PPN
Psychological
Professions Network

NHS

Psychological Professions Week

PPN Psychological Professions Network

NHS

Digitally Enabled Psychological Healthcare (PPN SE & PPN London)

Welcome, Housekeeping, Introductions

Psychological Professions Week

Time	Agenda Item	Owner
09:30	Welcomes and Housekeeping Introductions	Dr Bill Tiplady PPN Co-Chair, South East Dr Adrian Whittington PPN CoChair, South East Dr Estelle Moore PPN Chair, London
09:35	Psychological Digital Practice: The Basics and Beyond	Professor Helen Pote Royal Hollaway University of London
09:55	Introduction to next speaker	Dr Bill Tiplady PPN Co-Chair, South East
09:56	Digital interventions for psychosis	Professor Daniel Freeman and Dr Julia Jones University of Oxford
10:15	Introduction to next speaker	Dr Bill Tiplady PPN Co-Chair, South East
10:16	Digital front door – experiences of implementing Artificial Intelligence in Talking Therapies	Dr John Pimm and Dr Jo Ryder Oxford Health
10:36	Q&A	All
11:00	Close	Dr Bill Tiplady PPN SE Co-Chair Dr Estelle Moore PPN Chair, London

What is the Psychological Professions Network?

Psychological Professions Week

The PPN South East and PPN London are regional membership networks. Our audiences include:

- Psychological professionals – qualified, training and aspiring
- Experts by Experience and people with lived experience
- Policymakers
- Education, workforce and career leads and teams
- NHS commissioned service providers
- Members of the public interested in the psychological professions and NHS services.

Being a member of the Psychological Professions Network is free (PPN – Register)and gives you access to a wide variety of resources and opportunities to contribute and influence NHS commissioned healthcare.

Psychological Digital Practice

Professor Helen Pote, Royal Holloway, University of London

11th November 2025

Outline

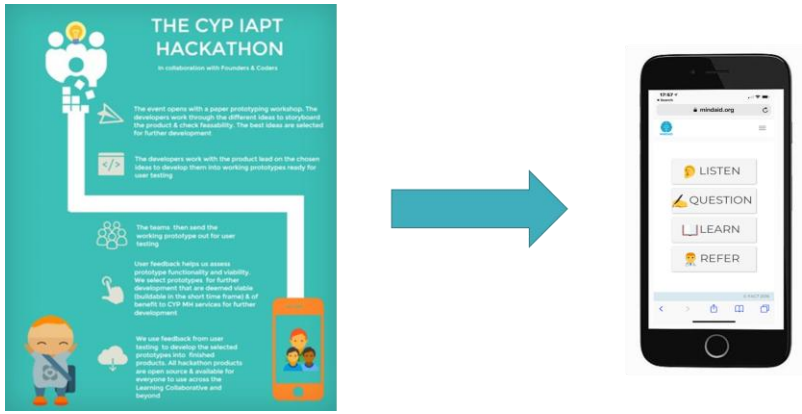
What does a digital future for psychological practitioners look like?

Benefits and risks of integrating digital technology and AI into practice

Training psychological professionals for digital practice

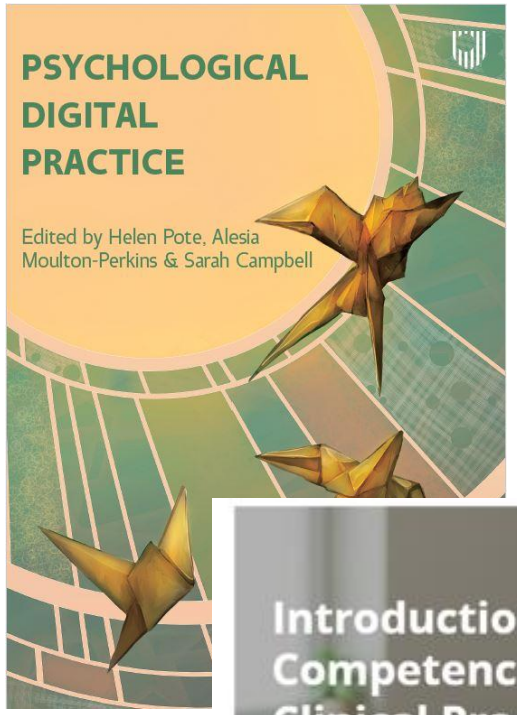
Digital Introductions

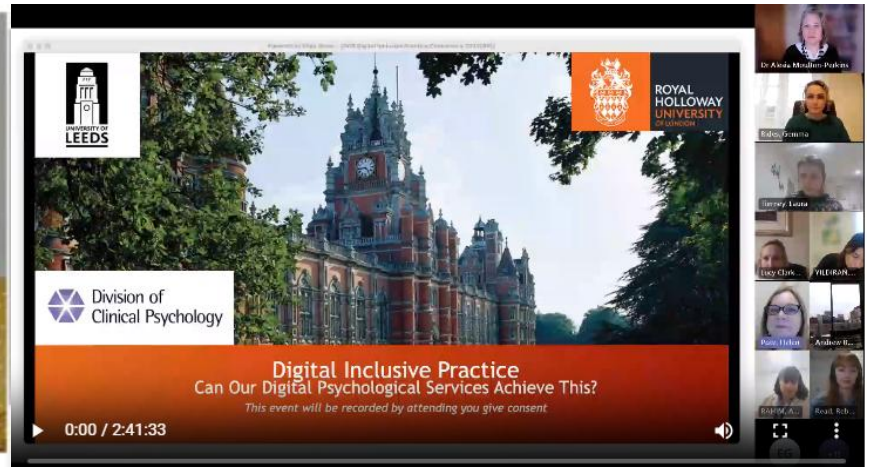
Helen's digital journey



www.digitalhealthskills.com

Division of Clinical Psychology



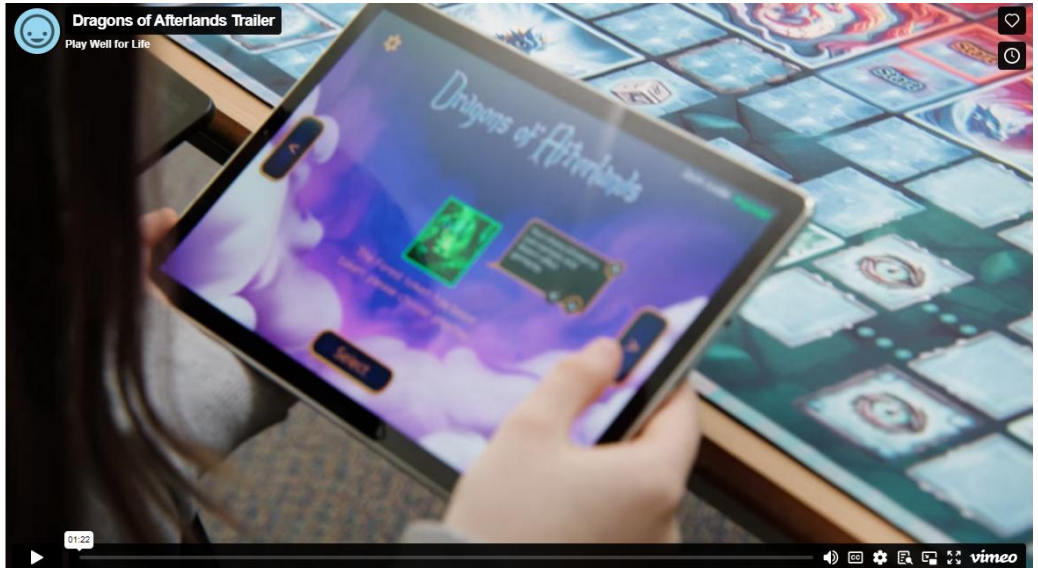


Definition:
Digital Mental Health (DMH)

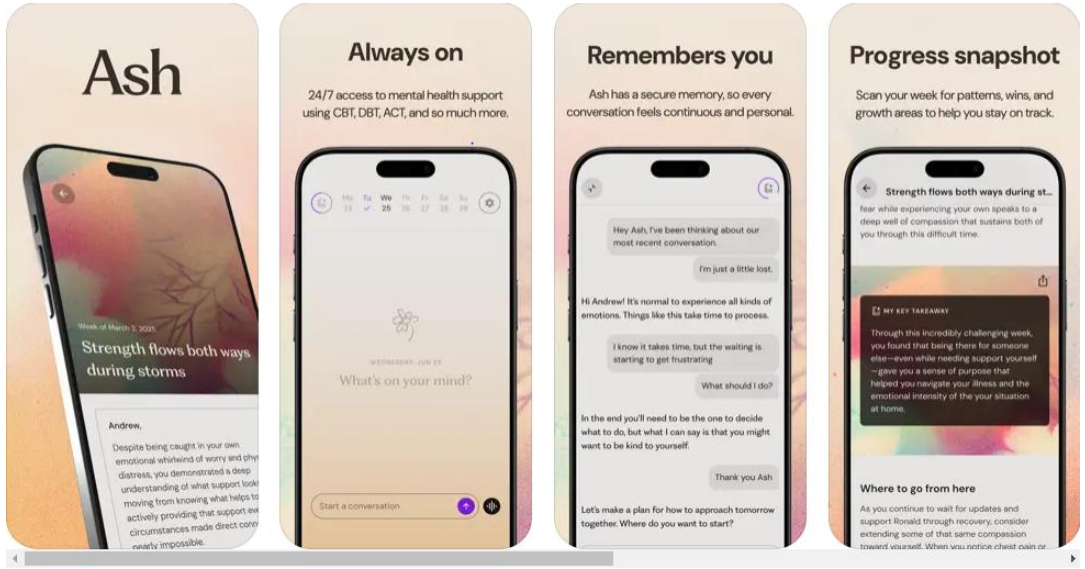
- Working Definition of Digital Health Technologies. *NICE, 2022*

> *“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’*

https://www.youtube.com/watch?v=LITRxW2kWHQ

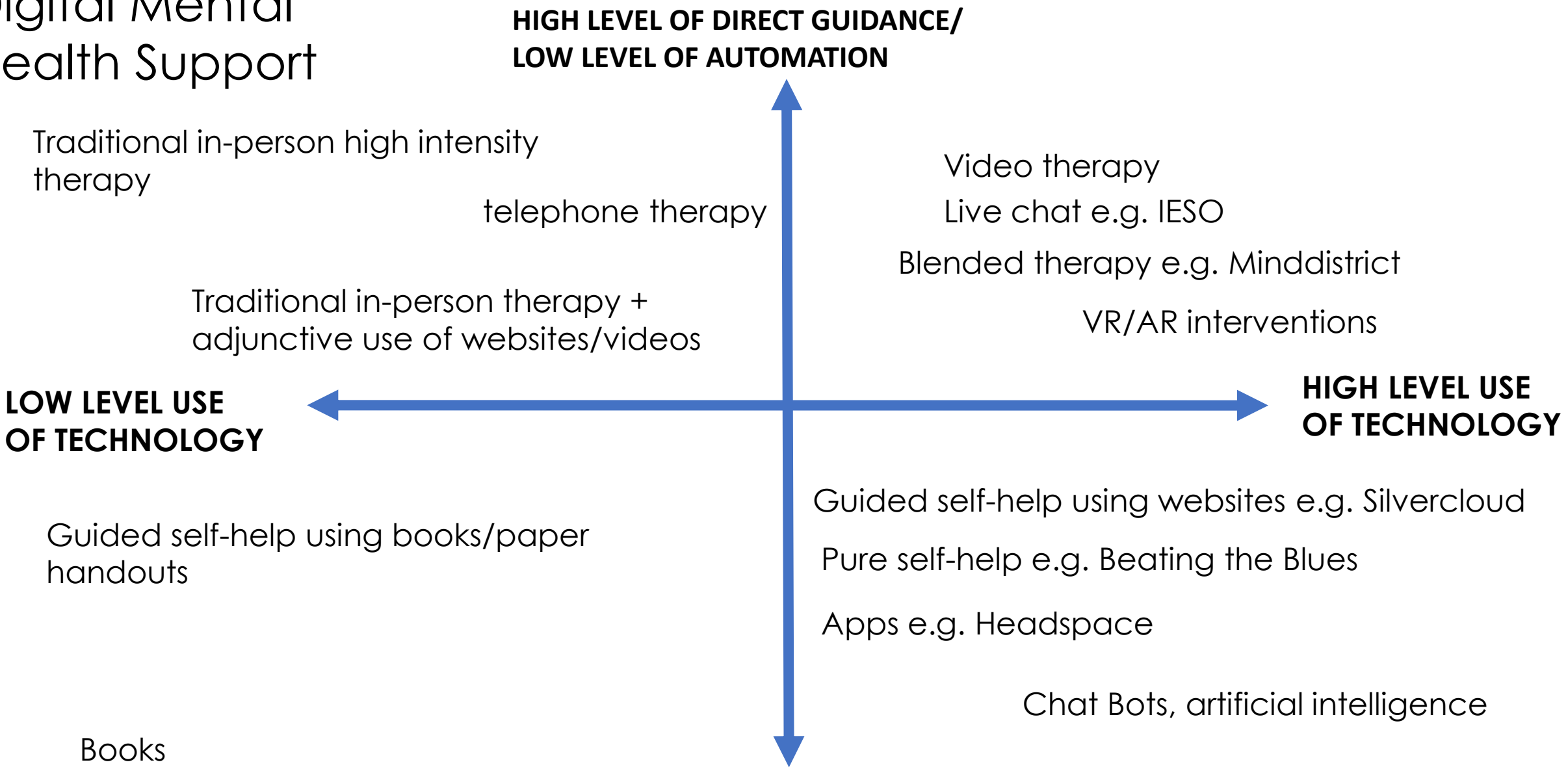


https://www.pwflhealth.com

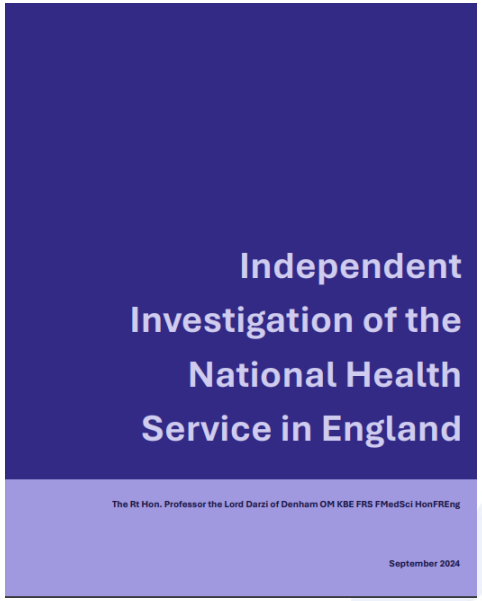


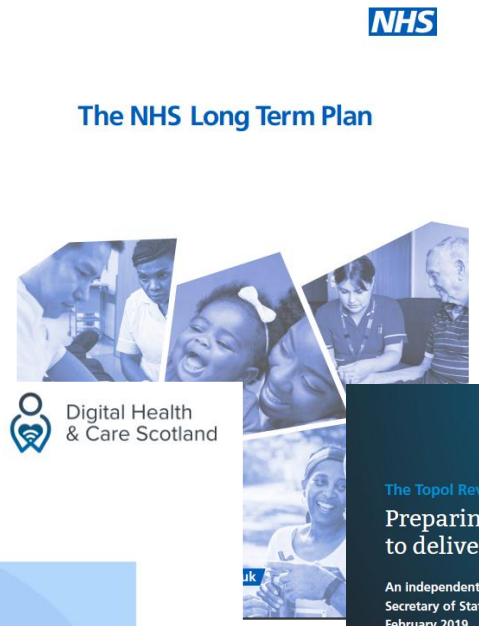
https://ash-therapy.com/

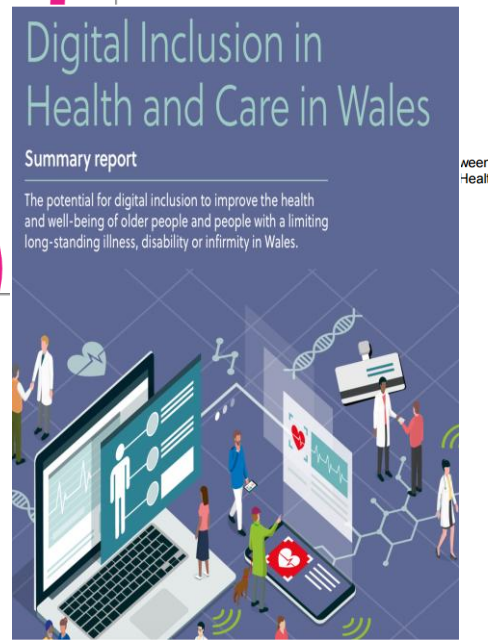
Digital Mental Health Support



NHS policy says ‘The Future’s Digital’





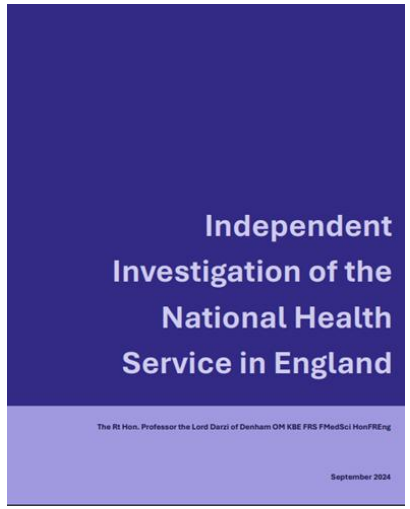


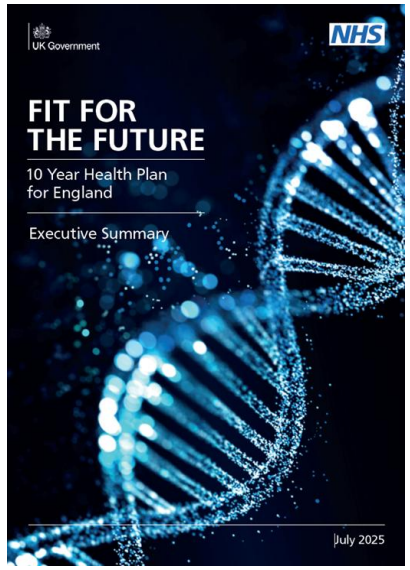
NHS Long Term Plan (2025)

Cure to Prevention

Hospital to Community

Analogue to Digital





The NHS Long-term plan (2025): Digital

Increased use of the NHS app

‘Dr in your pocket’

‘2028 full front door’

New single patient record (SPR) - interoperable

Data, AI, Wearables and Robotics for transforming care

Healthstore with approved apps

AI to support staff productivity

Many services are already using digital therapy methods effectively

- Hard to determine how many NHS services are currently trailing digital interventions.
  - O**nline therapy programs**, **mental health apps**, **text-based services**, **AI-driven chatbots**, and **virtual therapy platforms, e.g.** e.g. Togetherall, SilverCloud.
  - Chatbots being used in the NHS: WYSA, TESS, Your Mind Matters
  - Talking Therapies - estimated over 50% of primary care mental health services are now providing digital mental health options, and this number continues to grow

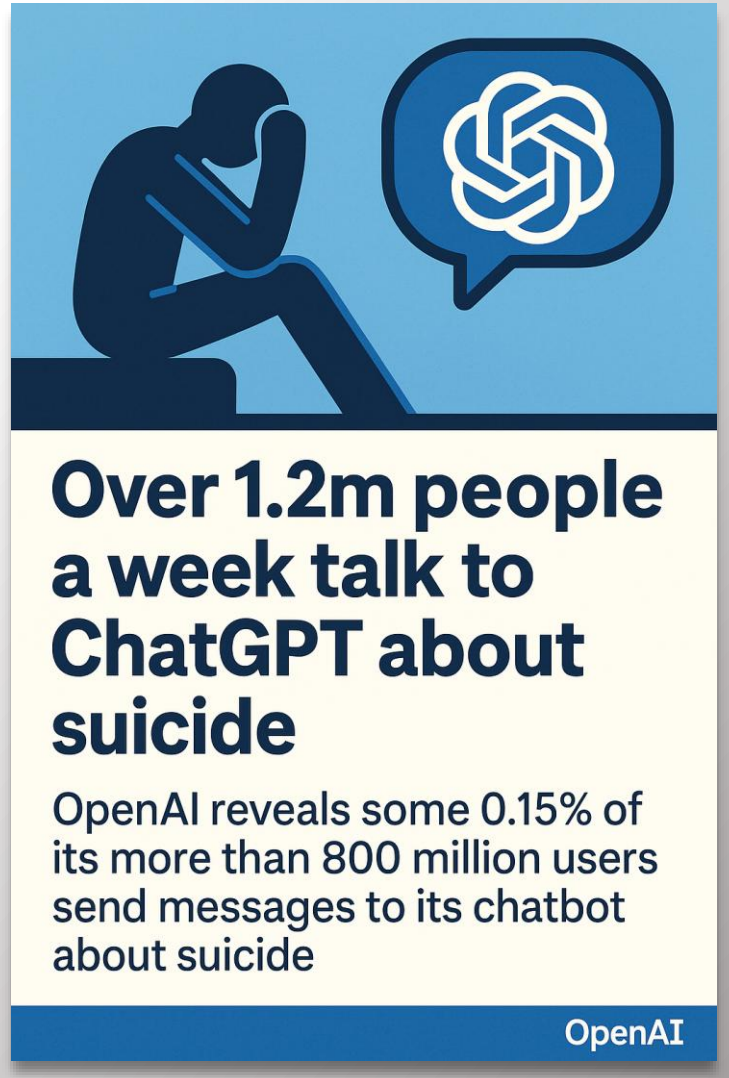
Evidence base is well established

- Self help resources, small but significant effects which improve if humans are involved
- Similar outcome for digital and in-person human supported interventions
- Similar ratings of therapeutic alliance and acceptability
- Small but significant short term effects of chat-bot based interventions on symptoms of anxiety and depression

Public are already using digital tools for mental health

- Open AI Data (2025) shows that on ChatGPT's each week
  - Over 1.2m people talk to ChatGPT about suicide
  - 560 000 are showing signs of psychosis or mania

- Giray (2025) looked at Reddit posts - using it for coping with grief and loss, simulating conversations with deceased loved ones, seeking emotional support, developing social skills, managing ADHD symptoms, and serving as an on-demand mental health resource



Benefits of Digital Mental Health

Availability	Scalability	Anonymity
• 24/7 • Remote access • No geographical limitations	• Overcomes limited workforce • Personalised at scale	• Tackling stigma • Encouraging early access

Democratisation of therapy

Ethics and risks of Digital Mental Health

Inclusive Practice
- Bias in LLM
- Bias in research
- Access to tech and digital literacy

Choice
- An ‘offer’ at each stage of the care pathway

Confidentiality & Consent
- Data security
- Client & professional understanding

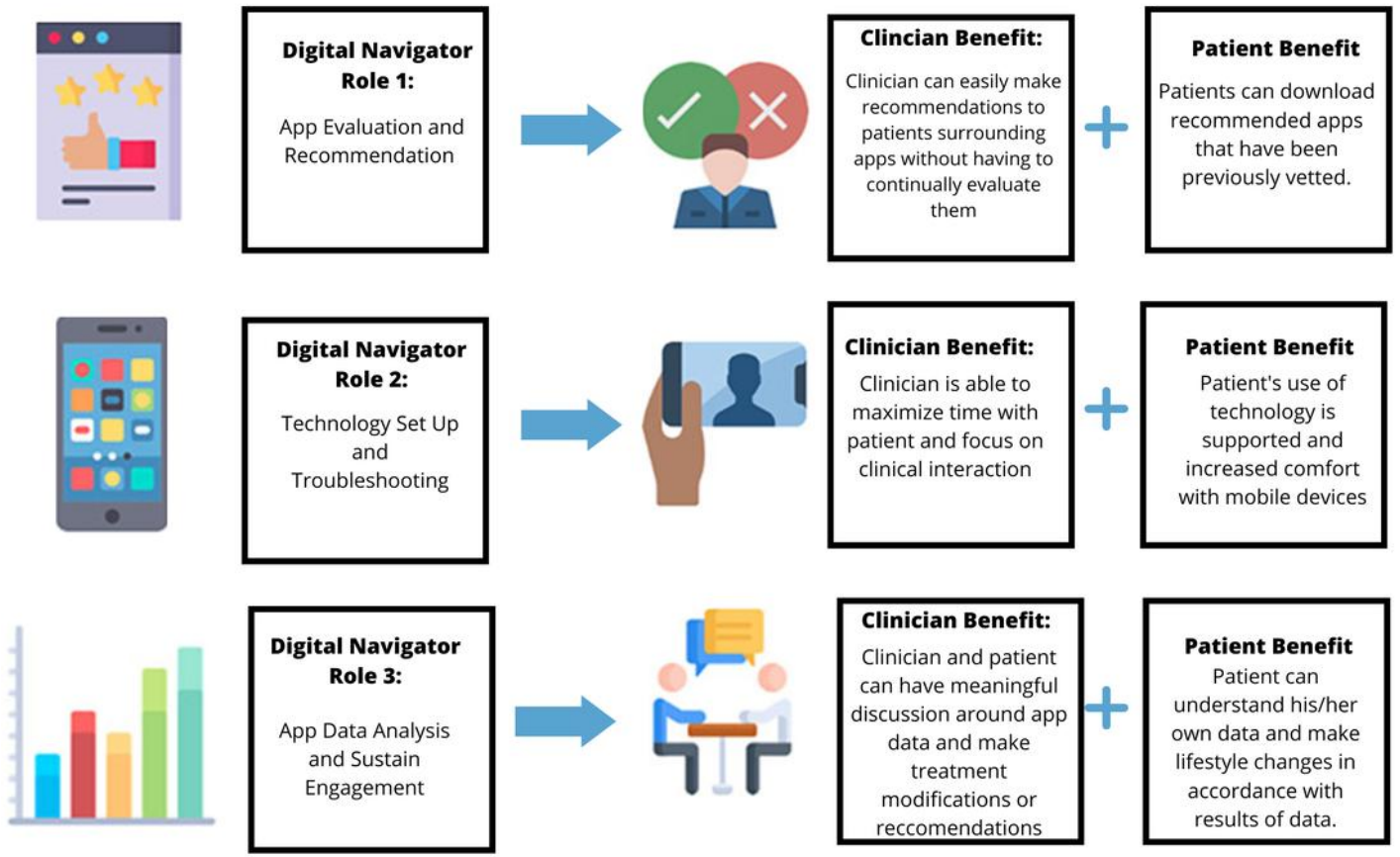
Risk & Accountability
- AI tools directing to professional resources
- 9% of time not happening for OpenAI

Parents of teenager who took his own life sue OpenAI

Nadine Yousif
BBC News
27 August 2025

Successful Implementation

Supporting the public to access digital mental healthcare



Digital Navigator - John Torous

Supporting Professionals - Digital Competence Framework for the Psychological Professions

www.digitalhealthskills.com

These digital competencies are applicable to all applied psychologists and psychological practitioners working online and via telephone (the core and advanced subcategories to the competencies can be found in the supplementary material).

Ethical Statement:

In using these digital competencies and working digitally with clients and other professionals it is important that practitioners adhere to the usual professional and ethical guidelines that guide their practice. When working digitally practitioners should pay particular attention to issues of client consent and participation, equity of access and choice.

Pote, H., Moulton-Perkins, A., Latchford, G., Holloway-Biddle, C., Rides, G., Raczka, R., Jacques, C., Papadopolou, E., Thew, G., Read, R., Clarkson, L., Griffith, E., Priest, P., Cavanagh, K. (2020). Competence Framework for Digital Clinical Practice: Psychological Practitioners. British Psychology Society, Division of Clinical Psychology, Digital Healthcare Committee. Launched 26-05-2020. Available online https://digitalhealthskills.com/digitalcompetencies/

	Knowledge	Ability
Meta-competencies	Knowledge of ethical practice, opportunities and limitations of digital practice related to access and efficacy	Ability to practice digitally, including establishing and maintaining a positive therapeutic alliance in online work

Complete our international survey to map your current digital competencies

DCP Digital Healthcare Committee
www.digitalhealthskills.com

Free Elearning 4 Modules

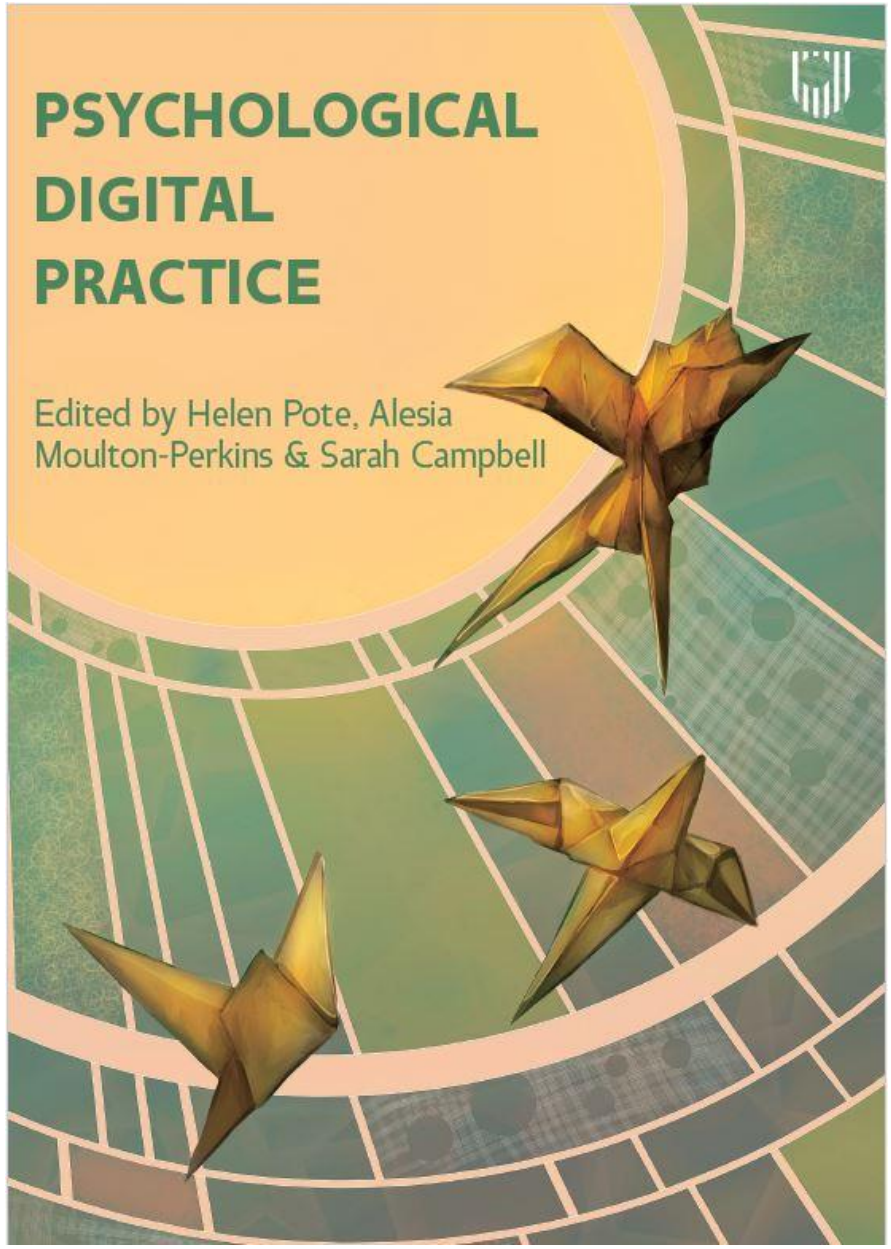
Learn.bps.org.uk

Digitalhealthskills.com

E-Learning

Developing competencies for digital clinical practice

Moulton-Perkins, A., Pote, H., Latchford, G., Rides, G., Raczka, R., Jacques, C., Papadopolou, E., Thew, G., Read, R., Clarkson, L., Grifith, E., Priest, P., Saunders, T., Dowzer, D., Cavanagh, K. (2022). Developing Competencies for Digital Clinical Practice: ELearning (2022). British Psychology Society, Division of Clinical Psychology, Digital Healthcare Committee. Launched 12-5-2022. Available online https://digitalhealthskills.com/elearning/



Psychological Digital Practice: The Basics and Beyond (2025)

Editors Prof Helen Pote, Dr Alesia Moulton-Perkins & Dr Sarah Campbell.

Paperback and eBook.
Open University Press ISBN10-**0335251765**

1. Frameworks for Digital Practice
2. Direct Online Skills
3. Indirect work - co-production, supervision & working with digital industry
4. Digital Futures

Stay in touch…

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Evidence: Digital

- Self help resources such as mental health apps targeting symptoms of anxiety and depression have small but significant effects, increased by use of CBT content, mood monitoring and chatbot features (Linardon et al, 2024, k=176)
- Human guided self-help is generally found to be more engaging and more effective than unguided approaches (Baumeister et al., 2014; Bennet et al., 2019; Mosche et al., 2022, Musiat et al, 2022)

Kate Cavanagh summary 2025

Evidence: Human + digital resources

- Human supported digital mental health resources are found to be acceptable and effective for a range of mental health problems in a range of populations (e.g. Andersson et al., 2019; Bennet et al., 2019; Bennet et al., 2020).
- Similar outcomes to more traditional in-person approaches (Carlbring et al., 2018; Hedman-Lagerlof et al., 2023; Rozental et al, 2015), although lower in studies of children & adolescents (Bennet et al., 2019)

Kate Cavanagh summary 2025

Evidence: Chatbot and AI Resources

- Small but significant short term effects of chat-bot based interventions on symptoms of anxiety and depression (Zhong, Luo & Zhang, 2024, *k*=18)

- Evidence from earlier rule-based chatbots and more recents machine learning powered models

- Some promise from early studies, but limited robust, real world evidence (Torous et al., 2025)

Kate Cavanagh summary 2025

SPECIAL ARTICLE

The evolving field of digital mental health: current evidence and implementation issues for smartphone apps, generative artificial intelligence, and virtual reality

John Torous[1], Jake Linardon[2], Simon B. Goldberg[3], Shufang Sun[4-6], Imogen Bell[7,8], Jennifer Nicholas[5,8], Lamiece Hassan[9], Yining Hua[1,10], Alyssa Milton[11,12], Joseph Firth[13]

[1]Division of Digital Psychiatry, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA, USA; [2]SEED Lifespan Strategic Research Centre, School of Psychology, Faculty of Health, Deakin University, Geelong, VIC, Australia; [3]Department of Counseling Psychology and Center for Healthy Minds, University of Wisconsin, Madison, WI, USA; [4]Department of Behavioral and Social Sciences, Brown University School of Public Health, Providence, RI, USA; [5]Mindfulness Center, Brown University, Providence, RI, USA; [6]Center for Global Public Health, Brown University, Providence, RI, USA; [7]Orygen, Parkville, VIC, Australia; [8]Centre for Youth Mental Health, University of Melbourne, Melbourne, VIC, Australia; [9]School for Health Sciences, University of Manchester, Manchester, UK; [10]Department of Epidemiology, Harvard T.H. Chan School of Public Health, Boston, MA, USA; [11]Central Clinical School, Faculty of Medicine and Health, University of Sydney, Sydney, NSW, Australia; [12]Australian Research Council (ARC) Centre of Excellence for Children and Families Over the Life, Sydney, NSW, Australia; [13]Division of Psychology and Mental Health, University of Manchester, and Greater Manchester Mental Health NHS Foundation Trust, Manchester Academic Health Science Centre, Manchester, UK

The expanding domain of digital mental health is transitioning beyond traditional telehealth to incorporate smartphone apps, virtual reality, and generative artificial intelligence, including large language models. While industry setbacks and methodological critiques have highlighted gaps in evidence and challenges in scaling these technologies, emerging solutions rooted in co-design, rigorous evaluation, and implementation science offer promising pathways forward. This paper underscores the dual necessity of advancing the scientific foundations of digital mental health and increasing its real-world applicability through five themes. First, we discuss recent technological advances in digital phenotyping, virtual reality, and generative artificial intelligence. Progress in this latter area, specifically designed to create new outputs such as conversations and images, holds unique potential for the mental health field. Given the spread of smartphone apps, we then evaluate the evidence supporting their utility across various mental health contexts, including well-being, depression, anxiety, schizophrenia, eating disorders, and substance use disorders. This broad view of the field highlights the need for a new generation of more rigorous, placebo-controlled, and real-world studies. We subsequently explore engagement challenges that hamper all digital mental health tools, and propose solutions, including human support, digital navigators, just-in-time adaptive interventions, and personalized approaches. We then analyze implementation issues, emphasizing clinician engagement, service integration, and scalable delivery models. We finally consider the need to ensure that innovations work for all people and thus can bridge digital health disparities, reviewing the evidence on tailoring digital tools for historically marginalized populations and low- and middle-income countries. Regarding digital mental health innovations as tools to augment and extend care, we conclude that smartphone apps, virtual reality, and large language models can positively impact mental health care if deployed correctly.

Key words: Digital mental health, smartphone apps, virtual reality, generative artificial intelligence, large language models, engagement, implementation science, depression, anxiety, schizophrenia, eating disorders, substance use disorders

(World Psychiatry 2025;24:156–174)

journal of family therapy

Journal of Family Therapy (2021) **43**: 169–184
doi: 10.1111/1467-6427.12336

Editorial

Digital approaches – a paradigm shift?

Frank Burbach and Helen Pote

Introduction

The COVID-19 pandemic has precipitated a rapid move online for systemic psychotherapists. Digital interventions have been necessary to provide healthcare in the context of increasing psychological distress. In parallel, the families we work with are renegotiating the role technology plays in their lives. For all of us, technology has become central to the many things we value because they support family functioning: employment, education, health, social support and social connection. Given this context the aim of this special edition is to explore systemic digital innovation. Is this move from Room to Zoom the start of a paradigm shift for systemic theory and practice?

For a decade prior to the pandemic there were signs that a 'digital revolution' in healthcare was on its way (NHS Long Term Plan, 2019; Topol Review, HEE, 2019), but in the field of mental health it was still in its infancy. The strongest research evidence for digital psychological therapy is for cognitive behavioural therapy (CBT) and psychoeducation-based interventions with people with mild to moderate mental health problems (Fairburn and Patel, 2017), but despite a growing evidence base, this had little impact on the delivery of psychological therapies in secondary care, specialist mental health services.

Digital Interventions for Psychosis

Professor Daniel Freeman and Dr Julia Jones, University of Oxford

Psychological Professions Week

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  - S

Digital interventions for psychosis: Feeling Safer and gameChange

Daniel Freeman and Julia Jones

Experimental Psychology
Medical Sciences Division

cap
oxford cognitive approaches to psychosis

NHS
Oxford Health
NHS Foundation Trust

A *face-to-face* six-month theory-driven psychological treatment for persecutory delusions.

Development process over a decade+

1. Establish a better understanding of the causes of persecutory delusions.
2. Develop a treatment for each causal factor.
3. Develop a better suited therapeutic style.
4. Test out each element (interventionist-causal approach).
5. Show each factor present and that patients would like each treated.
6. Work out how to combine each element effectively.
7. Test a full treatment in a case series.
8. Test in a randomised controlled trial against active control.

Throughout, work with people with lived experience.

Set of 30 booklets

Delivered by clinical psychologists:

- Average of 20hrs face-to-face contact
- Average of 6.5 sessions outside for behavioural tests
- Half of appointments home visits

Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial

Daniel Freeman, Richard Emsley, Rowan Diamond, Nicola Collett, Emily Bold, Eleanor Chadwick, Louise Isham, Jessica C Bird, Danielle Edwards, David Kingdon, Ray Fitzpatrick, Thomas Kabir, Felicity Waite, on behalf of the Oxford Cognitive Approaches to Psychosis Trial Study Group

Lancet Psychiatry 2021; 8: 696–707

Published Online July 8, 2021 https://doi.org/10.1016/S2215-0366(21)00158-9

See Comment page 644

Department of Psychiatry (Prof D Freeman DClinPsy, R Diamond DClinPsych, N Collett DClinPsych, E Bold BSc, E Chadwick DClinPsy, L Isham DClinPsy, J C Bird DClinPsych, F Waite DClinPsych) **and Nuffield Department of Population Health** (Prof R Fitzpatrick PhD), **University of Oxford, Oxford, UK; Oxford Health NHS Foundation Trust, Oxford, UK** (Prof D Freeman, R Diamond, N Collett, E Bold, E Chadwick, L Isham, J C Bird, F Waite); **Department of Biostatistics and Health Informatics, King's College London, Institute of Psychiatry, Psychology and Neuroscience, London, UK** (Prof R Emsley PhD, D Edwards DPhil); **Department of Clinical and Experimental Sciences, University of Southampton, Southampton, UK** (Prof D Kingdon MD); **McPin Foundation, London, UK** (T Kabir PhD)

Correspondence to: Prof Daniel Freeman, Department of Psychiatry, University of Oxford, Oxford OX3 7JX, UK **daniel.freeman@psych.ox.ac.uk**

Summary

Background There is a large clinical need for improved treatments for patients with persecutory delusions. We aimed to test whether a new theoretically driven cognitive therapy (the Feeling Safe Programme) would lead to large reductions in persecutory delusions, above non-specific effects of therapy. We also aimed to test treatment effect mechanisms.

Methods We did a parallel, single-blind, randomised controlled trial to test the Feeling Safe Programme against befriending with the same therapists for patients with persistent persecutory delusions in the context of non-affective psychosis diagnoses. Usual care continued throughout the duration of the trial. The trial took place in community mental health services in three UK National Health Service trusts. Participants were included if they were 16 years or older, had persecutory delusions (as defined by Freeman and Garety) for at least 3 months and held with at least 60% conviction, and had a primary diagnosis of non-affective psychosis from the referring clinical team. Patients were randomly assigned to either the Feeling Safe Programme or the befriending programme, using a permuted blocks algorithm with randomly varying block size, stratified by therapist. Trial assessors were masked to group allocation. If an allocation was unmasked then the unmasked assessor was replaced with a new masked assessor. Outcomes were assessed at 0 months, 6 months (primary endpoint), and 12 months. The primary outcome was persecutory delusion conviction, assessed within the Psychotic Symptoms Rating Scale (PSYRATS; rated 0–100%). Outcome analyses were done in the intention-to-treat population. Each intervention was provided individually over 6 months. This trial is registered with the ISRCTN registry, ISRCTN18705064.

Findings From Feb 8, 2016, to July 26, 2019, 130 patients with persecutory delusions (78 [60%] men; 52 [40%] women, mean age 42 years [SD 12·1, range 17–71]; 86% White, 9% Black, 2% Indian; 2·3% Pakistani; 2% other) were recruited. 64 patients were randomly allocated to the Feeling Safe Programme and 66 patients to befriending. Compared with befriending, the Feeling Safe Programme led to significant end of treatment reductions in delusional conviction (–10·69 [95% CI –19·75 to –1·63], p=0·021, Cohen's *d*=–0·86) and delusion severity (PSYRATS, –2·94 [–4·58 to –1·31], p<0·0001, Cohen's *d*=–1·20). More adverse events occurred in the befriending group (68 unrelated adverse events reported in 20 [30%] participants) compared with the Feeling Safe group (53 unrelated adverse events reported in 16 [25%] participants).

Interpretation The Feeling Safe Programme led to a significant reduction in persistent persecutory delusions compared with befriending. To our knowledge, these are the largest treatment effects seen for patients with persistent delusions. The principal limitation of our trial was the relatively small sample size when comparing two active treatments, meaning less precision in effect size estimates and lower power to detect moderate treatment differences in secondary outcomes. Further research could be done to determine whether greater effects could be possible by reducing the hypothesised delusion maintenance mechanisms further. The Feeling Safe Programme could become the recommended psychological treatment in clinical services for persecutory delusions.

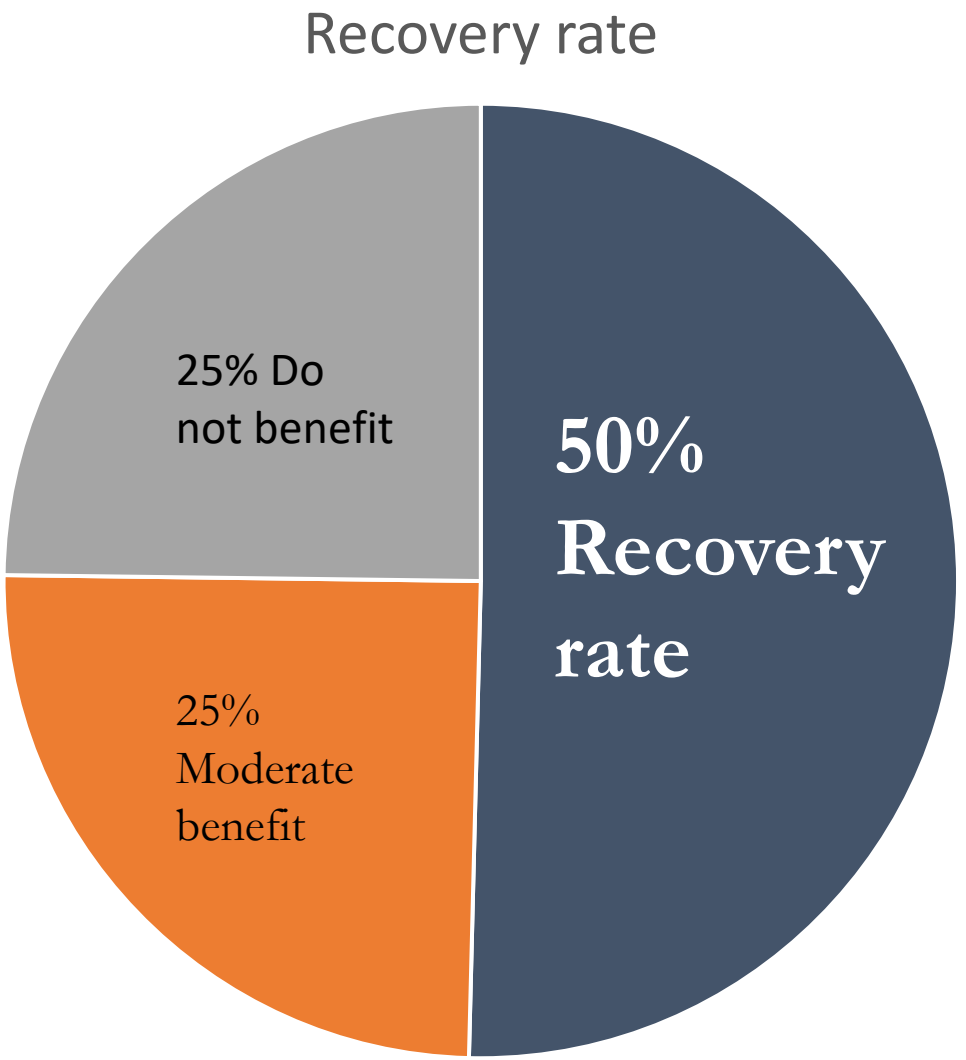
Funding NIHR Research Professorship and NIHR Oxford Health Biomedical Research Centre.

The effects on persecutory delusions

Total PSYRATS score	Cohen's d
Within group change at 6-months	2.8
Within group change at 12-months	2.8
Above alternative therapy (befriending) at 6-months	1.2
Above alternative therapy (befriending) at 12-months	0.9

Freeman, D., Emsley, R., Diamond, R., Collett, N., Bold, E., Chadwick, E., Isham, L., Bird, J., Edwards, D., Kingdon, D., Fitzpatrick, R., Kabir, T., Waite, F., & Oxford Cognitive Approaches to Psychosis Trial Study Group (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial. Lancet Psychiatry, 8, 696-707.

The persecutory delusions



What we want now

- Much greater access for patients to have *Feeling Safe*

- Even greater content coverage of the intervention

- Delivery possible from a wider number of staff groups, with less time taken

Programme Grants for Applied Research

NIHR | National Institute for Health and Care Research

Treating persecutory delusions successfully: enabling patients with psychosis to receive the most effective psychological therapy

2023-2027

Daniel Freeman, Felicity Waite, Louise Isham, Laina Rosebrock, Jason Freeman, Thomas Kabir, Alex Kenny, Kate Chapman, Stephanie Common, Robert Dudley, Tony Morrison, Gary Willington, Richard Emsley, Alison Brabban, Michael Larkin, José Leal, David Clark, Bradley Hall, Robbie Quested, Hollie Hymas, Alicia Ladbrook, Monalisa Bora-White, Jo Morris, Lucy Loftus, Lydia Penrose, Heather Peel, Eleanor Davey, Beth Cooper, Rory Byrne, Zobiya Choudhry, Samantha Bowe, Kathryn Wills, Katherine Watson, Harriet Wood, Zak Wootton, Lewis Marr, Gemma Williams, Miriam Kitchen, Rowan Diamond, Sinead Lambe, Eleanor Allen, Katie Elkes, Leah Mann, Cameron Hill, Alice Pyke, Memoona Ahmed, Niya Krasteva, Verity Westgate, Natalie Rouse, Hazel Kennedy.

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feeling safer

- A supported, expanded, customisable six-month online programme that patients can access whenever they choose via smartphone/computer/or tablet.
- A range of mental health workers (peer support workers, graduate workers, CBT therapists) can flexibly support the delivery of the treatment over six months.
- A certified medical device, extendable in content and localisable, developed with patients, staff, local community groups, UX designers, computer programmers, writers, animators, and our Oxford team.

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feeling safer

Patient and public involvement

- At the start, seven in-person group meetings held across the country to discuss opportunities, challenges, and preferences.
- 39 people with lived experience carried out a line-by-line review of the programme content.
- Lived Experience Advisory Panel (LEAP) and wider involvement network suggested and wrote a 'Bad Day' section.
- Iterative user testing during development phase led to very high usability ratings.
- To date, 67 people with lived experience have contributed over 400 hours of input.
- New programme development grant working on inclusion further.

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feeling safer

Security

- Azure-hosted database, which is encrypted at rest by default. Data in transit are protected by the use of Transport Layer Security 1.2 or higher.
- Azure Active Directory (AD) authentication to prevent unauthorized access. Access requires two-factor authentication.
- Nightly automated checks and weekly monitoring of firewall logs and system logs.
- Every three months there is internal penetration testing; manual inspection of the software to identify potentially vulnerable components; review of the cryptographic art to identify if any cyphers have become vulnerable.
- Annual external penetration testing.
- Designed to meet the requirements of the Organization for the Review of Care and Health Apps (ORCHA), which examines compliance with standards, guidelines, and best practice.

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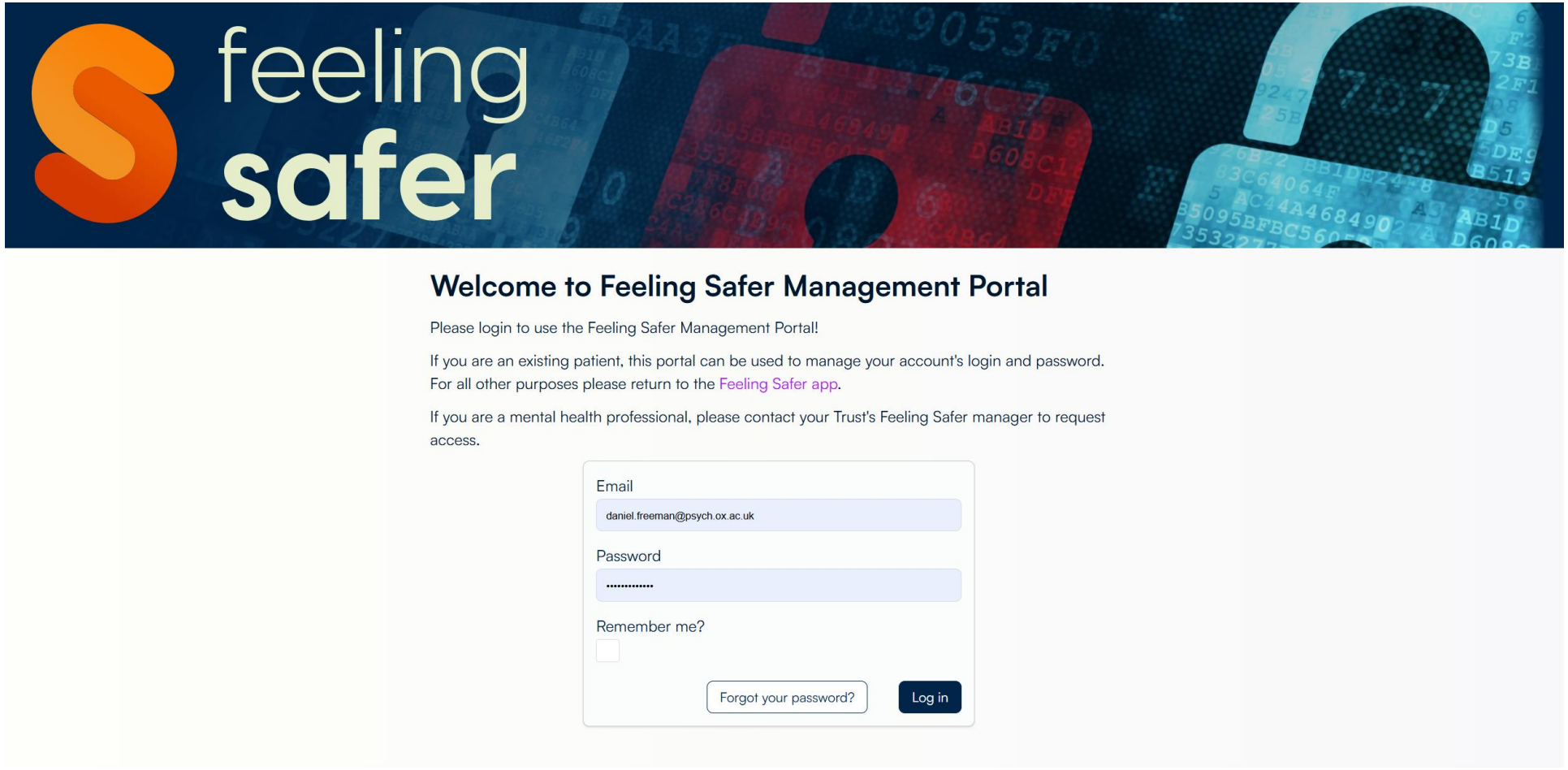
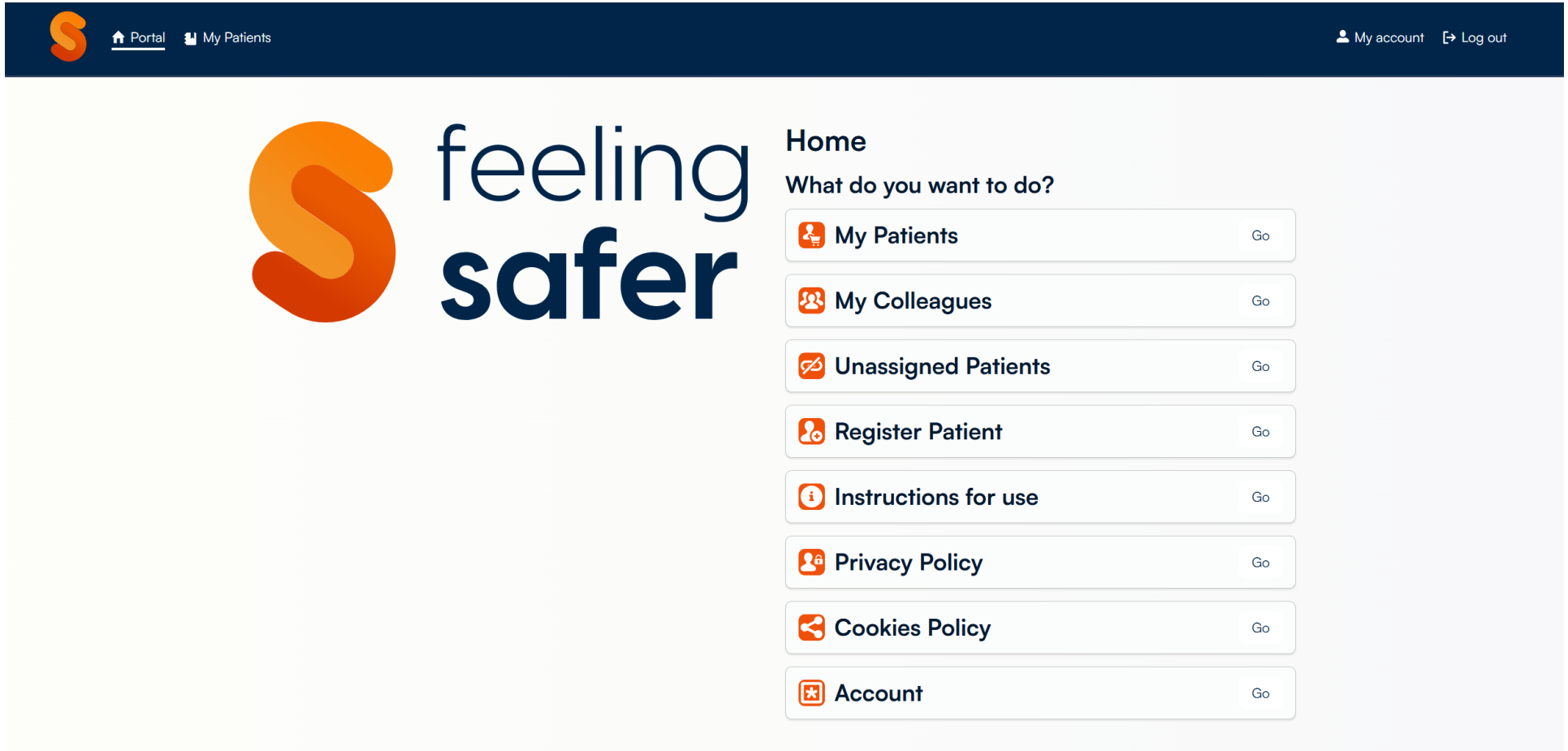
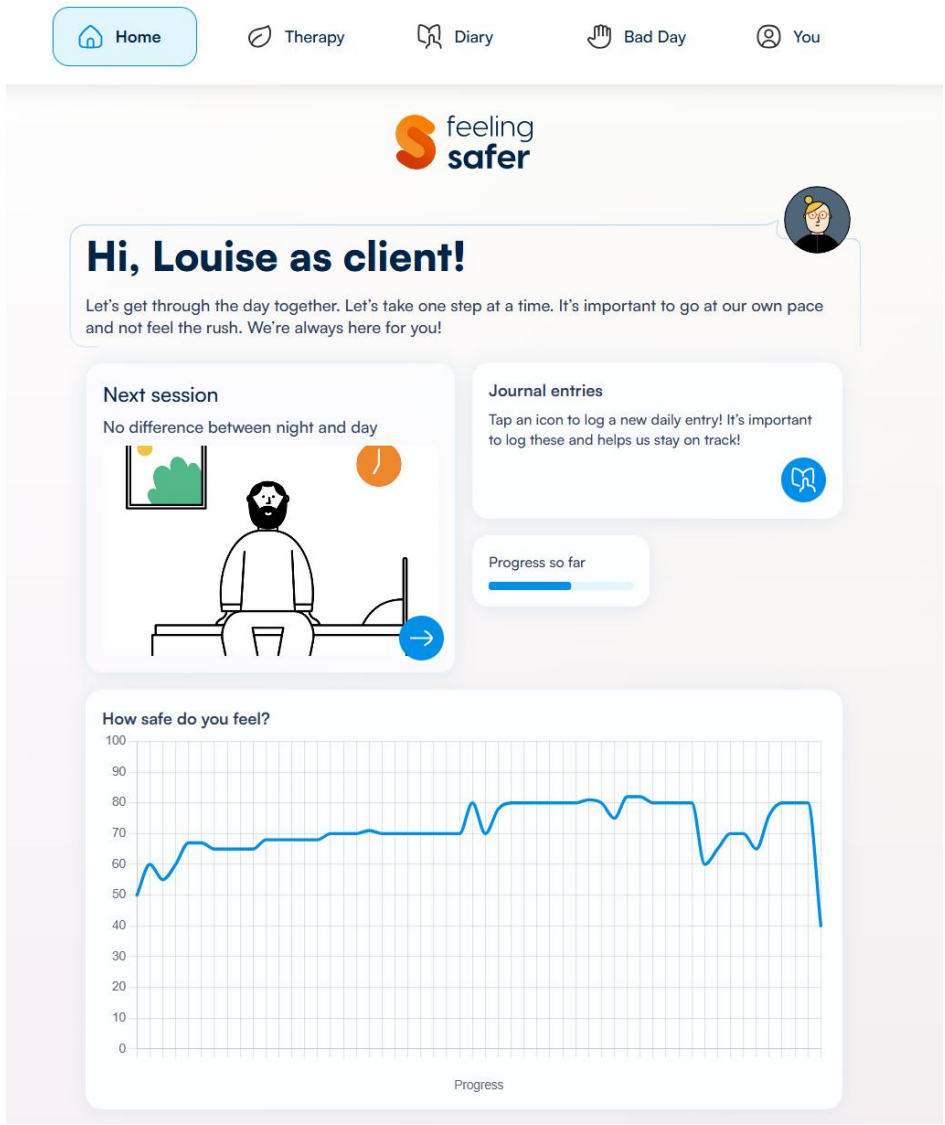
1. Administrator management



2. Mental health staff portal



3. Patient programme



Patient Reflection

Does *Feeling Safer* work?

To proceed with an RCT, we needed to demonstrate a pre-post effect size of at least Cohen’s d=0.6.

Psychological Medicine

www.cambridge.org/psm

A 6-month supported online program for the treatment of persecutory delusions: Feeling Safer

Daniel Freeman[1,2], Louise Isham[1,2], Jason Freeman[1], Laina Rosebrock[1,2], Thomas Kabir[1,3], Alex Kenny[4], Rowan Diamond[1,2], Ariane Beckley[1], Natalie Rouse[1], Memoona Ahmed[1], Felicity Hudson[1], Glory Sokunle[1] and Felicity Waite[1,2]

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Original Article

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cognitive therapy; digital intervention; persecutory delusions; psychosis; schizophrenia

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Abstract

Background. Based on an efficacious face-to-face theory-driven psychological therapy for persecutory delusions in the context of psychosis, we set out to develop a scalable guided 6-month online program. The aim was an intervention that patients can easily access and use, produces large clinical effects, and can be supported by a range of mental health professionals in less contact time than face-to-face therapy. We report here the proof-of-concept testing. At least moderate-sized clinical effects were required to progress to a randomized controlled trial (RCT).

Methods. In the 6-month Feeling Safer online program, a certified medical device, patients complete a brief assessment and then are provided with up to 10 modules that match their difficulties. Regular remote meetings with a mental health professional also take place. These may be supplemented by in-person visits. A pre- to post-treatment cohort trial was conducted with 14 patients with persistent persecutory delusions. The primary outcome was the Psychotic Symptoms Rating Scale (PSYRATS)-Delusions.

Results. Satisfaction and usability ratings of the program were high. Very large reductions in persecutory delusions were observed (PSYRATS mean reduction = 7.1, 95% C.I. = 3.4, 10.8, n = 13, Cohen's d = 3.0). There were large improvements in paranoia, anxiety, depression, agoraphobic distress, psychological wellbeing, meaningful activity, personal recovery, recovering quality of life, and moderate improvements in insomnia, agoraphobic avoidance, and quality of life.

Conclusions. The clinical effects associated with Feeling Safer were very high, comparable to those seen in the evaluations of the face-to-face therapy, and enable progression to an RCT.

Assessment	Baseline		End of intervention		Paired samples t-tests		
	n	Mean (SD)	n	Mean (SD)	Mean difference	95% confidence intervals	Effect size (Cohen's *d*)
Primary outcome							
Persecutory delusion severity (PSYRATS)	14	18.6 (2.4)	13	11.5 (5.5)	7.1	3.4, 10.8	3.0
Secondary outcomes							
Conviction in the persecutory delusion (0–100%)	14	83.9 (13.0)	13	44.2 (36.0)	38.8	17.1, 60.5	3.0
Paranoia: reference (R-GPTS Part A)	14	19.4 (8.8)	12	10.6 (11.0)	8.3	1.5, 15.2	1.1
Paranoia: persecution (R-GPTS Part B)	14	31.3 (7.6)	12	16.3 (14.5)	13.8	4.3, 23.4	1.8
Depression (PHQ–9)	14	16.9 (4.9)	13	11.2 (7.1)	5.6	1.4, 9.8	1.1
Anxiety (GAD–7)	14	16.1 (4.3)	13	10.5 (6.4)	5.5	1.9, 9.1	1.3
Insomnia (ISI)	14	11.1 (8.0)	13	9.5 (8.6)	1.5	−2.7, 5.8	0.6
Agoraphobic avoidance (O-AS)	14	2.4 (2.5)	12	1.1 (2.1)	1.5	−0.07, 3.1	0.6
Agoraphobic distress (O-AS)	14	43.2 (24.4)	12	25.2 (23.6)	18.4	−0.9, 37.7	0.8
Psychological well-being (WEMWBS)	14	33.6 (8.4)	13	43.1 (10.3)	8.4	4.5, 12.3	1.0
Personal recovery (process of recovery questionnaire)	14	23.4 (11.7)	12	36.5 (14.3)	12.8	5.4, 20.1	1.1
Meaningful activity (time budget)	14	54.1 (13.6)	9	70.0 (16.1)	14.1	4.2, 24.0	1.0
Quality of life (EQ–5D-L index)	14	0.58 (0.27)	13	0.71 (0.28)	0.13	−0.04, 1.68	0.5
Quality of life (EQ–5D-L) – Health Today	14	38.7 (24.1)	13	54.6 (27.3)	13.1	2.4, 23.8	0.5
Quality of life (ReQol)	14	28.7 (16.2)	12	45.2 (18.0)	14.8	6.4, 23.1	0.9

BMJ Open

Efficacy of a 6-month supported online programme (Feeling Safer) for the treatment of persecutory delusions: protocol for a randomised controlled trial

Daniel Freeman ,[1,2] Richard Emsley,[3,4] Laina Rosebrock,[1,2] Anthony Morrison,[5] Kate Chapman,[6] Stephanie Common,[7] Robert Dudley,[8,9] Louise Isham,[1,2] Thomas Kabir,[1,10] Alex Kenny,[11] Jason Freeman,[1] Ariane Beckley,[1] Verity Westgate,[1] Natalie Rouse,[1] José Leal,[12] Megan McGovern,[3] Felicity Waite[1,2]

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ABSTRACT

Introduction Persecutory delusions are very common in severe mental health disorders such as schizophrenia. Existing treatments often do not work well enough. We developed a face-to-face theory-driven psychological intervention, called Feeling Safe, that produces very large reductions in persistent persecutory delusions. The challenge now is to make Feeling Safe widely available. So, we developed a 6-month supported online version, called Feeling Safer. The aim is an intervention that patients can easily access and use, reduces persecutory delusions and can be supported by a range of mental health professionals in less contact time than face-to-face therapy. Initial proof of concept testing of Feeling Safer was very encouraging. In a randomised controlled trial, we now plan to test whether Feeling Safer is efficacious for patients and can be successfully delivered by any of three different mental health staff groups (peer-support workers, graduate psychologists and cognitive behavioural therapy (CBT) therapists). We will also test whether Feeling Safer works equally across gender, age, ethnicity and cognitive functioning (moderation) and whether Feeling Safer works via the targeted psychological processes (mediation).

Methods and analysis The study design is a multicentre, single-blind (outcome assessor), parallel, four-arm randomised controlled trial; 484 patients with persistent persecutory delusions will be randomised to one of the four conditions (1:1:1:1): Feeling Safer (added to treatment as usual (TAU)) supported by peer-support workers, or Feeling Safer (added to TAU) supported by graduate mental health workers including assistant psychologists, or Feeling Safer (added to TAU) supported by CBT therapists or TAU. Feeling Safer will be provided for 6 months with a staff member. Assessments will be conducted at 0, 3, 6 and 9 months by research assistants blind to group will be conducted under a treatment policy strategy following the intention-to-treat principle, incorporating data from all participants including those who do not complete treatment. Moderation and mediation will be tested. A within-trial cost-effectiveness analysis will be conducted of Feeling Safer compared with TAU.

Ethics and dissemination The trial has received ethical approval from the NHS Health Research Authority (23/LO/0951). Informed consent will be obtained from all participants. A key output will be an open-access publication in a peer-reviewed journal reporting on the clinical effectiveness of a high-quality supported online programme for the treatment of persecutory delusions that has the potential to be used at scale in mental health services.

Trial registration number ISRCTN93974770.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A supported online programme (Feeling Safer) is a means to provide access to evidence-based efficacious psychological therapy to many more people with psychosis.
⇒ This is a four-arm randomised controlled trial that will provide separate estimates of the treatment effects of Feeling Safer when it is supported by each of three different mental health staff groups.
⇒ Moderation, mediation and cost-effectiveness analyses are built into the trial design.
⇒ The trial will not be able to determine the components of Feeling Safer that lead to clinical benefits.
⇒ The trial is only powered to detect moderate improvements with treatment in persecutory delusions.

feeling safer

All mental health trusts can potentially participate

- Assessments and therapy can be delivered virtually by our team.
- Three-quarters of patients in the trial receive Feeling Safer.
- Need trusts willing to identify potentially suitable patients and we can work closely with the clinical teams.

NHS Oxford Health NHS Foundation Trust

cap oxford cognitive approaches to psychosis

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PPN Psychological Professions Network

NHS

gameChange
Improving lives through VR therapy

A Virtual Reality Therapy for People with Psychosis

Professor Daniel Freeman and Dr Julia Jones
The University of Oxford, and Oxford Health NHS Foundation Trust

University of Oxford

Experimental Psychology
Medical Sciences Division

cap
oxford cognitive approaches to psychosis

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gameChange
Improving lives through VR therapy

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Oxford Daniel Freeman, Sinéad Lambe, Ariane Petit, Laina Rosebrock, Ly-Mee Yu, Ushma Galal, Jenna Grabey, Aitor Rovira, David M. Clark, Felicity Waite, James Altunkaya, Emily Bold, Jason Freeman, John Geddes, Andrew Goodsell, Lucy Jenner, José Leal, Joanna Mitchell, Lydia Carr, Chiara Causier, Anna East, Miriam Kirkham, Sapphira McBride, Sophie Mulhall, Simone Saidel, Megan Smith, Ashley-Louise Teale, Eve Twivy, Poppy Brown, Nick Raven, Bill Wells, Aiden Loe.	**McPin Foundation** Thomas Kabir, Humma Andleeb, Jessica Bond, Alex Kenny, Tillie Cryer, Dan Robotham, Lisa Couperthwaite, Vanessa Pinfold. **Lived Experience Advisory Group** Including Debbie Butler, Susie Booth, Len Demetriou, Zach Howarth, Mary Mancini, Cheryl Williams, and Christopher Wright. **Aston** Michael Larkin.
Bristol Kate Chapman, Rosie Powling, Genevieve Quartey, Kira Williams, Charlotte Way, Eva Roberts, Harry Walker.	**Oxford VR** Deepak Gopalakrishna, Mike Desjadon, Samantha Lawson, and many programmers and 3D visual artists, including Rupert Ward, Andrew Forster, Emily Cheung, Benn Garnish, Hany Gohary.
Newcastle Robert Dudley, Charlotte Aynsworth, Maryam Pervez, Naomi Coulthard, Kelly Grieve, Negar Khozoee, Robert Nirsimloo, Lyndsey Tunney.	**NIHR MindTech** Jennifer Martin, Chris Hollis, Michael Craven, Susan Brown, Aislinn Bergin.
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Royal College of Art Jonathan West, Ed Matthews, Indira Knight, Paul Eliasz.	**Data Monitoring and Ethics Committee** David Kingdon, Issy Reading, Tom Craig, Andrew Gumley.

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NHS Greater Manchester Mental Health NHS Foundation Trust
NHS Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
NHS Nottinghamshire Healthcare NHS Foundation Trust
NHS Oxford Health NHS Foundation Trust

“To transform mental health services for patients with psychosis by showing that automated psychological therapy using VR can be scaled up to provide a powerful psychological treatment that changes lives.”

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gameChange VR therapy aims to help people with psychosis feel safer, more confident, and in control in everyday situations.

Psychological Professions Week

1. Clear treatment target and principles
2. Collaborative design approach.
3. Clinical testing

LEAP

gameChange
Improving lives through VR therapy

Psychological Professions Week

1. Treatment target and principles

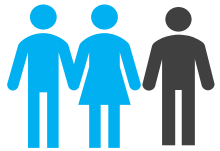
Impact of agoraphobic avoidance

Psychological Professions Week

Treatable clinical intervention targets for patients with schizophrenia

Daniel Freeman, Kathryn M. Taylor, Andrew Molodynski, Felicity Waite

In a survey of 1809 patients with non-affective psychosis attending NHS mental health services, it was found that two thirds of patients experienced anxious avoidance at agoraphobic levels.



"Simple things like going to the shop seem impossible. I was too anxious. I just withdrew into myself. Stopped seeing people. Life got very small. You feel very alone."

gameChange participant

Understanding agoraphobic avoidance in psychosis

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Cognitions

- 70% People will judge me negatively
- 69% I will panic
- 67% Everyone will watch me.
- 55% I will fail
- 52% I will be rejected
- 48% People will laugh at me
- 47% I will embarrass myself.
- 47% I won't be able to cope with the voices.
- 41% I will lose control
- 40% People will try to upset me
- 33% People will harm me physically
- 32% Voices will harm me

Defences

- 81% When out, I ido everything as quickly as possible.
- 69% When out, I kept my distance from others
- 66% I avoided making eye contact.
- 65% I watched out for signs of danger
- 62% I listened out for signs of danger
- 61% I spent excessive time thinking about what bad things might happen.
- 47% I left as soon as I felt anxious
- 41% I only went out if someone I knew was with me.
- 53% I scanned faces for signs of judgement.
- 44% I formed an escape plan

Treatment principles

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Enter feared situations

Drop defences

Build new memories

Advantages of using virtual reality

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- People are much more willing to do things they wouldn't do in real life
- People can take it at their own pace
- Can repeatedly be immersed in graded fashion
- Automation means we can substantially increase access to high quality psychological treatment
- Fun and engaging

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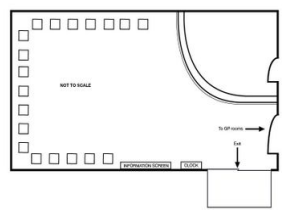
2. Collaborative design approach

Person centred design

gameChange design brief

- Three hours of novel VR experiences
- Graded levels of difficulty
- Drop defences and test beliefs.
- Automated through a virtual coach.

Scenario design



Tasks

	CAFE	PUB	BUS	WAITING ROOM	FOOD SHOP	STREET
Make a request/ order	✓			✓		
Stay in situation	✓	✓	✓	✓	✓	✓
Give personal information				✓		
Unexpected event/ erratic behaviour		✓				
People all looking towards you			✓	✓		✓
Trapped / shut in	✓		✓			
Find an item					✓	
Transition from safe place to unknown						✓
Open/ exposed place			✓			✓
Awkwardly quiet				✓		

User testing

		Usability testing 1 (pre-completion) (n=5)		Usability testing 2 (post-completion) (n=6)	
		Easy	Difficult	Easy	Difficult
1.	Knowing what to do in any given VR situation was…	2	3	6	0
2.	Understanding the coach's instructions was...	4	1	6	0
3.	Carrying out an action (for example, use the confidence rating scale, burst the bubbles) was….	5	0	6	0
4.	Using the circles to move through the program was….	5	0	6	0
5.	Learning what to do and how to do it was…	4	1	6	0
6.	Remembering how to do things a second time was…	5	0	6	0
		Agree	Disagree	Agree	Disagree
7.	When using the VR, I felt like I was in the situation.	3	2	6	0
8.	When other people were there in the VR, I felt like I was sharing the space with them.	4	1	6	0
9.	I enjoyed using the treatment	3	2	6	0
10.	The VR made me feel sick	1	4	0	6

Design Process: Patient Involvement

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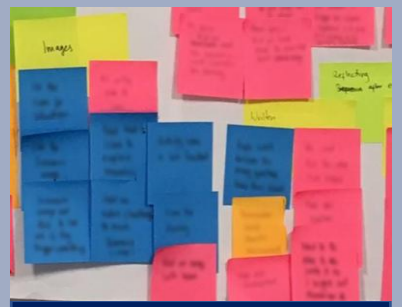
Choose scenarios



Select tasks

Test prototypes

User testing

Over 100 people with psychosis provided 500+ hours of input.

CE

Class I active medical device
(device code Z301)

gameChange delivery

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- 6 (+/-2) sessions with ~30 mins in VR.
- Delivered at home or in an NHS base.
- Supported by different members of staff.
- Real world practice set each session.

Six everyday scenarios

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Street

Shop

Bus

Coffee Shop

GP Waiting Room

Pub

Psychological Professions Week

3. Clinical Testing

Multi-site RCT

Psychological Professions Week

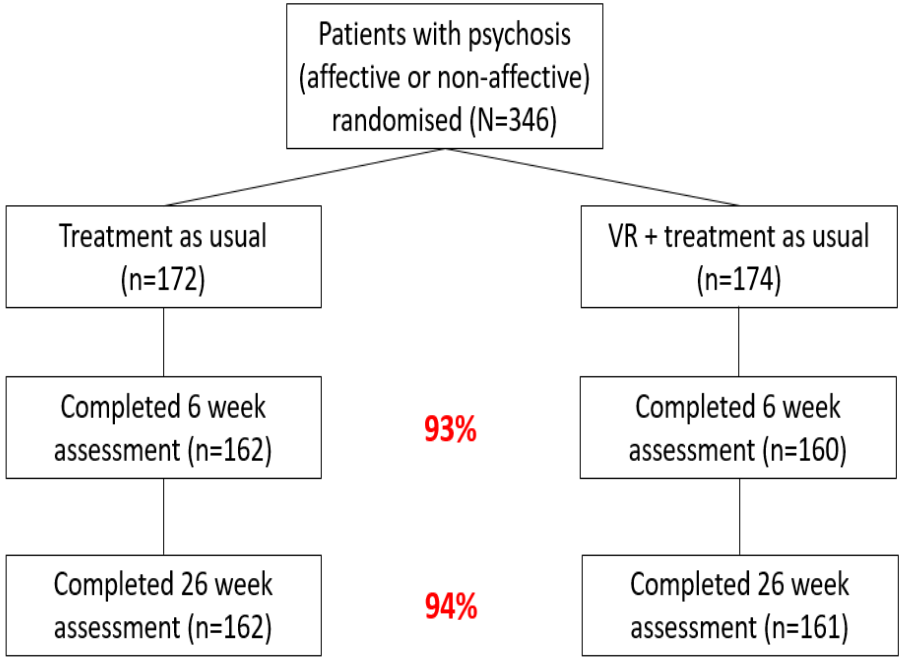
Automated virtual reality therapy to treat agoraphobic avoidance and distress in patients with psychosis (gameChange): a multicentre, parallel-group, single-blind, randomised, controlled trial in England with mediation and moderation analyses

Summary

Background Automated delivery of psychological therapy using immersive technologies such as virtual reality (VR) might greatly increase the availability of effective help for patients. We aimed to evaluate the efficacy of an automated VR cognitive therapy (gameChange) to treat avoidance and distress in patients with psychosis, and to analyse how and in whom it might work.

Methods We did a parallel-group, single-blind, randomised, controlled trial across nine National Health Service trusts in England. Eligible patients were aged 16 years or older, with a clinical diagnosis of a schizophrenia spectrum disorder or an affective diagnosis with psychotic symptoms, and had self-reported difficulties going outside due to anxiety. Patients were randomly assigned (1:1) to either gameChange VR therapy plus usual care or usual care alone, using a permuted blocks algorithm with randomly varying block size, stratified by study site and service type. gameChange VR therapy was provided in approximately six sessions over 6 weeks. Trial assessors were masked to group allocation. Outcomes were assessed at 0, 6 (primary endpoint), and 26 weeks after randomisation. The primary outcome was avoidance of, and distress in, everyday situations, assessed using the self-reported Oxford Agoraphobic Avoidance Scale (O-AS). Outcome analyses were done in the intention-to-treat population (ie, all participants who were assigned to a study group for whom data were available). We performed planned mediation and moderation analyses to test the effects of gameChange VR therapy when added to usual care. This trial is registered with the ISRCTN registry, 17308399.

Findings Between July 25, 2019, and May 7, 2021 (with a pause in recruitment from March 16, 2020, to Sept 14, 2020, due to COVID-19 pandemic restrictions), 551 patients were assessed for eligibility and 346 were enrolled. 231 (67%) patients were men and 111 (32%) were women, 294 (85%) were White, and the mean age was 37·2 years (SD 12·5). 174 patients were randomly assigned to the gameChange VR therapy group and 172 to the usual care alone group. Compared with the usual care alone group, the gameChange VR therapy group had significant reductions in agoraphobic avoidance (O-AS adjusted mean difference −0·47, 95% CI −0·88 to −0·06; n=320; Cohen's d −0·18; p=0·026) and distress (−4·33, −7·78 to −0·87; n=322; −0·26; p=0·014) at 6 weeks. Reductions in threat cognitions and within-situation defence behaviours mediated treatment outcomes. The greater the severity of anxious fears and avoidance, the greater the treatment benefits. There was no significant difference in the occurrence of serious adverse events between the gameChange VR therapy group (12 events in nine patients) and the usual care alone group (eight events in seven patients; p=0·37).



The trial questions and results

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DOES IT WORK?

HOW DOES IT WORK?

WHO DOES IT WORK FOR?

- ✓ Significant reductions in agoraphobic avoidance and distress in everyday situations.
- ✓ Reductions in threat cognitions and within-situation defence behaviours mediated treatment outcomes.
- ✓ Greatest benefits was for those with the severest symptoms.
- ✓ Sustained improvements at 6-months.
- ✓ Popular, high satisfaction rates, minimal side effects and no adverse events related to the intervention
- ✓ Cost-effective

Future directions

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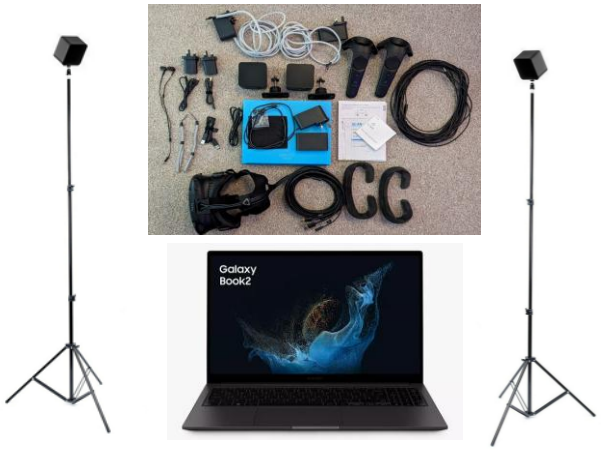
- Advances in technology reduced cost, staff training, and delivery time.
- New tech facilitates flexible methods of delivery.
- Can be used in the NHS while more evidence is generated



...and Now NICE EVA Approved for Use NHS

gameChange VR – NHS roll out

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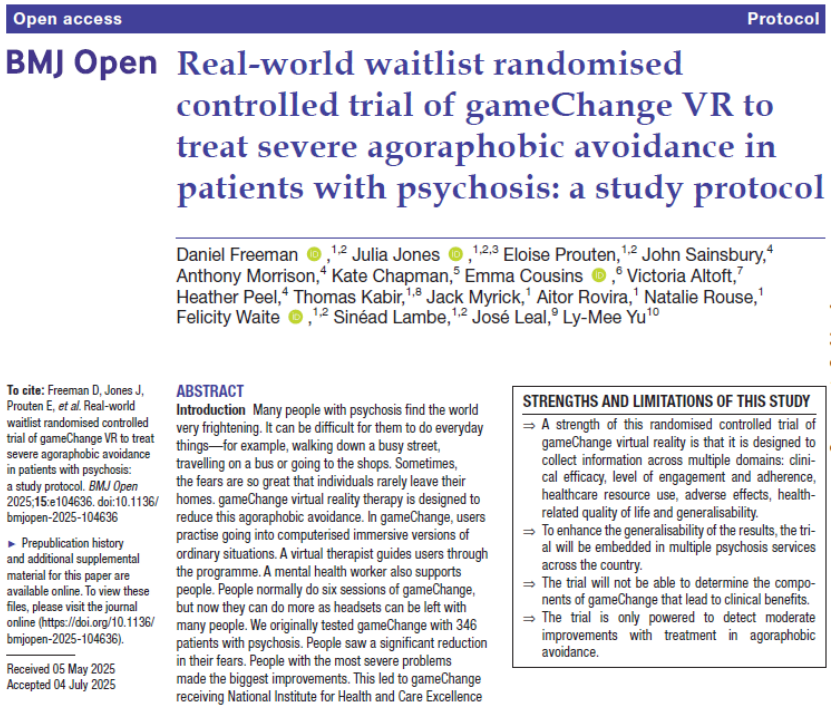

Open access Protocol

BMJ Open

Real-world waitlist randomised controlled trial of gameChange VR to treat severe agoraphobic avoidance in patients with psychosis: a study protocol

Daniel Freeman [1,2] Julia Jones [1,2,3] Eloise Prouten,[1,2] John Sainsbury,[4] Anthony Morrison,[4] Kate Chapman,[5] Emma Cousins [6] Victoria Altoft,[7] Heather Peel,[4] Thomas Kabir,[1,8] Jack Myrick,[1] Aitor Rovira,[1] Natalie Rouse,[1] Felicity Waite [1,2] Sinéad Lambe,[1,2] José Leal,[9] Ly-Mee Yu[10]

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► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2025-104636).

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ABSTRACT

Introduction Many people with psychosis find the world very frightening. It can be difficult for them to do everyday things—for example, walking down a busy street, travelling on a bus or going to the shops. Sometimes, the fears are so great that individuals rarely leave their homes. gameChange virtual reality therapy is designed to reduce this agoraphobic avoidance. In gameChange, users practise going into computerised immersive versions of ordinary situations. A virtual therapist guides users through the programme. A mental health worker also supports people. People normally do six sessions of gameChange, but now they can do more as headsets can be left with many people. We originally tested gameChange with 346 patients with psychosis. People saw a significant reduction in their fears. People with the most severe problems made the biggest improvements. This led to gameChange receiving National Institute for Health and Care Excellence

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ A strength of this randomised controlled trial of gameChange virtual reality is that it is designed to collect information across multiple domains: clinical efficacy, level of engagement and adherence, healthcare resource use, adverse effects, health-related quality of life and generalisability.
⇒ To enhance the generalisability of the results, the trial will be embedded in multiple psychosis services across the country.
⇒ The trial will not be able to determine the components of gameChange that lead to clinical benefits.
⇒ The trial is only powered to detect moderate improvements with treatment in agoraphobic avoidance.

- A real-world study of gameChange used in the NHS to treat severe agoraphobic avoidance in the context of psychosis

- A multi-centre two-arm waitlist randomised controlled trial across seven NHS sites.
  - Bristol, Cornwall, Gloucestershire, Humber, Manchester, West Midlands, and Oxford.

- Recruitment target 200

FUNDED BY
NIHR | National Institute for Health and Care Research

gameChange
Improving lives through VR therapy

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gameChange

Improving lives through VR therapy

Thank you!

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Psychological Professions Week

Digital Front Door – Experiences of Implementing Artificial Intelligence in Talking Therapies

Dr John Pimm and Dr Jo Ryder - Oxford Health

Oxfordshire Talking Therapies

Buckinghamshire Talking Therapies

Digital front doors: Implementing Limbic AI in Talking Therapies - Clinician Perspectives

Dr John Pimm and Joanne Ryder

Associate Directors of Psychological Professions (Buckinghamshire and Oxfordshire NHS Talking Therapies)

Annette O'Toole CBT Therapist, EMDR Practitioner, **Step 3 Team Lead** NHS Buckinghamshire Talking Therapies

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Charlie Stride CBT Therapist, City Locality and Digital Lead, NHS Oxfordshire Talking Therapies

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Oxfordshire Talking Therapies

NHS Talking Therapies

Buckinghamshire Talking Therapies

- For people with depression and/or anxiety who may also have comorbid Long-term physical health conditions (LTC)
- NICE recommended, evidence-based psychological therapies at the appropriate dose
- Stepped care
- Appropriately trained and supervised workforce
- Routine clinical outcome measure
- Integrated employment advice service

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Oxfordshire Talking Therapies

Combined BTT & OTT data April 2024 – March 2025

Buckinghamshire Talking Therapies

Total number of referrals	30,094
Total number of appointments for the year	219,250
Total number of step ups to AMHT/CMHTs	1.28%
Percentage of patients with severe anxiety &/or depression presentations	66.44%
Percentage of patient with risk	42.27%
Percentage of patients with LTC	38.14%
Percentage of ECDC	27.96%
Percentage of 65+	9.81%

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Oxfordshire Talking Therapies

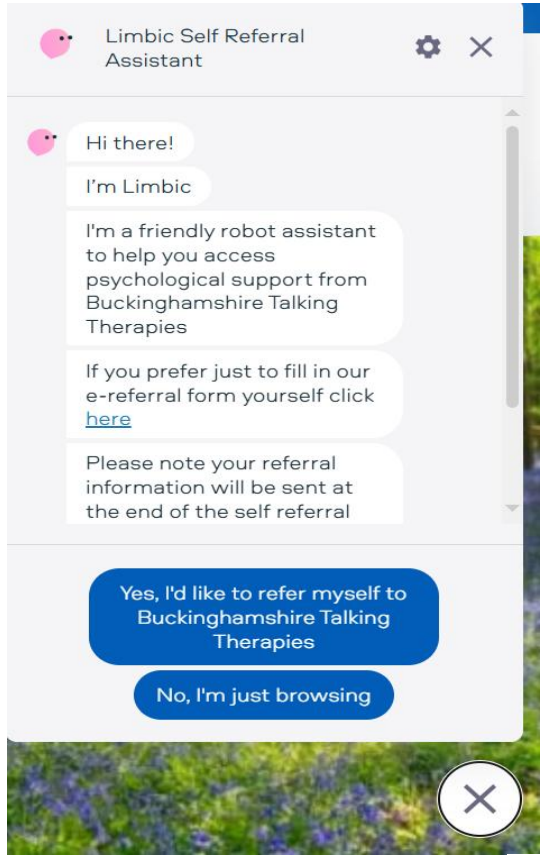
Buckinghamshire Talking Therapies

Limbic Access

- Limbic Access is a conversational Artificial Intelligence (AI) chatbot which is 'pre-programmed' with a clinical safety layer i.e.: the service sets the questions and the AI functionality responds to the answers to these questions within agreed parameters.

- The chatbot helps people access mental health support in Buckinghamshire Talking Therapies (BTT) and Oxfordshire Talking Therapies (OTT) and a large number of other TT services.

- NICE HealthTech guidance digital front door technologies to gather service user information for NHS TT (July 2025).



NHSTalking Therapies - for anxiety and depression Limbic Chatbot

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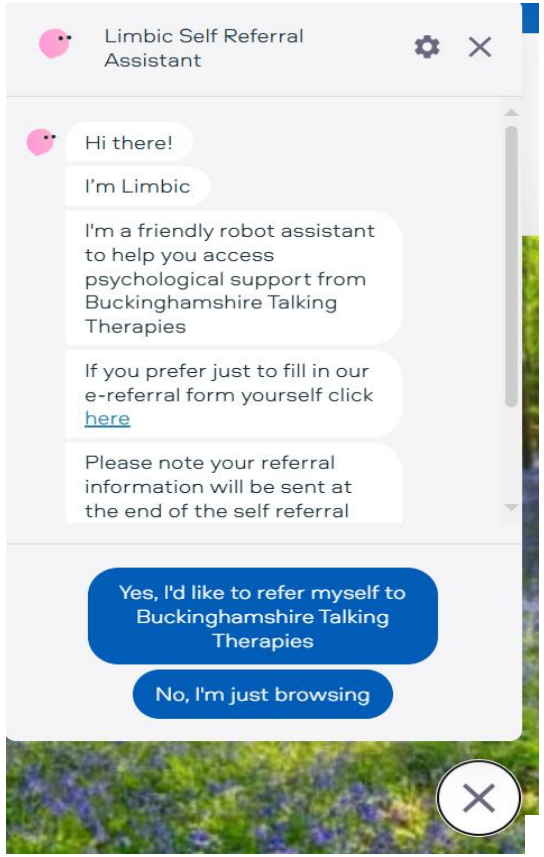
Oxfordshire Talking Therapies

Buckinghamshire Talking Therapies

Limbic Access:

- Collect **Patient demographics** and check the spine for eligibility/accuracy.
- Screen for immediate **risk** and **signpost** to crisis services if relevant
- Collect presenting problem and other **clinical information** (e.g. treatment history, long term conditions, perinatal, veteran, medication, substance use, employment, next of kin, etc.)
- Complete all the relevant **Questionnaires**, including the disorder specific ones if indicated (e.g. the PTSD measure – PCL5)
- Patients can then **choose and book** their initial appointment



NHSTalking Therapies - for anxiety and depression Limbic Chatbot

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Limbic Access: Opportunities and Risks

Opportunities	Risks
Time saving: Information gathered presented to clinician prior to the appointment	General **worries about** the **security** of AI systems
Person centred contact: allowing for more time in the assessment to talk about the presenting problem and the treatment options available	The potential for **errors**
Fully integrated: Information provided by patient automatically populated on the PCMIS patient record management system	Will it replace humans – **people will lose their jobs**
High patient satisfaction rate	**Increasing inequalities -** digital poverty

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Limbic Implementation Considerations in OHFT

- Rationale for use of AI tools
- Identifying and meeting with potential providers
- Procurement process
- Clinical safety
- Information Governance
- IM&T/Clinical Systems
- Development and testing of the OHFT Limbic tool
- Development of Limbic SOP
- Clinical Governance
- Communication internal and external
- Training of staff
- Launch (Little Bot and Big Bot)

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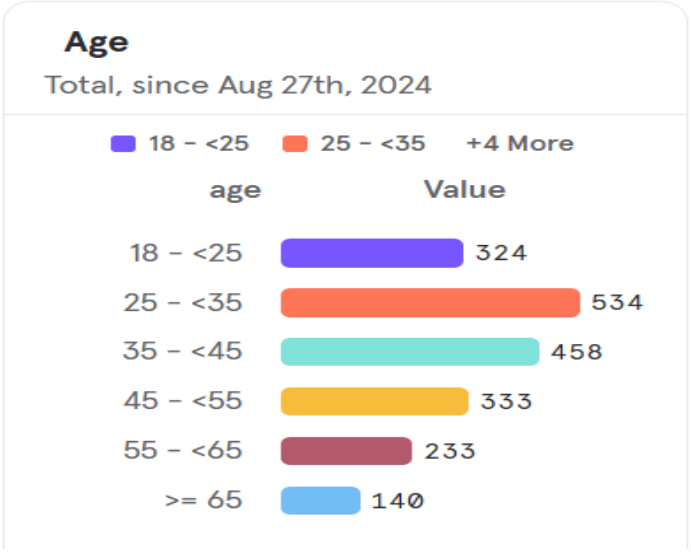
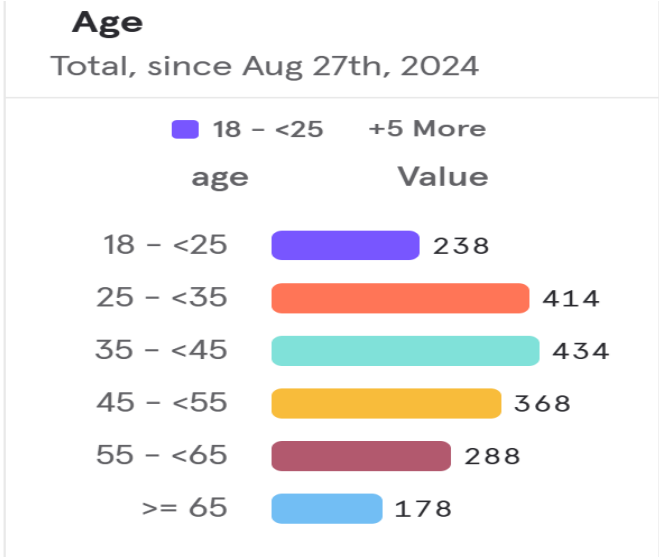
OTT Limbic Access (27/08/24 – 28/10/25)

- **20,378** TOTAL OTT referrals
- **2,107** Limbic referrals i.e.: 10% of total referrals
- **1,572 of 1,677** stated Limbic was helpful (94%)
- **828** out of office hours
- **84** required urgent support and was signposted
- **38** out of area and provided with details of local NHS TT service
- **46** underage and signposted to CAMHS



BTT Limbic Access (27/08/24 – 28/10/25)

- **17,325** Total BTT referrals
- **1,925** Limbic referrals i.e.: 11% of total referrals
- **1,460 of 1,541** stated Limbic was helpful (94%)
- **759** out of office hours
- **73** required urgent support and was signposted
- **58** out of area and provided with details of local NHS TT service
- **37** underage and signposted to CAMHS



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Initial Quick Time observations

- **Problem descriptor –** Limbic identifying higher proportion of PTSD.
- **Gender –** slightly higher proportion of males using Limbic
- **Ethnicity –** no major differences in use of Limbic between White British and ECDC
- **LTC –** people with some LTCs choosing Limbic more
- **Age –** higher proportion of 35+ using Limbic, compared to under 35s

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Limbic Referrals by Month

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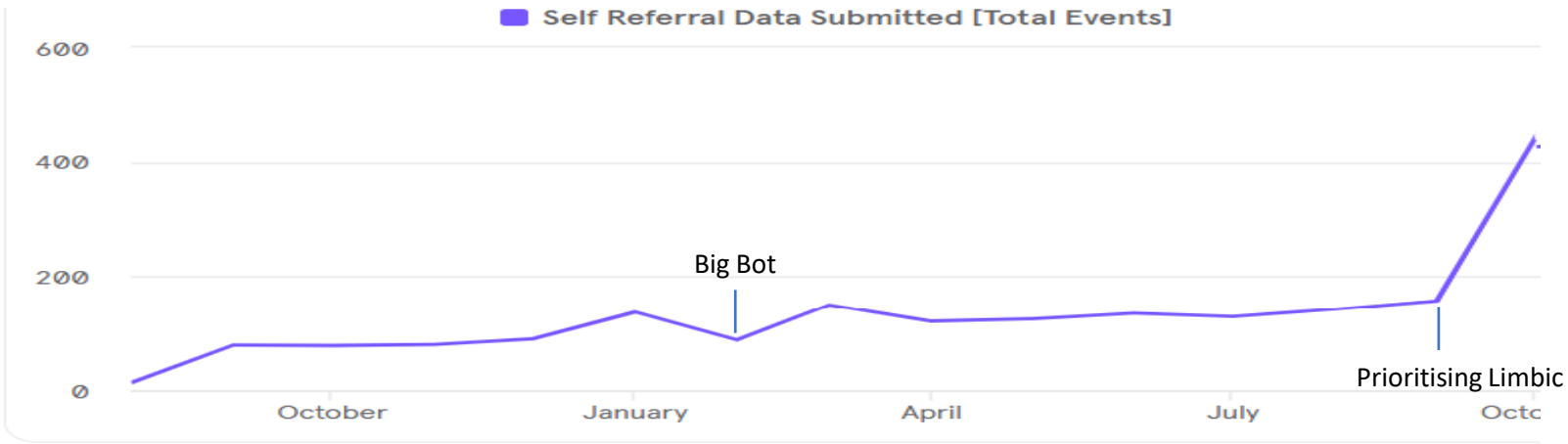
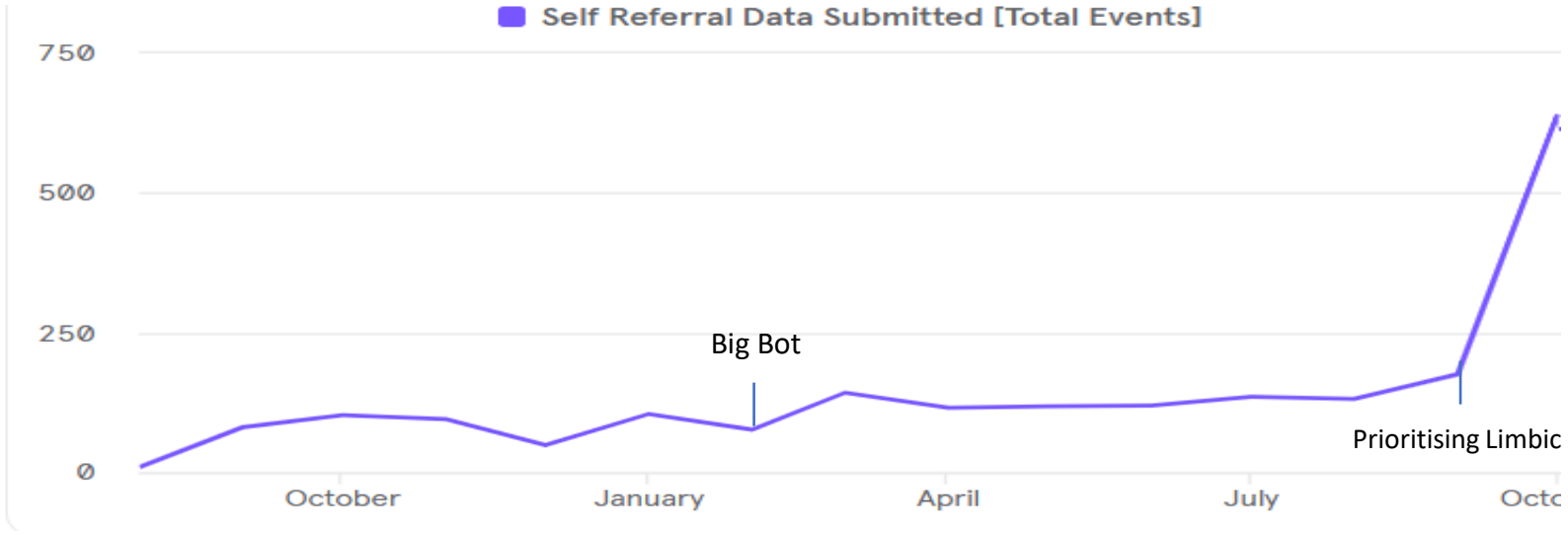
Buckinghamshire Talking Therapies

BTT



OTT



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Initial Evaluation Questions

- Does LIMBIC increase access?
- Does it reduce admin and/or appointment time?
- Does it positively affect Therapist experience i.e.: does it help with the assessment?
- Including identification of risk issues
- Does it generate an accurate Problem Descriptor? So therefore, generate an appropriate ADSM?
- Does it improve the patient pathway?

And of course:

- Did Service Users like it?
- **Focus today on clinician views of Limbic.**

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Staff Feedback Questionnaire: Usefulness of the Limbic Access Chatbot in Assessments.

August 2025

This questionnaire aims to gather feedback from staff about their experiences using the Limbic Access Chatbot during assessments. Your responses will help us evaluate and improve the chatbot to better support your clinical workflow.

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All clinical and admin staff were asked to complete the survey

- 332 respondents (OTT: 164 | BTT: 168): **71% response rate**

- Step 2 staff: 166 (50%), Step 3 Staff: 119 (36%), Admin: 16 (5%), Other: 31 (9%)

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Areas covered by survey:

- Staff were asked how frequently they referred to the Limbic notes gathered by the chatbot in their initial assessments.

69% of clinicians always/often used the Limbic output.

- We explored how confident staff felt using the information gathered by chatbot and asked to what extent they felt the chatbot helped them to identify the client's presenting problem.

67% of clinicians were very/somewhat confident in using Limbic. In cases where they have, they would process the assessments as per standard procedures.

- The accuracy of the Anxiety Disorder Specific Measures (ADSM) - did it match the problem descriptor.

68% found ADSMs to be inaccurate. Clinicians often felt that ADSMs were administered too frequently and were oversensitive to trigger words.

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- We were interested to find out if the chatbot helped in identifying risk factors such as suicidal ideation, self-harm.

72% of clinicians found that Limbic consistently/sometimes helps identify risk. Clinicians found that Limbic would flag risk based on the PHQ 9 score, question 9.

- Did the information captured by chatbot decrease or increase the time spent on initial assessments.

56% of clinicians found that Limbic made no changes to assessment time. Clinicians would proceed with standard assessments to double check information that were gathered by Limbic.

- The information captured by the chatbot flows into our clinical record system, so we explored how easy it was to integrate the chatbot notes and questionnaires into assessment documentation.

73% reported Limbic notes as very easy/easy or neutral to merge with existing system's notes. Some clinicians found that the Limbic outputs were difficult to integrate as they did not follow the same format as internally used notes.

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- Overall satisfaction with Limbic chatbot as a clinical tool, whether clinicians and clients reported any problems/concerns and whether staff had any suggestions for improvements with the chatbot.

Only 7% of clinicians reported feeling negative towards Limbic. Majority of clinicians viewed Limbic neutrally or positively. This may be due to Limbic not having significant impacts on standard procedures.

Feedback from Patients (through Clinician)

- Sometimes question why they had to do an assessment when they had already filled out the LIMBIC form
- Form can get quite long and overwhelming if multiple questionnaires are administered
- Confusion surrounding risk question "keeping themselves and others safe"

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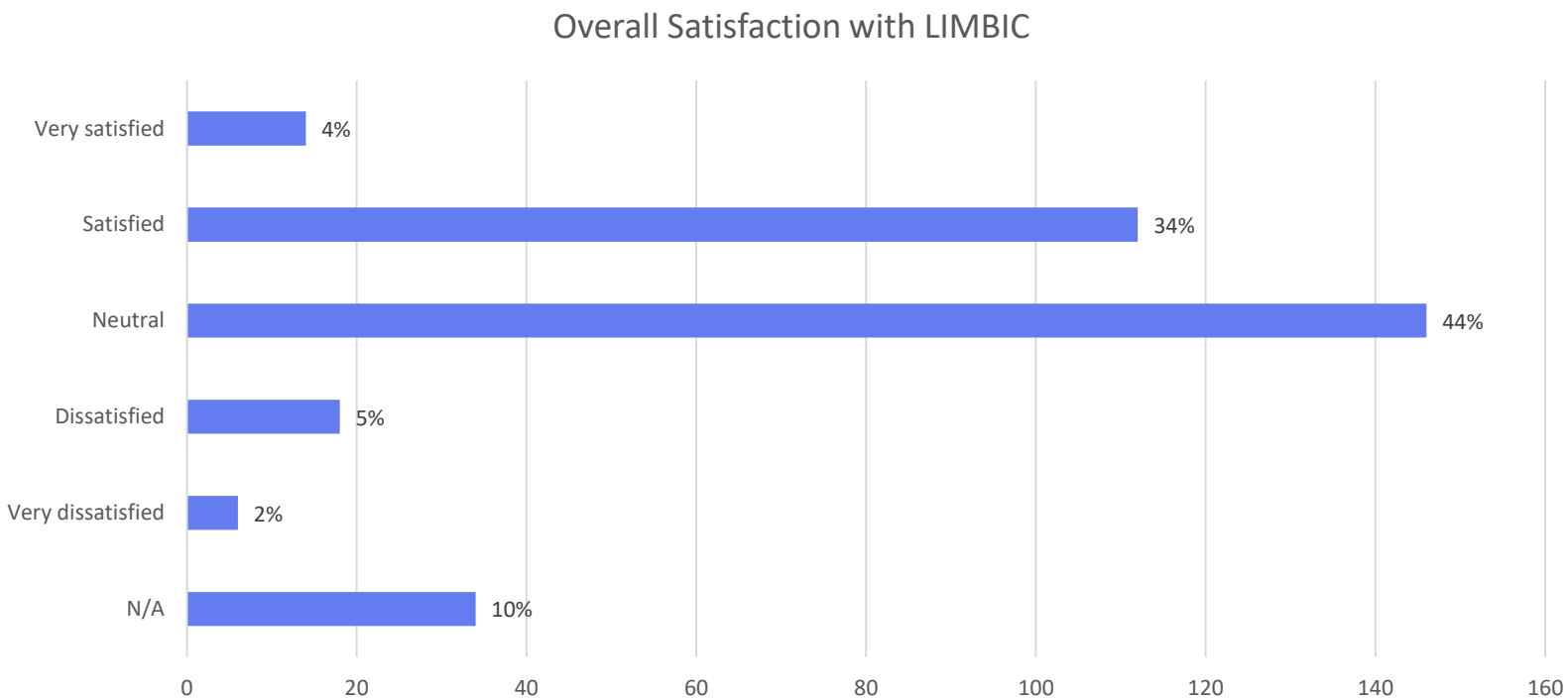

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Future Evaluation

Having gathered our clinician's feedback, we are further interested in whether Limbic:

- Is it effective as a clinical tool?
- Is it improving clinical practice?
- Does it improve productivity?
- Is it cost effective?
- What is the patient's experience?

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Questions ?

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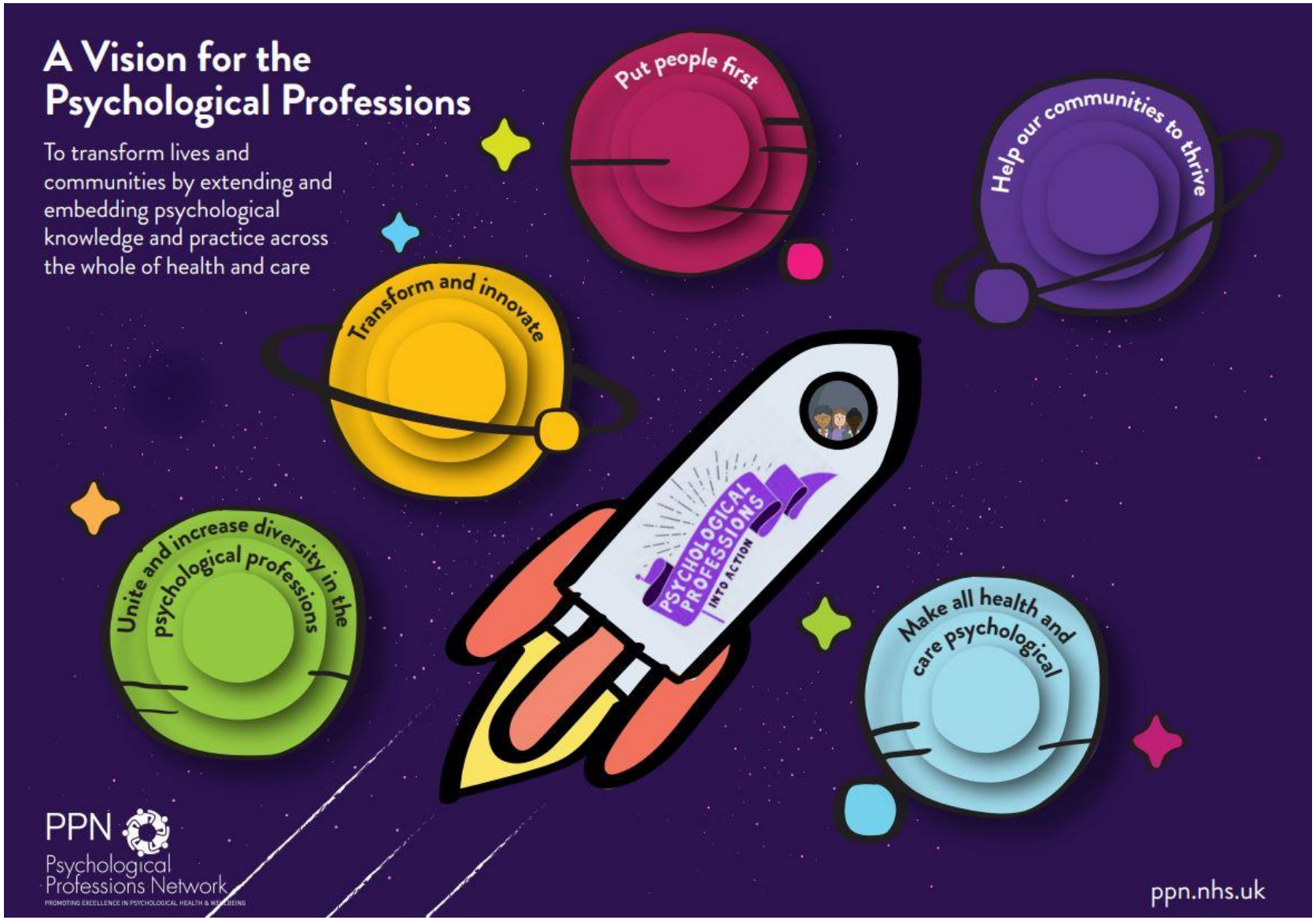

Psychological Professions Vision for England

#PsychologicalProfessionsWeek2025

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