

# Growing up in an online world

Report of the FPH Formal Response to  
the Department for Science, Innovation,  
and Technology (DSIT) National  
Consultation



FACULTY OF  
PUBLIC HEALTH

### **About this report**

This report presents the Faculty of Public Health's (FPH) formal response to the DSIT national consultation 'Growing Up in the Online World' (March–May 2026), reformatted as a policy report for wider dissemination to practitioners, policymakers, commissioners, and researchers.

The FPH response was developed collaboratively across five Special Interest Groups. It is grounded in peer-reviewed evidence, applies precautionary public health principles where evidence is emerging, and frames social media explicitly as a commercial determinant of health.

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## Executive Summary

The Faculty of Public Health (FPH) welcomes the DSIT national consultation on ‘Growing Up in the Online World’. Digital technologies – including social media platforms, AI systems, online gaming environments, and algorithmically curated content services – are not neutral tools whose effects depend solely on individual choices. They are commercial products and services, engineered with engagement-maximising features that shape adolescent cognition, behaviour, and health at population scale. The harms and benefits they may generate are therefore structural and commercial in nature, not merely a function of how individual children or families choose to use them. This framing, grounded in the commercial determinants of health framework, should guide policy across all chapters of this consultation.<sup>[1]</sup>

Our responses are grounded in the best available peer-reviewed evidence. Where evidence is limited or contested, we have applied precautionary principles and public health values. Where the evidence base is observational or of limited certainty, we have indicated this clearly and applied precautionary principles accordingly.

The FPH recognises that digital technologies and online environments provide important educational, social, creative, and health-related benefits for many children and young people. The focus of this response is therefore not on digital technology in itself, but on identifying proportionate, evidence-informed approaches to reducing avoidable harms within current commercial digital environments.

### Summary of FPH recommendations

<b>Minimum age</b>	Support a legal minimum age of 16 for social media access, co-developed with young people, with robust privacy-preserving age assurance.
<b>Digital consent</b>	Raise age of digital consent to 16; 18 for services using data for commercial profiling and advertising.
<b>Platform design</b>	Restrict all five persuasive design features for under-16s; restrict commercial algorithmic profiling for under-18s.
<b>Risky functionalities</b>	Age-restrict livestreaming, nude image sharing, disappearing content, location sharing, and stranger-pairing for under-16s; extend to adver gaming and branded virtual environments.
<b>Scope</b>	Extend restrictions to apps marketing health-harming products, online gambling platforms with loot-box mechanics, and AI companion services.
<b>AI chatbots</b>	Introduce minimum age requirements and feature-level restrictions; distinguish consumer AI from clinically governed digital health tools.

<b>Co-production</b>	Co-produce legislation and implementation mechanisms with young people, parents, and carers to ensure approaches are proportionate, effective, and reflective of real-world use.
<b>Enforcement</b>	Replace self-declaration with independently audited, technically robust age assurance; platform liability and meaningful penalties.
<b>Schools</b>	Support making the Department for Education's mobile phone guidance statutory, with appropriate exemptions.
<b>Digital literacy</b>	Develop independently funded, industry-free digital literacy materials covering commercial determinants and algorithmic systems.
<b>Data access</b>	Establish a statutory right for independent researchers to access platform data for public health monitoring.
<b>Equity</b>	Structural, platform-level defaults protecting all children by design; policy must not place undue burden on individual families.
<b>Conflicts of interest</b>	Mandate full funding transparency and robust conflict-of-interest policies for all research and advisory bodies informing regulation.
<b>Systems &amp; evaluation</b>	Treat social media restrictions as complex systems interventions; mandate independent monitoring and evaluation including unintended consequences, platform adaptation, user migration, and differential effects across groups.
<b>Monitoring</b>	Closely monitor international evidence including from Australia; adapt policy in response to emerging findings; evaluation must go beyond screen time to encompass system-wide effects.

### **The FPH's central position**

These recommendations relating to age-based restrictions reflect the current commercial and regulatory environment, in which existing safeguards, platform design standards, and enforcement mechanisms remain insufficient to adequately protect children and adolescents from harmful content exposures, persuasive design features, behavioural profiling, and exploitative commercial targeting.

These recommendations are not based on a view that digital technologies or online services are inherently harmful to children. Rather, they reflect a precautionary public health response to the current evidence base and the current inadequacy of protections within existing platform ecosystems. If platforms and services were able to demonstrate, through robust independent evaluation and effective regulatory oversight, that these harms had been substantially mitigated, then the rationale for stricter age-based restrictions may reasonably change over time.

### Benefits of social media and online use for children

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The FPH draws an important distinction between 'being online' and 'social media use'. These represent distinct activities with different evidence bases. Social media platforms are a specific subset of online activity defined by user-generated content, social networking, and algorithmic feed curation. Conflating the two risks generating policy responses that are either too broad or too narrow. With this framing in mind, the principal benefits of being online and of social media for children include:

- **Educational access:** Online tools are routinely used by schools to set and guide homework, and children independently access resources that build skills and knowledge. Online learning tools, educational videos, and interactive content can support attainment, particularly for children with limited access to tutoring or additional support.
- **Social connection and peer support:** Social media enables peer relationship maintenance, particularly important for adolescents navigating identity development and for those who may be geographically isolated or part of minority or marginalised groups. For LGBTQ+ young people and others whose identities are not reflected in their immediate environment, online communities can be a vital source of support and belonging. For example, a systematic review found that social media may support the mental health and well-being of LGBTQ+ young people by enabling peer connection, identity development, and social support.<sup>[2]</sup>
- **Access to health information:** Online access lowers the barrier to health information, particularly in areas where stigma or embarrassment may otherwise prevent help-seeking (e.g. sexual health, mental health peer support, information about substance use). For children on long NHS waiting lists for mental health or other health services, clinically governed and regulated digital tools – subject to MHRA oversight, operating within clinical governance frameworks, and including crisis escalation pathways – may offer structured support while awaiting clinical care. It is important to distinguish these from general-purpose consumer AI products, which do not carry these safeguards and should not be positioned as substitutes for clinical care.
- **Civic and creative participation:** Online platforms provide opportunities for creative expression, civic engagement, and developing digital literacy skills that are increasingly central to participation in modern life.
- **Benefits for neurodivergent and disabled young people:** Children with autism spectrum disorder (ASD) often experience difficulties with face-to-face social interactions, making online communication an effective alternative. Research suggests that children with ASD who use digital media for social purposes report stronger friendships than those who do not.<sup>[3]</sup> Digital media, particularly video games, allow engagement in structured activities where children can control their surroundings, which can be emotionally regulating.
- **Mental health support and help-seeking:** Social media-based interventions may help overcome barriers to mental health treatment for young people. The number of children and young people in contact with secondary NHS mental health services has more than doubled since January 2020.<sup>[4]</sup> In this context, social media can serve as a gateway to initiating mental health care. Where structured, evidence-based, and subject to appropriate clinical

oversight, social media-delivered low-intensity support programmes may complement formal care pathways. However, this must be distinguished from unmoderated peer/influencer content, unregulated AI companions, or platforms that simulate therapeutic relationships without clinical governance – all of which risk causing harm to vulnerable young people, particularly those in crisis. Any role for social media in mental health support should be contingent on robust safeguarding, clear escalation pathways, and independent evaluation of outcomes.

It is important to note that benefits are not uniformly distributed. A ‘digital divide’ persists even in affluent nations due to structural and individual factors.<sup>[5,6,7,8,9]</sup> The nature of benefits varies by age, developmental stage, socioeconomic circumstances, geography, and the specific platforms and activities involved. A public health approach to online benefits must attend to these inequalities. The onus should be on platforms and government to ensure that benefits are accessible and harms mitigated by design, rather than placing the burden on individuals and families.

### Harms and risks of social media use for children

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The evidence base is now substantial. It is important to conceptualise harms not as arising from the technology in isolation, but through specific mechanisms, including exposure to harmful content, platform design features that promote engagement and displace health-promoting activities, and the commercial exploitation of adolescent attention.<sup>[1]</sup>

The harms associated with social media use are multidimensional, spanning behavioural, psychological, physical, and safeguarding domains, with growing evidence that platform design and commercial incentives shape patterns of exposure and risk.

#### Behavioural harms

A systematic review and meta-analysis of 126 studies covering 1,431,534 adolescents (mean age 15 years) found that frequent social media use was associated with significantly increased odds of: alcohol consumption (Odds Ratio (OR) 1.48, 95% Confidence Interval (CI) 1.35–1.62); drug use (OR 1.28, 95% CI 1.05–1.56); tobacco use (OR 1.85, 95% CI 1.49–2.30); sexual risk behaviours (OR 1.77, 95% CI 1.48–2.12); anti-social behaviour (OR 1.73, 95% CI 1.44–2.06); multiple risk behaviours (OR 1.75, 95% CI 1.30–2.35); and gambling (OR 2.84, 95% CI 2.04–3.97). Exposure to content showcasing health-risk behaviours was associated with increased e-cigarette use (OR 1.73, 95% CI 1.34–2.23) and unhealthy dietary behaviour (OR 2.48, 95% CI 2.08–2.97), the latter with moderate GRADE (Grading of Recommendations, Assessment, Development and Evaluation) certainty derived from randomised controlled trial evidence.<sup>[9]</sup>

Longitudinal causal analyses of the UK Millennium Cohort Study (MCS) found that time spent on social media at age 14 was associated with significantly increased risk of cigarette use (Adjusted Odds Ratio (AOR) 2.76, 95% CI 2.19–3.48), e-cigarette use (AOR 3.24, 95% CI 2.59–4.05), and dual use (Adjusted Relative Risk Ratio (ARRR) 4.11, 95% CI 2.77–6.08) at age 17, in a dose-response manner.<sup>[10]</sup> Similarly, social media use at age 14 was associated with alcohol use and binge drinking at age 17 in a dose-response pattern, with those using social media for ≥2 hours/day having over three times the odds of binge drinking (AOR 3.07, 95% CI 2.54–3.70) compared with minimal users.<sup>[11]</sup>

These findings are drawn from a UK-representative cohort, adjusted for a wide range of potential confounders, and represent some of the strongest observational evidence currently available regarding the potential causal relationship between social media use and adolescent health-risk behaviours. While randomised controlled trials are unlikely to be feasible or ethical in this context, these studies strengthen causal inference through longitudinal designs, temporality, dose–response analyses, and extensive confounder adjustment using real-world population data.

### **Mental health harms**

Beyond behavioural outcomes, substantial concern has focused on the potential relationship between social media use, mental health, self-harm, and suicidality among adolescents, though the evidence requires careful interpretation.

A large UK MCS study found that for both boys and girls, greater social media use was related – through multiple pathways including poor sleep, low self-esteem, and poor body image – to depressive symptoms, with the magnitude of association larger for girls than boys, and a stepwise increase in depressive symptoms in girls from none to 5+ hours of use.<sup>[12]</sup> A longitudinal cohort study of 2,350 adolescents in London (the SCAMP study) found that exceeding 3 hours per day of social media use was associated with increased risks of depressive and anxiety symptoms, suggesting a potential threshold effect.<sup>[13]</sup>

A systematic review and meta-analysis found no association between the frequency of social media use and self-injurious thoughts and behaviours, but did find robust associations between cybervictimisation and self-injurious thoughts and behaviours – including suicidal ideation, suicide attempts, and non-suicidal self-injury – with the association between cybervictimisation and suicidal ideation stronger for adolescents than for adults.<sup>[14]</sup>

A large US cohort study (Adolescent Brain Cognitive Development Study, 2016–2022) found that ‘addictive’ screen use – rather than total screen time – was more strongly associated with suicidality and adverse mental health outcomes.<sup>[15]</sup> This supports the FPH’s position that regulatory approaches should focus not solely on time spent online, but also on addictive and persuasive design features that shape patterns of engagement.

### **Physical health harms**

Harms associated with social media use also extend to physical health outcomes, though these are often overlooked in policy debates. Physical health harms from excessive screen use are well evidenced and include:

- **Sleep disruption:** Specific patterns of use, such as evening and night-time use, can impact sleep time and quality through psychological and physiological arousal from emotionally salient content before sleep, melatonin suppression caused by screen light emission at bedtime, and interruptions due to notifications.<sup>[16]</sup> Displacement of sleep due to screen time can elevate depressive symptoms, particularly in girls.
- **Musculoskeletal disorders:** An emerging issue of neck pain (‘text neck’) potentially related to extended smartphone use has been noted in children and adolescents.<sup>[17]</sup>
- **Myopia (short-sightedness):** Screen time is associated with increased risk of myopia. Global rates of myopia have been rising sharply, from 24% in 1990 to 36% in 2023, with evidence that each additional hour of daily screen use increases risk.<sup>[18,19]</sup>

- **Cardiometabolic risk:** Higher screen time in adolescence is associated with increased risk of obesity and cardiometabolic disease in adulthood.<sup>[20]</sup>

### **Grooming, exploitation, extremism, and explicit content**

Social media platforms also present important safeguarding risks, including grooming, sexual exploitation, exposure to extremist material, and violent content online.

Police recorded 7,263 ‘Sexual Communication with a Child’ offences in the past year – almost double since the offence came into force in 2017/18. Where the platform could be identified, 40% of offences took place on Snapchat, 9% on WhatsApp, and 9% on Facebook and Instagram.<sup>[21]</sup> Online gaming platforms have also been identified as problematic, as they allow users of all ages to interact. Roblox, with over 80 million daily players (roughly 40% of whom are under 13), has faced criticism for exposing children to inappropriate contact and content.

Concerns regarding extremism and violence are also increasing. The Home Affairs Committee (2026) highlighted a rising trend of young people being drawn into extremism, with increasing referrals of under-18s to the Prevent programme, and identified the role of influencers, social media, and algorithmic amplification in spreading extremist narratives.<sup>[22]</sup> Survey evidence found that 64% of teenagers who perpetrated violence in the past year reported that social media played a role in their behaviour.<sup>[23]</sup> A 2024 survey further reported that 28% of British under-18s had received an unwanted sexual image or had their intimate photos misused.<sup>[24]</sup>

### **Health misinformation**

Digital platforms may also shape health indirectly through the spread of misinformation and manipulative content.

Mis- and disinformation can be spread online, often targeting children, and has been identified as a ‘pressing public issue’ by UNICEF.<sup>[25]</sup> Estimates suggest up to a quarter of YouTube videos during the COVID-19 pandemic involved health misinformation, potentially impacting vaccination uptake and adherence to public health guidance.

Due to the prevalence of young people turning to online spaces for information and support, health misinformation can result in inappropriate self-diagnosis, stigma, inappropriate treatments, and erosion of trust in health authorities. Specific concerns have also been raised regarding misinformation related to sexual and reproductive health.

### **Platform design and commercial harms**

Importantly, many harms associated with social media do not arise solely from exposure to technology itself, but from platform architectures intentionally designed to maximise engagement, behavioural retention, and commercial profit.

Features such as quantified social feedback (“likes”), algorithmic curation, and infinite-scroll interfaces may shape patterns of exposure and behaviour, including reinforcement of harmful content and prolonged engagement.<sup>[1]</sup> Echo chambers formed by algorithmic curation can normalise attitudes and behaviours including glorification of violence, self-harm, and substance use. Research on youth violence has highlighted the role of unregulated digital spaces in amplifying antisocial content, with algorithms on platforms such as TikTok and X prioritising

sensationalist material to maximise engagement, potentially fuelling real-world harms including knife crime and youth violence.<sup>[27]</sup>

Gambling-related harms via online platforms represent an additional and often overlooked public health concern. Young people are exposed to gambling advertisements widely present on social media, despite the Gambling Act banning strongly appealing content to under-18s. Ofcom (2025) data reported that 58% of children spent money online in the past month across gaming, video-sharing, and social media sites; of those who made purchases on social media, 43% regretted the purchase, and 41% reported overspending.<sup>[28]</sup> Evidence indicates a link between money spent on loot boxes in video games and severity of problem gambling, while young people's early engagement with gambling-style features may embed harmful gambling practices later in life.<sup>[29]</sup>

The digital marketing of health-harming products – including alcohol, unhealthy food and drink, tobacco, and vaping products – represents another well-evidenced harm category. Exposure to marketing of health-harming products on social media is strongly associated with consumption, with the strongest evidence of a causal relationship observed for alcohol<sup>[30]</sup> and unhealthy dietary behaviour.<sup>[9]</sup> Digital marketing is more targeted, more personalised, and less visible to parents than traditional advertising, often reaching children through trusted intermediaries such as peers and influencers.

The UN Committee on the Rights of the Child has called on states to prohibit digital profiling of children for commercial purposes and to ban neuromarketing and immersive advertising directed at children.<sup>[31]</sup> Sleep disruption, cyberbullying, and displacement of physical activity represent additional documented harms. Emerging evidence also suggests that harms are not equally distributed, with some studies finding greater absolute risks among adolescents from more advantaged socioeconomic backgrounds, indicating complex inequality effects.<sup>[10,11]</sup>

Taken together, the evidence indicates that social media-related harms are shaped not only by time spent online, but by the interaction between platform design, commercial incentives, algorithmic amplification, and exposure to harmful content. This reinforces the need for proportionate, systems-level regulatory approaches focused on child health and safety.

### **The balance of benefits and risks**

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The balance of benefits and risks is not fixed and varies by age, platform, design feature, type of content, developmental stage, socioeconomic circumstance, and patterns of use. Views within the FPH group ranged from those considering that benefits somewhat outweigh risks to positions emphasising that, even where overall benefits are acknowledged, the risks associated with specific commercial and design features require independent regulatory action regardless of the overall balance. Treating this as a single binary judgement risks generating policy that is either overly permissive or unnecessarily restrictive across all contexts.

With those important caveats in mind, current evidence suggests that the risks associated with contemporary social media environments likely outweigh the benefits for many children and adolescents, while recognising that this balance may differ across developmental stages, patterns of use, and individual circumstances. Current evidence suggests that harms may be particularly

pronounced for younger adolescents, girls, and those exposed to harmful content or problematic patterns of use.

Importantly, the evidence does not support a simplistic “more time = more harm” interpretation. In several outcome domains, including alcohol use and binge drinking, associations have been found to be stronger among adolescents from more advantaged socioeconomic backgrounds.

[10,11] This suggests that risks are shaped not only by exposure itself, but also by broader social, developmental, and contextual factors. In effect, digital environments may narrow traditional social gradients in exposure by increasing exposure to health-risk behaviours among groups who may otherwise have had lower offline exposure.

Equally, social media can provide meaningful benefits, including opportunities for social connection, identity exploration, peer support, creativity, and access to information, particularly for marginalised groups and young people with limited offline support networks. Critically, the evidence does not support placing the burden of mitigation solely on children, parents, or individual behaviour change. Rather, the evidence increasingly points towards the need for structural and platform-level interventions that reduce harmful exposure while preserving opportunities for benefit.

Every child should have the right to play, learn, socialise, and develop online without routine exposure to content and systems designed to maximise engagement with harmful commercial products or to exploit developmental vulnerabilities. Policy must prioritise health and avoid compounding socioeconomic disadvantage by placing the burden of managing risks on individual parents, carers, and children. Structural, platform-level interventions are required.

### 2.1 Minimum Age of Access for Social Media

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Age restrictions already apply to the purchase of health-harming products such as alcohol, tobacco, and vapes; similar principles apply to platforms that promote these products and may independently contribute to adverse health outcomes. Industry self-regulation has demonstrably failed: many platforms nominally set minimum ages at 13 but make little meaningful effort to enforce them.

The FPH therefore supports a minimum age of 16 for access to social media platforms in their current form. These recommendations reflect the realities of the current digital ecosystem, in which existing safeguards, platform design standards, and enforcement mechanisms remain insufficient to adequately protect children and adolescents from harmful content exposures, persuasive design features, behavioural profiling, and exploitative commercial targeting.

This position is not based on a view that digital technologies or online services are inherently harmful to children. Rather, it represents a precautionary public health response to the current evidence base and the inadequacy of protections within existing platform ecosystems.

This position is based on three core considerations:

- **Longitudinal dose–response evidence:** Adolescents using social media for  $\geq 5$  hours/day at age 14 had significantly higher odds of later substance use behaviours at age 17 in dose–response patterns.<sup>[10,11]</sup> Associations between social media use and health-risk behaviours were also stronger among adolescents aged  $\geq 16$  compared with younger adolescents, suggesting that even older adolescents remain vulnerable within current platform environments.<sup>[9]</sup>
- **Neurodevelopmental vulnerability:** Brain systems involved in impulse control, emotional regulation, reward processing, and susceptibility to peer influence continue to develop throughout adolescence and into early adulthood.<sup>[32]</sup> Contemporary social media platforms are intentionally designed to maximise engagement through persuasive features such as infinite scroll, autoplay, algorithmic recommender systems, intermittent reward mechanics, streaks, and quantifiable social feedback, which may disproportionately exploit these developmental vulnerabilities.
- **Commercial determinants framework:** The current digital environment is characterised by highly personalised algorithmic systems capable of amplifying exposure to harmful content, commercial marketing, and social comparison pressures at population scale. This mirrors other commercial determinants of health, where stronger protections for children are necessary because markets alone do not adequately safeguard wellbeing.<sup>[1]</sup>

Importantly, this position relates to social media platforms as they are currently designed and regulated. If platforms and services were able to demonstrate – through robust independent evaluation, effective regulatory oversight, and meaningful enforcement – that harmful exposures and exploitative design features had been substantially mitigated, then the rationale for stricter age-based access restrictions could reasonably evolve over time.

**Critical requirement:** Any minimum age requirement must be accompanied by robust, technically effective age assurance – not the current tick-box self-declaration systems, which are wholly inadequate. Any implementation mechanisms should be co-developed with young people, consistent with the UN Convention on the Rights of the Child.<sup>[33,35]</sup> Legislation designed without young people’s input risks being ineffective and may produce unintended harms, including migration into less visible online spaces.

### Anticipated impacts of a minimum age higher than 13

A minimum age higher than 13 would be expected to have the following impacts:

- **Child safety and wellbeing:** Reducing exposure of younger children to social media’s most harmful features – algorithmic content recommendation, affirmation-based social comparison, and marketing of health-harming products – would, on the basis of existing evidence, reduce risk of substance use initiation, disordered eating, self-harm, and mental health deterioration.<sup>[9]</sup> Dose–response relationships suggest that even partial reductions in time spent on social media at younger ages may yield meaningful health benefits.<sup>[10,11]</sup> However, an important unresolved question is whether these benefits arise from reduced time spent online itself, or from reduced exposure to harmful content and engagement-driven platform design features. This distinction is important because it suggests that meaningful public health benefit may ultimately depend not only on time-based restrictions, but also on regulation of harmful content exposure and platform design architectures that shape young people’s digital environments.
- **Health inequalities:** Longitudinal MCS analyses found that the absolute increase in cigarette use associated with social media exposure was larger among adolescents from higher parental education groups (AOR 12.45 vs 1.45), despite lower baseline risk in more advantaged groups.<sup>[10]</sup> One possible interpretation is that more advantaged young people may historically have been relatively protected from certain offline risk environments, but social media exposure may erode this protection by exposing them to risk-promoting content online. In effect, digital environments may narrow traditional social gradients in exposure by increasing exposure to health-risk behaviours among groups who may otherwise have had lower offline exposure.<sup>[10,11]</sup>
- **Circumvention:** Children may use VPNs, parental accounts, or false ages to circumvent restrictions. Circumvention does not negate the case for minimum ages – age restrictions for alcohol and tobacco do not eliminate underage access but demonstrably reduce it. Mitigation therefore requires technically robust age assurance, education for parents and children, platform liability for inadequate verification, and enforcement action against non-compliant services.
- **AI displacement risk:** Some young people who currently rely on social media for peer connection or emotional support may migrate towards AI companions or unregulated AI chatbot platforms if restrictions are introduced without parallel investment in accessible, regulated, evidence-informed alternatives.
- **Equity and individual burden:** Age restrictions should be accompanied by structural, platform-level protections built in by default, including protective privacy settings, restrictions on algorithmic personalisation, and removal of health-harming product marketing from children’s feeds, so that children are protected by the system rather than required to navigate it alone.
- **Unintended consequences:** Early evidence from Australia’s social media ban (in force from December 2025 for under-16s) raises important caution regarding implementation and unintended effects. Kids Helpline, Australia’s equivalent of Childline, reported distress

among children cut off from peer support networks, including some experiencing suicidal ideation and crises linked to loss of online social connection.<sup>[34]</sup> Australia's national youth mental health agency further reported that 10% of new referrals were related to the ban, despite the relatively small proportion of accounts actually removed. The eSafety Commissioner also noted a spike in downloads of alternative apps when the ban came into force, consistent with concerns about migration toward less regulated or less visible online spaces. These findings do not argue against protective regulation, but rather highlight the importance of careful implementation, co-development with young people, provision of alternative support structures, and rigorous independent monitoring for unintended harms, including differential impacts on vulnerable groups such as LGBTQ+ young people and those with limited offline support networks.

The FPH acknowledges that respected bodies urge caution regarding blanket bans. The Council of Europe Commissioner for Human Rights has stated that the source of harm – and therefore the primary focus of regulation – should be platform design and incentives, rather than children themselves.<sup>[35]</sup>

## 2.2 Age of Digital Consent

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The FPH supports setting the age of digital consent at 16 as a minimum, with consideration also given to a threshold of 18 for services that use personal data for commercial profiling, behavioural targeting, or personalised advertising purposes. The primary purpose of large-scale data collection and profiling by many commercial online services is to enable the targeting, optimisation, and amplification of content and advertising. Evidence that exposure to targeted marketing for health-harming products influences attitudes, intentions, and consumption behaviours among young people is substantial.<sup>[1]</sup> Allowing children below 16 (or potentially 18) to consent to commercial data profiling exposes them to a specific, evidence-based form of harm.

The UN Convention on the Rights of the Child defines childhood as under 18 years of age, and the UN Committee on the Rights of the Child has explicitly called on states to prohibit profiling and targeting of children for commercial purposes on the basis of digital records or inferred characteristics.<sup>[31]</sup> The FPH endorses this position in relation to commercial profiling and targeted advertising. However, where data processing demonstrably supports genuine educational, safeguarding, accessibility, or health-related functions, a more graduated and proportionate approach may be appropriate.

The FPH recommends a differentiated and risk-proportionate approach:

- **Services using data for commercial profiling, behavioural targeting, and advertising (including health-harming products):** Age of consent 18. Where comprehensive under-18 protections are not implemented, the digital age of consent should at minimum align with existing legal age restrictions for the relevant products (e.g. 18 for alcohol, tobacco, and vaping products).
- **Social media platforms with user-generated content and algorithmic recommendation systems:** Minimum age 16, reflecting developmental vulnerabilities of younger adolescents and current evidence regarding persuasive platform design.
- **Educational platforms, health services, safeguarding services, and public information services:** More permissive and proportionate thresholds where data processing demonstrably supports educational, health, or safeguarding functions, with strong privacy

protections, transparency, and child-centred safeguards built in by design. In these contexts, parental consent mechanisms may be appropriate for younger children depending on the nature of the service and the sensitivity of the data involved.

### 2.3 Restricting Access Based on Risky Functionalities

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The FPH supports age restrictions on all of the following functionalities for under-16s: livestreaming; sending nude images or videos; disappearing content; location sharing; and connecting or talking to strangers. These features are associated with significant safeguarding risks, including grooming, sexual exploitation, coercion, cyberbullying, exploitation by strangers, and exposure to harmful peer norms, with risks likely to be amplified among younger adolescents due to developmental vulnerabilities in risk assessment, impulsivity, and susceptibility to social influence.

These recommendations reflect the fact that many contemporary platform functionalities are intentionally designed to maximise engagement, prolong user attention, and amplify emotionally salient or commercially valuable content. In the current regulatory environment, safeguards remain insufficient to ensure that these systems consistently operate in ways compatible with children's developmental needs and wellbeing. The FPH's position is precautionary and evidence-led, reflecting concerns regarding how these features currently operate within commercial platform ecosystems rather than a view that digital technologies are inherently harmful. As platform design standards, safety protections, and independent oversight evolve, the appropriateness of specific functionality-based restrictions may also reasonably require re-evaluation.

Beyond the functionalities explicitly listed, the FPH emphasises the need to regulate platform features that amplify exposure to harmful or commercially exploitative content, including marketing of health-harming products. Evidence demonstrates that active engagement with online content – including liking, sharing, downloading, commenting on, or creating content – is more strongly associated with increased alcohol consumption and binge drinking among young people than passive exposure alone.<sup>[36,37]</sup> Functionalities designed to maximise engagement and virality (including social affirmation mechanics, recommender systems, content-sharing tools, streaks, and advergaming) therefore warrant regulatory consideration beyond the listed items.

While the available evidence supports the view that restricting access to specific high-risk functionalities would likely reduce certain harms, functionality restrictions alone are unlikely to deliver a comprehensively safer online environment. Effective child online safety requires a systems-based public health approach combining: robust and privacy-preserving age assurance; proportionate functionality restrictions; effective content moderation standards; algorithmic transparency and accountability; media and digital literacy education; accessible reporting and safeguarding pathways; and meaningful regulatory enforcement against non-compliant platforms.

**The 'digital sanitation' analogy:** Just as improvements in water safety and infectious disease control required system-wide standards, independent monitoring, infrastructure investment, and enforceable regulation – rather than reliance on voluntary industry action alone – improving online safety for children requires sustained structural intervention at platform and regulatory level.<sup>[27]</sup>

Reducing children's exposure to harmful content, persuasive platform features, and commercially exploitative digital environments would likely reduce: substance use initiation; harmful drinking; exposure to unhealthy product marketing; body image harms; disordered eating behaviours; cyberbullying; and deterioration in mental wellbeing. There would be clear public health benefits to restricting children's exposure to marketing and content promoting health-harming products, given the evidence linking such exposure to increased consumption and related harms.<sup>[10,11,12]</sup> Business impacts are likely to include reduced advertising revenues and increased compliance costs, which may generate industry resistance.

Commercial interests should not override child health protection. Regulatory approaches applied to tobacco advertising, alcohol marketing, gambling promotion, and consumer product safety have not prevented commercial activity but instead shifted markets towards safer practices. Displacement effects must be monitored: measures that are weak, inconsistent, or easily circumvented risk displacing harms toward less regulated digital spaces.

The FPH advocates that any legislation setting age-based restrictions, and the mechanisms for implementation, should be co-developed with young people to ensure approaches are practical, proportionate, and reflective of real-world use, as required by the UN Convention on the Rights of the Child.<sup>[31,33]</sup> Legislation and implementation mechanisms designed without young people's input risk being ineffective and may produce unintended harms, including greater activity in less visible online spaces.

## 2.4 Persuasive Design Features and Compulsive Platform Design

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The commercial accountability dimension of compulsive platform design was underlined by a landmark US civil case in March 2026, in which Meta and YouTube were found liable for designing social media apps that cause addiction and led to poor mental health in young users.<sup>[38]</sup> This case establishes important legal precedent that harmful design is a deliberate commercial choice for which companies can and should be held responsible. It reinforces the FPH's position that platforms should be required to ensure their products are designed to bring benefits to users, not to maximise addictive engagement.

The FPH considers all five of the listed design features (infinite scrolling, autoplay, affirmation features, alerts and push notifications, and content recommendation algorithms) to be potentially persuasive to children and adolescents, and recommends that all are age-restricted.

These recommendations reflect concerns about how persuasive design features currently operate within commercial social media environments, where engagement-maximising systems are often deployed without sufficient safeguards for children and adolescents. The FPH's position is therefore precautionary and evidence-led, rather than based on a view that engagement-oriented technologies are inherently harmful in all contexts. As platform standards, safety protections, and independent oversight evolve, the appropriateness of specific feature-based restrictions may reasonably require re-evaluation.

Content recommendation algorithms are among the most powerful and pervasive persuasive design features within contemporary digital platforms. These systems determine what content children are exposed to, how frequently they encounter it, and in what sequence, shaping attitudes, behaviours, norms, and emotional responses at scale.<sup>[1]</sup> Affirmation features (including likes, comments, follower counts, streaks, and social metrics) create systems of quantified social

feedback that may intensify social comparison, reward-seeking behaviours, and sensitivity to peer evaluation. Research on platform ‘affordances’ identifies these mechanisms as plausible pathways linking social media use to negative mental health outcomes, particularly among adolescents with existing vulnerabilities related to body image, self-esteem, or emotional wellbeing.<sup>[39]</sup> Infinite scrolling and autoplay remove natural stopping cues and encourage prolonged engagement through mechanisms resembling intermittent variable reward schedules, well recognised in behavioural and addiction research. Alerts and push notifications further reinforce compulsive checking behaviours, disrupt concentration, and negatively affect sleep and wellbeing.<sup>[16]</sup> Evidence suggests that active engagement with digital marketing for health-harming products may be more strongly associated with harmful behaviours than passive exposure alone.<sup>[40]</sup>

Beyond the five listed features, the FPH recommends that the following additional marketing-related and engagement-amplifying functionalities be considered for restriction or enhanced regulation, drawing on evidence from digital marketing research into how children are commercially targeted online.<sup>[40,41]</sup> These include: simulated images and videos including flash animations; music used for brand promotion; advergames; loyalty schemes, promotions, and competitions; chat rooms or forums associated with brands or health-harming products; interactive brand characters; branded recipe ideas and downloadable activities; influencer marketing of health-harming products; brand-promoted user-generated content; and emerging commercial environments within virtual and metaverse spaces. Research into online metaverse environments found that six of twenty metaverses investigated included alcohol-related content, with two involving direct alcohol company marketing, including virtual drinking activities and non-fungible tokens exchangeable for real-world alcohol.<sup>[42]</sup>

The FPH recommends the following minimum ages as a precautionary starting framework, recognising that these thresholds should remain subject to ongoing independent evaluation and revision as evidence evolves:

Feature	Minimum age	Rationale
Infinite scrolling	16	Removes stopping cues; promotes prolonged, compulsive engagement patterns particularly harmful during early and mid-adolescence.
Autoplay	16	Reduces user agency; prevents natural stopping points and increases time on platforms beyond original intentions.
Affirmation features (likes, comments, follower counts, streaks)	<b>16 (consider 18 for highly quantified systems)</b>	Intensify social comparison, peer evaluation, reward-seeking, and dependence on external validation; plausible pathways to body image and mental health harms. <sup>[26]</sup>
Alerts and push notifications	16	Encourage compulsive checking behaviours, interrupt concentration,

		and contribute to sleep disruption – one of the most consistently documented harms. <sup>[16]</sup>
Content recommendation algorithms (commercial profiling and behavioural targeting)	18	Algorithmically targeted marketing of health-harming products influences consumption behaviours. UN CRC recommends prohibiting commercial profiling of children. <sup>[31]</sup>

The public health rationale for restricting specific persuasive platform features and introducing proportionate time limits is strong. Longitudinal MCS analyses demonstrate dose-response relationships between social media use and later health-risk behaviours: greater time spent on social media at age 14 was associated with increased odds of cigarette use, e-cigarette use, alcohol use, and binge drinking at age 17.<sup>[10,11]</sup>

Particular benefits may arise from limiting overnight use and reducing sleep disruption, given that disturbed sleep is among the most consistently documented harms of adolescent digital media use.<sup>[16]</sup> Time limits and feature restrictions should not be viewed as standalone solutions. They are most effective when implemented as part of a broader systems-based approach including robust age assurance, platform accountability, content standards, algorithmic transparency, digital literacy education, parental support, and independent monitoring and evaluation.

The FPH advocates that any legislation setting age-based restrictions, and the mechanisms for implementation, should be co-developed with young people to ensure approaches are practical, proportionate, and reflective of real-world use, as required by the UN Convention on the Rights of the Child.<sup>[31,33]</sup> Legislation and implementation mechanisms designed without young people’s input risk being ineffective and may produce unintended harms, including greater activity in less visible online spaces.

## 2.5 Scope: Which Services Should Restrictions Apply To

In addition to mainstream social media platforms, the FPH recommends that minimum age of access restrictions should apply to:

- **Apps, sites, and services substantially oriented toward the promotion, marketing, or sale of health-harming products and brands** (including alcohol, tobacco, vaping products, gambling, and HFSS food and drink). Digital environments can shape health behaviours, consumption patterns, social norms, and mental wellbeing through highly personalised and persuasive commercial systems. There is already clear legislative and regulatory precedent: the Tobacco and Vapes Act 2026 introduced restrictions on vape advertising across all media.<sup>[43]</sup>
- **Online gambling platforms and services incorporating gambling-like mechanics**, including loot boxes, chance-based rewards, and psychologically persuasive in-game purchasing systems. Ofcom (2025) data found that 58% of children had spent money online in the past month, with 41% reporting overspending and many finding in-game purchases unclear.<sup>[28]</sup> Evidence indicates a link between money spent on loot boxes and severity of

problem gambling.<sup>[29]</sup> The Australian Government has introduced age-graded restrictions on games including in-game purchases with an element of chance (not recommended for under-15s) and casino-style simulated games (restricted to over-18s). The UK should consider comparable provisions.

- **Consumer-facing generative AI chatbot and AI companion services** that simulate social, emotional, or relational interactions with children and adolescents.

The scale and influence of online commercial ecosystems warrants consideration. In 2024, approximately four-fifths of UK advertising expenditure was spent online, reflecting the central role of digital platforms in shaping consumer attention and behaviour.<sup>[44]</sup> Platforms and services that profit from large-scale behavioural targeting and engagement of children should therefore be subject to proportionate public health scrutiny and child protection standards.

## 2.6 Artificial Intelligence Chatbots

### Benefits of AI chatbots for children

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AI chatbots may offer several evidence-informed benefits for children and adolescents when appropriately designed, deployed with robust safeguards, and subject to appropriate human and clinical oversight:

- **Personalised, on-demand learning and support:** AI chatbots can provide adaptive educational support tailored to different learning needs, literacy levels, and communication styles.<sup>[45]</sup> AI-enabled tools are increasingly being explored as ‘waiting well’ approaches for children facing long delays accessing NHS mental health services. NHS England data indicate that hundreds of thousands of children and young people are currently in contact with or waiting for mental health services, with many experiencing substantial waiting periods.<sup>[4]</sup> Within this context, chatbot-delivered CBT tools and psychoeducation platforms may help extend access to low-intensity support while young people await formal care.<sup>[46]</sup> The MHRA has set out new guidance on digital mental health technologies; however, many direct-to-consumer tools fall outside current regulation.<sup>[47]</sup>
- **Low-barrier access to health and emotional information:** AI chatbots may reduce stigma-related barriers to seeking information and support, particularly for sensitive topics where young people may otherwise avoid help-seeking.
- **Accessibility and support for children with SEND:** AI-enabled tools may support children with special educational needs and disabilities through features such as text-to-speech, simplified language generation, translation support, communication aids, and personalised interaction formats.

These benefits are conditional on appropriate safeguards, transparency, and oversight. A critical distinction must be drawn between general-purpose consumer AI chatbots and clinically governed digital health technologies. The latter require robust clinical governance, crisis escalation pathways, evidence-based design, and safeguards that avoid inappropriate emotional dependency or simulation of therapeutic relationships that may displace professional care.

## Risks of AI chatbots for children

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The FPH considers the following AI chatbot features to present the greatest risks for children and adolescents:

- **Hallucination and false or misleading responses:** Large language models are known to generate plausible but inaccurate information with a high degree of confidence.<sup>[48]</sup> This poses particular risks when children seek medical, psychological, educational, or factual guidance and may act upon responses without independent verification.
- **Personalisation and persistent memory:** Persistent memory and deep personalisation can reinforce harmful behavioural or emotional patterns, particularly among vulnerable young people.<sup>[49]</sup> These systems may create increasingly tailored interaction loops that intensify compulsive use, emotional dependency, or exposure to harmful content. When children disclose sensitive personal, behavioural, or health information to AI systems, there are also important concerns regarding commercial profiling, behavioural targeting, and secondary data use.
- **Relationship simulation (friendship and romantic interactions):** AI systems that simulate friendship, emotional intimacy, or romantic relationships risk displacing human social relationships, encouraging unhealthy attachment, and fostering emotional dependency on non-human systems, particularly among children with social difficulties, loneliness, neurodevelopmental conditions, or existing mental health vulnerabilities.
- **Realism and anthropomorphic interaction design:** The increasing realism of AI chatbot interactions amplifies all of the above risks. Children and younger adolescents may be less able than adults to recognise that they are interacting with a non-human system, critically evaluate outputs, or understand the limitations and incentives underlying AI-generated responses.<sup>[1]</sup>
- **Ability to generate mature, harmful, or exploitative content:** This includes sexual or romantic roleplay, violent content, self-harm or suicide-related content, extremist material, and content promoting disordered eating. The capacity of AI systems to generate highly personalised harmful content in real time represents a significant safeguarding concern. Recent international cases have raised concerns regarding AI chatbot interactions linked to self-harm and suicide-related discussions among vulnerable young people.

## Age restrictions and regulation of AI chatbots

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The FPH supports both minimum age requirements and restrictions on specific AI chatbot features and functionalities. AI chatbots present a qualitatively distinct risk profile from traditional social media platforms. They combine persuasive conversational design, highly realistic human-like interaction, generative content creation, emotional simulation, and deep personalisation in ways that may be particularly harmful during childhood and adolescence. The precautionary principle supports both minimum age thresholds and feature-level restrictions, given the rapidly evolving evidence base and the current absence of regulatory frameworks proportionate to these risks.

The FPH supports a tiered, developmental approach: stricter protections for younger children with graduated access to functionalities for older adolescents, consistent with the UK ICO Children's Code.<sup>[50]</sup> General-purpose consumer AI systems should be subject to robust age restrictions,

safeguarding standards, and limitations on high-risk functionalities. By contrast, clinically governed AI-enabled health tools, appropriately regulated through MHRA and NHS England digital health frameworks, may play an important role in carefully governed ‘waiting well’ approaches.<sup>[51,52]</sup> Any expansion of digital-first mental health support tools must include strong clinical governance, crisis escalation pathways, and explicit safeguards against widening digital inequalities.

Impacts of introducing age restrictions on AI chatbots would include:

- **Children’s safety and wellbeing:** Restrictions on mature content generation, relationship simulation, persistent personalisation, and emotionally manipulative interaction features would likely reduce exposure to psychologically harmful interactions.<sup>[53]</sup> Restrictions must be proportionate to preserve beneficial uses of AI, including educational support, accessibility tools, and clinically governed digital mental health interventions.
- **Privacy, profiling, and data protection:** Restricting persistent memory functions, behavioural profiling, and deep personalisation for minors would align with the UK ICO Children’s Code<sup>[50]</sup> and reduce risks associated with exploitative data collection and commercial targeting, directly relevant to digital commercial determinants of health.<sup>[1]</sup>
- **Health equity and digital exclusion:** Poorly designed digital-first regulatory approaches risk widening existing inequalities. Digital exclusion disproportionately affects children from lower-income households, children with SEND, children in rural areas, and those with limited access to private digital spaces. Regulatory frameworks should incorporate explicit equity safeguards and ensure that clinically governed digital health tools remain accessible to those who may benefit from them.
- **Unintended consequences and displacement effects:** Overly broad or inconsistently enforced restrictions may unintentionally displace children toward less regulated AI systems, offshore services, or open-source models with weaker safeguarding protections. International coordination, including alignment with the EU AI Act,<sup>[52]</sup> will be important for effective and proportionate regulation.

### 3.1 Age Assurance

The FPH supports the principle that age assurance measures should be proportionate, evidence-based, and effective, and that some additional verification requirements for adults may be justified where they demonstrably improve child safety online. However, age assurance systems must balance effectiveness with privacy, accessibility, inclusivity, and data minimisation principles. Poorly designed systems risk creating unnecessary barriers for legitimate adult users, excluding vulnerable populations who may lack formal documentation, or introducing new privacy and surveillance concerns through excessive collection of biometric or identity data. Crucially, existing approaches based solely on self-declared age, date-of-birth entry, or simple tick-box confirmation are clearly inadequate and do not constitute meaningful age assurance. Age assurance alone cannot deliver child online safety – it must form part of a broader systems-based approach.

Effective minimum age restrictions must include:

- Technically robust age assurance going beyond self-declaration (e.g. facial age estimation, photo ID verification, credit reference checks, device-level age signals, privacy-preserving third-party verification services)
- Platform liability for inadequate verification
- Independent auditing of compliance
- Rapid enforcement mechanisms with meaningful penalties
- International coordination to reduce regulatory arbitrage
- Digital literacy education, parental support tools, and clear public communication regarding purpose and limitations

Critically, the FPH urges government not to treat minimum age restrictions as the primary or sole policy lever. Harmful platform features – algorithmic recommendation systems, affirmation mechanics, compulsive design features, and targeted marketing of health-harming products – can negatively affect users across all age groups. Policies that directly regulate these features through mandatory platform design standards are essential complements to age restrictions. A framework that focuses exclusively on age gates while leaving harmful platform architectures unchanged risks creating only partial protection.

Effective monitoring will also require independent access to platform data, a major current regulatory gap. Just as 19th-century public health reforms depended on systematic monitoring of water quality through independent oversight, modern ‘digital sanitation’ requires researchers and regulators to have meaningful access to platform data to assess what children are actually exposed to, how recommendation systems shape that exposure, and whether regulatory interventions are working in practice.<sup>[27]</sup> Public trust in age assurance systems will depend on transparency regarding what data are collected, how long they are retained, who can access them, and whether biometric or identity data can be reused for commercial purposes.

The FPH advocates that any legislation setting age-based restrictions, and the mechanisms for implementation, should be co-developed with young people to ensure approaches are practical, proportionate, and reflective of real-world use, as required by the UN Convention on the Rights of the Child.<sup>[31,33]</sup> Legislation and implementation mechanisms designed without young people’s

input risk being ineffective and may produce unintended harms, including greater activity in less visible online spaces.

### 3.2 Circumvention of Age Limits

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The FPH supports a combined approach involving both education for children, parents and carers, and structural measures to reduce circumvention. Neither approach alone is sufficient. Education without structural safeguards places excessive responsibility on children and parents/carers to navigate commercially engineered online environments; structural restrictions without education fail to address the motivations, social pressures, and digital literacy gaps that drive circumvention behaviours.

Where proportionate and evidence-based, measures to reduce circumvention through VPNs and similar technologies may form part of this approach. However, any such measures must carefully balance child safety objectives with legitimate uses of privacy and security tools by adults, businesses, journalists, activists, and vulnerable groups. Age restrictions do not eliminate access entirely, but they demonstrably reduce population-level exposure and associated harms – the analogy with public health approaches to reducing underage alcohol and tobacco access is instructive. The objective is therefore not perfect enforcement, but meaningful reduction in the ambient, casual, and algorithmically driven exposure to harmful content that currently occurs at scale.

The FPH also notes the potential for displacement effects. If restrictions on mainstream platforms are implemented without broader safeguards, some children – particularly those seeking emotional support or social connection – may migrate toward less regulated AI companion services or fringe platforms that may present equal or greater risks. This reinforces the need for a systems-based regulatory approach rather than reliance on single-policy interventions.

The FPH advocates that any legislation setting age-based restrictions, and the mechanisms for implementation, should be co-developed with young people to ensure approaches are practical, proportionate, and reflective of real-world use, as required by the UN Convention on the Rights of the Child.<sup>[31,33]</sup> Legislation and implementation mechanisms designed without young people's input risk being ineffective and may produce unintended harms, including greater activity in less visible online spaces.

### 3.3 Mobile Phones in Schools

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The FPH supports making DfE guidance on mobile phones in schools statutory in principle, recognising that unrestricted mobile phone and social media use during the school day may displace learning, disrupt peer relationships and concentration, and expose young people to harmful or distracting content within an environment where schools have a clear duty of care. Making guidance statutory could improve consistency across schools and reduce pressure on individual school leaders to negotiate these issues in isolation.

It should be noted that early evaluations of school-based smartphone restrictions have shown mixed evidence on academic performance and mental health outcomes. These evaluations have often not accounted adequately for variables such as children's ages, overall smartphone usage outside school, and wider environmental factors. More rigorous and independent research is needed to understand which school-based approaches are most effective and for which groups of

children. These considerations reinforce the case for thoughtful implementation with clear exemptions rather than blanket approaches.

However, school-based mobile phone restrictions should be understood as one component of a broader systems approach, not as a substitute for platform-level regulation. Much children's exposure to harmful content, algorithmic targeting, compulsive platform design, and marketing of health-harming products occurs outside school hours, particularly during evenings and weekends. School policies cannot, on their own, address the wider commercial and technological drivers shaping children's online environments. Any statutory guidance must include clear and robust exemptions for medical needs, SEND requirements, safeguarding concerns, caring responsibilities, and legitimate educational uses. Some children rely on mobile phones for personal safety, travel coordination, or communication with carers, particularly where public transport, long travel distances, or family vulnerabilities are involved.

### Media and digital literacy: priority gaps

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The FPH identifies five critical gaps in current media and digital literacy provision for children and families. These should be the primary focus of government investment:

- **Understanding algorithmic content curation and recommendation systems:** Children and parents generally have limited understanding of how social media recommendation algorithms operate, why particular content is served, and how user behaviour influences future exposure. Without this understanding, meaningful critical evaluation of online content is difficult. Greater public understanding of algorithmic systems is increasingly necessary for informed digital participation.
- **Recognising non-traditional forms of digital marketing:** Evidence shows that children and young people experience significant difficulty identifying less overt forms of digital marketing, including advergames, influencer marketing, branded entertainment content, user-generated sponsored content, loyalty schemes, and immersive advertising formats. A systematic review found that exposure to both marketer-generated and user-generated social media content was associated with increased health risk behaviours, with user-generated content often showing stronger associations than traditional advertising.<sup>[9]</sup> Media literacy programmes must therefore explicitly address these evolving forms of commercial influence.
- **Critical evaluation of AI-generated content:** As generative AI becomes increasingly embedded within digital environments, children require support to distinguish AI-generated content from authentic human communication, identify misinformation and hallucinated content, and understand the limitations of AI systems, particularly when seeking health, emotional, or educational advice.
- **Managing compulsive design features, screen time, and sleep disruption:** Many children and parents lack practical strategies for managing persuasive design features such as infinite scroll, autoplay, push notifications, and algorithmic recommendation systems. Guidance should be evidence-based, developmentally appropriate, and co-designed with young people rather than focused solely on individual responsibility.
- **Understanding commercial determinants and industry influence:** There is a well-documented pattern across adjacent industries – tobacco, alcohol, gambling, and unhealthy food – whereby industry-funded ‘educational’ materials frame harms primarily as matters of individual choice and responsibility while minimising the role of commercial design, targeting, and regulation. The FPH recommends that digital literacy materials used in schools be independently developed, transparently evaluated, free from platform or industry influence, and grounded in the public health evidence base. Government should establish independent standards for acceptable digital literacy education, analogous to standards used in health education more broadly.

## Supporting children outside of schools

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The FPH recommends a comprehensive, multi-sector approach combining platform regulation, public education, community support, and child-centred design. Supporting parents and carers is critical: digital marketing and algorithmically curated content are often highly personalised and largely invisible to adults, making it substantially harder for parents and carers to understand what children are exposed to compared with traditional mass media environments. Parents therefore require accessible, evidence-based information about how platforms operate, how recommendation systems shape exposure, and how to have constructive, non-stigmatising conversations about online experiences and safety.

Government should also work with online platforms and services to ensure that child-protective defaults are built into systems by design, so that children and families are protected proactively rather than being required to seek out and configure protections themselves.<sup>[54]</sup> This should include default high-privacy settings for under-18 accounts, restrictions on algorithmic profiling and commercial personalisation for minors, stronger controls on contact from unknown adults, and robust limitations on marketing of health-harming products to children and adolescents. Youth organisations, libraries, community groups, and trusted local services should be supported to deliver digital literacy and online safety programmes, including targeted support for children with additional needs and for digitally excluded families. The FPH strongly supports involving children and young people directly in the design, implementation, and evaluation of these programmes.

### Parental controls and family support

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The FPH supports parents and carers having access to meaningful tools that help them guide and support their children's online experiences in age-appropriate ways. However, framing parental control as the primary mechanism for ensuring child online safety risks placing disproportionate responsibility on individual families rather than on platforms and regulators. Even sophisticated parental controls cannot substitute for effective platform-level regulation.

Digital environments are highly personalised, algorithmically curated, and largely invisible to adults, meaning parents often cannot see or fully understand the content, advertising, and recommendations being served to their children in the way they could monitor traditional broadcast media.<sup>[55]</sup> Existing parental control tools are inconsistent across platforms, technically limited, poorly understood by many families, and frequently circumvented by children and adolescents. Importantly, harms associated with social media and digital environments are not confined to families with weaker supervision or lower engagement. Evidence suggests that associations between social media exposure and adolescent health-risk behaviours persist across socioeconomic groups, indicating that individual family-level interventions alone are insufficient to mitigate risk.<sup>[1]</sup>

Parental controls should therefore be understood as one component of a broader systems-based approach, with the primary responsibility for child safety online resting with platforms, service providers, and regulators rather than individual parents. The FPH recommends that such tools be standardised, genuinely effective, privacy-preserving, and easy for families to use.

**Key principle:** The government is clear that it is the responsibility of industry, not parents or carers, to make services safe and appropriate for children. Policy must not compound socioeconomic disadvantage by placing the burden of managing risks on individual parents, carers, and children. Structural, platform-level interventions are required.

## Cross-Cutting Public Health Perspectives

The FPH wishes to draw attention to four cross-cutting themes that should inform the legislative and regulatory framework arising from this consultation.

### **Theme 1: Social media as a commercial determinant of health, industry influence, and conflicts of interest**

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This consultation must be understood within the broader framework of commercial determinants of health. Digital technology is neither intrinsically positive nor negative for children, but there are specific commercial interests that use it to cause harm, and these interests are well-resourced, politically connected, and experienced in resisting regulation. Digital marketing represents a step-change in reach, targeting, personalisation, and the immersive nature of commercial exposure compared with traditional channels. Four out of every five pounds spent on advertising in the UK in 2024 was spent online.<sup>[44]</sup> This consultation and any legislation that follows must take seriously the commercial interests that stand to gain from unrestricted access to children as a marketing audience, and must not allow these interests to dilute child health protections.

The FPH draws urgent attention to the influence of industry on the research evidence base, on political lobbying, and on media literacy materials used in schools. The history of tobacco research offers a sobering precedent: for years, industry contested growing evidence of harm, argued that associations could not be proven causal, invested in the search for putative confounders, and argued that complexity meant nothing could be done.<sup>[58]</sup> The FPH notes parallels between historical industry responses to regulation in other public health domains and some contemporary responses within the technology sector. Government must be alert to this pattern.

Of particular concern to the FPH is the narrow focus of much high-profile research and policy attention on mental health, to the exclusion of the broader range of health risk behaviours for which the evidence is equally, or in some cases more, compelling. As Daszkiewicz & Tennant (2026)<sup>[56]</sup> note, this narrowing of focus mirrors the early tobacco era, when researchers concentrated on lung cancer and ignored the many other consequences. Systematic review evidence has demonstrated robust associations between social media use and alcohol use, tobacco use, drug use, gambling, sexual risk behaviours, anti-social behaviour, unhealthy dietary behaviour, sleep disruption, and attention fragmentation.<sup>[9]</sup> Policy based solely on the mental health evidence base is therefore inadequate and risks missing the majority of the public health burden.

The FPH also notes that mental health outcomes are methodologically complex to measure consistently across studies. Mental health is heterogeneous, developmentally variable, socially patterned, and operationalised differently across datasets and disciplines. Many studies rely on relatively short self-report mental health scales that may not fully capture cumulative, developmental, behavioural, or social consequences of prolonged exposure to digitally mediated environments. By contrast, many health-risk behaviours – alcohol use, smoking, gambling, and sleep disruption – are more proximally linked to exposure, more consistently measured across population studies, and more readily observable within digital environments themselves. Emerging evidence suggests that compulsive platform design features, including rapid content

switching driven by algorithmic feeds, persistent notifications, and infinite scrolling, may contribute to difficulties with sustained attention, concentration, and cognitive regulation, particularly in developing adolescents whose prefrontal cortex is not yet fully mature. The absence of large consistent effects on mental health across all studies should not be interpreted as evidence of safety.

**Conflicts of interest in research advising government:** There is a well-documented relationship between funding source and study conclusions.<sup>[57]</sup> The FPH notes with concern that some of the most prominent researchers advising government on digital technology and youth health have declared financial relationships with technology companies.<sup>[57]</sup> The FPH has purposely grounded this response in research that is independent of industry. Government must apply the same standard to the evidence it commissions and the advisory groups it convenes. Full transparency of funding relationships and robust conflict-of-interest policies are essential for public trust.

The FPH also draws attention to methodological choices embedded in current government-commissioned research. An overreliance on randomised controlled trials as the primary standard of evidence, while dismissing or downgrading observational and quasi-experimental evidence, mirrors the tobacco industry's historical strategy of demanding an impossible evidentiary standard to delay regulation.<sup>[56,58]</sup> The public health community has long adopted the precautionary principle: the burden of proof for a potentially harmful exposure should not be to demonstrate harm beyond all doubt, but to demonstrate safety. A genuinely comprehensive public health approach requires drawing on a broader range of disciplines – epidemiology, public health, sociology, computer science, and commercial determinants research – not solely psychology.<sup>[56]</sup>

## Theme 2: Prioritise health as the primary policy goal

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There is a risk that policy in this area becomes dominated by technical debates about age verification, VPN circumvention, and enforcement mechanisms – important as these are – while losing sight of the underlying public health imperative: to reduce the substantial documented harms that current social media platforms cause to children's health and wellbeing. Age restriction is a necessary but insufficient policy response.

Harmful platform features – including algorithmic amplification of health-risk content, compulsive engagement design, social affirmation systems, sleep-disrupting notification architectures, and targeted marketing of health-harming products – may negatively affect users across all age groups. A regulatory framework focused solely on keeping younger children off platforms, while leaving these harmful features intact for older users and adults, fails to address the commercial and design drivers of harm at their source.

**FPH call to action:** A parallel programme of mandatory platform design standards must require harmful features to be modified or removed, not merely age-gated. Health must be the primary policy goal, not technical compliance.

### **Theme 3: Data access, ‘digital sanitation’, and independent research**

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A critical gap in both the evidence base and the regulatory framework is the absence of independent researcher access to platform data. The evidence cited in this response is based largely on observational data from population cohorts and self-reported social media use. Without platform data, we cannot assess what children are actually being shown by algorithms, how those algorithms are designed to influence behaviour, and whether specific design choices are driving the harms we observe. This is the central challenge of ‘digital sanitation’.<sup>[27]</sup>

Just as 19th-century public health could not protect populations from waterborne disease without independent monitoring of water quality, 21st-century public health cannot protect children from digital harms without independent monitoring of the digital environment. Much like water companies, the technology industry resists regulation and data sharing, potentially fearing reduced profits.<sup>[27]</sup> Any legislation arising from this consultation should include a statutory right for independent researchers to access platform data for public health monitoring purposes, alongside clear public health standards for what constitutes a ‘safe’ digital environment for children, analogous to water quality standards.

### **Theme 4: Health inequalities and the digital divide**

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The FPH emphasises that the harms and benefits of social media are not equally distributed across the population. The longitudinal MCS analyses demonstrate complex inequality effects: the absolute risk of cigarette use and binge drinking from social media use was larger in higher parental education groups, suggesting that social media may narrow inequalities by increasing harms in more advantaged groups.<sup>[10,11]</sup> These findings require further research and should inform targeted policy.

Critically, policy must not compound socioeconomic disadvantage by placing undue burden on individuals and families to manage digital harms. A ‘downstream’ policy response that relies primarily on parental controls, digital literacy education, and individual awareness campaigns is both inequitable and insufficient. The most equitable and effective approach is structural: platform-level defaults that protect all children by design, mandatory content and design standards enforced by independent regulators, and statutory rights to independent data access that enable ongoing public health monitoring. Children’s safety online should not be a function of their parents’ digital literacy or economic resources.<sup>[1,59]</sup>

### **Theme 5: Social media restrictions as complex systems interventions**

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Policy debates around adolescent social media restrictions often assume that limiting access will directly and predictably reduce harms and improve wellbeing. However, evidence from public health shows that complex systems may not respond in simple or linear ways.<sup>[60]</sup> Social media platforms are not isolated technologies – they are embedded within a broader system that includes companies, advertisers, governments, schools, families, peer networks, content creators, and the technologies that shape online experiences. Interventions in this system may yield intended benefits but can also generate unintended consequences, adaptive responses, and uneven effects across populations as the system adjusts over time.

The FPH urges that adolescent social media restrictions be understood as complex systems interventions rather than isolated behavioural policies.

## Summary of All Recommendations

### Chapter 1: Evidence base

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- Engage with the full breadth of social media health harms beyond mental health, including substance use, sleep, gambling, dietary behaviour, and attention.
- Commission independent research free from technology industry ties, with full transparency of funding in all evidence relied upon.
- Apply appropriate causal inference methodologies, not solely RCT evidence, to the evidence base.
- Methodological pluralism is required: combining longitudinal cohort studies, natural experiments, digital trace data, qualitative research, and ongoing policy surveillance.
- Apply robust conflict-of-interest policies to all advisory bodies and commissioned research; require balanced multidisciplinary representation across epidemiology, public health, sociology, computer science, and commercial determinants research.

### Chapter 2: Interventions

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- Introduce a legal minimum age of 16 for social media access, co-developed with young people in line with the UN Convention on the Rights of the Child.
- Accompany any minimum age requirement with robust, technically effective, privacy-preserving age assurance – not self-declaration systems.
- Raise the digital age of consent to 16; with 18 for services using data for commercial profiling and advertising of health-harming products.
- Restrict all five persuasive design features (infinite scroll, autoplay, affirmation features, push notifications, algorithmic recommendation) for under-16s; restrict commercial algorithmic profiling for under-18s.
- Apply age restrictions to all listed high-risk functionalities (livestreaming, nude images, disappearing content, location sharing, stranger-pairing) for under-16s.
- Extend regulation to advergames, influencer marketing, loyalty schemes, branded virtual environments, and metaverse marketing.
- Introduce minimum age requirements and feature-level restrictions for consumer AI chatbots; apply a tiered, developmental approach.
- Distinguish clearly between consumer AI (restrictive approach) and clinically governed digital health tools (regulated access with robust clinical governance, crisis escalation pathways, and equity safeguards).
- Extend scope of restrictions to apps and services marketing health-harming products, online gambling platforms with loot-box mechanics, and AI companion services.

### Chapter 3: Enforcement

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- Apply meaningful enforcement penalties; pursue international coordination to prevent regulatory arbitrage.
- Establish independent technical standards for age assurance with mandatory compliance and independent auditing; require platform liability for inadequate verification.

- Support making DfE school mobile phone guidance statutory, with appropriate exemptions for medical needs, SEND, safeguarding, caring responsibilities, and legitimate educational purposes.

#### **Chapter 4: Digital literacy and families**

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- Develop independently funded, industry-free digital literacy materials covering commercial determinants, algorithmic systems, and recognition of non-traditional digital marketing.
- Ensure parental controls are standardised, genuinely effective, and privacy-preserving across all platforms.
- Build child-protective defaults into all platform systems by design (not requiring parental configuration): default high-privacy settings, restrictions on algorithmic profiling and commercial personalisation, and limits on health-harming product marketing to under-18s.
- Involve children and young people directly in designing, implementing, and evaluating online safety programmes.

#### **Chapter 5: Supporting families**

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- The primary responsibility for child safety online must rest with platforms, service providers, and regulators rather than individual parents.
- Parental control tools must be standardised and genuinely effective; government should provide accessible, evidence-based guidance to support families.

#### **Cross-cutting**

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- Establish a statutory right for independent researchers to access platform data for public health monitoring, analogous to water quality monitoring frameworks.
- Introduce mandatory platform design standards requiring harmful features to be modified or removed – not merely age-gated.
- Develop clear public health standards defining a ‘safe’ digital environment for children.
- Mandate full funding transparency for all research and advisory bodies informing regulation; prioritise industry-independent evidence.
- Ensure health remains the primary policy goal throughout: addressing the commercial and design drivers of harm at their source, not solely through age-gating.
- Commission targeted research on the complex and differential inequality effects of social media use across socioeconomic groups.
- All interventions to protect children from online harms must be subject to robust, continuous, and independent monitoring and evaluation to understand their impact on the mental and physical health and wellbeing of children and young people, including unintended consequences and differential effects across groups.
- The UK Government should closely monitor emerging international evidence – particularly from the Australian social media age restriction – and use findings to inform and adapt its approach, with special attention to unintended consequences for vulnerable young people.
- Evaluation frameworks must go beyond screen time or short-term mental health measures to encompass adaptive responses, platform migration, industry behaviour, differential effects

across socioeconomic groups, and long-term outcomes, drawing on systems thinking and methodological pluralism.

- Understand social media restrictions as complex systems interventions: map wider system effects including platform adaptation, commercial determinant responses, and user migration to unregulated spaces before and during implementation.

## Conflicts of Interest

All contributors have reviewed the Faculty of Public Health (FPH) conflict-of-interest guidance and declared any relevant interests.

Dr Amrit Kaur Purba is funded by the Wellcome Trust and leads the Digital Determinants of Health Hub at the London School of Hygiene & Tropical Medicine. She has received honoraria for invited talks relating to social media, online harms, and adolescent health from academic, public health, policy, and third-sector organisations. She has provided unpaid advisory input to UK government and regulatory bodies, including the Home Office, Department for Science, Innovation and Technology, Ofcom, Metropolitan Police, and No 10 Downing Street, on issues relating to online harms, digital regulation, youth violence, and adolescent health. She previously served as Deputy Director of a UK Department for Science, Innovation and Technology commission examining the impact of social media and smartphones on youth health and wellbeing. She also holds unpaid advisory roles with the Alliance 4 Children and the UK Department for Education's Technical Advisory Board (Education and Outcomes Panel) and has contributed to advisory activities relating to youth wellbeing and public health through collaborations with the World Health Organisation and United Nations initiatives. No commercial funding, technology company funding, or industry sponsorship was received for this work.

Professor Tracy Daszkiewicz – Has no conflicts of interest. Professor Daszkiewicz holds two roles, President of the Faculty of Public Health and Executive Director of Public Health for The Aneurin Bevan University Health Board.

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Dr Niran Rehill – has no conflicts of interest. Dr Rehill is a Public Health Specialist at UCL Partners and Research Fellow at UCL, funded by the UK Prevention Research Partnership, an initiative funded by UK Research and Innovation Councils, the Department of Health and Social Care (England) and the UK devolved administrations, and leading health research charities.

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## **Publication details**

**Published:** June 2026

**Submitted to DSIT:** 26 May 2026

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