WPA Position Statement on Responsible, Equitable and Evidence-Based Digital Mental Health in the Era of Artificial Intelligence (2024–2026)

Proposed by the WPA Digital Mental Health Section
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Executive Summary

Digital technologies are now embedded in psychiatric practice, service organization, education, research, and public mental health. Telepsychiatry has become an established modality of care, while mobile applications, digital therapeutics, remote monitoring, wearable devices, digital phenotyping, and artificial intelligence (AI) increasingly influence how mental healthcare is accessed, delivered, documented, and evaluated. These developments offer major opportunities to extend specialist care, support continuity, reduce avoidable barriers, and improve the use of scarce professional resources. They also create new risks involving clinical validity, accountability, privacy, cybersecurity, commercial influence, algorithmic bias, exclusion, and erosion of the therapeutic relationship.

This proposed Position Statement updates and complements the World Psychiatric Association (WPA) Position Statement on Global Digitalization in Mental Health and Care adopted in 2023 [1]. It reflects the growing strategic importance of digital health, alongside persistent disparities in policy, implementation capacity, clinical guidance, and professional education across countries and WPA regions [2–4].

The central position of the WPA Digital Mental Health Section is that digital technologies should augment, not replace, psychiatrists and other mental health professionals. Responsibility for diagnosis, treatment planning, prescribing, involuntary interventions, suicide and violence risk management, and crisis decisions must remain with appropriately qualified professionals. Digital technologies—including AI-enabled decision support, predictive analytics, remote-monitoring tools, digital phenotyping, and other automated systems—may inform such decisions, but they must not determine them without competent human review or obscure or displace human accountability.

The Section further holds that evidence requirements should be proportionate to risk and intended use; evaluation must continue throughout the technology lifecycle; patients and service users should be involved in design and governance; and implementation must protect confidentiality, human rights, cultural safety, and access to non-digital care. Systems that affect high-stakes clinical decisions require rigorous validation, transparent governance, human review, auditability, incident management, and monitoring for performance drift and unequal outcomes.

The Statement sets out twelve core positions and recommendations for the WPA, National Psychiatric Associations, governments, regulators, healthcare organizations, clinicians, educators, researchers, technology developers, journals, service users, and carers. Its purpose is not to endorse particular products or prescribe a single model for all countries. It provides a common professional framework that can be adapted to local law, resources, cultures, languages, and patterns of care while maintaining shared minimum standards for safety, evidence, accountability, and equity.

1. Purpose and Scope

This Statement presents the proposed position of the WPA on the responsible integration of digital technologies into mental health and psychiatric care. It is intended for psychiatrists, multidisciplinary teams, healthcare organizations, educators, researchers, regulators,

policymakers, technology developers, National Psychiatric Associations, service-user and carer organizations, and international bodies.

"Digital mental health" is used here as an umbrella term covering telepsychiatry and hybrid care; mobile health; internet-based interventions; digital therapeutics; virtual and augmented reality; wearable and sensor technologies; ecological momentary assessment; digital phenotyping; clinical decision-support systems; machine learning; generative AI; large language and multimodal models; and related digital infrastructure.

The Statement addresses technologies used for prevention, assessment, diagnosis, treatment, rehabilitation, monitoring, service organization, clinical documentation, education, research, and public mental health. It does not replace applicable law, professional regulation, device regulation, data-protection requirements, local clinical guidelines, or product-specific assessment. Where requirements differ, the more protective standard for patients and service users should ordinarily prevail. Detailed operational guidance should be developed or adapted by relevant authorities and professional bodies, taking account of local resources and legal frameworks. The Statement should be read alongside the 2023 WPA Position Statement [1], the WPA Telepsychiatry Global Guidelines [5], and the forthcoming WPA Mobile Health, Artificial Intelligence and Digital Technologies Guidelines.

2. Rationale and Current Context

2.1 Developments since the 2023 WPA Position Statement

Since adoption of the 2023 WPA Position Statement, digital mental health has moved rapidly from broad technology adoption towards questions of governance, clinical accountability, and sustainable implementation. Generative AI and large multimodal models have become widely accessible; telepsychiatry has consolidated its role within routine and hybrid care; and international frameworks have placed greater emphasis on transparency, risk management, human oversight, cybersecurity, and post-deployment monitoring [1,2,6–13].

At the same time, evidence and implementation remain uneven across countries and WPA regions. Global WPA surveys identify substantial gaps in policy, guidance, education, and workforce preparation, reinforcing the need for internationally shared minimum principles that can be adapted to local legal, cultural, linguistic, economic, and service contexts [3,4].

A major achievement of the WPA Digital Mental Health Section during 2024–2026 has been the completion of the WPA Mobile Health, Artificial Intelligence and Digital Technologies Guidelines. Developed over more than two years under the leadership of the late Professor Donald M. Hilty and by an international group of experts, the Guidelines are currently being finalized for publication and global dissemination. Together with the Section's expanded educational and collaborative activities, this work supports a shift from describing technologies to defining the conditions under which they can be used safely, equitably, and effectively in psychiatric practice.

2.2 Telepsychiatry and hybrid care

Telepsychiatry is the most mature component of digital mental health. Reviews and professional guidance support its use across a wide range of populations and clinical settings when services are appropriately designed, staff are trained, privacy and emergency procedures are established, and the modality is clinically suitable [5,14–17]. Its particular value lies in extending specialist access across distance, supporting continuity, and enabling collaboration between levels of care.

The question is no longer whether all care should be digital or face to face. Good practice increasingly involves hybrid care, with modality selected according to clinical need, risk, patient preference, accessibility, therapeutic relationship, stage of treatment, and local capacity. A digital consultation should not be used merely because it is administratively convenient, and a face-to-face consultation should not be required when it offers no clinical advantage and creates avoidable barriers.

2.3 Mobile applications, digital therapeutics and self-management

Digital psychological interventions and mobile tools can support psychoeducation, symptom tracking, medication adherence, relapse prevention, and treatment delivery. Evidence is

promising for several common mental disorders, particularly when interventions are structured and supported by professionals [18–20]. The commercial marketplace, however, remains heterogeneous. Popularity, user ratings, and marketing claims are not substitutes for evidence, safety assessment, or privacy review.

Selection and procurement should therefore use structured, transparent evaluation frameworks. The required evidence should reflect the product's intended purpose, the vulnerability of the users, the degree of autonomy, and the consequences of error. Risk-tiered approaches, such as the NICE Evidence Standards Framework and the American Psychiatric Association App Evaluation Model, provide useful examples [21,22].

2.4 Artificial intelligence (AI) and generative systems

AI is increasingly used for administrative support, documentation, information retrieval, prediction, triage, decision support, education, and patient communication [23,24]. Generative systems can produce fluent and persuasive output, yet fluency does not establish accuracy, clinical understanding, or professional judgement. Large language and multimodal models may hallucinate, omit critical context, reproduce bias, provide inconsistent answers, and generate apparently authoritative recommendations that are unsafe [6,7].

The sensitivity of psychiatric information and the high consequences of some decisions make mental healthcare a particularly demanding environment for AI. World Health Organization (WHO) guidance, emerging regulation, and risk-management frameworks emphasize human oversight, clearly defined intended use, transparency, data governance, evaluation, and post-deployment monitoring [8–13,25]. These requirements are especially important when AI influences access to care, diagnosis, treatment, prescribing, risk assessment, coercive interventions, or crisis management.

2.5 Wearables, remote monitoring and digital phenotyping

Smartphones, wearables, and connected sensors can provide longitudinal information on sleep, activity, mobility, physiology, speech, social interaction, and device use. Ecological momentary assessment and digital phenotyping may complement clinical interviews, reduce recall bias, and support earlier recognition of change, including treatment response [26,27]. Their clinical utility nevertheless depends on measurement validity, patient acceptability, reliable interpretation, and integration into care pathways.

Passive monitoring can easily become intrusive surveillance. Patients must understand what is collected, how often, for what purpose, who can access it, how long it is retained, and what will happen when an alert is generated. Collection should be limited to data that are necessary for a defined purpose and can be securely protected, and services should avoid generating more alerts than clinicians can safely review.

2.6 Equity, cultural safety and global implementation

Digital technologies may reduce some barriers while creating others. Access depends on connectivity, devices, affordability, private space, language, literacy, digital confidence, disability access, trust, and availability of support. Algorithms may also perform differently across demographic or clinical groups when training data are unrepresentative or when social inequities are encoded in data [28–30].

Equity must therefore be treated as a clinical quality outcome and embedded by design rather than assumed from technological availability. Culturally safe implementation requires co-design, linguistic adaptation, attention to local explanatory models, and respect for the different ways in which privacy, family involvement, and therapeutic relationships are understood [29–31]. Equity by design requires these considerations to be integrated throughout the development, validation, procurement, implementation, monitoring, and evaluation of digital technologies, rather than addressed only after deployment. Global standards should set minimum safeguards without imposing resource-intensive models that are unrealistic in low-resource settings.

2.7 Education and organizational readiness

Global surveys undertaken through WPA structures show substantial gaps in policy, clinical guidance, and formal education in digital mental health across National Psychiatric Associations and training programmes [3,4]. Digital competence involves more than knowing how to use a

platform. It includes evidence appraisal, clinical appropriateness, informed consent, privacy, cybersecurity, data governance, AI literacy, communication, cultural competence, workflow design, incident response, and the ability to recognize when digital care is unsuitable [32,33].

Many implementation failures arise not from the technology alone but from insufficient attention to workflow, leadership, staffing, reimbursement, interoperability, training, procurement, and evaluation. Established implementation frameworks emphasize the need to assess context, adoption, sustainability, and unintended consequences rather than focusing solely on initial uptake [34–36].

3. Core Positions

The WPA Digital Mental Health Section proposes the following positions as minimum principles for responsible digital mental health care. They apply across technologies and settings, with the intensity of safeguards proportionate to clinical risk.

1. **Clinical purpose must precede technological adoption.** A digital tool should be introduced only when it addresses a defined clinical, educational, organizational, or public-health need. The relevant comparison is not whether the technology is innovative, but whether it improves care, access, safety, experience, equity, or responsible use of resources compared with realistic alternatives.
2. **Digital technologies should augment, not replace, professional care.** Technology may extend the reach and capacity of mental health services, but it must not be used as a general substitute for adequate staffing, therapeutic relationships, or comprehensive assessment. Services should preserve meaningful human contact and a route to direct professional review whenever clinically required.
3. **Human accountability is indispensable for high-stakes decisions.** Responsibility for diagnosis, treatment planning, prescribing, involuntary care, suicide and violence risk management, safeguarding, and crisis decisions must remain with appropriately qualified professionals. Digital technologies—including AI-enabled decision-support systems, predictive analytics, remote monitoring, digital phenotyping, and other automated tools—may inform but must not determine these decisions without competent human review. The responsible professional or organization must be identifiable.
4. **Evidence and evaluation must be proportionate to risk.** Evidence requirements should reflect intended use, degree of autonomy, user vulnerability, and consequences of error. Systems that influence diagnosis, treatment, access, or safety require robust clinical validation in relevant populations and settings. Evaluation should include patient-relevant outcomes, comparative effectiveness, usability, economic impact, and subgroup performance.
5. **Safety management must continue throughout the lifecycle.** Approval or procurement is not the end of evaluation. Organizations should monitor performance, model drift, changes in software or data, adverse events, near misses, workarounds, alert burden, and unequal outcomes. There must be clear processes for incident reporting, escalation, correction, suspension, and withdrawal.
6. **Privacy, confidentiality, data governance and cybersecurity are clinical obligations.** Mental health data require a high level of protection. Data collection should be necessary and proportionate; purposes and access rights should be explicit; retention should be limited; and secondary use should be governed. Identifiable patient information must not be entered into unapproved generative AI systems. Cybersecurity, business continuity, and recovery plans are essential components of patient safety.
7. **Transparency and explainability must support informed use.** Patients and professionals should know when AI is being used, what role it plays, what data it uses, its material limitations, and how a human review can be requested. Consumer-facing systems should disclose that they are automated, avoid anthropomorphic deception, and provide appropriate

routes to professional and emergency support. Explainability should be appropriate to the decision and the needs of the user [37].

8. **Equity and cultural safety must be designed and measured.** Equity by design requires accessibility, affordability, representativeness, language, literacy, disability access, and cultural safety to be considered from initial design and procurement through deployment and ongoing evaluation. Implementation should assess who benefits, who is excluded, and whether performance differs across groups. Services should provide accessible design, multilingual and low-bandwidth options where feasible, digital-literacy support, and reasonable alternatives for people who cannot or do not wish to use digital tools. No person should be denied clinically necessary care solely because of digital exclusion [29–31].

9. **Autonomy, informed consent and patient involvement must be meaningful.** Consent should address the specific digital process, relevant data flows, automation, foreseeable risks, alternatives, and the consequences of declining. Participation in digitally supported care should be voluntary, and patients should be informed that they may discontinue use of a digital modality and request an appropriate alternative, where clinically feasible, without jeopardizing access to necessary care. Consent should not be treated as a single click or a blanket authorization. Patients, carers, and people with lived experience should participate in design, procurement, governance, evaluation, and revision.

10. **Organizations must be ready before technologies are deployed.** Implementation requires accountable leadership, trained staff, appropriate staffing ratios, workflow integration, emergency procedures, interoperability, technical support, documentation standards, and realistic financing. Procurement contracts should address data portability, audit access, updates, performance reporting, subcontractors, incident notification, and safe exit from the product.

11. **Digital competence should be a core psychiatric competency.** Education across digital mental health—including telepsychiatry and hybrid care, AI-enabled tools, data governance, and cybersecurity—should be incorporated into undergraduate medical education, psychiatry residency, continuing professional development, and leadership training. Competence should be demonstrable and updated over time, with particular attention to evidence appraisal, ethics, data governance, cybersecurity, bias, cultural safety, and communication with patients.

12. **Research and reporting should be rigorous, inclusive and globally relevant.** Studies should report intended use, data provenance, comparator, clinical setting, human–technology interaction, subgroup performance, errors, unintended consequences, and changes to the system during evaluation. AI studies should follow relevant reporting guidance, and research agendas should include low-resource settings, children and older people, people with disabilities, severe mental illness, and culturally diverse populations [38–40].

4. Recommendations for Action

4.1 World Psychiatric Association and National Psychiatric Associations

- Develop or adapt national guidance that translates these principles into clinically usable standards while respecting local law and resources.
- Include core competencies across digital mental health—including telepsychiatry and hybrid care, AI literacy, data governance, and cybersecurity—in psychiatric curricula and continuing professional development.
- Support independent, multidisciplinary evaluation and provide clinicians and the public with accessible information on benefits, limitations, and risks.
- Promote exchange between WPA regions so that implementation models and evidence do not remain concentrated in high-income settings.
- Engage service users, carers, ethicists, legal experts, data scientists, primary care, and other relevant Sections when positions or guidance affect their expertise.

4.2 Governments and regulators

- Use risk-proportionate regulation that addresses both pre-market evidence and post-deployment performance, including substantial software updates and adaptive systems.
- Clarify responsibility and liability across developers, deployers, institutions, and professionals without transferring unreasonable risk to individual clinicians or patients.
- Require meaningful transparency, cybersecurity, data protection, auditability, incident reporting, and equity-by-design measures, including evaluation and mitigation of discriminatory effects throughout the technology lifecycle.
- Invest in connectivity, accessible infrastructure, and digital-literacy support while maintaining non-digital access to essential mental healthcare.
- Align reimbursement and procurement with evidence, quality, equity, and long-term sustainability rather than short-term adoption targets.

4.3 Healthcare organizations and service leaders

- Establish multidisciplinary governance for digital and AI-enabled services, with named clinical, technical, information-governance, and executive accountability.
- Apply equity-by-design principles and conduct clinical, ethical, privacy, cybersecurity, accessibility, workflow, and equity impact assessments before deployment and after material changes.
- Define who reviews digital output, expected response times, escalation routes, documentation requirements, and what happens during outages or vendor failure.
- Monitor effectiveness, safety, workload, patient experience, access, subgroup performance, and unintended consequences using predefined indicators.
- Ensure procurement contracts permit appropriate audit, incident investigation, data export, interoperability, and termination without loss of continuity of care.

4.4 Psychiatrists and clinical teams

- Use professional judgement to decide whether a digital modality is appropriate for the individual patient and clinical task.
- Discuss the role and limitations of relevant technology with patients in clear language and document material consent and shared decisions.
- Verify AI-generated summaries, recommendations, translations, and documentation before clinical use. The apparent confidence of an output must not be treated as evidence of correctness.
- Do not enter identifiable or confidential information into systems that have not been approved for that purpose by the responsible organization.
- Recognize digital exclusion, accessibility needs, cultural and linguistic factors, and signs that technology is weakening communication or the therapeutic relationship.
- Report adverse events, near misses, bias, unsafe output, and workflow failures through the appropriate clinical and technical governance routes.

4.5 Educators and training bodies

- Define stage-appropriate learning outcomes and assessment methods across digital mental health, including telepsychiatry and hybrid care, artificial intelligence, and data governance.
- Use supervised clinical practice and case-based learning rather than relying only on theoretical instruction.
- Teach trainees to appraise claims, recognize automation bias, communicate uncertainty, and understand the limits of prediction and explainability.
- Include perspectives from patients, carers, ethics, law, information security, and implementation science.

4.6 Researchers, developers and scientific journals

- Design studies around clinically meaningful questions and realistic care pathways, including appropriate comparators and human factors.
- Report data provenance, missingness, inclusion and exclusion criteria, subgroup performance, model changes, errors, and external validation.

- Include service users and clinicians throughout co-design and development, and test systems in representative populations, languages, and settings for which they are intended.
- Publish negative findings, failure modes, and implementation barriers, not only technical performance or successful pilots.
- Use relevant reporting standards, including CONSORT-AI, SPIRIT-AI, and DECIDE-AI where applicable [38–40].

4.7 Service users, carers and representative organizations

- Participate in governance and evaluation, including decisions about acceptable data use, consent, accessibility, communication, and escalation.
- Seek clear information on what a technology does, what it does not do, whether a human reviews the output, and how to obtain alternative care.
- Report harms, exclusion, confusing information, or changes in the therapeutic relationship through available clinical, regulatory, and patient-safety channels.

5. Implementation and Accountability

These positions should be translated into locally appropriate policies, clinical procedures, educational standards, and procurement requirements. Implementation should be proportionate to risk and staged. Each deployment should have a defined purpose, accountable owner, evidence base, data-flow map, human-review arrangements, incident procedures, and criteria for continuation or withdrawal. Pilots should include predefined evaluation and stopping criteria, and scale-up should depend on acceptable safety, effectiveness, equity, and workload.

Organizations should monitor clinical outcomes, patient experience, workload, equity, and unintended consequences throughout the technology lifecycle. Staff and patients should have clear guidance on approved use, safe alternatives, and non-punitive routes for reporting problems or emerging practices.

6. Relationship to Existing and Forthcoming WPA Documents

This proposed Statement updates and complements the WPA Position Statement on Global Digitalization in Mental Health and Care adopted in 2023 [1]. It retains that document's emphasis on quality, accessibility, professional responsibility, education, and collaboration while responding to major developments in generative AI, regulation, and implementation practice.

The WPA Telepsychiatry Global Guidelines [5] provide comprehensive guidance on the clinical, ethical, legal, technological, educational and cross-cultural aspects of telepsychiatric practice. The forthcoming WPA Mobile Health, Artificial Intelligence and Digital Technologies Guidelines provide detailed evidence-based and consensus-based recommendations concerning mobile health, artificial intelligence, and related digital technologies. The present Position Statement complements rather than substitutes for these operational Guidelines.

This Statement is designed to function at a higher level: it establishes the positions that should guide policy, professional conduct, education, organizational governance, procurement, and research across digital mental health technologies. Product-specific and country-specific guidance should remain consistent with these principles while adapting implementation to local needs.

7. Conclusion

Digital mental health has entered a phase in which responsible implementation matters as much as technological capability. Psychiatry should neither reject useful innovation nor accept it uncritically. The profession has a duty to shape digital transformation so that it improves care, protects patients, supports professionals, and reduces rather than reinforces inequity.

The WPA Digital Mental Health Section therefore calls for a patient-centered, evidence-based, rights-respecting, and globally inclusive approach. Digital technologies should augment human expertise; high-stakes clinical responsibility must remain human; evidence and monitoring must be proportionate to risk; data and cybersecurity must be treated as clinical safety issues; and every implementation should preserve transparency, cultural safety, equity, and meaningful access to professional care.

These principles provide a common foundation for international action while allowing adaptation to diverse legal, cultural, economic, and healthcare contexts. Their implementation will require sustained collaboration among patients, carers, clinicians, professional associations, health systems, educators, researchers, regulators, and technology developers.

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