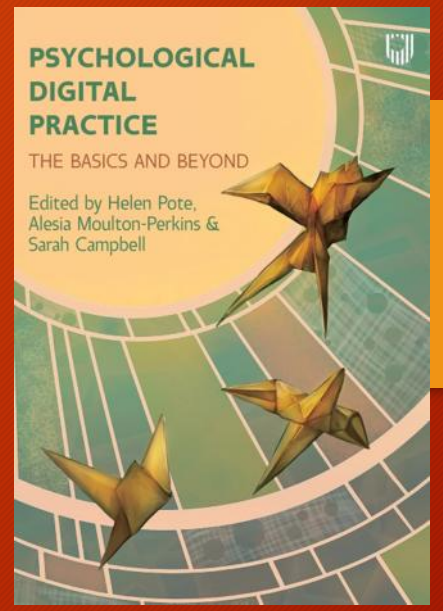


ACAMH Webinar

Prof Helen Pote, Dr Lisa Summerhill and Dr Gemma Rides

15th October, 2026

The Association for Child and Adolescent Mental Health

Definition:
Digital Mental Health (DMH)

- Working Definition of Digital Health Technologies. *NICE, 2022*

“digital products intended to benefit people or the wider health and social care system. This may include: smartphone apps, standalone software, online tools for treating or diagnosing conditions, preventing ill health, or for improving system efficiencies, and programmes that can be used to analyse data from medical devices such as scanners, sensors or monitors’

Aims of the webinar

Digital and AI: Safe and Effective Practice for Clinicians working with Children, Young People and Families

OUR AIM

To offer a practical, evidence-informed introduction to how clinicians can meaningfully and safely integrate digital tools, including AI, into everyday professional practice. Talks, discussion and interactive exercises will develop digital competencies that can be applied in your own work context.

By the end of the webinar, participants will:

1 Know the landscape

Develop knowledge of the current digital and AI landscape across child services.

2 Weigh practical and ethical issues

Have considered practical and ethical issues in developing and implementing digital tools within child services.

3 Understand competencies

Understand current digital and AI practice competencies and guidelines for safe and effective practice

4 Map and plan

Be able to map your own digital and AI practice competencies and identify areas for development.

Webinar content and timings

	Time	Session	Focus	Led by
14.00	**60 mins**	**Introduction** The digital and A landscape in child practice: common tools, evidence base, ethics and emerging practice	Develop knowledge of the landscape	HP, GR, LS
14.40	**30 mins**	**Mapping your digital and AI skills** BPS digital competencies and AI guidelines; DCAPP self-assessment exercise	Map competencies and identify development areas	HP, GR
15.30	**15 mins**	**Break**		
15.45	**30 mins**	**Case study** Mixed Reality Psychosocial Screening in Paediatrics: key learning points from developing and implementing a digital tool in an NHS Trust	Understand competencies and guidelines for safe practice	LS
16.15	**30 mins**	**Interactive exercise: Vignette** Practical and ethical application of digital tools in child services	Apply knowledge to specific child contexts	HP, GR, LS
16.45	**15 mins**	**Questions** Reflection and discussion	Reflect on learning and clarify understanding	HP, GR, LS

HP: Helen Pote, LS: Lisa Summerhill, GR: Gemma Rides

An Introduction to Digital Psychological Practice and AI in Child Contexts

- 1. What is Digital Psychological Practice and AI - how can it be helpful in enhancing clinical practice?
- 2. What are examples of common digital / AI tools used in child psychological practice. What is the evidence base for these?
- 3. What are advantages, challenges and ethical considerations for child practitioners in using digital tools and AI?

Rising mental health needs in young people

1 in 4

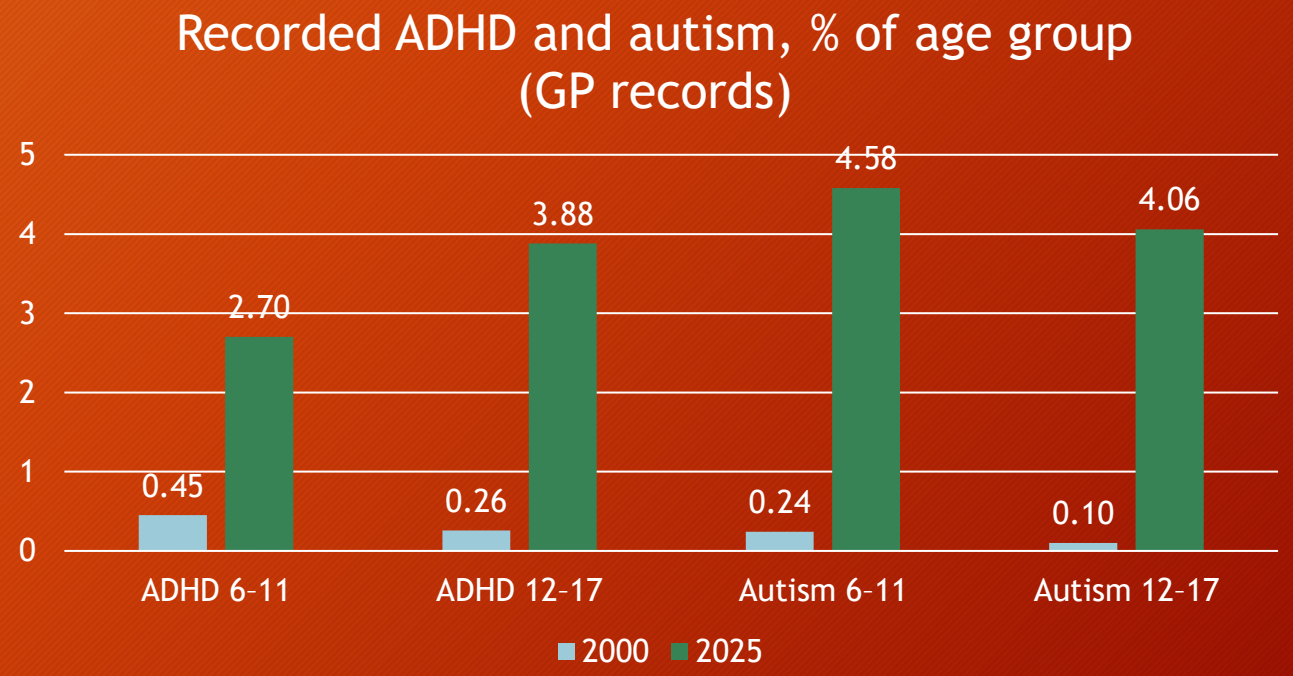
16–24-year-olds meet criteria for a common mental disorder (2024), up from about 1 in 6 in 1993. Young women report the highest rates.

57%

of 16–24s with a common mental disorder also screen positive for ADHD (61% for autistic traits). Co-occurrence is the rule.

1 in 5

secondary pupils describe themselves as neurodivergent (OxWell), well above the share with a formal diagnosis.



Read with care: recorded rates reflect recognition and demand, not underlying prevalence. Population estimates are dated (2017): ADHD about 3% of 5–15s (rough current estimate 3.8%), autism about 1.2% of young people.

Source: Independent Review into prevalence and support for mental health conditions, ADHD and autism (Fonagy, Baird & Wessely), Final Report, Oct 2026

A wide treatment gap in child mental health

1 Long waits

560,000+

open ADHD referrals at end 2025, 17 times the 2019 level. Over 254,000 open autism referrals, 90%+ waiting more than 13 weeks.

2 Delay does harm

25% → 70%+

of CYP see their difficulties worsen while waiting: under 2 weeks vs over 6 months.

3 Thin support after diagnosis

40%

of clinicians report no ongoing post-diagnostic support for autism; only 12.6% describe more than one session.

Who is least well served

- Nearly half of looked-after children have a diagnosable mental health condition
- About 8 in 10 children cautioned or sentenced have identified SEN
- Severe, complex needs often can't reach specialist care

The Review's answer: Needs-led, not diagnosis-led

- Support before, during and after assessment, not locked behind a diagnosis
- 'No wrong front door'; nobody leaves a waiting list without alternative help
- Expand NICE-recommended therapies and protect specialist services

Source: Independent Review into prevalence and support for mental health conditions, ADHD and autism (Fonagy, Baird & Wessely), Final Report, Oct 2026

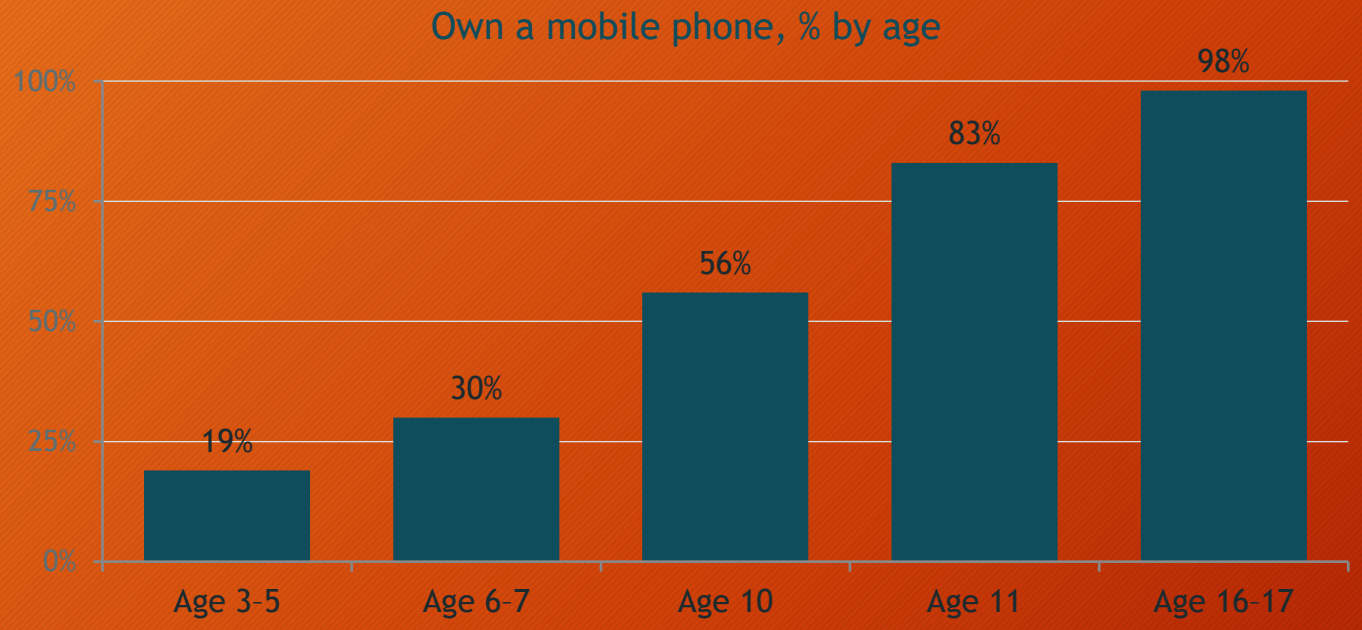
Young people live digital lives

99%
of 8-17s go online

78%
of 8-17s own a mobile phone

59%
of online 8-17s use a tablet; 55% use a games console

2h 59m
average time online per day, ages 8-14



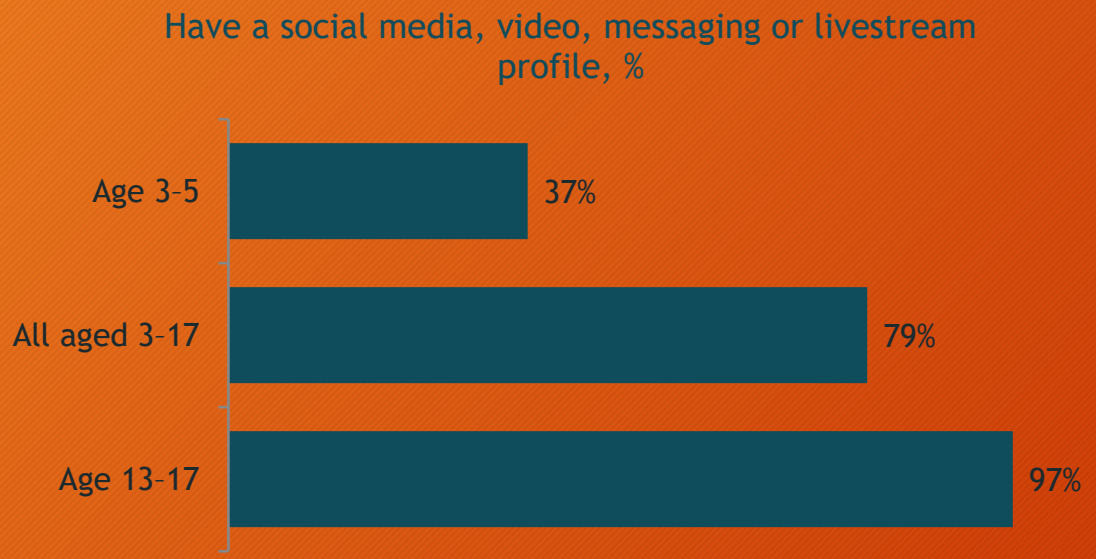
Where the time goes

- 18-24s spend the most time online of any age group: 6h 20m a day on personal devices
- YouTube and Snapchat make up 52% (1h 31m) of 8-14s' daily online time
- Most widely used: YouTube (96%) and Google Search (95%)

- 5008 Parents / 3426 CYP, 8-17yrs

Source: Ofcom (2026), children and parents' media use and attitudes, Ofcom (2025) Online Nation Report

CYP online life: activity, AI and oversight



Artificial intelligence

56% of 8-17s use AI tools

66% of 16-17s use AI tools

51% of young AI users use it for schoolwork

In free time: gaming (43%), watching TV or films (36%) and seeing friends in person (27%) rank highest. 72% of 8-17s game online.

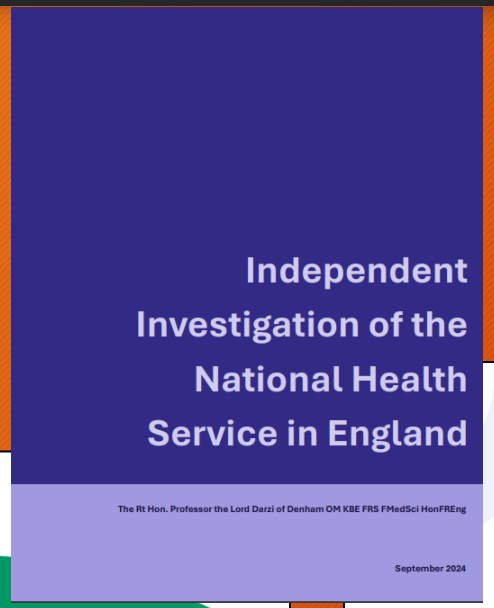
94% have at least one restriction on phone use at home or school

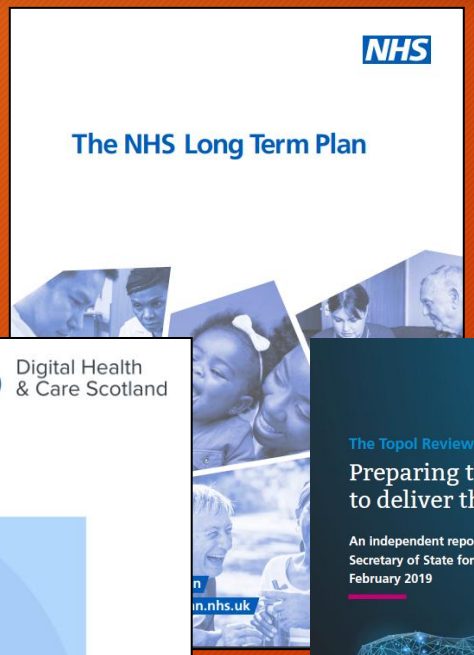
56% are banned from smartphones in school hours

92% recall a school lesson on online safety

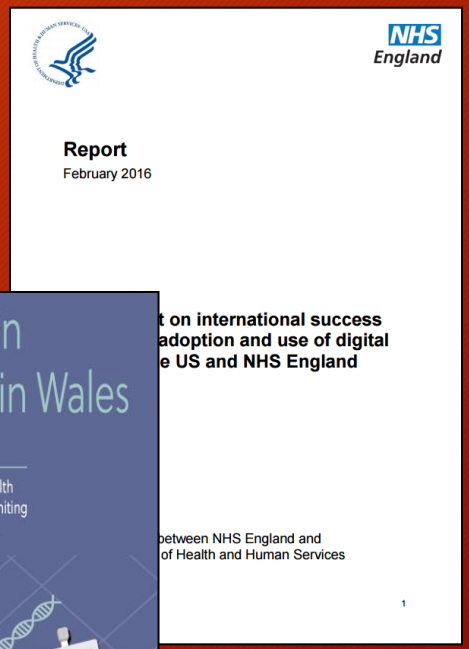
Source: Ofcom (2026), children and parents' media use and attitudes. Ofcom (2025) Online Nation Report

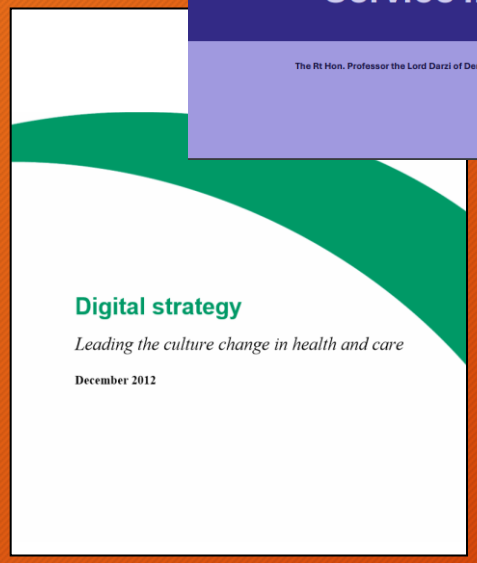
NHS policy says ‘The Future’s Digital’

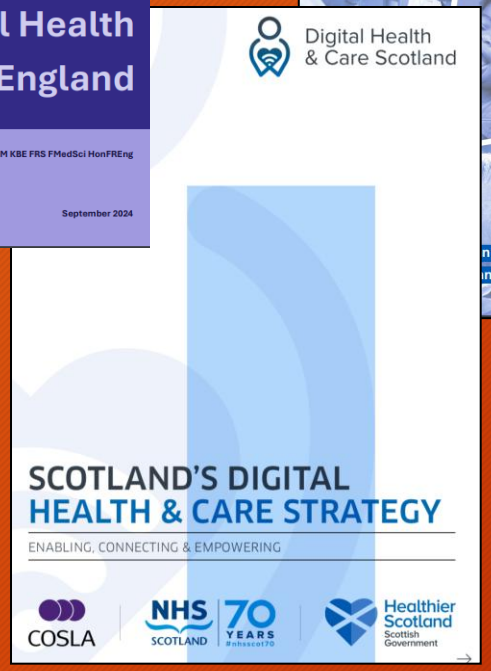




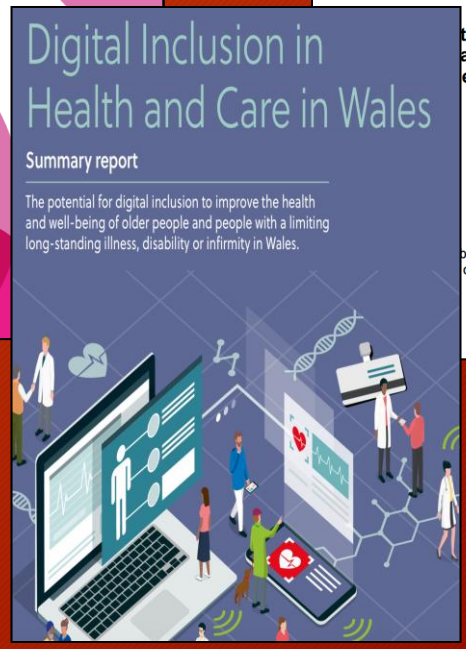










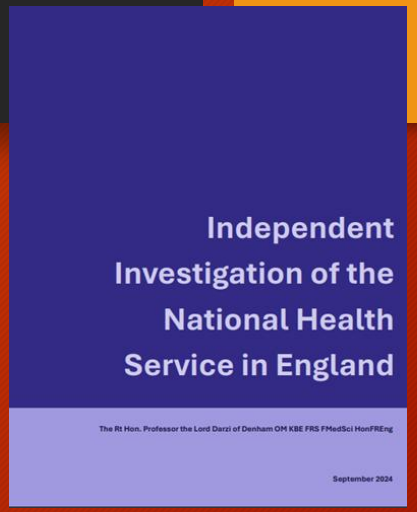


NHS Long Term Plan (2025)

Cure to Prevention

Hospital to Community

Analogue to Digital





The NHS Long-term plan (2025): Digital

Increased use of the NHS app

‘2028 full front door’

Digital:

New single patient record (SPR) - interoperable

Digital:

Data, AI, Wearables and Robotics for transforming care

Digital:

Healthstore with approved apps

AI to support staff productivity

Digital or in-person: what do young people prefer?

42% vs 2%

first choice: face-to-face counselling vs apps

Youth Talk Growing up survey, n≈1,200, ages 11-25 (2026)

16%

expressed a preference for online treatment

Australia, n=231, ages 15-19 (2014)

32% / 72%

would choose online over face-to-face / would use it

Australia, n=217, ages 13-18 (2019)

60%

want a mix of face-to-face and online in future

Sussex CYP digital review (2021)

What draws CYP to digital

- Anonymity and less stigma
- Available late at night and at home
- Control over what to share; peer connection
- Boys more open to online than girls

What holds them back

- Harder to build trust and rapport
- No private space at home
- Easier to skip or drop out
- Want a person to ask, not just a programme

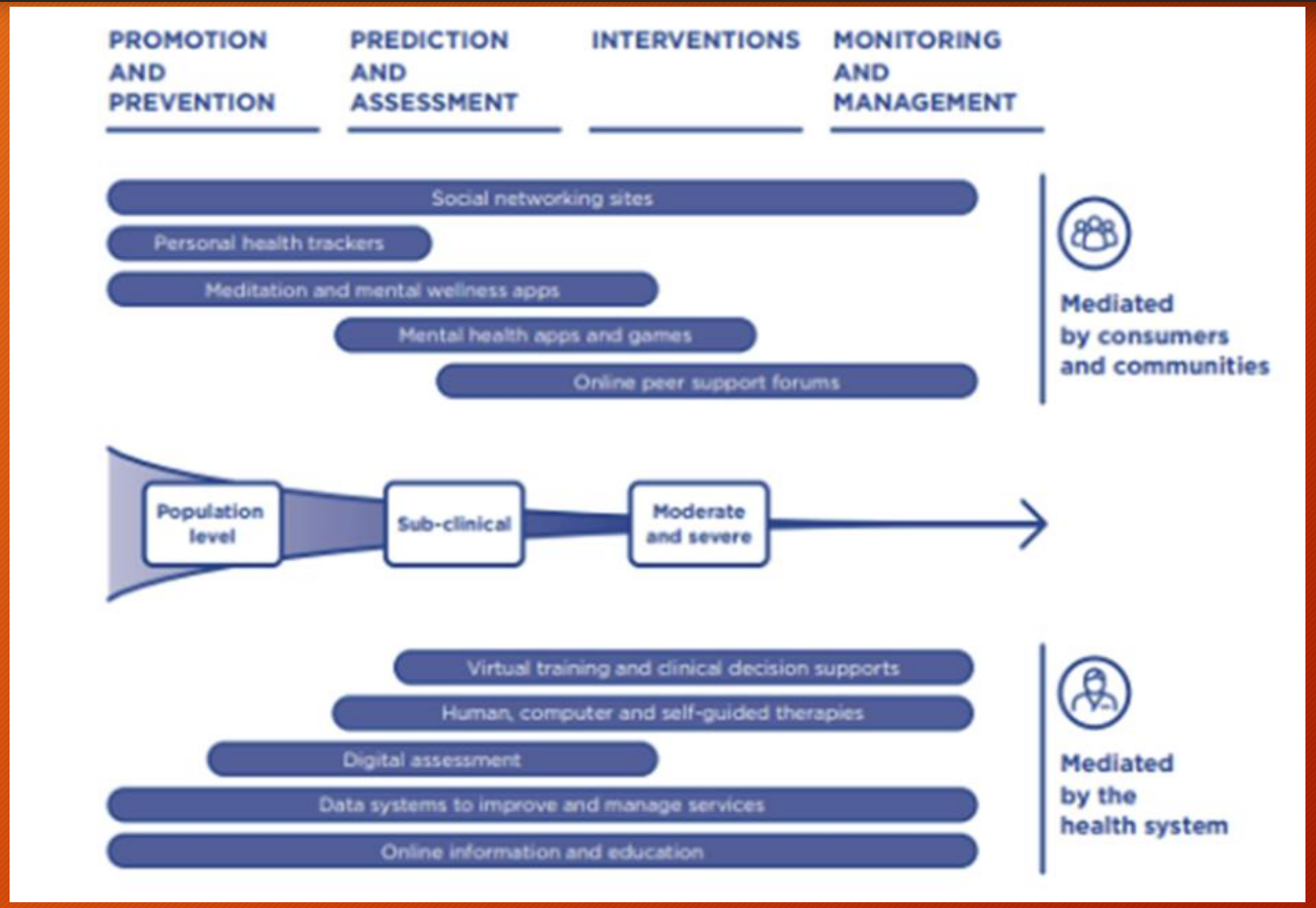
In-person is the clear first choice, but most would use digital.

Offer choice and blended care, with a human in the loop.

Most evidence is stated preference from surveys, not outcomes.

Sources: Youth Talk Growing Up Survey, Oct 2026; Bradford & Rickwood, CAMH 2014; Sweeney et al., Internet Interv 2019; Pan-Sussex CYP Digital Review 2021; Pretorius et al., JMIR 2019; BMC Psychiatry 2023 (doi:10.1186/s12888-023-05126-8); Ho et al., Appl Health Econ Health Policy 2025

Digital technologies span the needs continuum



WISH framework, 'Pieces of the Puzzle' (Roland et al., 2020, p. 5),

Lumi Nova

BfB Labs · mobile game (iOS and Android)

Ages 7–12 | **Mild-moderate anxiety**

What it is

- An intergalactic adventure game that delivers graded exposure and psychoeducation
- Co-designed with children, parents, teachers and clinicians; used with practitioner oversight

Evidence

- Pilot study: anxiety severity fell over 8 weeks of play (d = 0.35); no change in daily impairment
- Supported roll-out in deprived areas of northern England: 87% of 113 children took it up
- NICE HealthTech Guidance HTG660 (2023) conditionally recommended while evidence is gathered



87%

of referred children used it in a supported NHS roll-out

Sources: JMIR 2022 (doi:10.2196/29008); JMIR 2025 implementation study (PMC12520645); NICE HealthTech Guidance HTG660 (2023)

OSCA

Online Social anxiety Cognitive therapy for Adolescents · University of Oxford

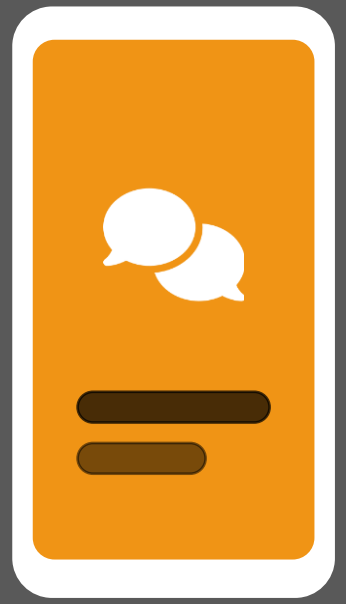
Ages 14–18 | **Social anxiety disorder**

What it is

- Online, therapist-assisted version of Cognitive Therapy for social anxiety (Clark and Wells model)
- Keeps the key elements of face-to-face therapy; young people log on whenever suits them

Evidence

- RCT of 43 young people recruited via schools, compared with a 14-week waitlist
- 77% lost their diagnosis after treatment (vs 14%), rising to 91% at 6 months
- Small trial, waitlist comparison only; NICE HTE3 conditional recommendation



77% vs 14%

no longer met criteria for social anxiety disorder after OSCA vs waitlist

Sources: Leigh and Clark, J Child Psychol Psychiatry 2023 (doi:10.1111/jcpp.13680); trial ISRCTN15079139; NICE HTE3

OSI

Online Support and Intervention for child anxiety · University of Oxford

Ages 5-12 | **Child anxiety, parent-led**

What it is

- Parents learn and apply CBT strategies online, with brief weekly therapist calls
- Optional child game app helps keep children engaged

Evidence

- Multisite RCT: 444 families across 34 CAMHS in England and Northern Ireland
- As effective as usual CAMHS care on anxiety interference at 26 weeks (non-inferior)
- Lower costs; likely cost-effective, though with uncertainty;
- NICE HealthTech Guidance HTG660 (2023)conditional recommendation. Being trailed internationally.



182 vs 307

average minutes of therapist time:
OSI vs usual care

Sources: Creswell et al., Lancet Psychiatry 2024 (doi:10.1016/S2215-0366(23)00429-7); University of Oxford, Feb 2024; NICE HealthTech Guidance HTG660 (2023)

Space for teens

SilverCloud (now Amwell) · guided online CBT

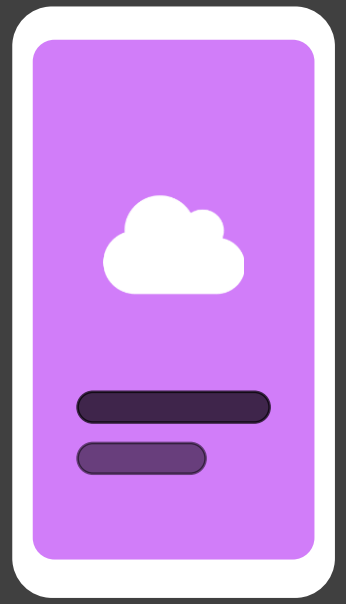
Ages 15-18 | **Anxiety and/or low mood**

What it is

- Three programmes: Space from Anxiety, Space from Low Mood, and Space from Low Mood and Anxiety for Teens
- Interactive CBT modules with an online supporter reviewing progress

Evidence

- NICE HealthTech Guidance HTG660 (2023): conditionally recommended as an initial treatment option
- NICE evidence plan rates effectiveness vs usual care as "limited", with studies ongoing
- Strong adult SilverCloud evidence does not transfer automatically to teenagers



3

teen programmes covering anxiety, low mood, or both

Sources: NICE HTE3 and evidence generation plan; HRA study summary IRAS 328322; ClinicalTrials.gov NCT06004414

Kooth

Kooth plc · anonymous online support service

Ages 11-25 **Wellbeing and early support**





What it is

- Free, anonymous access to text-based counselling with accredited practitioners
- Moderated peer forums, journals, articles and self-help activities; age range varies by local contract

Evidence

- 2022 Pilot evaluation (n = 302): likely cost-effective preventative support; calls for a controlled trial
- 75% of peer-forum feedback scores rated posts as helpful
- No published RCT; most studies are by or funded by Kooth

75%

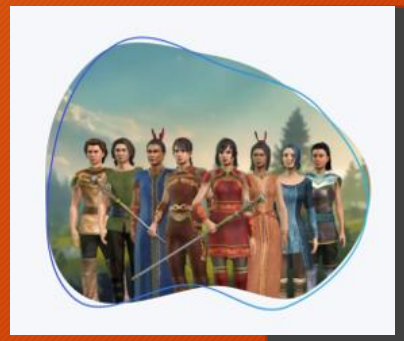
of forum feedback scores rated peer posts as helpful (11,045 ratings)

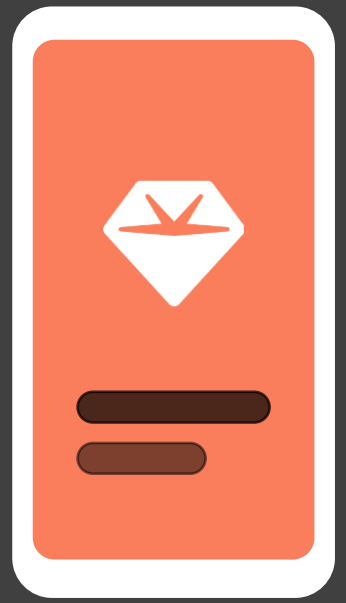
Sources: BMC Public Health 2022 (doi:10.1186/s12889-022-14223-4); JMIR 2022 (doi:10.2196/36432); Internet Interventions 2024

SPARX

University of Auckland · computerised CBT game

Ages 12-19 **Mild-moderate depression**





What it is

- A 3D fantasy game: seven levels of around 30 minutes over 4–7 weeks
- Players learn CBT skills to restore the "gems of power"; can be used self-directed

Evidence

- BMJ 2012 RCT (n = 187): at least as effective as usual care in primary care and schools
- Remission 44% vs 26% among those completing four or more levels
- Named in NICE HealthTech Guidance HTG660; evidence mainly from New Zealand; UK pilot (SPARX-UK) completed

44% vs 26%

remission, SPARX completers vs usual care (BMJ 2012)

Sources: Merry et al., BMJ 2012;344:e2598; Fleming et al., CAMH 2021; SPARX-UK protocol 2024 (ISRCTN15124804)

BlueIce

Oxford Health NHS FT and University of Bath · smartphone app

Ages 12-17 **Self-harm urges and distress**

What it is

- Co-designed with young people who self-harm; draws on CBT and DBT techniques
- Mood diary, personalised mood-lifting toolbox and routing to emergency numbers; used alongside CAMHS

Evidence

- Open pilot: 73% of those recently self-harming reported reductions after 12 weeks
- BASH RCT (n = 170): both groups improved, no significant difference on self-harm
- 77% said it prevented at least one episode; fewer adverse events; none said it triggered self-harm



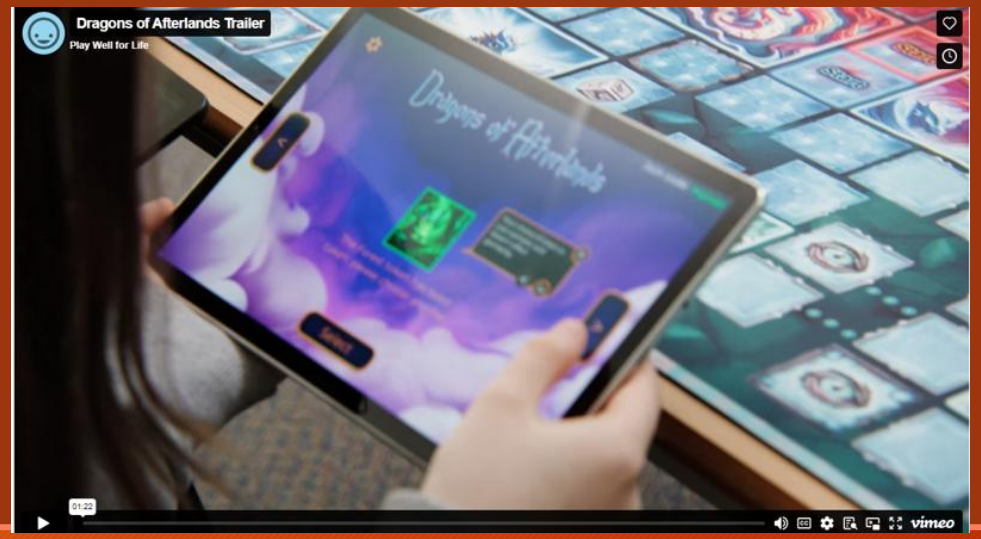
77%

of users said BlueIce prevented at least one episode of self-harm

Sources: Stallard et al., JMIR mHealth 2018; BASH trial 2024 (ISRCTN10541045); BASH qualitative findings (University of Bath)

Innovation - VR and AR Games

- **Extended reality: promising but early. Small effect sizes and poor designs.**
- Halldorsson et al. (2021): some success for youth anxiety and depression, pain management and social skills



Dragons of Afterlands: AR board game

- 2–4 players co-produced with CYP
- Wellbeing challenges across four realms: physical, social, cognitive, emotional
- Game based socioemotional, problem solving and communication skills
- Controlled trial in UK schools (N = 83): small effect sizes for some wellbeing and socio-emotional skills outcomes

play well for life

Evidence Summary

Interpreting the evidence

- Adult evidence is better established than youth evidence
- Study quality poor: few controlled comparisons, narrow outcome measures
- Some clinical benefit, especially cCBT for adolescent and young adult depression and anxiety
- Cost effectiveness and long-term benefits unclear

Take a developmental approach

- 3 RCTs adult + child digital interventions synthesized by Chew (2026) (n=603)
- Liverpool et al. (2025) review of 51 revies
- 21 reviews synthesised in Hollis et al.'s (2017) meta-review

Artificial Intelligence

AI is already part of clinical practice

505,000

clinical and support staff in NHS England = roll out Microsoft 365 Copilot

Source: NHS England

37%

of UK adults have used an AI chatbot for mental health

Source: Mental Health UK, 2025

What is AI, and how can it be used in practice?

What is AI?

Computer systems that perform tasks we would normally associate with human intelligence, such as understanding language, spotting patterns and generating responses

Rule-based	Scripted and predictable.
Machine and deep learning	Systems that learn patterns from data
Generative AI	Creates new text, e.g. ChatGPT and Copilot. Evidence is most limited

Examples in psychological practice

Admin and documentation: summarising notes, drafting letters and reports

Psychoeducation and between-session support: chatbots, journaling and skills apps

Screening and monitoring: tracking mood and symptoms

Ambient Voice Technology (AVT)—AI-powered tools that listen to clinician-patient consultations to automatically draft clinical notes

Therapy agents: AI-delivered CBT-style support

Review of AI apps for child mental health (Yang et al., 2025)

Quality
Rated suboptimal for usability and engagement for young people

Content
chatbots, journaling apps, and psychotherapeutic treatment apps

74%
(20 of 27) used clinically validated technologies

Only 2
apps had undergone clinical trials

26%
were free, raising accessibility concerns

AI apps show potential, but development should focus on clinical testing, accessibility, and usability for young people



Yang et al. (2025). Artificial intelligence-based mobile phone apps for child mental health: comprehensive review and content analysis. DOI: 10.2196/58597

Systematic Review of AI in Child and Adolescent Interventions (Mutluer et al., 2026)

AI Format

Conversational agents, game-based interventions, robot-based interventions

Outcomes

- Clinical improvements (depression, anxiety, and emotional distress).
- Improved accessibility and engagement

Points to consider:

- Inconsistent use of active vs inactive controls
- Limited evidence for long-term follow up
- Implementation studies are needed to assess feasibility, adoption and acceptability
- Chatbots can fail to detect safeguarding concerns/emergencies
- Many models are trained on adult data so should not be directly applied to younger users

AI is seen as a complement to traditional psychological care, not a replacement for clinicians

Mutluer et al. (2026). A systematic review of artificial intelligence in child and adolescent interventions: from psychotherapy to developmental support. DOI: 10.1007/s00787-025-02867-7

APA advisory: AI and adolescents

Potential benefits

Information, emotional support and opportunities for self-expression



AI isn't 'good' or 'bad': application of AI, design features, and the context to which they are being used.

Age ≠ maturity and competence: two adolescents of the same age are unlikely to be at the same level of maturity or development

Safeguarding: additional safeguards especially important for this group

Biases & discrimination: the use of unrepresentative training data, the lack of diversity of input in product testing and development

Model healthy behaviour & critical thinking: the use of AI by adults can be highly influential in adolescents' own attitudes and practices around AI

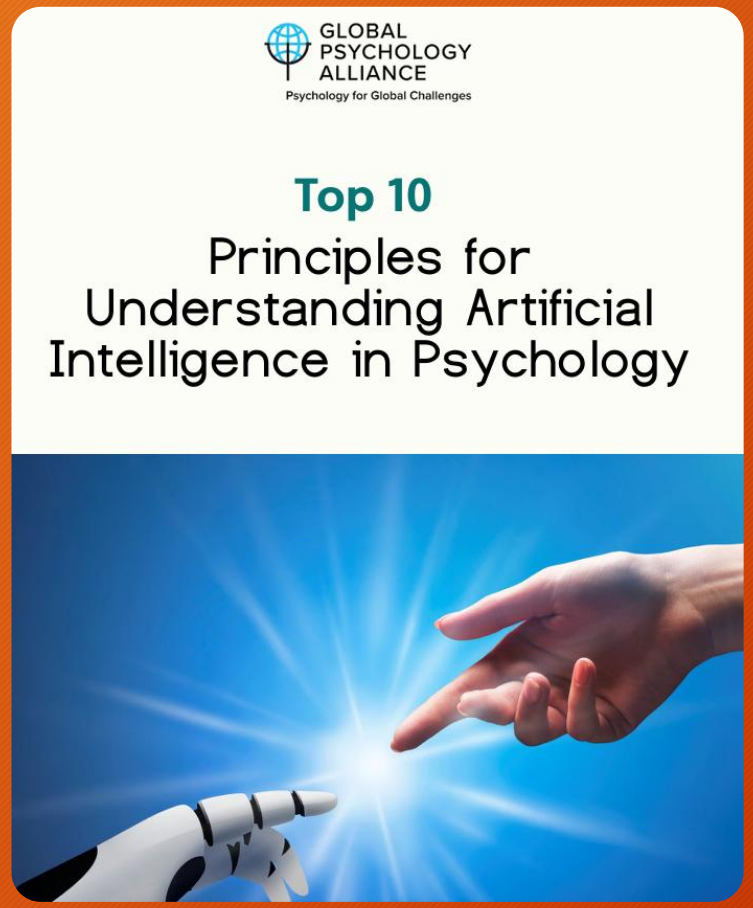
APA Health Advisory: Artificial intelligence and adolescent well-being. apa.org/topics/artificial-intelligence-machine-learning/health-advisory-ai-adolescent-well-being

APA Recommendations

Age-appropriate use	**AI for adults should differ from AI for adolescents:** privacy settings, age-appropriate content, transparency of AI use.
Promote healthy use	**Encourage appropriate use of AI (e.g., learning and development):** while also teaching about limitations
Accuracy of health information	**Young people seek out health information online:** AI developers should provide explicit and repeated warnings that health information may not be accurate and is not a substitute for professional health advise.
Human oversight and Safeguarding	**Mechanisms for human intervention:** Easy routes to human help and to report concerns, e.g. crisis support
Rigorous testing	**Continuous testing:** diverse young users, with advisory boards that include youth, scientists, ethicists and health professionals

APA Health Advisory: Artificial intelligence and adolescent well-being. apa.org/topics/artificial-intelligence-machine-learning/health-advisory-ai-adolescent-well-being

Ten principles for AI in psychology



Ethics, transparency and AI

1 Ethical responsibility
2 Transparency in selecting AI tools
3 Informed consent
4 Accountability, governance and professional responsibility

Professional competence and AI

5 Evidence base
6 Human oversight and professional judgement
7 Psychological safety and harm prevention

Access, bias and inclusion

8 Validation and scientific evidence
9 Algorithmic bias and fairness
10 Access, equity and inclusion

Source: Top 10 Principles for Understanding Artificial Intelligence in Psychology

Practice points

1

The evidence is still emerging

Rigorous, peer-reviewed research on engagement and outcomes with AI therapy agents and AI support tools is at an early stage, so be cautious about recommending them.

2

Ask about AI use

Ask clients whether they use AI chatbots, invite them to weigh up the pros and cons, and gently explain any risks they have not considered.

3

Keep responsibility with the clinician

Formulation, risk assessment and the therapeutic relationship stay with you. Never delegate accountability to AI.

Human in command is essential for safe AI-assisted practice

Questions for you!

- What digital technology are you using with young people in your service?
- What benefits have you experienced?
- What challenges have you experienced?

Digital technology in your service

Digital Advantages & Challenges

Benefits of Digital Mental Health

Availability

- 24/7
- Remote access
- No geographical limitations

Scalability

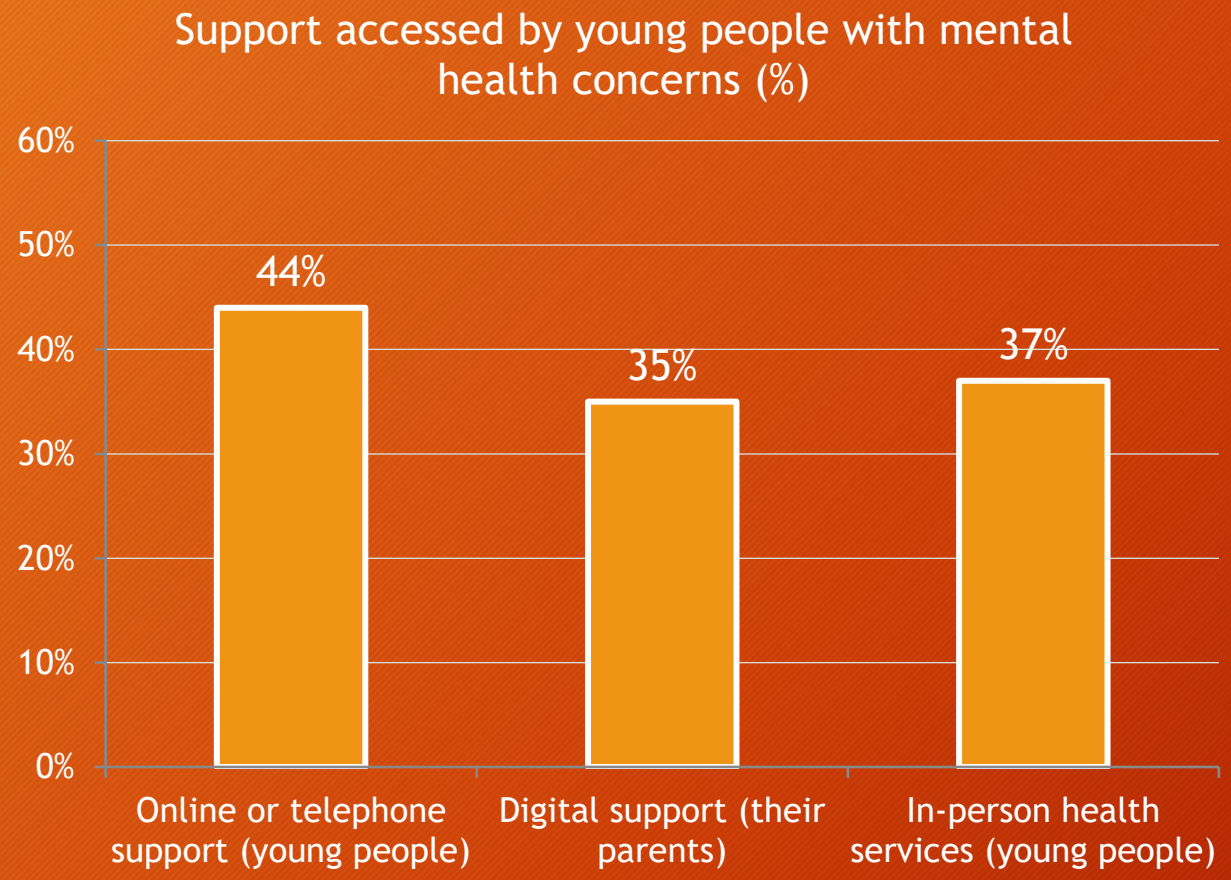
- Overcomes limited workforce
- Personalised at scale

Anonymity

- Tackling stigma
- Encouraging early access

Democratisation of therapy

Advantage 1: digital can extend the reach of services



Source: NHS Digital (2021)

Why reach matters

- Most young people with mental health problems do not access evidence-based psychological help
- Digital delivery may help close this resource gap
- Presumed efficiencies: saves time, money and reliance on professional delivery
- Offers autonomy, flexibility and anonymity

Source: Gee et al. (2021)

Advantage 2: engagement, if the design fits young people

83

studies by Liverpool et al.'s (2020) systematic review

79%

average retention, but lower in naturalistic settings

CBT
Affective Disorders
websites, apps, games, VR, robots, text messaging

What young people prefer

- Videos and active engagement
- Personalisation
- Ways to connect with others
- Text message reminders
- Not text-heavy resources

Social context matters

- Social connectedness influences youth engagement, so design with the young person's social world in mind.
- Needs to be Interactive, relevant, usable and enjoyable.

Co-production: involve young people at every stage

Co-production is critical (Bevan Jones et al., 2020; Hill et al., 2017). WHO (2020) framework, key messages:

1. Involve young people at every stage of the digital development process
2. Digital is not always the best solution: follow a clear needs assessment
3. Reuse digital interventions rather than reinventing them
4. Integrate with existing health interventions; avoid stand-alone solutions

Advantage 3: digital outcome measurement and feedback

Why it helps

- Engaging way to gather brief, sensitive data
- Accessible and cost-effective
- Young people may prefer electronic to paper measures
- Supports self-monitoring and service feedback

Examples

- MyLifeTracker, built into the Headspace app (ages 12–25): valid, reliable, sensitive to change
- CORC: free outcome and experience measures suitable for online use

Caution

- Do not just upload paper measures
- Online format can change responses and normative data
- Cut-offs and scoring may shift (Patalay et al., 2016)
- Check validity and reliability first

Challenge 1: protecting the therapeutic alliance

What the evidence suggests

- Adult research: digital alliance at least as strong as in-person, but processes may differ
- Clients report satisfaction; therapists may worry more about alliance quality
- Child and youth research is less advanced; qualitative accounts are positive
- Alliance may vary by client group, modality and digital method

Adapting our practice

- Exaggerate or combine ostensive cues (tone of voice, facial expression) to address mistrust
- Take a position of curiosity: ask for feedback regularly
- Keep the choice of delivery mode a priority
- Consider the computer as the “invisible third party” (Cataldo et al., 2021)

Challenge 2: risk assessment and digital self-harm

5–7×

increase in reporting suicidal thoughts

9–15×

increase in likelihood of a suicide attempt

Digital self-harm

"The anonymous online posting, sending or otherwise sharing of hurtful content about oneself". Associations above are from large-scale US adolescent studies (Patchin et al., 2023).

In practice

- Ask explicitly and regularly about risk to self and risk from others
- Without physical signs, build risk screens into session-by-session monitoring
- Take risk assessment in digital forums seriously

Challenge 3: privacy, data, competence and cost

Private space

- Young people may lack a safe, private space at home
- Particularly important where there is violence, abuse or risk of abuse

Data and consent

- Worries about who sees data from online tools
- Need data security and creative ways to ensure informed consent to storage

Practitioner competence

- Training is needed to set up online work carefully
- Free eLearning: www.digitalhealthskills.com (DCP Digital Healthcare Committee)

Economic burden

- Many tools are free, but devices and data are not
- Poverty will impede access to digital interventions

Safe Digital Practice

Always follow these three key principles in applying safe digital practice:

1. Know your technology – how it works, its benefits, its risks (including data security), and how to use it
2. Know your client and their context – is the digital application appropriate to use, and if so, what support, skills or processes does your client need to engage safely and productively?
3. Know yourself – what are your strengths and deficits, what are the skills you require to use the application safely and effectively?

Joint guidance on access to digital psychological practice (Psychological Professions Network, British Psychoanalytic Council, Association of Child Psychologists, BABCP, BACP, ACP, AFT, BPS) (2020)

- "Digital delivery should not be ruled out on the grounds of age (children and adults), disability, language, or type of difficulty. Reasonable adjustments should be made to enable all to engage in this as far as possible, recognising that it will not be possible for all"
- "Consent to digital delivery is implied through a service user accepting the invitation or engaging in the communication through the requested channel, although practitioners should endeavor to discuss the implications of digital delivery with service users at the outset"

Digital inclusion: choice, access and equity

9 million
people in the UK (16%) cannot access the internet independently

1 in 4
children in the UK live in poverty

⅓
of working-class households have no home internet

NHS Confederation (2020): four principles for digitally inclusive services

1. Understand needs
Know who can and cannot access services; co-produce and co-design

2. Be flexible
Plan ahead for when digital access goes wrong

3. Keep communicating
Allow time for feedback; digital is novel for many clients

4. Personalise
Support informed choice; tailor solutions to individual barriers

Digital inclusion solutions

- **Provide devices & connectivity** Ensure access to smartphones/tablets, data packages, and low-bandwidth platforms.
- **Support digital literacy** Use simple onboarding, intuitive design, and offer help through schools/families.
- **Design for privacy** Create tools that work in crowded homes: discreet interfaces, silent modes, short sessions.
- **Cultural adaptation** Co-design with marginalised youth; use relevant language, imagery, and multiple languages.
- **Add human support** Blend digital tools with brief check-ins, peer support, or clinician guidance.
- **Reduce cognitive load** Prioritise visual, interactive, low-text formats; keep navigation simple.
- **Include marginalised youth in research**
- **Policy & system-level action** Invest in digital inclusion, device provision, school-based digital mental health, and equitable commissioning.

Next frontier: how do digital interventions work?

25

studies in Domhardt et al.'s (2021) systematic review of mechanisms of change

21

mediators with some empirical support

Candidate mechanisms of change

- Affective processes: emotional factors such as fear and hopelessness
- Cognitive processes: such as perceived control and post-event processing
- No definitive conclusions yet because of study variability and quality

Next step

Quantitative research into "active ingredients" is only just emerging, and could underpin AI-personalised digital interventions for young people.

Summary: Key Messages for practice

1. Co-produce

Involve young people at every stage of design, delivery and evaluation

2. Offer choice

Digital should not be the only option; integrate it with existing care

3. Tailor and target

Evidence favours higher-risk groups and personalised, CBT-informed tools

4. Keep safety central

Ask about risk explicitly and regularly; protect privacy and data

5. Appraise the evidence

Self-directed tools show mixed results; examine new products carefully

6. Build competence

Develop digital skills and actively address digital exclusion

Discussion and resources

Discussion

Questions for discussion

- Where could digital add reach in your service without removing choice?
- How would you adapt risk screening and outcome measurement for online work?
- What digital competences does your team need next?
- Who should be involved in choosing or co-designing the tools you use?

Resources

- digitalhealthskills.com: free eLearning for practitioners
- CORC outcome and experience measures: corc.uk.net
- Child and Adolescent Mental Health (2023), vol. 28: special issue on technology and mental health

Digital Competencies

Assessing your digital competences

Safe & effective implementation of digital tools is key, particularly in child contexts where issues of informed consent and confidentiality are critical.

In order to practice safely and effectively. Psychological practitioners need to develop their digital competencies

Various frameworks of digital capabilities exist – often related to professional bodies

- Division of Clinical Psychology Digital Competence Framework
- Royal College of Psychiatry Digital Literacy Framework
- Royal College of Nursing
- NHSE Health and Digital Capabilities framework

BPS, DCP Digital Competence Framework (2022)



The DCAPP (Digital Competence in Applied Psychological Practitioners)

Background

- Digital delivery of psychological therapies now routine in mental health care in the NHS and internationally.
- **NHS 10 Year Health Plan for England**: ongoing digital development is crucial to improving care quality
- Importance of psychological practitioners having skills to deliver therapy safely and effectively using digital methods.
- Need for practical tools to support training, practice, supervision & policy in this area

DCAPP: A self-report measure of knowledge & ability in using digital tools in psychological practice

Based on Digital Competence Framework (mapped to NHSE Health and Digital Capabilities framework), developed with expert input



Major Research project: Establishing psychometric properties in UK & Sweden

RECRUITING! Further info: Research Participant Information Sheet

Can be completed via Link → The DCAPP Questionnaire or QR Code →

AI Competencies

Self reflection: What AI competencies have you already developed?

Complete the AI questions of the Digital Competence in Applied Psychological Practitioners (DCAPP) scale

DCAPP AI Questions

Digital Practice Road Map

Digital Practice Road Map

My digital practice values

1.
2.
3.

Areas of knowledge I need to develop

1.
2.
3.

Areas of practice I would like to improve

1.
2.
3.

Personal and structural barriers I might face

1.
2.
3.

15 MINUTE BREAK

Digital Case Study

Interactive Exercise

Vignette: Aanya, aged 11

Aanya and her family

- Lives with mother Priya (teaching assistant), father Rakesh (accountant), brother Dev (15), sister Mira (6) and paternal grandmother, Ba
- Family of Gujarati Hindu heritage: Ba migrated from Gujarat via East Africa; Priya and Rakesh were born in the UK
- Multigenerational household: Ba leads daily prayers, cooks and does school pick-ups; temple and festivals matter to the family
- Aanya has just transitioned to a state grammar secondary school which has been stressful
- Family values education, duty and togetherness; views on “worry” and help-seeking may differ across generations

Presentation and the work so far

- School referral: Aanya has persistent worries (“something bad will happen” to family), stomach aches, and school refusal one or two mornings a week
- Eight weekly online CBT sessions have been offered: some with the family, some alone; Aanya joins from her bedroom on a shared laptop, siblings often nearby
- Aanya uses TikTok anxiety content as self help (breathing, grounding, reassurance clips) via Dev’s account; she says it helps her calm down and asks to brings clips to session
- Her parents do not know how much Aanya watches and uses social media; Ba worries about screen use and favours prayer and family support

Exercise: offering help to Aanya and her family

1	Read the case again. You will explore one of three lenses; practical, ethical and relational.	5 min
2	Consider the following questions on the right and use the prompts for each lens on the next slide.	10 min
3	Discuss what would you do at the next session?	10 min
4	Everyone reflects. Agree 3 learning points and share in the poll.	5 min

Consider the following questions:

- What stands out to you?
- What matters to Aanya and the different people involved?
- What do we need to ask rather than assume?
- How can Aanya's voice, choice and autonomy remain central?
- Where are the opportunities, tensions or dilemmas in using digital approaches here?
- What would you want to consider before deciding what happens next?

Three lenses: practical, ethical and relational

Practical

- How can individual sessions be made private and safe?
- How will you assess and manage risk when Aanya is alone online?
- How will your respond to the request to integrate social media self-help advice into the work?

Ethical

- TikTok is for ages 13+ and Aanya uses her brother's account: what issues arise?
- What responsibility do you have to ensure the the self-help content is safe, evidence-based and helpful to Aanya?
- How do you stay curious regarding the intergenerational differences about digital/technology as a mental health support?

Relational

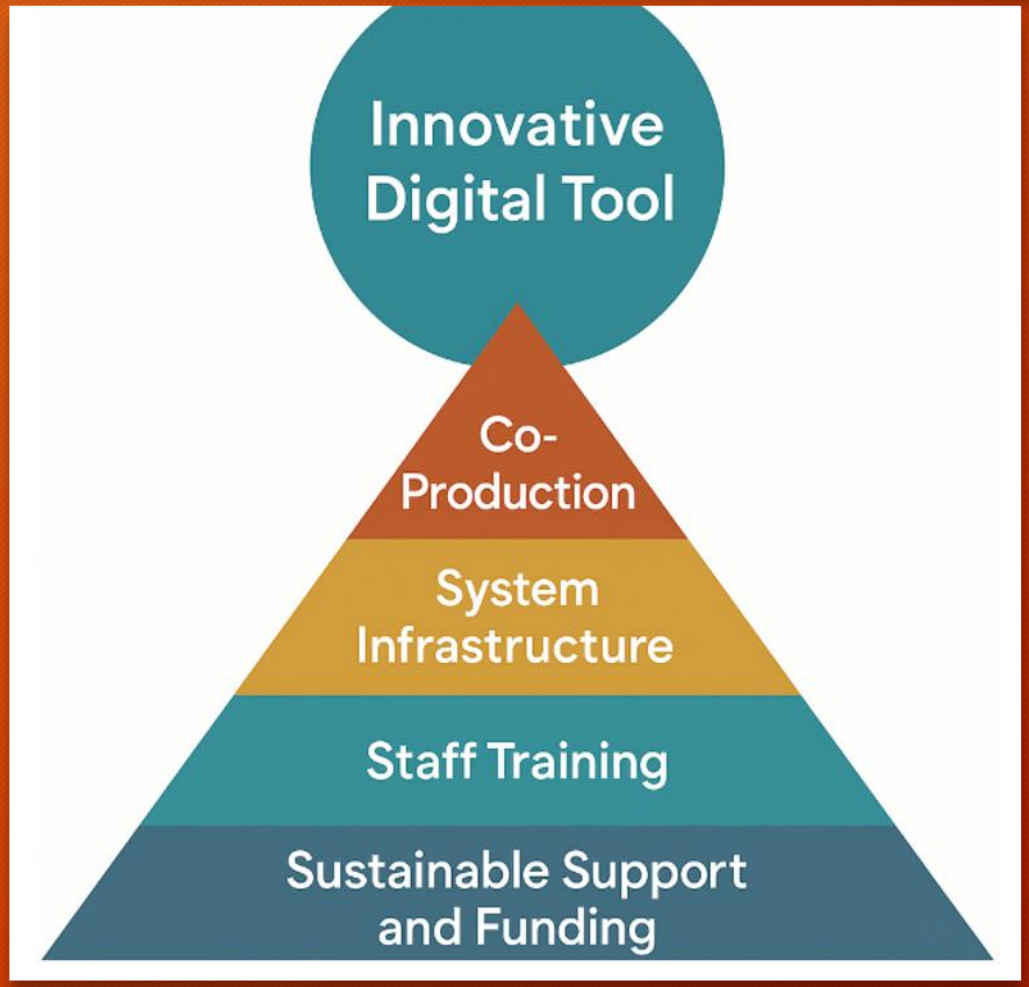
- How do you integrate external digital factors/information into your therapeutic conversations?
- How do you attend to a variety of family voices in online sessions?
- What assumptions about digital practice might you bring to the therapeutic work?

Output: Three reflections or learning points to share with the larger group

Learning Points & Reflections

Vignette Feedback

Conclusion: Digital is not a quick fix



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