Texas Society of Psychiatric Physicians

From Hype to Help: AI Tools Your Psychiatric Practice Can Use Right Now

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Disclosures & CME Information

Disclosures & CME

Financial Disclosures
[Speaker to complete prior to presentation]

CME Credit
This activity has been designated for AMA PRA Category 1 Credit™

Off-label / Investigational Use
None of the AI tools discussed today constitute a direct prescription, diagnosis, or treatment recommendation. All clinical decisions remain the responsibility of the treating physician.

Conflict of Interest
[Speaker to disclose or state 'None to disclose']

Learning Objectives

At the conclusion of this session, participants will be able to:

01 Identify currently available AI tools for psychiatric documentation, diagnosis support, risk assessment, and treatment planning — and evaluate their evidence base and practical utility

02 Apply federal and Texas-specific regulatory frameworks (FDA, HIPAA, TRAIGA, SB 1188) and professional society guidelines (APA, AMA, TMA, TMB) to the responsible integration of AI in practice

03 Develop a personal framework for evaluating, adopting, and monitoring AI tools while maintaining patient safety, privacy, and the therapeutic relationship

The AI Moment in Medicine — Where Are We?

66%
of physicians used AI in practice in 2024 (AMA, up from 38% in 2023)

1,350+
FDA-authorized AI-enabled medical devices as of 2026

SB1188
Texas healthcare AI law effective Sept 1, 2025

-13.9%
reduction in physician burnout rate with AI scribe use (JAMA Netw Open 2025)

The question is no longer whether AI belongs in psychiatry — it's how to use it safely and effectively.

AI in psychiatry spans 5 domains: Documentation · Diagnostic Support · Risk Assessment · Treatment Planning · Patient-Facing Apps

Sources: AMA 2024 Digital Health Survey; FDA AI/ML-Enabled Medical Device Database 2025; Yale School of Medicine 2025

AI Terminology: What Are We Actually Talking About?

Machine Learning (ML)

Algorithms trained on data to identify patterns and make predictions (e.g., suicide risk models)

Large Language Model (LLM)

AI trained on vast text data — powers ambient scribes, clinical summarizers, chatbots (e.g., GPT-4, Claude)

Ambient AI / AI Scribe

Listens to the clinical encounter in real-time and auto-generates documentation

Clinical Decision Support (CDS)

Software providing evidence-based recommendations at point of care

SaMD

Software as a Medical Device — FDA regulatory category for AI clinical tools

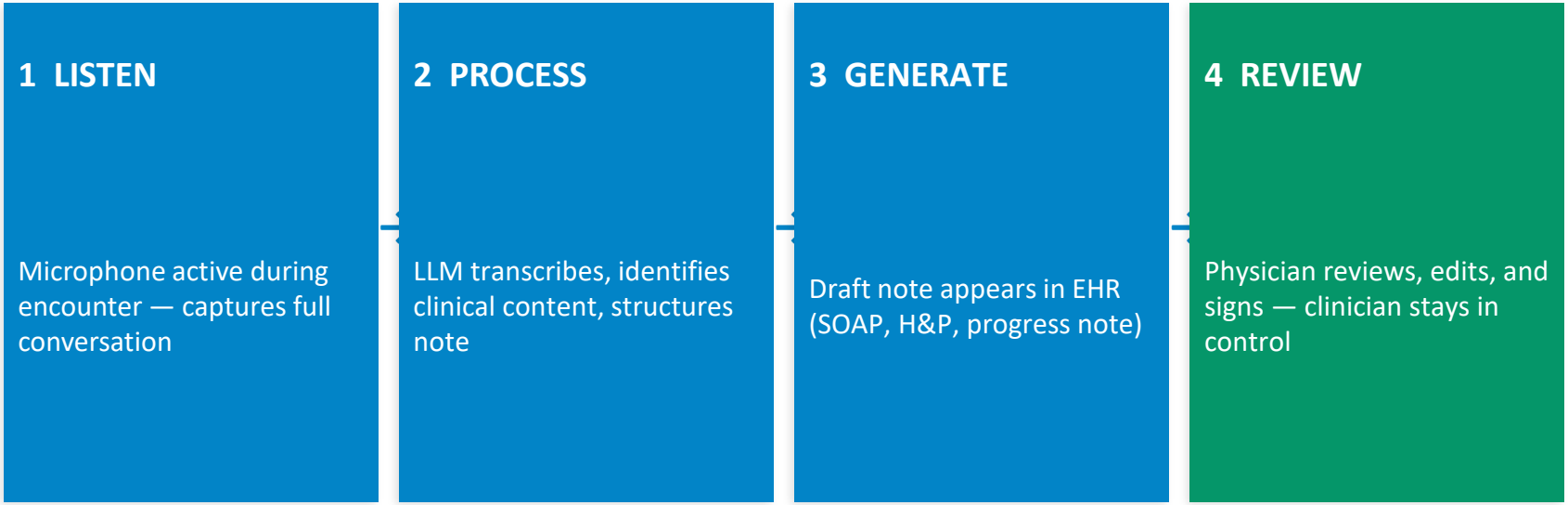
Augmented Intelligence

TMA/AMA preferred term: AI designed to co-exist with — not replace — physician judgment

01

AI for Clinical Documentation: Ambient Scribes & Beyond

How Ambient AI Documentation Works



⚠️ **Key requirement: Physician must review, edit, and attest to every AI-generated note.**

Informed consent and patient notification of AI use are recommended (APA, TMA) and may be legally required (TX SB 1188)

AI Scribe Tools for Psychiatry — 2025/2026 Comparison

Tool	Best For	EHR Integration	Key Strength	Caution / Note
Dragon Copilot (was DAX Copilot)	Large health systems	Epic, Cerner, Oracle	600+ orgs; 3M+ monthly encounters; rebranded Mar 2025	Not ideal for small practices; cost
Nabla	Independent & small groups	Most major EHRs	No audio stored by default; multilingual; HIPAA-compliant	Requires vigilant review for psychiatric nuance
Abridge	Academic medical centers	Epic native	Best in KLAS 2025 AND 2026; 250+ health system deployments	Limited psychiatry-specific note templates
Freed	Solo & small group practice	Copy/paste + integrations	Affordable ($99/mo); fast setup; DAP + therapy SOAP notes	Less enterprise-grade security documentation
Glass Health	Diagnosis + documentation	Major EHRs	Differential generation + ambient scribe + Clinical Questions	AI dx suggestions need careful clinical judgment

Documentation AI — Evidence & Practical Realities

What the Evidence Shows

- JAMA Netw Open 2025: burnout rate fell 51.9% to 38.8% (-13.9 pp) after 30 days of ambient AI scribe use (n=263, 6 health systems)
- First RCT (NEJM AI 2025): Dragon Copilot + Nabla vs. usual care — approx. 10% doc-time reduction; 7% burnout improvement
- Abridge: Best in KLAS for Ambient AI 2025 and 2026
- Epic-integrated AI scribe review (PMC12259616, 2025): strong psychiatry resident satisfaction; 15-min average

Key Concerns in Psychiatry

- Loss of nuance in psychiatric narratives — AI may miss affect, subtext, ambiguity
- Real-world correction time higher than planned — always build in review time
- Privacy: sensitive psych content requires extra HIPAA scrutiny; BAA required
- Accuracy varies; hallucination risk in complex presentations

Implementation Checklist for Your Practice

- Obtain Business Associate Agreement (BAA) with any AI scribe vendor
- Notify patients and obtain consent before using AI in sessions
- Establish a review protocol — never sign without reading the AI-generated note
- Audit accuracy quarterly; report significant errors to vendor and document
- Check for EHR-specific integration vs. copy-paste workflows

Sources: JAMA Netw Open 2025 (Ref 43); NEJM AI 2025 doi:10.1056/AIoa2501000 (Ref 44); PMC12259616 2025 (Ref 15); Abridge Best in KLAS 2025/2026

02

AI for Diagnostic Support & Clinical Assessment

AI-Assisted Diagnostic & Assessment Tools

Glass Health

Differential diagnosis generation from clinical notes; evidence-based DDx with citations

Wysa (FDA Breakthrough Device 2025)

CBT-based chatbot for symptom tracking; PHQ-9 / GAD-7 automated monitoring; Woebot Health shut down B2C app June 30, 2025 — regulatory/cost signal

Spring Health

AI-powered precision mental health matching — matches patients to evidence-based treatments

Eleos Health

Session analysis tool — tracks clinical themes, treatment adherence, symptom progression

Osmind

Specialty platform for TMS/ketamine/psychiatry — AI outcome tracking and treatment analytics

EHR-embedded CDS

Epic, Oracle Health, Athena now include AI-based clinical decision support alerts and recommendations

03

AI for Suicide & Violence Risk Assessment

AI in Suicide Risk Prediction — What Exists?

A 2025 systematic review of RCTs identified 6 trials (n=793) testing AI-based suicide risk prediction, automated interventions, and AI-guided treatment allocation. (MDPI Healthcare 2025;6(4):143)

Current AI Risk Models

- ML algorithms analyzing EHR data (labs, notes, prior visits) for suicide risk scoring
- NLP models analyzing clinical notes, speech patterns, social media language
- Columbia Suicide Severity Rating Scale (C-SSRS) now has AI-assisted completion tools
- Crisis Text Line uses AI triage to prioritize highest-risk conversations

In Clinical Practice Today

- Epic's Deterioration Index and suicide risk flags embedded in workflow
- Behavioral health EHR platforms (Osmind, ICANotes) include AI risk alerts
- Predictive models in emergency/inpatient psych settings — most evidence here
- Outpatient use still emerging; fewer validated tools available

CRITICAL CAUTIONS

High false-positive rates can overwhelm clinical workflows. **Low false-negative risks** can create dangerous false reassurance. AI risk scores must never replace clinical judgment — they are decision support only. FDA SaMD regulations require clinical validation before deployment.

04

Treatment Planning & Precision Psychiatry

AI for Personalized Treatment Planning

62% of surveyed clinicians support AI for 'precise, personalized therapy'; 58% for 'easier treatment selection' (BMC Psychiatry 2025;25:576, Ref 6)

Pharmacogenomics + AI

GeneSight (15 genes): Meta-analysis 2025 (n=3,532 MDD) validates clinical utility. UHC coverage updated Jan 2025. ~$330 cash pay.
Genomind (26 genes) ~$599. Competitors: Tempus AI (DNA + real-world data analytics) and Neurokaire (iPSC-based 'brain-in-a-dish' direct drug testing on patient's own neurons).

Precision Mental Health

AI subtyping: identifies which patients respond to CBT vs. medication vs. combined

MLModel predicts antidepressant response from baseline fMRI + clinical features (Stanford research)

April 2025: Extended reality + AI (VR-CBT) for precision treatment

Outcome Monitoring

Eleos Health, Osmind: track symptom trajectory across sessions using AI

Automatic PHQ-9/GAD-7 trend analysis with anomaly alerts

Routine Outcome Measurement (ROM) + AI = true learning health system

05

Patient-Facing AI:
Apps, Chatbots & Wearables

Consumer AI & Mental Health Apps — The Real Picture

APA Health Advisory (Nov 2025): "Generative AI chatbots and wellness applications currently lack the scientific evidence and necessary regulations to ensure users' safety."

What Patients Are Using

- Wysa (FDA Breakthrough Device), Youper — CBT chatbots; Woebot Health shut down June 30, 2025 (cautionary signal)
- Headspace, Calm — mindfulness/sleep apps (evidence for mild anxiety/depression)
- Crisis Text Line — AI triage (evidence-based crisis support)
- ChatGPT/Claude — patients self-treating with general LLMs (serious safety concern)
- Wearables: Apple Watch, Oura — passive mood/sleep/HRV tracking

Safety Concerns to Discuss with Patients

- CRITICAL: Character.AI linked to teen suicide (2024); 13 U.S. legal cases by Jan 2026
- FDA Digital Health Advisory Committee met Nov 6, 2025 on GenAI mental health chatbots — no GenAI app FDA-cleared yet
- 29 chatbots tested: NONE met criteria for adequate suicidal ideation response (2025)
- EmoAgent study (2025): 34.4% of Character.AI interactions led to psychological deterioration in testing
- Privacy: most apps sell de-identified data; HIPAA does NOT apply

Your role: Ask patients at every visit what apps/AI they are using. Know the evidence. Guide appropriately.

Apps with better evidence: Wysa (FDA Breakthrough Device 2025), Osmind, Spring Health (employer benefit), Crisis Text Line, Headspace

The Mental Health App Spectrum — Three Very Different Tiers

TIER 1
Wellness & Mindfulness

Apps:

Headspace · Calm · Insight Timer · Ten Percent Happier

Evidence:

Modest benefit for mild anxiety, stress, and sleep. Helpful adjunct; not treatment.

Regulation & Billing:

No FDA regulation. HIPAA does NOT apply. Most sell de-identified data.

Not prescribed. No billing codes.

TIER 2
AI Chatbot Therapy Apps

Apps:

Woebot · Wysa · Youper · Earkick · Replika

Evidence:

Woebot: reduced depression symptoms at 2 weeks (peer-reviewed). Wysa: FDA Breakthrough Device 2025. Evidence moderate for mild-moderate symptoms only.

Regulation & Billing:

HIPAA does not apply to most. Woebot Health shut down B2C app 2025 — cautionary signal.

SAFETY RISK: Crisis handling failures, emotional dependency, safeguard bypass documented.

TIER 3
Prescription Digital Therapeutics (PDTs)

Apps:

Rejoyn · DaylightRx · SleepioRx · MamaLift Plus · EndeavorRx

Evidence:

FDA-cleared RCT-validated CBT protocols. 80% patient registration rate; 74% showed clinical improvement (published data).

Regulation & Billing:

FDA SaMD clearance required. HIPAA applies. Cigna coverage began Sept 2025. CMS created 3 new Medicare billing codes (2025 Fee Schedule).

PRESCRIBED by physician. Billable. Adjunct to — not replacement for — clinical care.

Sources: APA Health Advisory Nov 2025; MobiHealthNews June 2025 (Woebot); AJMC 2025 (Ref 24); FDA SaMD Database 2025; CMS 2025 Physician Fee Schedule (PDT codes)

Prescription Digital Therapeutics (PDTs) — What You Can Now Prescribe & Bill

PDTs are FDA-cleared software prescribed by a physician — think of them as a 'digital pill' delivering validated CBT protocols. New CMS billing codes (2025) make these reimbursable.

PDT Name	Indication	FDA Status	Mechanism	Key Note
Rejoyn	MDD (adjunct, 22+)	FDA Cleared Mar 2024	CBT app (Click Therapeutics / Otsuka)	1st PDT for MDD; Phase 3 RCT 2025; NHS UK June 2025
DaylightRx	Gen. Anxiety Disorder (22+)	FDA Cleared Aug 2024	CBT: cognitive restructuring	1st FDA-cleared PDT for GAD
MamaLift Plus	Mild-mod. postpartum depression	FDA Cleared Apr 2024	CBT / DBT / IPT / behavioral activation	1st PDT for maternal mental health
SleepioRx	Insomnia disorder	FDA Cleared Aug 2024	Digital CBT-I (6 sessions)	Cigna coverage Sept 2025; Big Health raised $23.7M
EndeavorRx / OTC	ADHD — age 8-17 (Rx); adults (OTC)	FDA Authorized	Gamified attention training	Label expanded Dec 2023; OTC adult version 2024

Billing: CMS added 3 new Medicare CPT codes for FDA-cleared mental health PDTs in the 2025 Physician Fee Schedule. Cigna began coverage Sept 2025. Check your payer contracts.

Important: PDTs are adjuncts — not replacements for psychiatric care. Prescribing physician retains clinical responsibility. Validate patient access and digital literacy before prescribing.

Digital Twins of Therapists & Physicians — A New Frontier

Two distinct concepts are emerging — both with real clinical potential and unresolved legal questions.

Digital Twin of YOUR Physician

What exists: AI-generated avatar replicating a specific physician's likeness, voice, and clinical content — available 24/7.

Evidence: Mayo Clinic pilot (2025, n=30): surgeon avatar using HeyGen model for post-op education. Patients with prior relationship responded well. Acceptable, improved access.

Requires: Informed consent from both physician AND patient. Predetermined, pre-recorded clinical content — not real-time autonomous AI decisions.

AI Therapist Avatars & Training Simulators

STELLAR (2026): $4M Wellcome Trust project (Penn/NYU) — builds psychiatric 'digital twin' virtual patients for clinician training. Adjustable symptom profiles. Announced July 2026.

Taxonomy (Springer 2026): Two roles — Therapist-Twin (delivers interventions) vs. Self-Twin (patient representation for personalization). Research-stage evidence for both.

Regulatory line: AI may train and support clinicians, but autonomous AI therapy is a regulatory red line. No RCT-level clinical care evidence yet.

Emerging: Digital Twin of the PATIENT — Predict Before Symptoms Appear

AI model of a patient's brain, behavior, and physiology that predicts mental health deterioration before clinical symptoms emerge. **Currently research-stage** — but advancing rapidly. Key open questions: **Who owns the twin? Who is liable for its predictions? Does a patient have a right to their own digital twin?**

Sources: Ref 26 (Mayo Clinic HeyGen pilot, J Clin Med 2025); Ref 27 (STELLAR/Wellcome Trust 2026); Ref 28 (Springer taxonomy 2026); Ref 34 (PubMed 41856487)

06

Legal & Regulatory Framework

Federal Regulatory Framework — What Governs AI in Your Practice?

FDA — SaMD & AI/ML Devices

Jan 7, 2025 Draft Guidance: AI-Enabled Device Lifecycle Management (premarket submissions, bias analysis, PCCP, SBOM required). Dec 2024 Final PCCP Guidance allows pre-approved AI algorithm updates. Feb 2, 2026: QMSR/ISO 13485 alignment effective for AI device manufacturers.

HIPAA — Updated 2025-2026

BAA required for all AI vendors handling PHI. Jan 6, 2025 NPRM: AI tools must be included in mandatory annual risk analysis; MFA and encryption of ePHI proposed (finalization delayed to July 2027). OCR $8.33M in fines in 2025 — many for hidden data flows to third-party analytics without BAAs.

CMS — Two Major 2026 Rules

WISeR model (Jan 1, 2026): AI screening of prior auth requests in traditional Medicare in Texas + 5 states; 72-hour turnaround. CMS-0057-F (Jan 1, 2026): Mandates FHIR APIs and 7-day prior auth timelines for MA, Medicaid, ACA payers.

ACA §1557 & AI Action Plan (2025)

ACA §1557 Final Rule: biased clinical AI in federally funded programs may constitute civil rights violations; non-discrimination notice required for CDS tools. HHS AI strategy: safe, responsible, explainable federal health AI. AMA endorsed 2025 AI Action Plan.

Sources: Ref 8 (FDA Draft Guidance Jan 2025); Ref 45 (HIPAA NPRM Jan 2025); Ref 46 (CMS WISeR Jan 2026); CMS-0057-F; ACA Final Rule 2024; HHS AI Strategy 2025

Texas-Specific AI Laws — What Applies to Your Practice?

HB 149 — Texas Responsible Artificial Intelligence Governance Act (TRAIGA) · Effective January 1, 2026

Scope: Patient interaction disclosure — when patients interact with AI during service or treatment, disclose no later than date of service. Disclosure must be in plain language, clear and conspicuous (no 'dark patterns'); hyperlinks to disclosure webpage are allowed. **Enforcement:** TX Attorney General has exclusive authority; 60-day cure period before enforcement; NO private right of action. High-risk AI risk assessment obligations apply to clinical decision-making tools. Establishes Texas AI Council for ongoing governance.

SB 1188 — Texas Healthcare AI Law · Effective September 1, 2025

Healthcare-specific: Requires healthcare practitioners using AI diagnostically to be licensed, review all AI-generated records per TMB standards, and disclose AI use to patients (verbal or written). **Penalties: $5,000-$250,000 per violation; repeat violators face license suspension/revocation.** Prohibits physical offshoring of electronic medical records. Providers retain liability — AI use does not transfer responsibility to the vendor.

Sources: Ref 20 (HB 149 TRAIGA, signed June 22 2025); Ref 21 (SB 1188, eff. Sept 1 2025); Ref 10 (Holland & Knight July 2025); Texas Legislature 89th Session

What These Laws Mean for Your Psychiatric Practice — Today

📋 Document AI Use in Your EHR

Note which AI tools were used in assessment, documentation, or treatment planning. This creates a legally defensible record and supports informed consent.

🗣️ Inform & Obtain Consent from Patients

TRAIGA (Jan 2026) + SB 1188 (Sept 2025) require patient notification when AI is used in diagnosis/treatment. Use intake forms, verbal consent, document in chart.

📄 Sign BAAs with All AI Vendors

Any AI tool touching PHI requires a signed HIPAA Business Associate Agreement. No BAA = HIPAA violation. Verify before using any new tool.

⚖️ Understand Your Liability Position

Texas law (and AMA policy) is clear: AI use does not transfer liability to the vendor. You remain the responsible treating physician. Standard of care evolving to include AI literacy.

🔍 Validate Tools Before Clinical Use

SB 1188 requires clinical validation for AI diagnostic tools. Ask vendors for published evidence. FDA clearance/approval = stronger validation.

📊 Monitor for Bias & Disparate Outcomes

ACA §1557 creates civil rights exposure for biased AI. Audit outcomes by race, gender, language. Report disparities. Choose vendors with bias testing.

07

Professional Society Positions on AI

American Psychiatric Association (APA) — Official Position on AI

APA Board of Trustees — Position Statement: The Role of Augmented Intelligence in Clinical Practice & Research

- APA Member Survey (Jan-Feb 2026, Psychiatric News June 2026): most psychiatrists do not yet use AI; among those who do, majority are optimistic
- Most common AI use among members: clinical notetaking (26%), administrative tasks (16%)
- 80% of APA members 'very or moderately concerned' that mental health professionals lack adequate AI training
- Only 27% believe patients will ever prefer AI chatbots to human practitioners
- APA formed new Council on Digital Health, Innovation & Technology — watch for formal position statement
- Health Advisory (Nov 2025): 'AI wellness apps currently lack scientific evidence and necessary regulations to ensure user safety'

AMA Health Advisory (Nov 2025) — American Psychological Association

"Generative AI chatbots and wellness applications currently lack the scientific evidence and necessary regulations to ensure users' safety." Systemic reform needed to make care affordable and accessible — AI should support, not replace, human professionals.

American Medical Association (AMA) — AI Policies

66%
physicians using AI in practice
(AMA 2024, up from 38% in 2023)

+28 pp
jump in AI adoption in one year
(38% to 66%; AMA Digital Health Survey)

AMA 2025 Federal AI Action Plan Statement

Encourages federal investment in AI literacy in medical education. Supports limits on physician liability for AI tool errors when following vendor guidance. Calls for transparency, explainability, and safety data in all clinical AI.

AI Prior Auth Oversight (June 2025 HOD)

AI-based coverage decisions must be evidence-based and reviewed by physicians. Opposes bulk denial of prior auth by AI without physician review. Requires transparency: clinical logic, data sources, and guidelines used must be disclosed.

AI Literacy in Medical Education (Nov 2025 HOD)

Standardized AI training required in medical school curriculum and CME. Increased access to AI-focused CME for practicing physicians. Model AI learning objectives and curricular toolkits to be developed.

AI Must Support — Not Replace — Physicians (June 2026 HOD)

AI must strengthen patient care and not stand between patients and care. AMA calls on Congress to mandate stronger safeguards for AI health chatbots. Evidence-based AI required; meaningful physician oversight non-negotiable.

Liability & Augmented Intelligence

Supports limiting physician liability for AI errors when following reasonable practice. Liability must be appropriately apportioned to developers. Prefers 'augmented intelligence' — AI enhances, never replaces, physician judgment.

Texas Medical Association (TMA) & Texas Medical Board (TMB)

Texas Medical Association (TMA)

- Official policy: 'Augmented intelligence is intended to co-exist with human decision-making and should NOT be used to replace physician reasoning'
- Prefers term 'augmented intelligence' (aligned with AMA)
- Testified before Texas Senate (Aug 2024): recommended guidelines ensuring physician knowledge is integrated with AI, not replaced
- Developed AI Vendor Evaluation Tool — free for TMA members to assess AI systems
- Developed free CME webinar on integrating AI/ChatGPT into patient care
- Legislative priority 2025: 'Balanced Regulation of AI' — supported TRAIGA, SB 1188
- Active AI Committee established; seeking expert physician volunteers

Texas Medical Board (TMB)

- Jan 9, 2025: Major TMB rule reorganization — reduced from 40 to 25 chapters (structural, not AI-specific)
- SB 1188 (eff. Sept 1, 2025) is the operative enforcement framework — TMB is the license discipline body for violations
- Standard of care: AI does not modify physician duty of care — you remain responsible for all clinical decisions
- No standalone AI-specific TMB rule as of Sept 2026; monitor TMB proposed rules page for 2026-2027 rulemaking
- Unprofessional conduct standard applies to reckless AI use (e.g., unsupervised autonomous diagnosis)
- Telehealth rules (updated 2024) apply when AI is used in remote care delivery
- Recommendation: Document rationale for all AI-assisted clinical decisions in the medical record

Bottom line: Texas physicians are on the front lines of AI governance. Stay engaged with TMA and TMB for emerging guidance.

Joint Commission — New Responsible AI Standards (2025-2026)

First-ever formal guidance from a U.S. healthcare accrediting body on responsible AI — developed with Coalition for Health AI (CHAI), 20+ organizations.

RUAIH Guidance — Sept 17, 2025

- Joint Commission + CHAI released initial guidance to support responsible AI adoption in healthcare
- 5 focus areas: (1) Governance, (2) Data management, (3) Risk & bias mitigation, (4) Ongoing monitoring & validation of AI safety/performance, (5) Transparency, education & workforce training
- Developed with 20+ healthcare and technology organizations
- Not yet an accreditation standard — framework for organizational readiness
- Provides the conceptual backbone for the June 2026 certification program

RUAIH Certification — Launched June 1, 2026

- First-of-its-kind voluntary AI certification for U.S. healthcare organizations
- Open to ALL U.S. healthcare organizations — does not require existing JC accreditation
- Requirements: AI governance structure; risk & bias assessment processes; data security; ongoing quality monitoring; voluntary AI safety event reporting; patient privacy & transparency; staff training
- IMPORTANT: Certifies organizational governance — NOT individual AI products or specific use cases
- Practical takeaway: Pursue RUAIH certification to demonstrate AI accountability to payers, patients, and regulators

Sources: Ref 41 (Joint Commission + CHAI RUAIH Guidance, Sept 17 2025); Ref 42 (RUAIH Certification launch June 1 2026); jointcommission.org

LLMs in Psychiatry — How Do They Actually Perform? (2025-2026 Data)

Frontier AI models now exceed physician board-passing thresholds on psychiatric knowledge. Clinical performance still uneven — especially in crisis scenarios.

Claude Sonnet 4.5 Pro

94%

Highest score on 100-item psychiatry MCQ benchmark (USMLE-type + expert-authored)

Gemini 2.5 Pro

92.8%

Strong performance on psychiatry board questions; competitive with GPT-5

GPT-5 (OpenAI)

92.6%

Exceeds board-passing threshold; competitive with Gemini 2.5 Pro on psychiatric MCQs

Source: Psychiatric Quarterly 2026 (PubMed 41860633) — 9 LLMs tested on 100 psychiatry questions

Where LLMs Still Fall Short (Refs 36-39)

- Suicide risk: limited alignment with expert clinicians on high-risk cases (Psychiatric Services 2025)
- Crisis: 29 chatbots tested — none met criteria for adequate suicidal ideation response
- Schizophrenia vignettes: underperform vs. psychiatrists on ambiguous cases (PMC 2025)
- Safety training backfire: AI guardrails may refuse clinically appropriate crisis discussions (arXiv:2604.23445, 2026)

Emerging Clinical Uses

- Psychoeducation generation for psychosis — LLMs produce individualized content at appropriate tone
- Child/adolescent psychiatry MCQs: GPT-4o and Gemini 2.0 Flash match board-eligible physician performance
- Diagnostic support for structured vignettes (not ambiguous presentations)
- Administrative: prior auth letters, patient education handouts, referral summaries

08

Ethics, Bias & Liability in AI Psychiatry

Informed Consent in the AI Era — New Obligations

Emerging legal consensus: Patients have a right to know when AI is being used in their care — especially in psychiatry where privacy and autonomy are paramount.

What Patients Should Be Told

- That AI tools are being used in documentation, assessment, or treatment planning
- What data is collected, stored, and by whom (especially audio recordings)
- That AI recommendations are reviewed and may be modified by their physician
- Their right to decline AI use in their care (where clinically feasible)
- How to report concerns about AI-generated content in their record

Legal & Regulatory Basis

- TRAIGA (HB 149, eff. Jan 2026): notification required for AI in consequential decisions
- SB 1188 (eff. Sept 2025): patient notification for AI in diagnostic contexts
- ACA §1557: non-discrimination notice requirement for CDS tools
- APA Position Statement: informed consent explicitly required for AI use
- American Law Institute (May 2024): informed consent law evolving for AI — separate malpractice theories emerging

Practical tip: Add a single sentence to your intake consent form: 'Our practice may use AI tools to assist with documentation and clinical support. Your physician reviews all AI-generated content.' Have attorney review for compliance with current TX law.

Algorithmic Bias in Mental Health AI — A Clinical & Legal Problem

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AI outcomes are NOT objective — algorithms encode their training data's biases

Known Bias Examples in Psychiatric AI:

- **Facial recognition tools:** more accurate for white men; less for women of color
- **AI-simulated crisis scenarios:** different outcomes based on patient's stated race
- **NLP models:** trained on clinical notes may perpetuate racial/socioeconomic biases in documentation

Clinical Obligations

- Audit AI outputs by race, gender, age, language — at least annually
- Be especially alert to bias in: suicide risk scores, treatment recommendations, diagnostic suggestions
- EmoAgent study (2025): 34.4% of Character.AI interactions led to measurable psychological deterioration in testing
- Report disparities to your vendor and document your audit in quality records
- ACA §1557: biased AI in federally funded practices = potential civil rights violation

What to Look for in AI Vendors

- Published bias testing methodology and results across demographic groups
- Training data demographic representation — ask vendors directly
- Feedback mechanisms for reporting biased outputs
- Commitment to ongoing model monitoring and retraining
- Regulatory compliance certifications (ISO, HIPAA, FDA submission if applicable)
- Peer-reviewed clinical validation — not just internal white papers

Liability — Who Is Responsible When AI Gets It Wrong?

'The standard of care changes with clinical practice — where an AI-enabled device becomes pervasive, the expectation of what a reasonable physician would do will shift accordingly.' — Bipartisan Policy Center / American Law Institute, 2024

Treating Physician

- Remains the responsible party — AI use does not transfer liability
- Liable for failure to review AI-generated notes before signing
- Liable for following AI recommendations without applying clinical judgment
- Standard of care will increasingly include AI literacy and appropriate use

AI Vendor / Developer

- Product liability for defective AI tools (when functioning as marketed)
- FDA enforcement for unauthorized SaMD claims or unsafe devices
- HIPAA liability for data breaches if BAA obligations not met
- AMA policy supports allocating appropriate vendor liability

Healthcare System / Employer

- Vicarious liability for physicians using employer-provided AI tools
- Liability for failing to establish AI governance policies
- Responsibility to ensure staff training on AI tool limitations
- IT security obligations for AI systems integrated into clinical workflow

09

Your Practical AI Evaluation Framework

The PAVE Framework — Evaluate Any AI Tool Before Adoption

P Proven	Is there peer-reviewed clinical evidence? FDA clearance or approval? Published validation data in your patient population (psychiatry, outpatient, similar demographics)? Randomized trial? Real-world outcome data?
A Accountable	Clear data governance: Who owns the data? Where is it stored? Is there a BAA? Can you audit the AI's decisions? Transparent model documentation? Named responsible parties for errors?
V Value-Adding	Does it genuinely save time, improve outcomes, or reduce burden? Has it been tested in psychiatric settings specifically? Does benefit outweigh risk for your practice type? ROI beyond marketing claims?
E Ethical	Has bias been tested across race, gender, language, age? Does it protect therapeutic relationship and patient privacy? Is patient notification and consent embedded? Does it support — not replace — clinical judgment?

Use the PAVE checklist for every new AI tool — before signing any contract or going live in your practice.

From Hype to Help — Your Action Plan Starting Monday

You don't need to adopt every AI tool. You need a thoughtful, defensible approach.

Step 1: This Week

- Audit your current AI tool use — do you have BAAs for all of them?
- Add AI disclosure to your informed consent forms
- Review your EHR's built-in AI features — many are already active

Step 2: This Month

- Trial ONE ambient scribe for 2 weeks — Nabla offers a free trial
- Join TMA's AI Committee or attend their free AI CME webinar
- Review TRAIGA and SB 1188 with your practice attorney or malpractice carrier

Step 3: This Quarter

- Establish a practice AI governance policy (1-page is fine)
- Identify AI tools for your highest-need area: documentation OR risk assessment
- Audit AI outputs for at least 10 cases — check for bias, accuracy, nuance

Step 4: Ongoing

- Stay current: FDA AI clearances, TMB guidance updates, TMA alerts
- Report AI errors to your vendor and document in your quality program
- Share learnings with colleagues — we are all figuring this out together

Key Takeaways

- AI in psychiatry is real, here, and already in your practice — knowingly or not
- Documentation AI has the strongest evidence today: first RCT published (NEJM AI 2025); burnout reduction validated (JAMA Netw Open 2025); start here if you start anywhere
- Texas law (TRAIGA + SB 1188) is in effect now — inform patients, sign BAAs, validate tools. SB 1188 penalties: $5K-$250K per violation. TRAIGA: 60-day cure period, no private right of action
- Woebot's shutdown, Character.AI lawsuits, and the FDA's Nov 2025 Digital Health Advisory Committee meeting signal a regulatory inflection point for AI mental health apps — know what your patients are using
- You can now prescribe PDTs (Rejoyn, DaylightRx, SleepioRx) — CMS billing codes exist. Pharmacogenomics AI (GeneSight, Tempus AI) continues to mature. Frontier LLMs score >90% on psychiatry boards, but still fail on crisis cases
- APA, AMA, TMA, and the Joint Commission (RUAIH Certification, June 2026) are aligned: AI must augment — never replace — physician judgment
- Use the PAVE Framework: Proven · Accountable · Value-Adding · Ethical — and pursue Joint Commission RUAIH Certification for your practice or health system

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