days to submit a report to the Board herself. The report shall provide and/or address:

- 1) A brief statement of the topics discussed at each consultation session;
- 2) What Licensee has learned from the consultations, including her own statement as to her comprehension and knowledge of the issues that gave rise to this Agreement;
- 3) A statement as to how Licensee has changed or will change her practice as a result of the knowledge and skills obtained or honed through the consultation; and
- 4) Any other information Licensee believes would assist the Board in its review of this matter.

4. Licensee shall be responsible for all costs incurred as a result of compliance with this agreement.

5. If any due date required by the Agreement for Corrective Action is not met, the Committee may fine Licensee \$100 per violation. Licensee shall pay the fine and correct the violation within five days after service on Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed \$500 per violation. The total of all fines may not exceed \$5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by *writ of certiorari* under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

6. No condition imposed as a remedy by this Agreement for Corrective Action shall be used as a continuing education activity for the purpose of renewal of Licensee's license to practice psychology, unless it is specifically stated in this Agreement for Corrective Action that the condition may be used for this purpose.

OTHER INFORMATION

7. This agreement does not constitute disciplinary action.

8. Upon Licensee's satisfactory completion of the corrective action referenced above, the Committee agrees to dismiss the complaint(s) referenced in paragraph 1. Licensee agrees that the Committee shall be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the facts in paragraph 1, the Committee may reopen the dismissed complaint(s).

9. If Licensee fails to complete the corrective action satisfactorily, or if the Committee receives additional complaints similar to the facts described in paragraph 1, the Committee may, at its discretion, reopen the investigation and proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14. Licensee agrees that the Committee will be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to that referenced in the Facts section, the Committee may reopen the dismissed complaint. In any subsequent proceeding, the Committee may use as proof of the facts of paragraph 1 Licensee's agreements herein. Licensee agrees that failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 148.941, subd. 4, and may subject Licensee to disciplinary action by the Board.

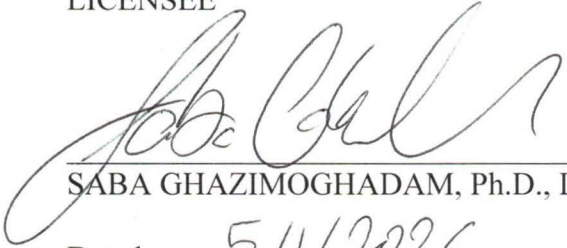
10. Licensee has been advised by Committee representatives that Licensee may choose to be represented by legal counsel in this matter. Licensee is represented by Melissa Heinlein, Esq. The Committee is represented by Rebecca Huting, Assistant Attorney General.

11. This agreement shall become effective upon execution by the Committee and shall remain in effect until the Committee dismisses the complaint, unless the Committee receives additional information that renders corrective action inappropriate. Upon receipt of such information, the Committee may, at its discretion, proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14.

12. Licensee understands and acknowledges that this agreement and any letter of dismissal are classified as public data.

13. Licensee hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Licensee, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

LICENSEE


SABA GHAZIMOUGHADAM, Ph.D., L.P.

Dated: 5/11/2026

MINNESOTA BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE


For the Committee

Dated: 5/5/26

**BEFORE THE MINNESOTA
BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE**

In the Matter of the License of
Richard McLellan, M.S., L.P.
License Number: LP0295

**AGREEMENT FOR
CORRECTIVE ACTION**

This agreement is entered into by and between Richard McLellan, M.S., L.P. (“Licensee”) and the Complaint Resolution Committee of the Minnesota Board of Psychology (“Committee”), pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a). Licensee and the Committee hereby agree as follows:

FACTS

1. For the purpose of this agreement, the parties agree to the following facts:
 - a. On, or about, October 27, 1989, the Board licensed Licensee to practice psychology in the State of Minnesota.
 - b. In 2024, Licensee was late in providing the evaluation report regarding several evaluations that he conducted, taking multiple months to complete the reports and failing to adequately communicate with the recipients of the reports.
 - c. Licensee’s methodology for conducting psychological assessments for autism spectrum disorder, including administration of test instruments and his reporting of the results on a timely basis, did not meet accepted standards.
2. The Committee concludes that the conduct above constitutes a violation of Minnesota Statutes section 148.941, subdivision 2(a)(1) (violated a statute, rule, or order that the Board issued or is empowered to enforce); Minnesota Rule 7200.4600, subpart 1 (failed to limit practice to services Licensee can provide competently); Minnesota Rule 7200.5010, subpart 2

(failed to base conclusions on information and procedures sufficient to substantiate those conclusions); Minnesota Rule 7200.5010, subpart 3 (improper use of psychological tests); Minnesota Rule 7200.5010, subpart 4 and subpart 4.A. through 4.E. (failed to include all necessary elements in a report); Minnesota Statutes section 148.941, subdivision 2(a)(3) and Minnesota Rule 7200.5700 (engaged in unprofessional conduct).

CORRECTIVE ACTION

3. Licensee agrees to address the conduct referenced above by taking the following corrective action:

a. ***Psychological Measurement Theory Education.*** Within 18 months of the date of this agreement, Licensee shall provide proof that Licensee has successfully completed either: (1) a graduate-level course in the subject of psychological measurement theory; or (2) 30 hours of continuing education regarding psychological measurement theory. Within three (3) months of the date of this agreement. Licensee shall submit a summary and description of the course and/or courses along with a summary of the instructor(s)'s credentials for pre-approval by the Committee prior to taking the course(s). The Committee reserves the right to reject the course and/or courses proposed by Licensee. If the Committee rejects the course and/or courses proposed by Licensee, the Committee may require that Licensee submit additional courses.

4. Licensee shall be responsible for all costs incurred as a result of compliance with this agreement.

5. If any due date required by the Agreement for Corrective Action is not met, the Committee may fine Licensee \$100 per violation. Licensee shall pay the fine and correct the violation within a reasonable period set by the Committee after service on Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines

not to exceed \$500 per violation. The total of all fines may not exceed \$5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by *writ of certiorari* under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

6. No condition imposed as a remedy by this Agreement for Corrective Action shall be used as a continuing education activity for the purpose of renewal of Licensee's license to practice psychology, unless it is specifically stated in this Agreement for Corrective Action that the condition may be used for this purpose.

OTHER INFORMATION

7. Licensee understands that this agreement does not constitute disciplinary action.

8. Upon Licensee's satisfactory completion of the corrective action referenced above, the Committee agrees to dismiss the complaint(s) referenced in paragraph 1. Licensee agrees that the Committee shall be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the facts in paragraph 1, the Committee may reopen the dismissed complaint(s).

9. If Licensee fails to complete the corrective action satisfactorily, or if the Committee receives additional complaints similar to the facts described in paragraph 1, the Committee may, at its discretion, reopen the investigation and proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14. Licensee agrees that the Committee will be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to that referenced in the Facts section, the Committee may reopen the dismissed complaint. In any subsequent proceeding, the Committee

may use as proof of the facts of paragraph 1 Licensee's agreements herein. Licensee agrees that failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 148.941, subd. 4, and may subject Licensee to disciplinary action by the Board.

10. Licensee has been advised by Committee representatives that Licensee may choose to be represented by legal counsel in this matter. Licensee is represented by Tom Pearson, Esq. The Committee is represented by Rebecca Huting, Assistant Attorney General.

11. This agreement shall become effective upon execution by the Committee and shall remain in effect until the Committee dismisses the complaint, unless the Committee receives additional information that renders corrective action inappropriate. Upon receipt of such information, the Committee may, at its discretion, proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14.

12. Licensee understands and acknowledges that this agreement and any letter of dismissal are classified as public data.

13. Licensee hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Licensee, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

LICENSEE

MINNESOTA BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE

Richard McClellan, MS, LP
RICHARD MCLELLAN, M.S., L.P.

Sonal Markanda
For the Committee

Dated: 4/30/2026

Dated: 5/4/2026

**BEFORE THE MINNESOTA
BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE**

In the Matter of the License of
Carol Potter, M.A., L.B.A.
Licensee Number: LBA0249

**AGREEMENT FOR
CORRECTIVE ACTION**

This agreement is entered into by and between Carol Potter, M.A., L.B.A. (“Licensee”) and the Complaint Resolution Committee of the Minnesota Board of Psychology (“Committee”), pursuant to the authority of Minn. Stat. § 214.103, subd. 6(a). Licensee and the Committee hereby agree as follows:

FACTS

1. For the purpose of this agreement, the parties agree to the following facts:
 - a. On, or about, November 21, 2024, the Board licensed Licensee to practice as a behavior analyst in the State of Minnesota.
 - b. In April 2025, the Licensee documented only one instance of directly observing and directing a treatment session provided by Early Intensive Developmental and Behavioral Intervention (“EIDBI”) providers, including Level 1 providers and students. Licensee failed to document providing the required clinical supervision for 20 percent of direct treatment sessions delivered by unlicensed EIDBI providers. Licensee acknowledged that in spring of 2025, there were times she could not provide the required level of supervision because of a family member’s health issues.
2. The Committee concludes that the conduct above constitutes a violation of Minnesota Statutes section 148.941, subdivision 2(a)(1) (violated a statute, rule, or order that the Board issued or is empowered to enforce); Minnesota Statute section 148.941, subdivision 2(a)(3), and Minnesota Rule 7200.5700 (unprofessional conduct).

CORRECTIVE ACTION

3. Licensee agrees to address the conduct referenced in paragraphs 1 and 2 by taking the following corrective action:

a. **Professional Consultation.** Licensee shall obtain one-on-one, in-person professional consultation to address topics including proper oversight of services provided by supervisees; and how to apply Licensee's understanding of the above issues to Licensee's future practice.

Licensee shall submit the *curriculum vitae* of her proposed professional consultant for pre-approval by the Committee. Licensee shall select a consultant with whom she has had no previous personal or professional relationship. The Committee reserves the right to reject the consultant proposed by Licensee. If the Committee rejects the consultant proposed by Licensee, the Committee may require that Licensee submit additional names.

Licensee shall meet with the consultant for at least two hours per month, for a period of six months.

Consultant Report. Licensee shall have the consultant submit a report to the Board on a quarterly basis while this condition is in effect. The reports shall provide and/or address:

- 1) A statement that the consultant has reviewed this Agreement and any other data deemed relevant by the Committee (applies to first report only);
- 2) The dates on which consultations were held with Licensee;
- 3) Licensee's active participation in each consultation;
- 4) The issues discussed in each consultation;
- 5) The consultant's assessment of Licensee's understanding and ability to deal with the topics addressed in the consultation;

6) The consultant's opinion as to Licensee's understanding of the issues that gave rise to this Agreement; and

7) Any other information the consultant believes would assist the Board in its review of this matter.

Self-Report. At the conclusion of the consultations, Licensee shall have 30 days to submit a report to the Board herself. The report shall provide and/or address:

1) A brief statement of the topics discussed at each consultation session;

2) What Licensee has learned from the consultations, including her own statement as to her comprehension and knowledge of the issues that gave rise to this Agreement;

3) A statement as to how Licensee has changed or will change her practice as a result of the knowledge and skills obtained or honed through the consultation;

4) Three complete client files for clients seen within the preceding three months, demonstrating implementation of changes to Licensee's practice; and

5) Any other information Licensee believes would assist the Board in its review of this matter.

4. Licensee shall be responsible for all costs incurred as a result of compliance with this agreement.

5. If any due date required by the Agreement for Corrective Action is not met, the Committee may fine Licensee \$100 per violation. Licensee shall pay the fine and correct the violation within five days after service on Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed \$500 per

violation. The total of all fines may not exceed \$5,000. Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by *writ of certiorari* under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

6. No condition imposed as a remedy by this Agreement for Corrective Action shall be used as a continuing education activity for the purpose of renewal of Licensee's license to practice psychology, unless it is specifically stated in this Agreement for Corrective Action that the condition may be used for this purpose.

OTHER INFORMATION

7. Licensee understands that this agreement does not constitute disciplinary action.

8. Upon Licensee's satisfactory completion of the corrective action referenced above, the Committee agrees to dismiss the complaint(s) referenced in paragraph 1. Licensee agrees that the Committee shall be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to the facts in paragraph 1, the Committee may reopen the dismissed complaint(s).

9. If Licensee fails to complete the corrective action satisfactorily, or if the Committee receives additional complaints similar to the facts described in paragraph 1, the Committee may, at its discretion, reopen the investigation and proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14. Licensee agrees that the Committee will be the sole judge of satisfactory completion. Licensee understands and further agrees that if, after dismissal, the Committee receives additional complaints similar to that referenced in the Facts section, the Committee may reopen the dismissed complaint. In any subsequent proceeding, the Committee

may use as proof of the facts of paragraph 1 Licensee's agreements herein. Licensee agrees that failure to complete corrective action satisfactorily constitutes failure to cooperate under Minn. Stat. § 148.941, subd. 4, and may subject Licensee to disciplinary action by the Board.

10. Licensee has been advised by Committee representatives that Licensee may choose to be represented by legal counsel in this matter. Licensee is represented by Jennifer Speas, Esq. The Committee is represented by Erin Farmer, Assistant Attorney General.


11. This agreement shall become effective upon execution by the Committee and shall remain in effect until the Committee dismisses the complaint, unless the Committee receives additional information that renders corrective action inappropriate. Upon receipt of such information, the Committee may, at its discretion, proceed according to the Board's practice act and Minn. Stat. chs. 214 and 14.

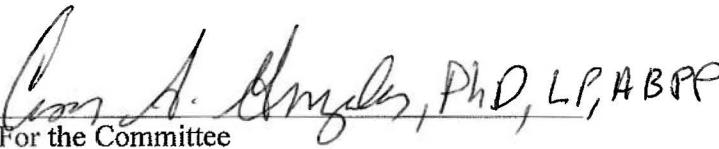
12. Licensee understands and acknowledges that this agreement and any letter of dismissal are classified as public data.

13. Licensee hereby acknowledges having read and understood this agreement and having voluntarily entered into it. This agreement contains the entire agreement between the Committee and Licensee, there being no other agreement of any kind, verbal or otherwise, which varies the terms of this agreement.

LICENSEE

MINNESOTA BOARD OF PSYCHOLOGY
COMPLAINT RESOLUTION COMMITTEE

Signed by:

69BA6046AEGF4F7...
CAROL POTTER, M.A., L.B.A.


For the Committee

Dated: 4/30/2026

Dated: 4/30/2026