Governing AI in Mental Health: A 50-State Legislative Analysis

J. Nicholas Shumate, Eden Rozenblit, Matthew Flathers, Carlos A. Larrauri, Christine Hau, Winna Xia, E. Nicholas Torous, John Torous

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Abstract

Background: Importance: The rapid expansion of mental health-related artificial intelligence (MH-AI) has outpaced regulatory frameworks, raising urgent questions about safety, accountability, and clinical integration. While federal oversight remains uncoordinated and inconsistent, state legislatures have begun to fill the regulatory void with far-reaching implications for mental health professionals.

Objective: To systematically analyze recent state-level legislation relevant to MH-AI, assess its implications for mental health professionals, and identify areas for policy engagement.

Methods: Design, Setting, and Participants: A comprehensive review of AI-related bills introduced in U.S. state legislatures from January 2022 through May 2025 was conducted using Legiscan. Bills were screened and categorized using a custom four-tier taxonomy based on their applicability to MH-AI.

Results: Among 793 state bills reviewed, 143 were identified as potentially impactful to MH-AI: 28 explicitly referenced mental health uses, while 115 had substantial or indirect implications. Of these 143 bills, 20 were enacted across 11 states. Legislative efforts varied widely, but four thematic domains consistently emerged: (1) professional oversight, including deployer liability and licensure obligations; (2) harm prevention, encompassing safety protocols, malpractice exposure, and risk stratification frameworks; (3) patient autonomy, particularly in areas of disclosure, consent, and transparency; and (4) data governance, with notable gaps in privacy protections for sensitive mental health data.

Conclusions: Conclusions and Relevance: Most states are actively shaping the regulatory future of MH-AI through legislation targeting AI in general or adjacent AI domains such as health care, with only a small minority attempting to address the unique challenges of regulating AI in mental health care. Clinician and patient engagement is urgently needed to ensure emerging policies are safe, ethical, and aligned with real-world clinical practice.

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Main Outcomes and Measures: Frequency and content of bills with direct, indirect, or incidental relevance to MH-AI; identification of thematic domains, policy gaps, and clinician-related impacts via a custom tag-by-topic system.

Results: Among 793 state bills reviewed, 143 were identified as potentially impactful to MH-AI: 28 explicitly referenced mental health uses, while 115 had substantial or indirect implications. Of these 143 bills, 20 were enacted across 11 states. Legislative efforts varied widely, but four thematic domains consistently emerged: (1) professional oversight, including deployer liability and licensure obligations; (2) harm prevention, encompassing safety protocols, malpractice exposure, and risk stratification frameworks; (3) patient autonomy, particularly in areas of disclosure, consent, and transparency; and (4) data governance, with notable gaps in privacy protections for sensitive mental health data.

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Introduction

The use of mental health artificial intelligence (MH-AI) is rapidly expanding, both in consumer and clinical domains. In this paper, MH-AI is broadly defined as any AI system used in the delivery, facilitation, or simulation of mental health services. In April 2025, the Harvard Business Review reported that therapy and companionship had become the most frequently cited use cases for generative AI systems mentioned online. [1] Tens of millions of individuals are already engaging with AI systems as human-like companions, so-called "emotional support tools," to ask mental health-related questions, or even as stand-in therapists. [2-4] On the clinical side, in one study 33% of psychiatrists recently reported using OpenAI's ChatGPT to assist with clinical care, and—in the same study—75% believed that patients are likely to consult generative AI before seeking a medical provider. [5] Practitioners, health systems, researchers, and other stakeholders are increasingly exploring AI's use in various applications, including administering mood scales, diagnosis and treatment, risk stratification, administrative support, drug design, and the detection and monitoring of severe mental illnesses, with varying degrees of success. [4,6-8]

These advances, however, are not without risk. While the authors identified no systematic review of harms related to MH-AI, numerous high profile reports in the media of troubling adverse events—including alleged suicidal [9-10] and homicidal [11] acts—have been documented, contributing to the development of a dedicated "AI Incident Database" aimed at raising public awareness of the potential dangers of AI. [12] Further illustrating the risks, the Center for Countering Digital Hate recently found that generative AI tools produced harmful eating disorder information in 41% of reviewed samples, such as recommending hiding uneaten food from parents and, with even the most restrictive AI tested, offering the advice of swallowing a tapeworm egg to lose weight under certain easily achieved conditions. [13] Such examples highlight how easily MH-AI tools can shift from supportive to harmful, particularly when deployed without clear standards, safeguards, or human oversight.

Multiple federal agencies and laws, including the Food and Drug Administration, Federal Trade Commission, Department of Health and Human Services, and the Health Insurance Portability and Accountability Act (HIPAA), exercise limited oversight over MH-AI technologies. However, federal authority in this space is constrained by the specific mandates and domains of each agency or statute. [14] As a result, many MH-AI tools fall into regulatory gray zones or remain exempt from rules governing other medical technologies. [7,14-17] In the absence of a comprehensive federal framework, there is little unified guidance for states or stakeholders. Consequently, states have become de facto policy laboratories, with state legislatures proposing hundreds of AI-related bills since 2022.

Despite the growing legislative interest in AI, public commentary from clinicians on specific proposed state MH-AI laws remains muted. Even major professional organizations, such as the American Psychiatric Association and the American Psychological Association (together, the "APAs"), have issued only limited

position statements, stopping short of offering detailed practice guidelines or public policy recommendations. [15,16] This absence of public clinical input is troubling given the complexity of regulating mental health care, where risks to patient safety, autonomy, professional ethics, and standards of care are profound. As explored throughout this paper, most proposed and enacted state laws lack meaningful integration of clinical insight and fail to address mental health use cases., thereby raising the risk that future norms (both regulatory and clinical) will be misaligned with the realities of patient care. In response, this paper synthesizes findings from a comprehensive review of state-level MH-AI legislation to identify emerging legislative trends and crucial gaps, as well as highlights the urgent need for clinician and patient engagement in shaping the future of MH-AI policy.

Methods

The authors conducted a systematic review of state legislative activity across all 50 U.S. states between January 1, 2022, and May 19, 2025, to identify bills relevant to the intersection of AI and mental health. This search was conducted on the Legiscan website to ensure that querying methods were consistent across states, regardless of variations in individual legislative website design and search functionality. [18] Boolean search queries that paired AI-related terms with mental health-related terms were used in order to narrow results to bills plausibly implicating MH-AI, while excluding bills referencing AI or mental health in isolation and unrelated contexts. The following process was used:

- Navigate to Legiscan
- Set sessions to "all"
- For each state, the following query was used:

intro:20220101..20250519 AND ("artificial intelligence" OR "predictive model" OR chatbot OR LLM OR "language model" OR "machine learning" OR "deep learning") AND (mental OR behavioral OR psych OR healthcare OR "health care")

Each retrieved bill underwent an initial relevance screen. Bills determined to have no plausible bearing on MH-AI were coded as Not Relevant (NR) and excluded from further analysis. Companion bills with versions in both state legislative chambers and bills continued from a prior legislative session were excluded if a more recent version was available. Bills passing the threshold screen were then independently reviewed by two research assistants using a four-tiered coding taxonomy developed by the study team (see **Table 1**). This taxonomy distinguished bills based on the specificity and relevance of their relationship to MH-AI systems and clinical practice. A legally trained researcher reviewed these codings and provided an opinion on any that lacked complete consensus. Any bills that received consensus from the majority of reviewers were labeled accordingly. The first author, also legally trained, reviewed all bills without a majority consensus and made a final determination for taxonomy coding purposes.

Code Taxonomy			
Code	**Category**	**Definition**	**Inclusion Criteria**
E	**Explicit**	Bills that explicitly reference mental health, behavioral health, psychotherapy, or related services in the context of AI development, regulation, or application.	The bill directly names mental health uses of AI, specific clinical applications, or mental health contexts as targets of regulation, policy, or oversight.
SR	**Substantively Relevant**	Bills that govern MH-AI in ways that have direct, foreseeable implications for mental health services or stakeholders, even if mental health is not explicitly or substantively discussed in the bill's text.	The bill regulates MH-AI in a way that predictably impacts mental health uses, delivery, or providers, regardless of whether mental health is explicitly mentioned.
II	**Incidentally Implicative**	Bills that are broadly written and might include MH-AI, but only in a general or indirect way. Clinical impact is uncertain or minimal.	MH-AI falls or could fall under the bill's scope, but direct mechanisms or practical effects at the clinical level are not apparent or minimal.
NR	**Not Relevant**	Bills with no meaningful relationship to MH-AI services, even under expansive interpretations.	The bill does not touch on mental health services.

Table 1.

Following taxonomy coding, each of the remaining bills was independently reviewed by two research assistants using a set of 25 predefined topic tags, as described in **Table 2**. These tags were developed through an iterative consensus process, selected for their topical significance to the intersection of AI and mental health. Tag assignment was descriptive rather than qualitative, signaling only that the tag's specific topic was addressed in the bill in some form. A second pair of research assistants subsequently reviewed and reconciled any discrepancies in tagging. Final review and quality control were conducted by a legally trained member of the research team to ensure consistency and interpretive rigor.

Results

The search yielded 793 total bills, of which 523 were excluded after initial threshold review as not relevant (NR), and 124 were excluded as companion bills or superseded versions. The 146 bills remaining underwent full taxonomy coding. Following consensus determination and final review, 3 additional bills were re-coded as not relevant, leaving 143 bills in the final analytic sample. Among these, 28 were classified as Explicit (E), 79 as Substantively Relevant (SR), and 36 as Incidentally Implicative (II). Notably, of these bills, 20 had been enacted into law at the time of this analysis.

A state-by-state summary of the distribution of these codes can be seen in **Figure 1** and **Appendix A**. Clear outliers include California with 19 bills meeting inclusion criteria and the 12 states with no bills meeting the inclusion criteria: Oregon, Michigan, Kansas, Tennessee, Idaho, Iowa, Delaware, Arizona, Wisconsin, West Virginia, Wyoming, and South Dakota.

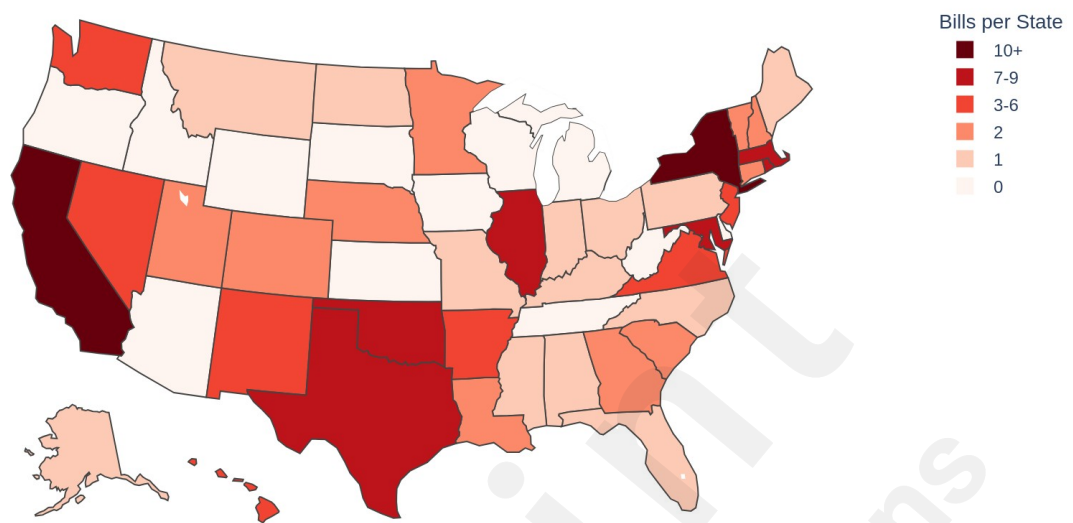Number of MH-AI Related Bills Introduced by State (2022-2025)

Figure 1. Map showing the distribution of MH-AI related bills introduced in state legislatures by state (not including NR bills).
Tagging across these 143 bills revealed instances of all 25 tags with variable incidence (see **Table 2** and **Figures 2-3**).

Tag	Number of Bills	Definition
Civil Penalties	100	Applies any kind of civil penalty to violators (e.g., non-criminal penalties such as system suspension, civil fines, creation of private right-of-action to sue, profit disgorgement, suspension of noncompliant systems, punitive monitoring, or application of a separate civil enforcement statute).
Disclosure/ Consent	96	Implements any requirement to disclose use or features of the AI system (including disclaimers) and/or consent to the use of such systems/features or the ability to revoke consent.
Transparency	90	Implements requirements involving public or patient rights to access AI system data (e.g., requests to obtain data, public inventories of AI systems, publication or transparency requirements).
Consumer Protection	84	Provisions concerning fraudulent, manipulative, or deceptive use of MH-AI systems, including in advertising.
Monitoring	80	Applies any kind of monitoring requirements for MH-AI (e.g., live supervision, submission to audits/documentation processes, generation of reports, or post-market surveillance).
Data Protection	77	Implements any requirements for data privacy, data security, or data retention/deletion (e.g.,

		encryption requirements, secure storage, or data purging policies).
Discrimination/ Bias	68	Implements any requirement regarding discrimination, bias, or fairness.
Post-Market Review	66	Implements requirements for any level of scheduled/routine review after the AI product has been marketed/implemented (e.g., post-market surveillance, auditing, risk assessments, efficacy reviews, etc.), subject to regulatory oversight.
Safety Standards	50	Pertains to safety standards for MH-AI (e.g., human overrides, emergency protocols, or prohibitions on high-risk uses) or safety-based exceptions to other requirements (e.g., bypassing procedures when delays risk harm, allowing immediate protective actions).
Vulnerable Populations	50	Creates any responsibilities related to vulnerable populations (e.g., elderly, children, disabled, foreign-language speakers, etc.), such as mandated reporting requirements, accessibility requirements, or parental controls.
Human-in-the-Loop	49	Explicitly requires a human to monitor, approve, or participate in an essential part of the provision of the MH-AI service.
Meta/Biometric Data	46	Regulates biometric data, behavioral data, or metadata used by MH-AI systems.
Research	45	Pertains to or would affect mental health research (e.g., data collection, consent requirements, ethical guidelines, exemptions for legitimate research use, etc.)
Practitioner Responsibilities	37	Applies any kind of requirements on practitioners—or waivers or exemptions—related to their use of AI systems.
Risk Classification	34	Implements or defines the scope of the law by a risk classification system (e.g., "high risk" AI system, consequential decisions, and similar frameworks).
Pre-Market Review	34	Implements requirements for any level of regulatory review prior to the AI product being offered/implemented (e.g., state commission approval, FDA approval, submission of risk assessments, etc.).
Event Reporting	29	Creates a system for reporting adverse events, near misses, or other safety events involving MH-AI.
Special Purpose Entities	22	Creates or assigns committees, subcommittees, task forces, or similar special-purpose bodies pertaining to MH-AI.
Opt Out	18	Provides for the ability to opt out of AI services in favor of receiving equivalent human-delivered health services.
Licensing Board Oversight	17	Applies any kind of oversight by state professional licensing boards (e.g., requiring board approval of MH-AI systems used in diagnosis/treatment or

		allowing boards to discipline individuals or systems).
Malpractice/ Liability	16	Pertains to medical malpractice involving AI, including liability allocation for AI-related harm (e.g., standards of evidence, assigning responsibility to deployers, developers, practitioners, or manufacturers, liability shields or limitations, use of MH-AI records and data in litigation, etc.).
Criminal Penalties	11	Applies any kind of criminal penalty to violators (e.g., criminal fines, incarceration, misdemeanor/felony designations).
Pilot/Sandbox	11	Provides for regulatory pilot programs or sandbox systems, allowing AI products to be tested and receive feedback from regulators prior to full marketing.
Payments/ Insurance	10	Regulations on insurance coverage, reimbursement, and payment models.
Prescribing	2	Applies any requirements or waivers regarding prescriptions.

Table 2. Table of the 25 tags used in the tagging system, the number of bills associated with each tag after analysis, and the definition of the tag.

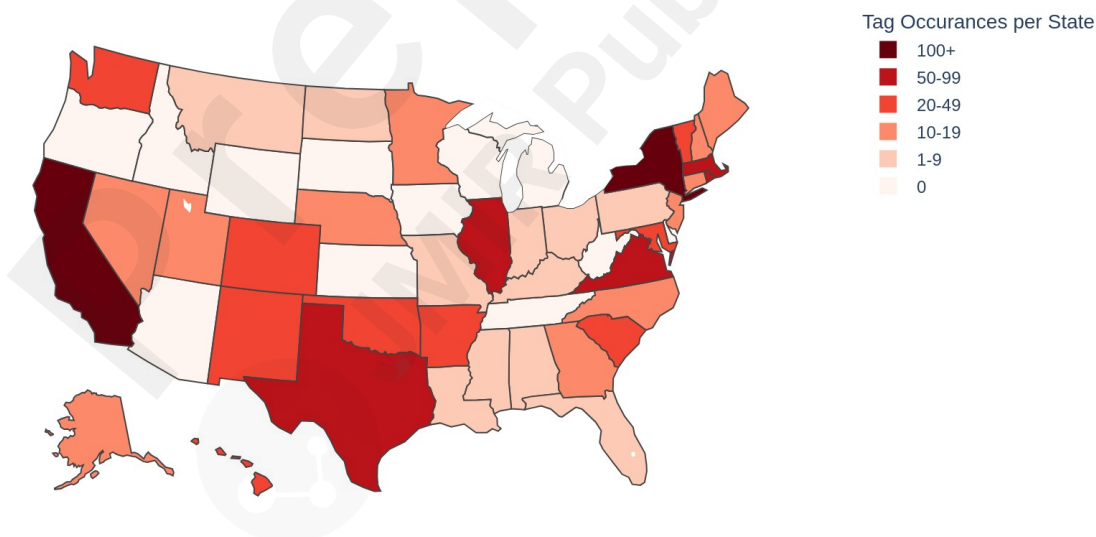Number of MH-AI Tag Occurances by State (All Bills, 2022-2025)

Figure 2. Map showing the total number of tags occurring in bills for each state, inclusive of identical tags across multiple bills.

How Many of 25 MH-AI Policy Tags Each State's Bills Touch (All Bills,2022-2025)
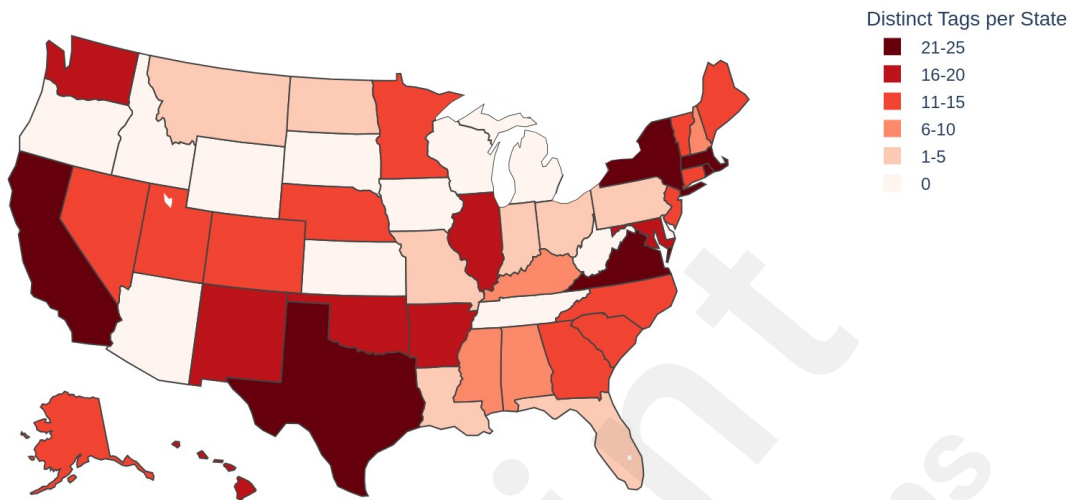

Figure 3. Map showing the number of tags out of the 25 possible that legislation from each state received.

Individual analysis of taxonomy coded bills and their tags revealed hundreds of variations of provisions potentially or explicitly impacting MH-AI. Several notable policy directions and gaps appeared, as seen in **Table 3** (sorted into significant areas of legal and clinical relevance).

Professional Oversight and Responsibilities	No. of Bills
Explicit oversight by licensed mental health professionals required	6
Authorization for oversight by professional licensing boards	17
Governance and Ethical Standards	
Formation of special task forces, committees, or relevant entities with jurisdiction overlapping with MH-AI	10
Ethical frameworks referenced to guide AI use	12
Alignment with National Institute of Standards and Technology (NIST) or other national best-practice standards	14
Consumer Protection and Enforcement	
Violations explicitly tied to existing state consumer protection laws	39
Explicit creation of private right of action for AI-induced harms	30
Assignment of punitive or super-compensatory damages/penalties	11
Violations tied directly to professional disciplinary actions	12

Allocation of malpractice liability or responsibility for MH-AI harms, including strict liability, immunities, and affirmative defenses	11
User Protections and Disclosures	
Explicit informed consent requirements for MH-AI use	4
Mandated disclosure of AI interactions, including continuous or repeated disclosures	33
Restrictions on AI systems simulating professional licensure or impersonating clinicians	6
Restrictions on advertising	14
Right to human review of AI-decision appeals	17
Allows for users to opt out of AI services in favor of human-provided services	9
Crisis Response and Safety	
Mandated crisis response planning for suicidal ideation or threats	8
Exemptions from certain requirements (e.g., data privacy) when compliance could result in harm	15
Special Populations and Agency-Specific Provisions	
Specific protections designated for children	39
Application exclusively to state agencies and organizations	9
Transparency and Accountability	
Public registry or inventory of AI systems mandated	19
Exemptions for entities or data covered under HIPAA	22

Table 3. Table of the number of bills associated with notable policy areas.

While beyond the intended scope of this study, an additional table and figures compiling tags associated only with enacted bills are provided in **Appendix B,** offering an interesting point of comparison.

Discussion

Despite growing interest in the use of artificial intelligence in health care, few state laws explicitly address its application in mental health. This analysis reveals a fragmented policy environment in which mental health-specific considerations are often overlooked or subsumed under broader AI or health care regulations. In the sections that follow, the authors examine trends in legislative activity and identify four key policy domains—oversight, harm, autonomy, and privacy—that warrant closer attention. These domains are likely to shape how enacted legislation is interpreted, implemented, and enforced. Illustrative examples of bill provisions are presented alongside a discussion of critical regulatory gaps. Together, these findings suggest the need for more targeted policymaking to ensure that MH-AI technologies are developed and deployed in a manner that protects patients and supports mental health professionals in delivering effective and innovative clinical care.

I. Taxonomy Analysis

Of the 143 bills identified, only 28 explicitly address MH-AI, while 115 regulate MH-AI either substantially or incidentally. State-level patterns reveal an even sharper contrast. Only 13 states had proposed bills specifically mentioning mental health (or related terms), and, of these, only 3 had been enacted by the close of the study window. By comparison, 34 states had proposed laws that substantially or incidentally affected MH-AI regulation through provisions aimed at adjacent areas such as data privacy, general health care, or other regulatory domains. Of those, 17 were enacted. In total, only 2 states had enacted any E-coded laws from the sample (Utah [19] and New York [20]), 7 states enacted an SR-coded law, and 11 states enacted an II-coded law (**Appendix A**) at the time of analysis.

An E-coded bill example would include New Jersey's Senate Bill (S.B.) 4463, which explicitly prohibits AI systems from being advertised as licensed mental health professionals. [21] An example of an SR-coded bill is Rhode Island's S.B. 627, which aims to regulate "high-risk" AI systems making "consequential decisions," including those related to health care, and likely encompasses MH-AI systems. [22] However, the bill does not explicitly mention mental health or tailor its scope for mental health-related systems or services. It is possible that Rhode Island case law or agency guidance already interprets "health care" broadly enough to include mental health; however, such a consideration falls outside the scope of this study. In contrast, Missouri's House Bill (H.B.) 1462, an II-coded bill, establishes general legal definitions and liability rules for AI systems without addressing health care. [23] Though not designed with MH-AI in mind, its provisions could still influence the regulatory context in which these technologies operate.

This jumbled distribution of MH-AI legislation underscores significant disparities in regulatory attention and preparedness. States with little or no relevant legislation may be relying on outdated or overly broad frameworks ill-suited to address the unique risks of MH-AI tools. [24,25] Conversely, states enacting broad AI or health care laws without mental health-specific provisions may inadvertently leave gaps in oversight, particularly for technologies operating at the margins of existing legal and clinical frameworks. In either case, there is a strong argument that mental health practitioners should take an active role in shaping these rapidly evolving laws.

II. Trends and Themes

A closer analysis of the sampled bills reveals substantial variation in how states regulate MH-AI, with most efforts reflecting fragmented provisions rather than cohesive regulatory frameworks. Despite this heterogeneity, at least four prominent thematic domains emerge that require clinicians' attention. The following section organizes these themes and highlights illustrative examples that reveal consequential divergences in scope, emphasis, and implementation strategies relevant to MH-AI. Equally important, this paper also discusses some of the ways in which state legislation has failed to engage with MH-AI, leaving prominent gaps that carry implications for both practice and oversight.

Oversight

This section examines how a subset of state legislation addresses clinician oversight in MH-AI, focusing on three areas: requirements for professional supervision, the integration of AI use into licensure and disciplinary frameworks, and the role of licensing boards in state MH-AI regulation.

A notable subset of legislation directly ties AI use to clinician responsibilities and professional licensure. For example, bills in Oklahoma, Texas, Rhode Island, and Massachusetts propose real-time professional supervision or continuous monitoring of MH-AI services. [26-30] Similarly, bills in Illinois, Louisiana, and Nevada would require clinicians to verify AI-generated outputs used in care delivery or communications (e.g., IL H.B. 5649, IL H.B. 1806, LA H.B. 114, LA H.B. 916, NV Assembly Bill (A.B.) 406). [31-35] Some states propose less stringent human oversight, mandating availability on request rather than continuous intervention (e.g., TX H.B. 4455). [36]

Several bills explicitly link compliance failures to professional disciplinary actions, effectively integrating AI use into the existing licensure framework (e.g., RI H.B. 6285, IL H.B. 5649). [29,31,32,35,37-46] Meanwhile, states such as Louisiana (H.B. 916), Georgia (H.B. 887), and Illinois (S.B. 2259) involve professional licensing boards directly, either to promulgate MH-AI rules or to explicitly approve clinical use (MA H.B. 1974, RI H.B. 6285). [29-30,34,37,46] California's S.B. 813 takes a distinctive approach by proposing voluntary certification by multidisciplinary stakeholder groups, which may potentially include clinicians. [47] Such board-based oversight offers potential advantages, including clinically informed standards, regulatory flexibility, and alignment with existing safety and ethical frameworks.

However, shifting oversight to licensing boards or individual licensed professionals also raises important concerns. Licensed clinical professionals may lack the expertise and resources to validate algorithmic reliability or effectively detect bias, potentially exposing them to disproportionate liability (as exemplified by North Carolina H.B. 934, discussed below). [48] Additionally, laws targeting only licensed clinicians risk creating regulatory gaps by leaving MH-AI use among unlicensed actors—such as life coaches, wellness influencers, peer support groups, and AI-driven self-help platforms—as well as AI system developers and deployers who fall outside traditional professional licensing requirements, underregulated. This could paradoxically compromise public safety while imposing undue and anti-competitive burdens on licensed practitioners (e.g., IL S.B. 2259, GA H.B. 887, CA S.B. 503, AR H.B. 1816, VA H.B. 916; TX S.B. 1188, RI H.B. 6285, OK H.B. 1915). [27-28,31-32,36-37,43,45-46,49-52]

Although these legislative efforts deserve attention, they remain the exception. Only 11 states propose bills involving clinician oversight or licensure frameworks in this sample, underscoring a striking lack of regulatory engagement with the clinical dimensions of MH-AI. While many laws regulate AI in abstract or

consumer-oriented terms, most fail to incorporate clinical or patient input to reflect the realities of therapeutic deployment. To address these challenges, MH-AI policy must move beyond treating clinicians as the default point of oversight and instead develop layered governance models that include professional boards, technologists, patient advocacy groups, and public regulators in shared accountability structures.

Harm

A small number of state legislatures have begun to confront the potential harms of MH-AI, introducing proposals focused on liability allocation, harm prevention and crisis response standards, safeguards for vulnerable users, fraud protections, and limited exemptions for research and therapeutic use.

For example, most states have yet to clarify how malpractice and liability laws specifically apply to MH-AI, leaving uncertainty about how courts might classify such technologies, whether as products, clinical tools, or services subject to standard-of-care analysis. Only a few states, most notably California and New York, explicitly proposed legislation that establishes specific claims for damages related to AI-induced harms such as self-harm or suicide [53-56], though a few other states propose a more general AI-harm liability framework (e.g., MO H.B. 1462, "Any direct or indirect harm caused by an AI system's operation, output, or recommendation…shall be the responsibility of the owner or user who directed or employed the AI."). [23] New York and Rhode Island both introduce strict liability (i.e., liability regardless of negligence or intent) for harms under certain circumstances. [55,57] Both California and Rhode Island also introduce affirmative defenses (i.e., a defense even if one is legally responsible for the harm): California S.B. 813 provides an affirmative defense linked to compliance with certification standards, while Rhode Island S.B. 358 grants an affirmative defense to strict liability if the model "satisfied the standard of care applicable to humans who perform the same function." [47,57] Conversely, North Carolina's H.B. 934 immunizes developers entirely, assigning liability solely to clinicians—a concerning policy that places disproportionate responsibility on providers who may lack sufficient technological expertise to foresee or mitigate AI failures, including those introduced through problematic automatic software updates. [48]

Only 16 of the 143 reviewed bills directly addressed malpractice and liability allocation, with just one enacted within the study period. [**Appendix B**] This scarcity signals significant policy gaps, increasing risks of inconsistent liability outcomes. Oklahoma's H.B. 1915 illustrates another liability-related challenge by mandating that developers track and document clinicians' overrides of AI recommendations, thereby creating potential evidence in malpractice litigation. [27] Such provisions underscore the need for more transparent standards and clinician engagement regarding the acceptable use of AI in clinical practice, as well as how that use will influence both standard of care and associated medicolegal risks.

Regarding safety standards, 52 bills addressed harm prevention, of which 8 bills

pertained to crisis response protocols and 15 bills addressed exemptions to other provisions (e.g., data privacy restrictions) to prevent imminent harm. California S.B. 243 and New York A.B. 6767, for example, explicitly mandate crisis intervention plans for detecting suicidal ideation, though incident reporting mechanisms remain uncommon. [23,53,56,58-67] California's S.B. 243 notably requires annual reporting on suicidal ideation incidents but without mandating public disclosure, thus limiting transparency. [53] Missouri's H.B. 1462 requires specifically "owners or developers" of AI systems involved in incidents resulting in bodily harm or death to "promptly notify the relevant authorities" but creates no special system for doing so. [23]

Risk stratification frameworks proposed in several states significantly influence MH-AI oversight, typically centering on "high-risk" AI systems used in "consequential decisions" impacting fundamental services, legal rights, and health care. Oklahoma's H.B. 1916 introduces a formally tiered risk categorization, labeling health care AI as high-risk and subjecting it to stringent oversight. [26] However, definitions of scope remain unclear, raising questions about how specific applications (e.g., cognitive behavioral therapy chatbots) should be categorized. At least 33 bills reviewed suggest a potential growing consensus around heightened scrutiny for MH-AI systems by placing them in the highest risk categories, although practical definitions remain ambiguous, and only 5 had been enacted at the time of the sample.

One of the most common harms addressed in these bills was the threat of deceit, fraud, or abuse, with 84 of the bills identified addressing consumer protection, whether directly by creating new standards or incorporating AI systems with existing state consumer protection laws (39 bills). Bills out of Nevada, New Jersey, California, and Utah explicitly prohibit AI systems from impersonating licensed clinicians or advertising without clear disclosures (NV A.B. 406, NJ S.B. 4463, CA A.B. 489, UT H.B. 452), [21,35,44,65] joining a total of 14 bills addressing advertising related to covered AI systems. [21,32,35,65,68-77] Nonetheless, significant gaps persist concerning manipulative designs, biased recommendations, undisclosed commercial influence, and misuse targeting vulnerable populations.

Protections for vulnerable populations also remain uneven. Although 50 bills addressed responsibilities toward vulnerable groups generally, 39 appear focused on protections for minors (e.g., CA A.B. 1064 [78], NV A.B. 406 [35]), with none explicitly considering risks to users with limited English proficiency, cognitive impairments, or severe mental illnesses, though some of these categories might fall under otherwise protected disability categories. Similarly, only one of the 143 bills reviewed addresses mandatory reporting obligations for MH-AI operators upon detecting signs of abuse or neglect, highlighting a potentially significant oversight and underscoring the tension between patient safety and practical feasibility for AI developers. [28]

Finally, despite 45 bills containing provisions exempting or touching on aspects of legitimate research use, all bills sampled appear to lack clear protections or exemptions for the legitimate use of MH-AI in research and treatment involving

techniques such as behavioral influence or limited disclosure. By contrast, the European Union's AI Act (Article 5) includes targeted exemptions for approved uses involving forms of persuasion, manipulation, or partial information to achieve clinically valid outcomes. [79] Without similar carveouts, well-intentioned bills like Montana H.B. 178, which broadly prohibits "cognitive behavioral manipulation of a person or group," may unintentionally limit future innovation and care in the mental health space. [80]

Autonomy

As MH-AI systems increasingly intersect with patient care, user autonomy has emerged as a critical regulatory and ethical priority, with state legislation primarily addressing transparency, disclosure, and informed consent.

Legislative efforts around transparency remain limited, with relatively few states proposing public registries or disclosure standards specifically targeting MH-AI systems. Of the 91 bills identified addressing transparency broadly, 19 explicitly mandate public-facing inventories or similar public registry reporting requirements (e.g., PA H.B. 290, GA H.B. 988, DE H.B. 333, IL H.B. 3529, IL H.B. 3720). [81-85] California's S.B. 813 uniquely integrates transparency benchmarks within its voluntary certification system. [47] Despite these initiatives, transparency mandates tailored specifically for MH-AI remain uncommon, leaving clinicians and patients reliant on opaque technologies with unclear risks and benefits.

Disclosure requirements are among the most frequently proposed regulatory strategies, with 96 bills addressing disclosure or consent in some form. Many explicitly mandate clear notification to users interacting with AI systems (e.g., CA A.B. 410, IN H.B. 1620, MA H.B. 1975, UT S.B. 226, IL H.B. 5649), and a few states, such as Nevada (S.B. 186) and New York (A.B. 6767), propose continuous or repeated disclosures in interactive settings. [19,31,38-39,56,86,87] California's A.B. 3030 creates an exemption to some disclosure requirements if a licensed provider has reviewed the AI-generated output. [45] Explicit informed consent requirements for MH-AI are considerably rarer; only a small number of bills, namely Texas H.B. 1265, Pennsylvania S.B. 631, and Rhode Island H.B. 6285, directly require informed consent specifically for MH-AI services. [28-29,88] Notably, bills such as Massachusetts H.B. 1975 and Illinois H.B. 5649 propose providing users with the option of non-AI alternatives for services, although such provisions remain exceptions. [31,38]

Without detailed statutory or professional guidelines, clinicians are left with unanswered practical questions, particularly regarding the level of understanding required of AI systems to meet disclosure and informed consent obligations. For example, should clinicians review and communicate error rates, data sources, or regulatory status in a manner comparable to how they communicate the risks, benefits, and limitations of medications or other clinical interventions? If the law protects such information as proprietary or fails to promote transparency or external validation of clinical MH-AI, it also raises the question of where responsibility—and liability—for harm should fall. Without

clear legislative or professional guidelines, clinicians face potential liability risks, and patient autonomy remains inadequately protected.

Privacy and Data

Despite the uniquely sensitive nature of mental health data, few states propose tailored privacy protections for MH-AI systems. Legislative efforts remain limited, focusing primarily on addressing gaps in existing privacy frameworks, ensuring user control over AI-generated data, and establishing exceptions for crisis-related interventions.

Traditional mental health records, such as psychotherapy notes and substance use treatment records, receive specialized privacy protections under HIPAA and 42 CFR Part 2. [89-90] However, none of the reviewed state bills explicitly extend similar protections to MH-AI-generated content such as therapy-like transcripts, emotional disclosures, or sensitive behavioral metadata (excepting, perhaps, Illinois H.B. 1806, which brings such records under the state's Mental Health and Developmental Disabilities Confidentiality Act, but analysis of this separate law is outside the scope of this review). [32] Of the 77 bills addressing data protection, the lack of specialized protections may be particularly pertinent for non-HIPAA-covered entities, such as app developers and commercial platforms, creating a potential regulatory gap that leaves clinicians and patients vulnerable to data misuse and potential reidentification. Perhaps compounding the issue, several bills specifically exclude HIPAA-covered entities from their protections, relying on a federal statutory framework that also does not consider many MH-AI uses and products (e.g., RI S0627 exempts HIPAA-covered entities providing health care recommendations that "are not considered to be high risk"). [22,67-68,77,91-107]

Few state bills meaningfully address users' rights to control their mental health data within MH-AI systems. Notable exceptions include California A.B. 1018 and Colorado S.B. 24-205, which grant users access rights to data involved in high-risk AI decisions. [71,94] In contrast, North Carolina's S.B. 624 uniquely mandates a 30-day self-destruction timeline for MH-AI chat data and imposes enhanced encryption and data reuse restrictions for such applications. [59] However, these data control provisions introduce practical challenges related to clinical documentation, adverse event review, and compliance with existing medical record retention laws—placing them in tension with clinicians' ethical and legal obligations.

Alongside the safety exemptions mentioned above, several bills aim to strike a balance between data privacy and immediate patient safety concerns, such as Colorado S.B. 24-205 and Virginia H.B. 747, which permit the temporary suspension of privacy rules during emergencies. [94,108] While potentially critical in crisis situations involving self-harm or suicide risk, such exceptions raise serious concerns about intervention protocols, accountability for misuse, and access by law enforcement or the legal system. Without well-defined protocols and robust oversight, these exemptions risk undermining patient trust and clinical integrity and could disproportionately impact communities already

experiencing heightened surveillance or systemic mistrust.

Limitations

This data should be approached with an understanding of several limitations. This review presents a snapshot of proposed legislation, reflecting the text of bills as they existed in May 2025, regardless of whether they were enacted, failed, or underwent subsequent amendments. The dynamic nature of the legislative process may substantially affect the scope, applicability, or legal significance of the bills reviewed. Moreover, statutory frameworks are frequently fragmented, relying on extensive cross-referencing to agency regulations, definitional clauses, and other legislative instruments. Consequently, despite comprehensive search protocols, some relevant legislation may have fallen outside the inclusion criteria of this study due to limitations in keyword-based retrieval, indirect statutory language, or the study's restricted timeframe. For example, North Carolina's H.B. 934, mentioned above, is not included in the data sample despite its considerable relevance to clinical AI due to its lack of qualifying keywords. Additionally, counting companion bills as a single legislative item for the purposes of this analysis overlooks the potential substantive differences between the house and senate versions of certain bills.

Conclusion

As state legislatures race to define the future of AI, mental health has quietly become one of its most consequential yet least prepared frontiers. This review reveals a policy landscape defined by promise but marked by fragmented execution. While many proposed laws seek to promote safety, accountability, and the ethical use of MH-AI, few are grounded in the clinical realities of mental health care. Critical gaps persist in areas such as professional oversight, liability, data protection, and the needs of vulnerable populations. In many cases, lawmakers have assigned duties to clinicians without offering corresponding guidance, protections, or tools, effectively outsourcing complex regulatory questions to the point of care. This is unsurprising when considering that only 2 bills creating task forces, committees, or workgroups focused on AI legislation reserve a stakeholder position for a mental health practitioner.

Clinicians cannot afford to remain passive. The laws shaping MH-AI are being written now. Mental health professionals should collaborate with their institutions, professional associations, patient advocacy groups, and state policymakers to ensure that these regulatory frameworks are informed by clinical expertise, ethically sound, and practically feasible. To this end, the authors offer (1) **Appendix C**, which proposes a scoring framework for interpreting state engagement across key legal domains relevant to MH-AI; and (2) access to the tagging database of MH-AI related bills created for this study. [109] By contributing their expertise at this critical juncture, clinicians can help shape policies that determine whether future systems advance mental health services and safety or exacerbate these gaps.

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Data Availability

Data used in this paper is publicly available. [109]

Authors' Contributions

J. Nicholas Shumate, M.D., J.D., conceptualized the project, curated data, performed data curation and validation, developed the methodology used, supervised contributors, provided formal analysis and investigation, administered the project, and wrote and edited the manuscript.

Eden Rozenblit, B.S., contributed towards the project's conceptualization, curated data, performed formal analysis and investigation of data, developed the methodology used, managed the project via software and visualizations, validated data, and contributed to review and editing of the manuscript.

Matthew Flathers, B.A., contributed towards the project's conceptualization, curated data, performed formal analysis and investigation of data, developed the methodology used, validated data, and contributed to review and editing of the manuscript.

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E. Nicholas Torous, J.D., contributed data curation, formal analysis, validation, legal citation review, and review and editing of the manuscript.

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Abbreviations

AI: Artificial Intelligence
A.B.: Assembly Bill
E: Explicit
H.B.: House Bill
HIPAA: Health Insurance Portability and Accountability Act
II: Incidentally Implicative
MH-AI: Mental Health Artificial Intelligence
NR: Not Relevant
S.B.: Senate Bill
SR: Substantively Relevant

State   Abbreviations:
AL: Alabama
AK: Alaska
AZ: Arizona
AR: Arkansas
CA: California
CO: Colorado
CT: Connecticut
DE: Delaware
FL: Florida

GA: Georgia
HI: Hawaii
ID: Idaho
IL: Illinois
IN: Indiana
IA: Iowa
KS: Kansas
KY: Kentucky
LA: Louisiana
ME: Maine
MD: Maryland
MA: Massachusetts
MI: Michigan
MN: Minnesota
MS: Mississippi
MO: Missouri
MT: Montana
NE: Nebraska
NV: Nevada
NH: New Hampshire
NJ: New Jersey
NM: New Mexico
NY: New York
NC: North Carolina
ND: North Dakota
OH: Ohio
OK: Oklahoma
OR: Oregon
PA: Pennsylvania
RI: Rhode Island
SC: South Carolina
SD: South Dakota
TN: Tennessee
TX: Texas
UT: Utah
VT: Vermont
VA: Virginia
WA: Washington
WV: West Virginia
WI: Wisconsin
WY: Wyoming

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99. VA HB2094 | 2025 | Regular Session. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/VA/bill/HB2094/2025

100. VT H0121 | 2023-2024 | Session. (2024). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/VT/bill/H0121/2023

101. VT S0071 | 2025-2026 | Regular Session. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/VT/bill/S0071/2025

102. TX HB4854 | 2025-2026 | 89th Legislature. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/TX/bill/HB4854/2025

103. RI S0824 | 2025 | Regular Session. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/RI/bill/S0824/2025

104. RI S1037 | 2025 | Regular Session. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/RI/bill/S1037/2025

105. RI H7917 | 2024 | Regular Session. (2024). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/RI/bill/H7917/2024

106. NY A04947 | 2025-2026 | General Assembly. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/NY/bill/A04947/2025

107. AL HB283 | 2025 | Regular Session. (2025). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/AL/bill/HB283/2025

108. VA HB747 | 2024 | Regular Session. (2024). LegiScan. Retrieved May 19, 2025, from https://legiscan.com/VA/bill/HB747/2024

109. Tagging and Taxonomy Database *[authors' note: uploaded as a separate file to preserve anonymity during review; however, the published version would include a link to the authors' web-hosted version]*
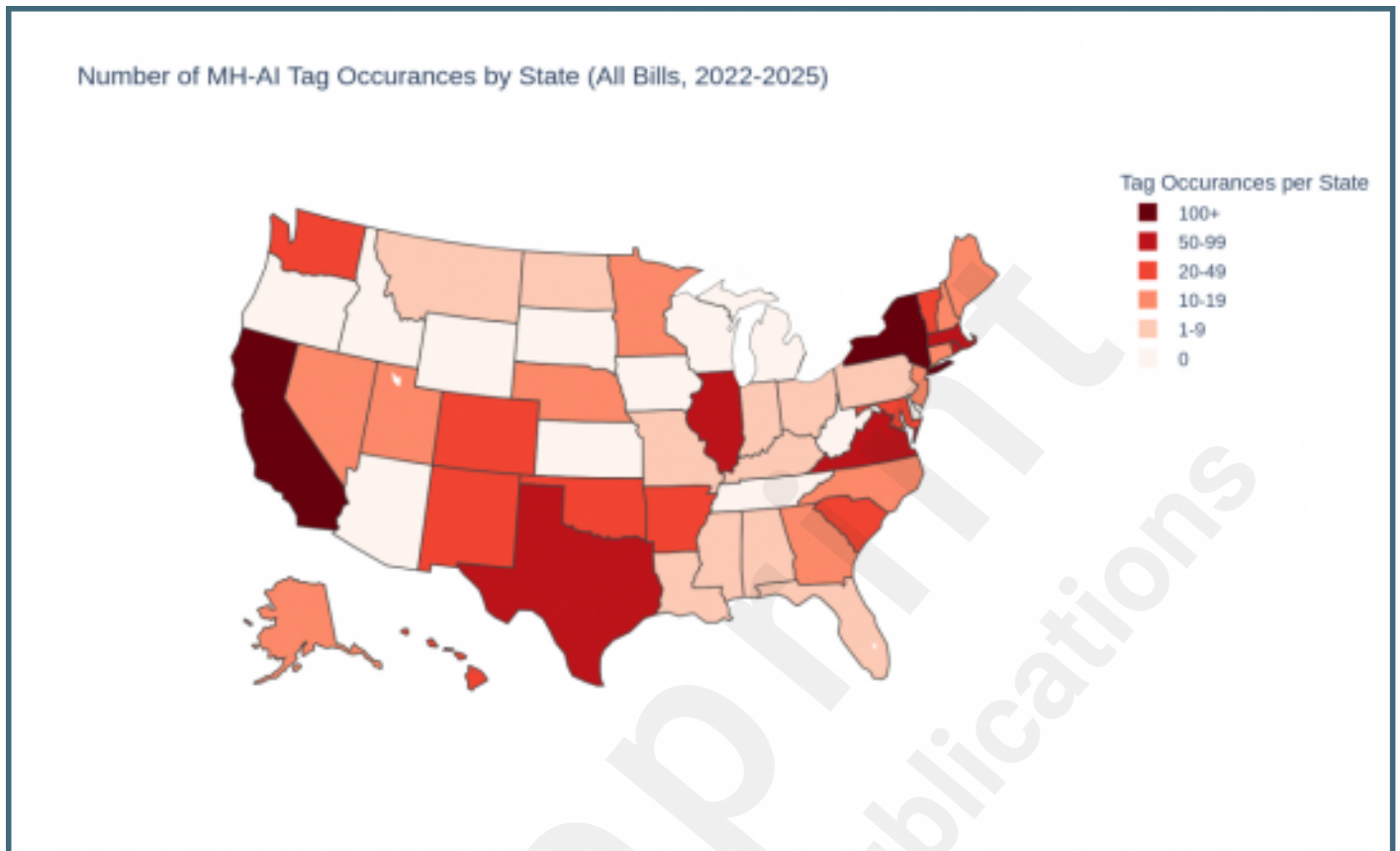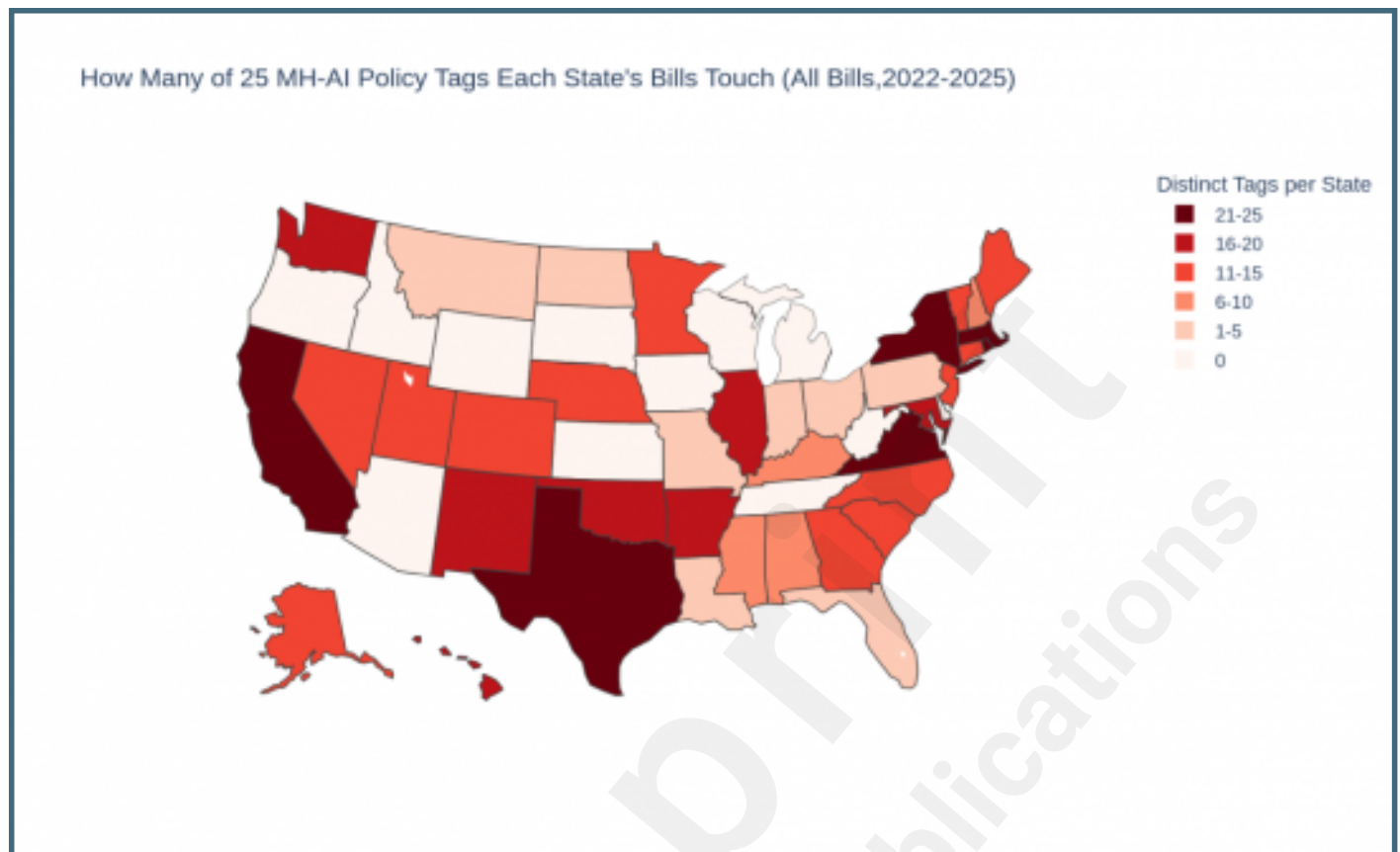
Supplementary Files

Figures

Map showing the distribution of MH-AI related bills introduced in state legislatures by state (not including NR bills).

Number of MH-AI Related Bills Introduced by State (2022-2025)

Map showing the total number of tags occurring in bills for each state, inclusive of identical tags across multiple bills.

Number of MH-AI Tag Occurances by State (All Bills, 2022-2025)

Map showing the number of tags out of the 25 possible that legislation from each state received.

How Many of 25 MH-AI Policy Tags Each State's Bills Touch (All Bills,2022-2025)

Distinct Tags per State
- 21-25
- 16-20
- 11-15
- 6-10
- 1-5
- 0
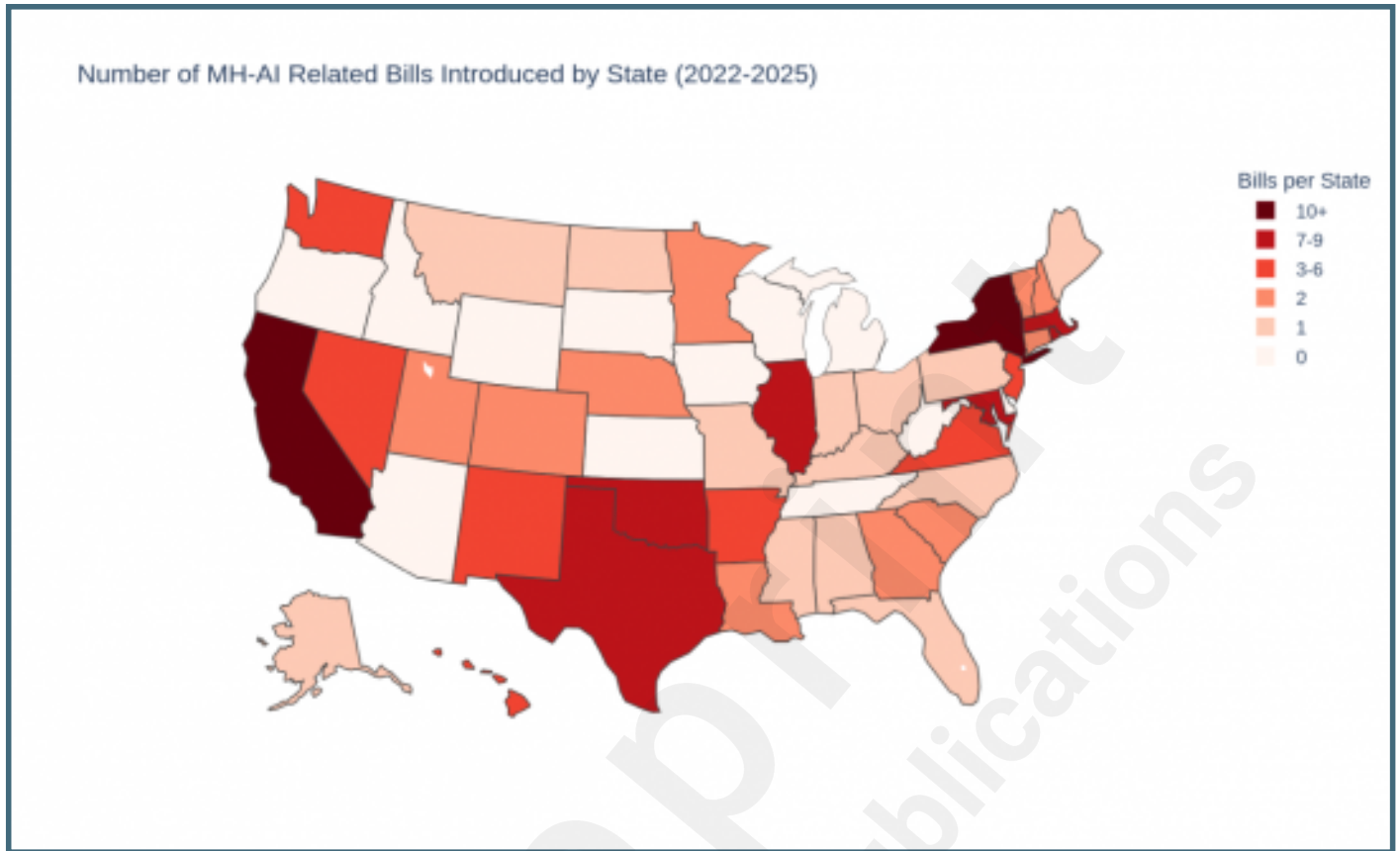
Multimedia Appendixes

Tables of taxonomy coding outcomes, enacted bill data with figures, and state Mental Health AI Regulatory Coverage Index Scoring Framework.
URL: http://asset.jmir.pub/assets/374dca413a2847f91e04be6fdc6ad3bf.docx