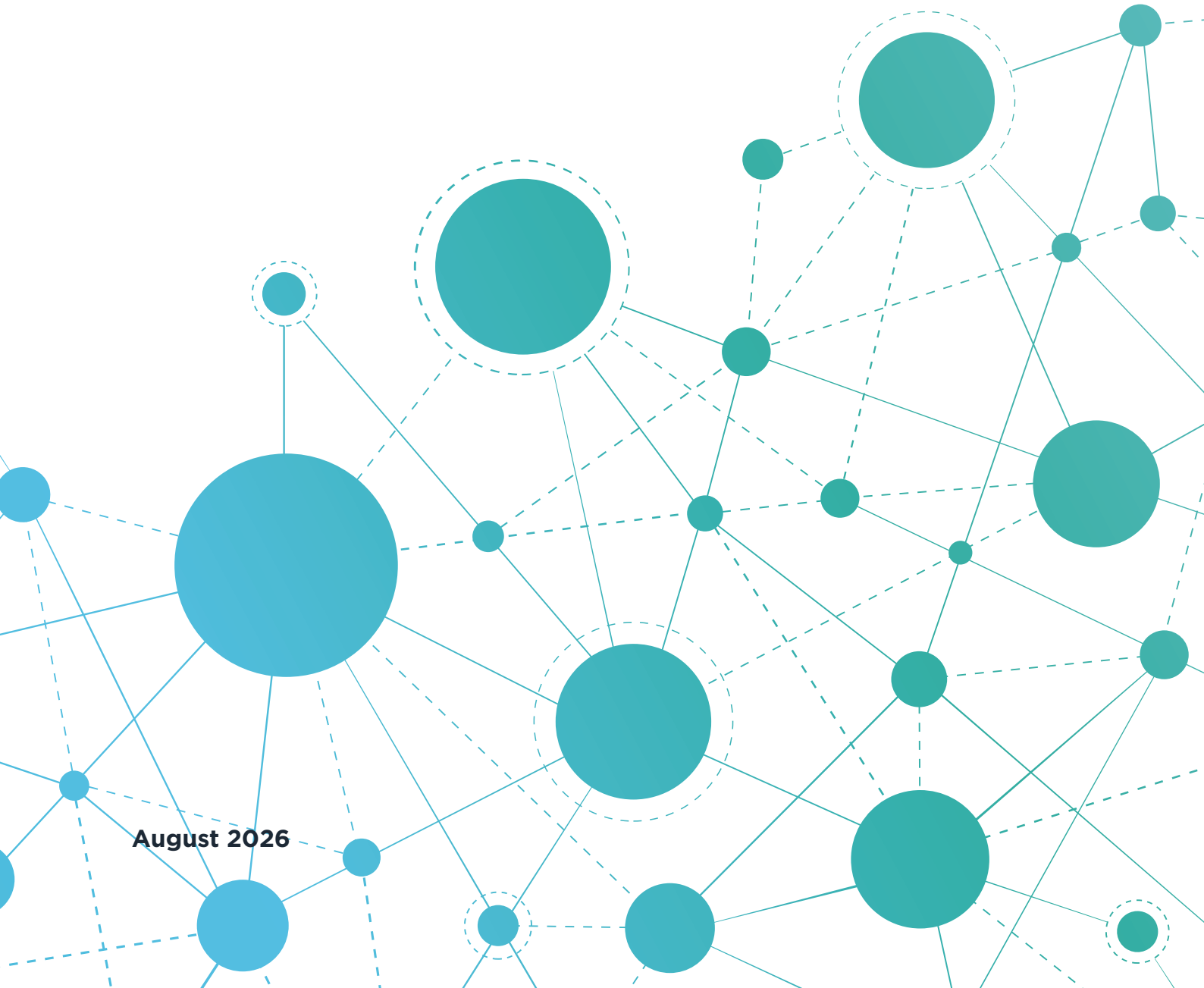
mhc
coimisiún meabhair - shláinte
mental health commission

Consultation Report

Development of a Code of Practice on the Use of Digital Monitoring Technologies



August 2026

ACKNOWLEDGEMENTS

The Mental Health Commission (MHC) wishes to acknowledge the contributions of everyone who was involved in the consultation which informed the development of the Code of Practice on the Use of Digital Monitoring Technologies. The MHC is grateful to those who took the time to complete the public questionnaire or to attend a focus group or interview. We also want to thank those who provided observations on the Code in the final stages of its development. The constructive feedback provided was much appreciated and was carefully considered and taken into account when developing the Code.

The MHC particularly wishes to thank the members of the Expert Advisory Group and the MHC's dedicated Mental Health Forum for generously giving their time and expertise to assist the MHC with this project. Their contributions were invaluable in shaping the final outcomes.

The MHC greatly appreciates the assistance of the Practice and Development Team in HSE Galway-Roscommon Mental Health Services who facilitated in-person focus groups with staff working in mental health services in the region and people with lived experience of mental health services.

The MHC is cognisant of the impact that the use of digital monitoring technologies may have on persons being cared for in approved centres. We greatly appreciate all persons with lived experience of mental health services who shared their perspectives with us on the impact digital monitoring technologies may have on care and treatment. The MHC very much hopes that this Code will encourage and promote good practice and high standards in relation to the safe, transparent, ethical and responsible use of digital monitoring technologies in approved centres.

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1 Introduction

1: Introduction

1.1 About the Mental Health Commission

The Mental Health Commission (MHC) is an independent statutory body. We are responsible for regulating in-patient mental health services (approved centres) in Ireland. Our main role is to promote, encourage and foster the establishment and maintenance of high standards and good practices in providing mental health services, and to protect the interests of people admitted and detained (held) under the Mental Health Acts 2001-2018 ("the Mental Health Acts"). Our mission is to safeguard the rights of people receiving care and treatment, encourage continuous quality improvement and report independently on the quality and safety of mental health services in Ireland. The MHC's remit will expand to include community services under the Mental Health Act 2026, once commenced.

The Assisted Decision-Making (Capacity) Act 2015 expanded our role to include setting up the Decision Support Service (DSS). The DSS helps adults who may need support – now or in the future – to make decisions about their personal welfare, including health care, and their property and finances. The Mental Health Act 2026, when commenced, will expand the MHC's regulatory remit to include community mental health services. Community mental health centres that are 24hr staffed will also be subject to similar regulatory requirements and inspections as approved centres.

1.2 Background

At present, regulation 25 of the Mental Health Act 2001 (Approved Centre) Regulations 2006 (the "2006 regulations") applies certain requirements regarding the use of CCTV and other monitoring devices for observation of people receiving care and treatment, referred to as "residents", in approved centres.[1] The following conditions apply where CCTV or other monitoring devices are used:

a. It shall be used solely for the purposes of observing a resident by a health professional who is responsible for the welfare of that resident, and solely for the purposes of ensuring the health and welfare of that resident;

b. It shall be clearly labelled and be evident;

c. The approved centre shall have clear written policy and protocols articulating its function, in relation to the observation of a resident;

d. It shall be incapable of recording or storing a resident's image on a tape, disc hard drive, or in any other form and be incapable of transmitting images other than to the monitoring station being viewed by the health professional responsible for the health and welfare of the resident;

e. It must not be used if a resident starts to act in a way which compromises his or her dignity.

Approved centres must disclose the use of CCTV or other monitoring devices to people receiving care and treatment, and where appropriate, their representatives. They must also disclose its use to the Inspector of Mental Health Services and the Mental Health Commission during an inspection or anytime on request. The Rules Governing the Use of Seclusion also contain requirements regarding the use of CCTV and other monitoring devices in seclusion rooms.[2] The new Code does not replace these requirements. The Code should be read in conjunction with the 2006 regulations and the Rules Governing the Use of Seclusion.

The MHC developed this Code of Practice on the Use of Digital Monitoring Technologies because it considers that further guidance is required to ensure that digital monitoring technologies are used in a safe, transparent, ethical and responsible manner. With the rise of digital innovation and technological advancements, the Department of Health and HSE continue to explore ways to promote the digitalisation of health and social care services in Ireland and a number of policies have been produced to encourage this movement.[3] For example, in 2026, the Department

1. The Mental Health Act 2001 (Approved Centre) Regulations 2006 (S.I. No. 551 of 2006).
2. Rules Governing the Use of Seclusion, see in particular section 12.
3. Digital for Care – A Digital Health Framework for Ireland 2024-2030; Digital Health Strategic Implementation Roadmap and Sláintecare.

of Health published its AI for Care 2026-2030 strategy which seeks to support the safe and responsible use of AI across health and social care services.[4]

At present, the main form of digital monitoring technology used in approved centres is CCTV. Regulation 25 states that CCTV or other monitoring devices cannot record a person's image and may only transmit to a live monitor monitored by health professionals responsible for the person's care and treatment. However, in light of the increased focus on digitalisation of services, and the increased use of digital monitoring technologies in in-patient mental health settings in other jurisdictions, the MHC considers that further oversight is needed regarding the use of these technologies in approved centres.

To ensure that the development of the Code was evidence-based, the MHC commissioned Queen's University Belfast, led by Professor Gavin Davidson to produce an evidence review, which is here. A summary report of the evidence review is available here. The MHC then undertook an extensive stakeholder engagement process to inform the development of the Code. This is summarised briefly below and further information will be provided on this throughout the consultation report.

1.3 Consultation process

Over a four-month period June 2025 to September 2025, the project team consulted with a wide range of stakeholders to inform the development of a Code of Practice on the Use of Digital Monitoring Technologies. The project team engaged with people with lived experience of mental health services, family members, friends, carers, staff working in mental health services and relevant organisations. Given the planned expansion of the MHC's remit to include community services, the MHC engaged with staff working in community services as well as staff working in approved centres. These engagements will inform future revisions of the Code as the current Code applies only to approved centres.

The consultation process is summarised in Table 1 below:

Table 1 - *Consultation process*

Expert Advisory Group	Three meetings between June 2025 and February 2026	18 members including two people with lived experience of mental health services
Mental Health Forum	Three meetings between April 2025 and September 2025	Stakeholder forum – people with lived experience of mental health services contribute to the development of MHC's work
Public consultation questionnaire	Live from 4 June 2025 to the 16 July 2025.	200 responses from people with lived experience, family members, staff and relevant organisations including professional associations
Focus groups and interviews	Took place between July 2025 and September 2025	6 online focus groups; 4 in-person focus groups and 6 one-to-one interviews
Engagement with additional stakeholders	Meetings and/or correspondence between September 2025 and April 2026	Engagement with Data Protection Commission, HSE Data Protection Office, HSE National Quality and Patient Safety Directorate, HSE Mental Health Engagement and Recovery Office, HSE Chief Technology Transformation Office.

4. AI for Care 2026-2030 strategy. Other developments include the introduction of the EU Artificial Intelligence Act and the progression of the Regulation of Artificial Intelligence Bill 2026 – the General Scheme of the Regulation of Artificial Intelligence Bill 2026 was published in February 2026.

2 Information gathering

2: Information gathering

2.1 Expert Advisory Group

To inform the development of the Code, the project team established an Expert Advisory Group to provide expertise on the subject matter in early 2025. It will also assist the MHC with the development of further guidance for staff on individual care planning. The Expert Advisory Group comprised a diverse range of stakeholders, including experts by lived experience, staff working in mental health services, and representatives from advocacy groups and other relevant organisations. The terms of reference stipulated that while all the feedback from the Expert Advisory Group would be analysed and carefully considered, the MHC is the ultimate decision maker and determines the content of the Code. A list of members of the Expert Advisory Group is outlined in Appendix B.

Three meetings of the Expert Advisory Group were held over the project's lifecycle. The first took place on 19 June 2025 where the purpose of the Expert Advisory Group was discussed and the public consultation process outlined. Queen's University Belfast presented on the main themes that emerged from the evidence review of the literature on the use of technology for surveillance in mental health services.[5] Members were invited to provide their initial views on the use of digital monitoring technologies in mental health services and various topics such as GDPR, human rights and consent were discussed. Prior to the first meeting, a scoping questionnaire was sent to members to ascertain preliminary views and obtain insights. The results of this scoping questionnaire were shared at the first meeting to generate discussion.

A second meeting was convened on 19 September 2025 to discuss the analysis from the public consultation (including the online questionnaire, focus groups and interviews). A project status update was also provided. The discussion centred around principles to guide the use of digital monitoring technologies, scope, level of prescriptiveness, impact assessments, proportionality and the use of digital monitoring technology in bedrooms and bathrooms. Members shared views on terminology, human rights implications and the need for regulatory oversight.

A third meeting was held on 26 February 2026 to obtain feedback from the Expert Advisory Group on the draft Code. The draft Code was circulated two weeks in advance of the meeting to allow for careful consideration. Subjects discussed included complaints mechanisms, the potential for digital monitoring technology to cause distress and exacerbate symptoms, the importance of accessible information and the need to insert references to recent AI developments.

A final version of the draft Code was circulated to the Expert Advisory Group in April 2026. Members were given two weeks to share final observations, following which the Code was deemed to be approved by the Expert Advisory Group.

Acknowledging that membership of the Expert Advisory Group was diverse, and opinions varied, the following non-exhaustive list outlines some of the points that were raised in discussions over the course of the three meetings and through email correspondence.

5. The previous title used throughout the public consultation was "Code of Practice was the Use of Surveillance Technologies". This was changed to digital monitoring technologies following consultation feedback. This occurred following submission of the Evidence Review – therefore the term "surveillance technology" is used in the Evidence Review.

Feedback and suggestions from the Expert Advisory Group on the Code: General points
The term "surveillance technologies" may be inappropriate as it has negative or criminal connotations. Alternatives were suggested such as "digital monitoring technologies", "digital monitoring devices" or "observation" care. Some members preferred "surveillance technologies" as it is more concrete.
Adopt a principle-led approach focusing on high-level principles, governance/oversight, consent and consultation, policies and procedures and staff training.
Include proportionality, least restrictive means, transparency, human rights-based approach, person-centeredness, and governance and oversight in guiding principles.
Avoid being overly prescriptive on the type of technology used to allow for flexibility.
Include a statement that digital monitoring technologies should not replace human interaction between staff and people receiving care and treatment or be used to reduce staff numbers.
Emphasise that a human rights approach is required and include human rights safeguards.
Include in definition of human rights approach references to participation and accountability and specifically mention "torture" and "punishment" to align with OPCAT definition.
Insert reference to child-centred in definition of person-centered in glossary.
State that an impact assessment should be carried out before using digital monitoring technology and services should consider the purpose, benefits, risks, data protection and human rights implications, clinical safety issues and evidence base.
Consider how the principle that technology should not replace staff or be used to address staffing shortages would be monitored and enforced in practice.
Include location as a component of the impact assessment.
State that the components in the initial impact assessment should be considered when an approved centre is carrying out a review of the impact assessment.
Clarify what health professionals are permitted to use digital monitoring technologies.
Reconsider whether "nominated person" is the appropriate term for people who are supporting people receiving care and treatment, in light of definition in new mental health legislation.
Stipulate that there needs to be clear communication and transparency with people receiving care and treatment where digital monitoring technologies are used. Ensure that staff provide accessible information.
Require services to involve and regularly consult people receiving care and treatment.
Include references to the importance of consent.
Ensure that the consent framework where digital monitoring technologies are used in bedrooms reflects clinical realities by including a more explicit clinical framing of consent.
Require services to explicitly consider the potential impact on therapeutic relationships when deciding to use digital monitoring technologies given their potential to alter trust, engagement and recovery, especially for those experiencing paranoia and trauma.
Emphasise the importance of staff training.
Provide that overreliance on digital monitoring technologies should be covered in training.
State that training should be co-produced with people receiving care and treatment.
Outline how data protection should be addressed.
Include references to complaints mechanisms.

Feedback and suggestions from the Expert Advisory Group on the Code: General points
State that where people receiving care and treatment raise concerns or indicate preferences regarding the use of digital monitoring technologies, services should document concerns raised and how they have been addressed, and if not addressed, why not.
Require services to assess impact and outcomes of digital monitoring technology where there is limited evidence on its benefits in care and treatment.
Concerns raised regarding the exclusion of AI technology used for administrative purposes from scope, for example for notetaking and scheduling.
Include references to National AI for Care Strategy; EU AI Act and National Guidance for the Responsible and Safe Use of Artificial Intelligence in Health and Social Care Services.
Include definition of artificial intelligence in glossary based on Article 3 of the EU AI Act.
Insert Fundamental Rights Impact Assessment under EU AI Act as a component of the impact assessment and address overlap in preamble.
Mention in preamble that digital monitoring technologies may cause distress and exacerbate symptoms and there is a need to take a trauma-informed approach.
Consider whether there should be a maximum time that an order permitting the use of digital monitoring technology in a bedroom and/or bathroom can last for.
Clarify how withdrawal of consent should be addressed where digital monitoring technology is used in a bedroom and/or bathroom.
Consider how clearer expectations could be set in relation to use in bedrooms and bathrooms, particularly around duration, review and oversight.
Clarify what is meant by "rare and exceptional circumstances" as it is somewhat undefined.
Expand list of potential representatives to include advocates and peer support workers.
Clarify in the Code that not all digital monitoring technologies used in approved centres will be the property of approved centres as they may be subscription based or procured from large AI companies.
Include rights-based language in section on use of digital monitoring technologies in the care and treatment of children.
Include reference that any use of digital monitoring technologies should be done in the best interests of the child.
Concerns raised that the Code is non-binding despite addressing areas that raise significant human rights and ethical concerns, particularly the use of digital monitoring technologies in bedrooms and/or bathrooms.
Avoid using definitive language like "must" given the non-binding nature of the Code.

2.2 Mental Health Forum

In addition to the Expert Advisory Group meetings outlined above, the MHC also held three meetings with its Mental Health Forum in April, June and September. The first meeting when the project was being considered took place on 9 April 2025. The project team outlined the rationale for developing a code of practice on this topic and provided contextual information in terms of existing regulation and developments. Members of the Mental Health Forum were invited to join the Expert Advisory Group to consider the project as experts by lived experience and one member agreed to take part.

The second Mental Health Forum took place on 11 June 2025 where the project team provided an update on the current status of the project and next steps. As this was the second forum, the members provided feedback based on questions which informed the development of the Code.

The third and final Mental Health Forum where the Code was discussed took place on 17 September 2025, a further project update and an overview of the public consultation analysis was provided by the project team. Members of the Mental Health Forum were given the opportunity to share their perspectives and provide further feedback to the project team.

It was not possible to share the draft Code with the Mental Health Forum for observations as the group finalised its engagement with the MHC in 2025. A new group was established with increased membership in late April 2026. The Code was shared with previous Mental Health Forum members ahead of publication. The feedback and suggestions identified below summarise the key points raised during Mental Health Forum meetings. The points outlined below may reflect contributions from one or more members. Each individual was given the opportunity to share their perspectives. This summary does not imply that all members reached a consensus on each point.

Feedback and suggestions from the Mental Health Forum on the Code: General Points
Provide a clear definition of digital monitoring technologies and clarify scope.
Consider whether term "surveillance" is appropriate and suggested "monitoring" as a suitable alternative.
Emphasise that the rationale for using digital monitoring technologies should be clearly explained and services should be able to provide a strong justification for its use.
Ensure that human rights are at the forefront of the Code.
Highlight that privacy is crucial.
Stipulate the importance of digital monitoring technologies being monitored by staff if it is used to ensure the safety of people receiving care and treatment.
Provide that staff training should include trauma informed care.
State that people receiving care and treatment should be informed that digital monitoring technologies are being used and they should be given clear, accessible and simple information on how it works and why they are used.
Provide that people receiving care and treatment should be given a choice on whether digital monitoring technologies should be used.
Reflect on the potential of digital monitoring technologies to replace human interaction, negatively impact therapeutic engagement in recovery, and reduce staff numbers.
Consider benefits of digital monitoring technologies and how it may assist in investigations into incidents and protect staff and people receiving care and treatment.
Ensure that the blanket use of digital monitoring technology in services is prohibited.
Emphasise that digital monitoring technology should only be used as a last resort.
Identify appropriate safeguards, particularly in relation to human rights and data protection.
Emphasise that where services intend to use digital monitoring technology in a bedroom and/or bathroom, a strong justification is required, and additional safeguards should be put in place.
Consider whether home care should be within scope of the Code.
Include appropriate governance and oversight mechanisms.
State that regular reviews should be carried out where digital monitoring technologies are used to assess impact and benefit.

2.3 Public consultation questionnaire

A public consultation questionnaire was developed to obtain feedback from key stakeholders. People with lived experience of mental health services, family members, staff working in mental health services and relevant organisations were asked to participate. The survey sought to examine stakeholders' views and perspectives on the use of digital monitoring technologies, including emerging ones, in mental health services and what key areas the Code should focus on. The organisations who responded to the questionnaire are listed in Appendix D.

The survey was hosted on EasyFeedback and publicly available through the MHC's website. It ran for six weeks from 4 June 2025 to 16 July 2025. A word version of the survey was also available on request. An extensive outreach campaign was conducted to gather as many responses as possible. This involved a press advertisement in the Irish Times on 31 May 2025, promotion on the MHC's social media channels (LinkedIn and X), and notifications via email to approved centres, senior managers in the HSE, Disabled Persons' Organisations, professional organisations, advocacy organisations and other key stakeholders. A summary of the views and perspectives shared by respondents is outlined below and a breakdown of the type of responses and the type of respondents are detailed in the tables below.

Table 2 *– Number of responses received to questionnaire*

Type of response	Number
Number of EasyFeedback responses	219
Responses received via email	5
Responses deemed invalid	24
Total number of valid responses	200

Table 3 *– Breakdown of respondents*

Type of stakeholder	Number
People with lived experience of mental health services	30
Family members, friends and carers	20
Staff working in mental health services	125
Organisations and other	25

2.3.1 General perspectives on the use of CCTV and newer digital monitoring technologies in mental health services

Most staff and organisations who responded to the questionnaire believed that a Code of Practice on the Use of Digital Monitoring Technologies in mental health services is required to provide further guidance to staff. The predominant view expressed throughout the responses to the questionnaire across all categories of respondents was that digital monitoring technologies should not replace staff and should only be used to augment person-centered care and direct engagement with people receiving care and treatment. The majority of staff, family members and organisations indicated that it should only ever be used in addition to, rather than as a replacement for, physical observations. However, people with lived experience agreed and disagreed in equal numbers on this. Overall, respondents were strongly against the use of digital monitoring technologies in bedrooms and/or bathrooms. There was stronger support for its use in communal areas, seclusion rooms and outside for security purposes. There was more support for the use of CCTV, particularly in communal areas and seclusion rooms, than emerging technologies. There was a large number of respondents who indicated they do not know whether they support the use of emerging technologies, reflecting that the type of technologies this term encompasses and their impact are unknown.

It is important to note that a small number of respondents were completely against the use of digital monitoring technologies in mental health services, particularly people with lived experience of mental health services and family members.

> One family member observed that digital monitoring technologies "cannot substitute the nuanced judgement, emotional intelligence, and therapeutic connection that staff provide through direct interaction".

Table 4 – *Views on CCTV in mental health services*

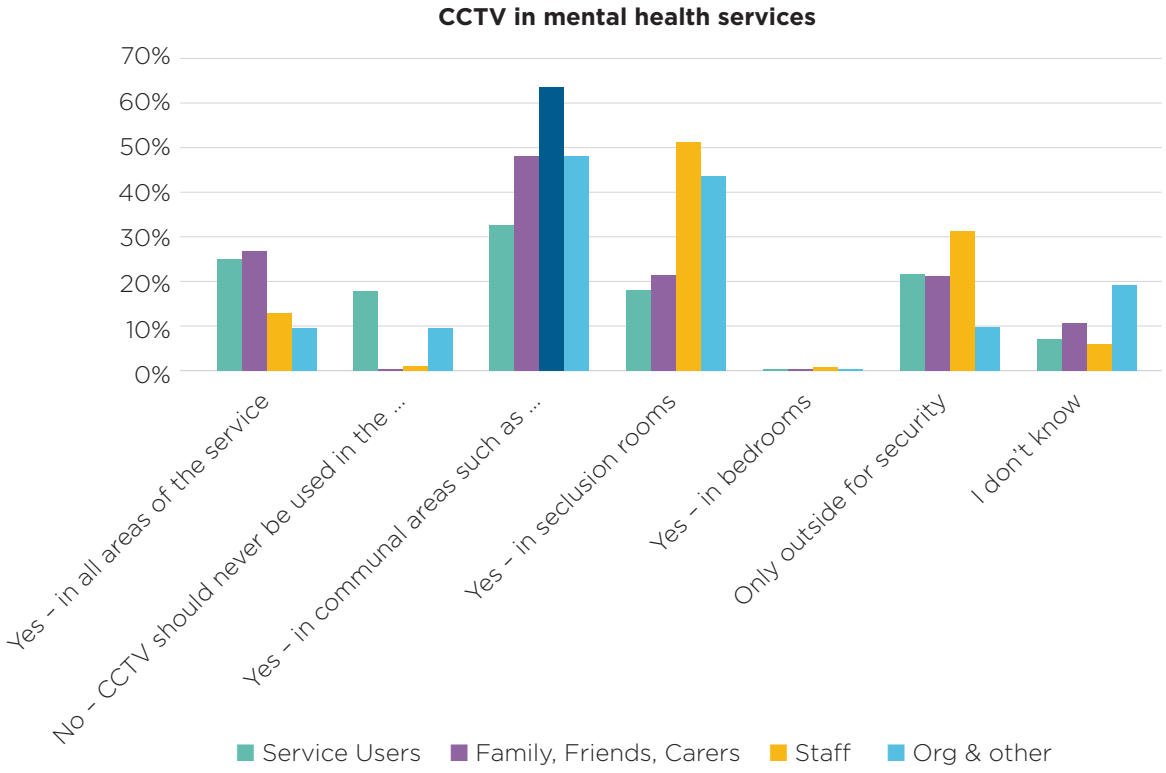
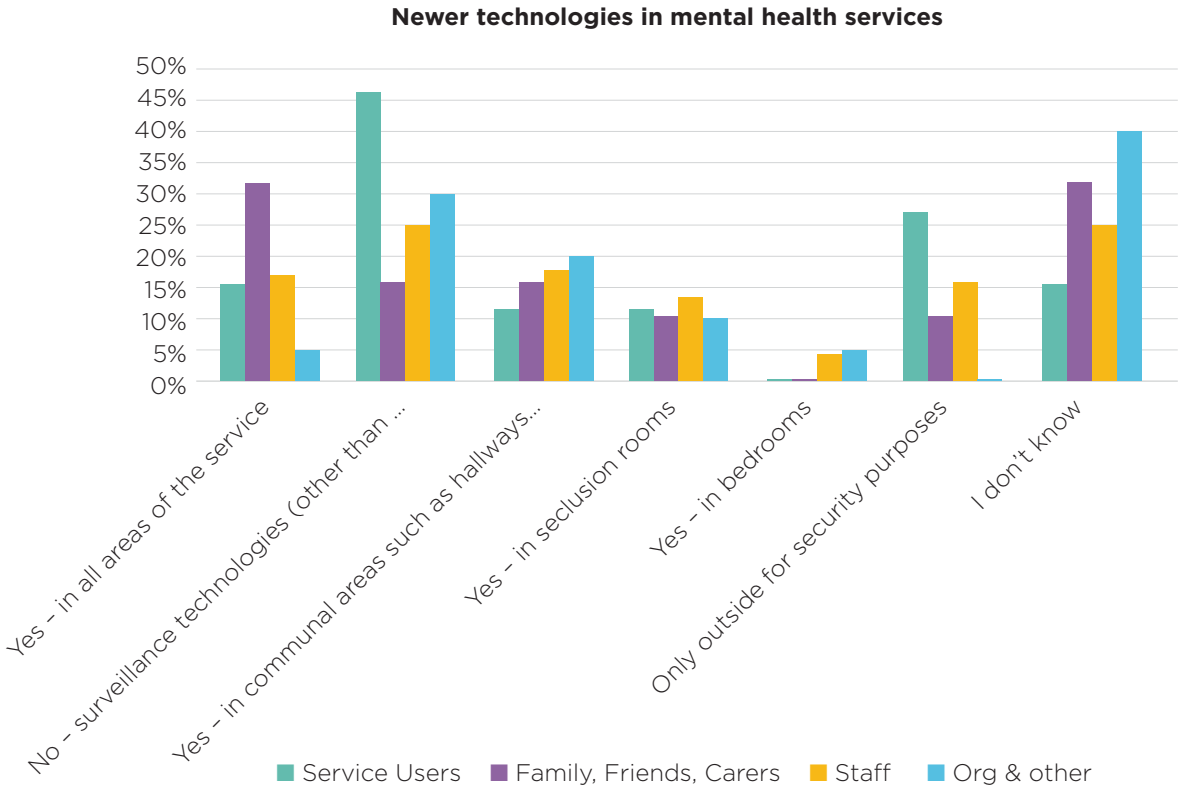


Table 5 – *Views on newer technologies in mental health services*



2.3.2 Impact of digital monitoring technologies on care and treatment and relationships between staff and people receiving care and treatment

Similar positive and negative themes were raised by all categories of respondents. Positive impacts identified by respondents included increased personal safety for people receiving care and treatment, staff and visitors, less intrusive monitoring and increased accountability and transparency where information is recorded. Some staff considered that it may assist with training and development and provide valuable data to tailor treatments and interventions. Others highlighted that it would increase staff's capacity to focus on other areas of care and treatment and may result in a reduction in suicides and self-harm.

Respondents also highlighted a number of negative impacts, such as invasion of dignity and privacy, potential to exacerbate symptoms, reduced human interaction, power imbalances and the risk that it will act as a barrier to recovery. A common issue identified was the potential for digital monitoring technologies to erode trust and negatively impact therapeutic engagement between staff and people receiving care and treatment. One family member stated that digital monitoring technologies "can escalate power imbalances, promote institutionalisation and lead to defensive practices by staff, rather than genuinely compassionate care". Concerns were also raised regarding data protection and unauthorised access to data. One service user feared that data gathering by digital monitoring technologies could be "used against them". Others raised concerns about confidentiality and privacy.

2.3.3 Key areas of focus in the Code of Practice

People with lived experience of mental health services identified a number of areas that the Code should focus on. Many of the respondents believed that the Code should require services to provide a clear rationale and identify a purpose for using digital monitoring technology. A common theme was that the Code should adopt a trauma-informed approach and include safeguards to protect the human rights of people receiving care and treatment. Data protection was raised as a key issue to be addressed alongside informed consent and involvement of people receiving care and treatment.

Family members believed the Code should focus on human rights, including people's right to be treated with respect and dignity. It was suggested that the Code needs to address circumstances where there are capacity issues and consent cannot be provided. Many family members suggested that risk assessments should be carried out to weigh up the benefits and risks of digital monitoring technologies. Data protection and cyber security were also highlighted as areas to focus on.

Staff and organisations identified a large number of areas the Code should focus on, including:

Clear definition of digital monitoring technologies
Scope, purpose, proportionality and justification
Human rights and ethical principles
Person-centered approach
Clinical validity and appropriateness
Clear parameters for use of digital monitoring technologies
Informed consent and participation
Involvement of family members and/or supporters and supported decision-making
Transparency and communication
Data protection
Staff training and culture
Data interpretation and limitations
Ongoing evaluation and feedback
Oversight, review and accountability

One organisation stated that "technology must serve recovery and not undermine it" and another suggested that the Code should "allow a practical means for staff and management to balance a service user's right to safety and their right to privacy".

2.3.4 Principles to guide the use of digital monitoring technologies

We asked respondents to the questionnaire to identify principles that should be included in the Code to guide the use of digital monitoring technologies. Similar themes were identified in the principles suggested by all categories of respondents which suggests a strong consensus. Suggested principles to guide the use of digital monitoring technology included:

Human rights including the right to dignity, respect and autonomy
Person-centred and trauma-informed approach
Evidence based
Must have therapeutic purpose
Do no harm
Informed consent
Collaboration
Safety of people receiving care and treatment and staff
Transparency and accountability
Proportionality and justification
Ethical approach
Risk minimisation
Psychological and physical safeguards
Independent oversight

2.3.5 Safeguards where digital monitoring technologies are used

Respondents were asked to share their perspectives on how the human rights of people receiving care and treatment could be upheld when digital monitoring technologies are used. A small number of people with lived experience and family members did not believe human rights can be protected where they are used as part of care and treatment. The majority of respondents across all categories believed that the Code needs to centre on a human rights based approach and comply with human rights legislation. Many respondents mentioned the importance of complying with data protection legislation and protecting rights to privacy, dignity and respect. Education and training were common themes amongst family members, staff and organisation respondents to ensure digital monitoring technologies are used ethically, legally and in compliance with human rights and data protection legislation. Some staff emphasised the importance of promoting awareness and knowledge among people receiving care and treatment and responding to any concerns they raise through feedback mechanisms. Many respondents suggested there needs to be robust oversight mechanisms and that compliance with the Code should be monitored. Others highlighted the need for complaint mechanisms.

Respondents were asked specifically about safeguards where a person is subject to continuous monitoring using digital monitoring technologies over a prolonged period of time, for example, in bedrooms or high support units. The majority of respondents who answered this question believed that ongoing informed consent for prolonged periods of monitoring should be a requirement. Equally evident in the responses was the view that prolonged monitoring using digital monitoring technologies should be subject to continuing risk assessment, with some suggesting this should be daily. This continuing assessment is to provide assurances that the clinical benefit of prolonged monitoring outweighs the privacy risks and that there are no alternative options available. Respondents unanimously called for strict controls around recording, monitoring and access to data.

> One organisation stated that safeguards "should be practical, rights-based, and aligned with trauma-informed care".

2.3.6 Consent and consultation

Respondents overwhelmingly agreed that meaningful consultation with people receiving care and treatment and/or their supporters should be required when using digital monitoring technologies. One respondent stated that consultation is essential to "uphold the autonomy, dignity, and legal rights of service users". One organisation stated that digital monitoring technologies should only be considered when

"there is clear and proportionate justification, with appropriate legal safeguards, regular review, and meaningful consultation with the person affected". Another organisation stated, "consulting with service users ensures that surveillance is transparent, accountable, and grounded in consent wherever possible". One staff member suggested that the HSE's national consent policy should be taken into consideration.

People with lived experience of mental health services unanimously agreed that informed consent should be obtained where digital monitoring technologies are proposed to be used as part of a person's care and treatment. However, there was a mixed response from family members, staff and organisations. While the majority of respondents in these categories agreed that informed consent should be obtained, a significant number of respondents also believed that it should not be required, particularly when compared with the responses to the questions about consultation. Those who said informed consent should not be required did not provide any additional comments to enable us to interpret the rationale for their response. In the focus group and interview analysis discussed further below, those who were against a requirement to seek informed consent claimed it would be impractical and unworkable, especially in communal areas.

Table 6 – *Views on whether there should be a requirement to consult*

Do you think the COP should require services to consult with service users or their decision making supporters when surveillance technologies are being used to monitor/observe service users?

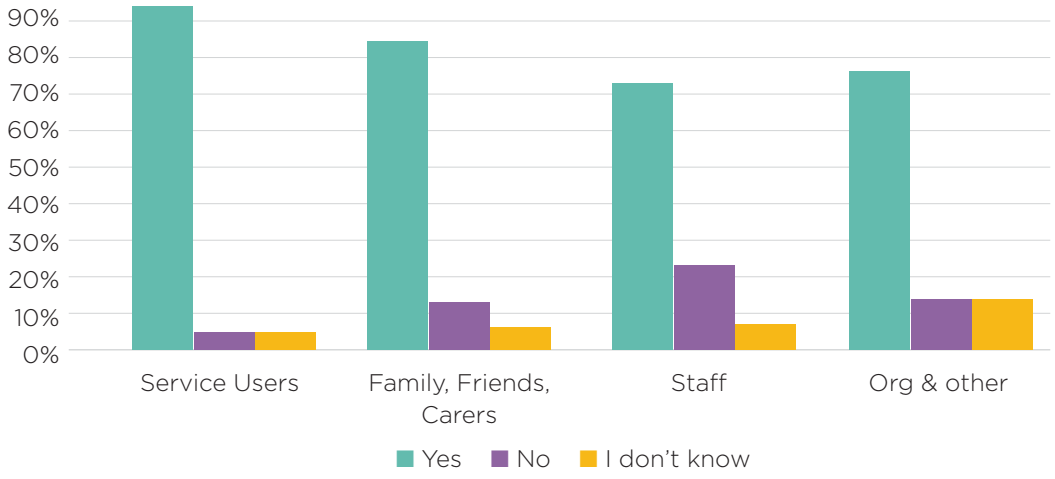
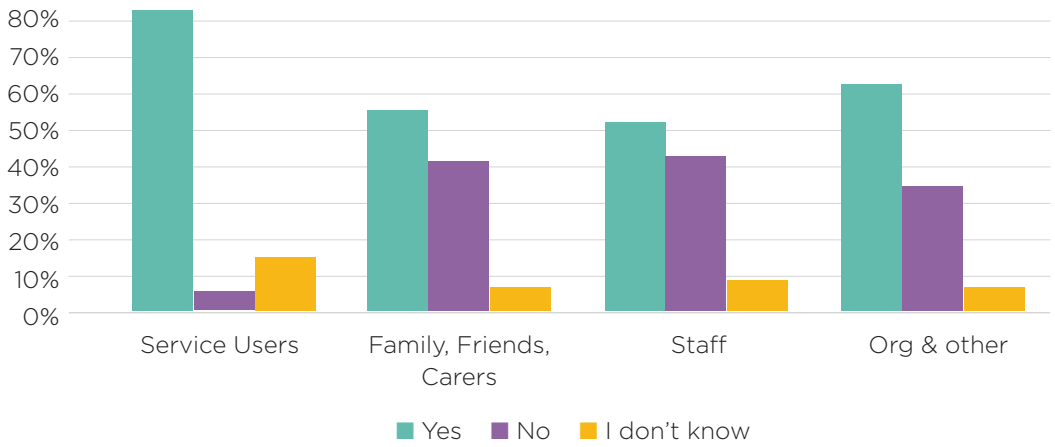


Table 7 – *Views on whether there should be a requirement to seek informed consent*

Do you think services should obtain informed consent wform service users or their decision making supporters when surveillance technologies are being used to monitor/observe service users?



2.3.7 Perspectives on staff training

Staff were asked a specific question about whether training should be provided where digital monitoring technologies are used. The majority agreed that training is necessary. Staff suggested the following subjects should be covered in the training:

- Technical training on how to use different types of digital monitoring technologies
- Best practice – when to use and not use digital monitoring technologies
- Relevant legislation – GDPR and human rights
- Trauma informed approach
- De-escalation techniques
- Compliance with new Code of Practice

It was suggested in terms of delivery formats that they should involve interactive workshops, seminars and include role playing. It was also suggested that they should be flexible and available online, for example, on HSELanD. Staff emphasised that the training should be continuous, and services should ensure that training is kept up to date. It was highlighted that training should involve people with lived experience.

2.4 Focus groups and interviews

Throughout July, August and September, the MHC conducted focus groups and interviews with people with lived experience of mental health services, family members/ friends/ carers, staff working in mental health services and representatives from key organisations, including various professional organisations. Expressions of interest to take part in focus groups and interviews were made by email contact with the Standards team and through questionnaire responses. The MHC sent email notifications to key stakeholders inviting them to complete the public consultation questionnaire and/or take part in a focus group or interview, including approved centres, HSE senior managers, Disabled Persons' Organisations, and other key organisations. The vast majority of people taking part in the focus groups and interviews also completed the questionnaire, with a small number of participants engaging solely through focus groups and interviews. The organisations who engaged with the MHC through focus groups and/or interviews are listed in Appendix C.

Those who expressed an interest were asked whether they would prefer to take part in a focus group or a 1:1 interview and whether they would prefer for these to be conducted online or in- person. The focus groups were primarily held online on Microsoft Teams in line with the preferences of the majority of participants. Four focus groups were held in-person in Galway on 10 September 2025 (three with staff working in mental health services and one with service users with lived experience of mental health services) with the assistance of the Practice and Development Team in HSE Galway Roscommon Mental Health Services.

A total of 10 focus groups were held on various dates. The numbers within each focus group depended on the availability of participants. Of these focus groups, two were held with service users with lived experience of mental health services, and 1 was held with family members/ carers/ friends. 12 service users and four family members /carers / friends took part. A total of six 1:1 interviews also took place with staff or representatives from organisations who preferred that method of engagement.

Participants were given a brief overview of the project and then were asked several questions regarding the development of the Code. The questions focused on participants' perspectives on the use of digital monitoring technology in mental health service and its impact on care and treatment. Specific questions were asked about the use of digital monitoring technology in private spaces versus communal areas and whether services should be encouraged to consult and seek informed consent from people receiving care and treatment. A variety of other questions were asked depending on the category of stakeholder.

2.4.1 Perspectives of people with lived experience of mental health services

The MHC engaged with a total of 12 people with lived experience of mental health services in focus groups to inform the development of the Code – three people participated online and nine participated in-person. As different perspectives were expressed in the focus groups, they are detailed separately below.

(a) Online focus group

Many participants questioned whether digital monitoring technology improves outcomes or is beneficial. It was suggested that digital monitoring technologies have the potential to be detrimental to recovery, especially those experiencing psychosis, paranoia, trauma or stigma. Participants were strongly against the use of body worn cameras and wearable devices. Many participants were concerned that increased use of digital monitoring technologies in mental health services would be a cost cutting exercise to reduce staff numbers and this would negatively impact on care and treatment, in particular the therapeutic environment and therapeutic relationships. Participants believed that enough skilled, suitably trained and qualified MDT staff should negate the need for digital monitoring technology.

One participant noted that the rising use of surveillance technologies in mental health services in the United Kingdom is a result of a sales drive by tech companies and questioned whether there is any evidence or research to demonstrate its positive impact on care and treatment. They noted that there are ongoing investigations and inquiries regarding patient safety where new forms of technology were relied upon in mental health services.

Where digital monitoring technologies are used, participants emphasized the need for people receiving care and treatment to be given information about the technology used, how it is being used and why, and be informed about their rights. One participant considered that services should be required to outline the evidence base for using digital monitoring technologies, how it would be beneficial and carry out a risk assessment. In terms of the MHC's role as a regulator, one participant believed that the MHC should approve or refuse to approve specific digital monitoring technology for use in each approved centre and such approval should be reviewed annually. In contrast, another participant believed that the Code should outline generally what is appropriate, leaving services discretion to decide how to use it, while requiring them to inform the MHC when new technology is being introduced. Participants cautioned against the blanket use of digital monitoring technologies within services and suggested that the Code needs to be robust and put in place significant safeguards that must be satisfied before they are introduced.

It was suggested by one participant that CCTV footage should be capable of being recorded in communal areas to enable services to address incidents that occur such as assaults and that the MHC/Gardaí should be permitted to view recordings to investigate incidents. Data protection and data security came up repeatedly, with participants concerned about unauthorised access, abuse of data, cybersecurity and confidentiality – particularly where data is stored externally. One participant raised concerns about data being collected for research or commercial purposes without passing robust ethical approval processes or obtaining informed consent from people subject to monitoring. This participant emphasised the need for services to fully disclose the exact nature and extent of personal data being gathered, recorded, used and stored and how it is being accessed and used and by whom.

In terms of consultation and consent, participants agreed that it would be more difficult to impose these requirements on services in communal areas as opposed to private areas. One participant cautioned that if services buy expensive technology, the corporate drive to use it will become the service imperative and services will use "soft coercion" to get service users to comply and grant consent. They believe that service users who opt in must be able to give truly informed consent, be permitted to withdraw consent at any time, and be given sufficient information on what the technology entails to make the decision.

(b) In-person focus group

Participants were generally in favour of digital monitoring technologies and noted that their use would increase their sense of personal safety. Two participants had experienced CCTV being used in their care previously and both expressed that it never bothered them. They highlighted that they were told that it was being used and there were signs saying CCTV is in operation. One of these participants shared that they would have liked to see more cameras being used and for them to be placed in better positions as they were concerned about blind spots. Both participants who experienced the use of CCTV mentioned that

they did not know if the CCTV was being recorded or not. Many of the participants live in community residences and noted that no cameras are used where they live, that doors are not locked and they feel safe, and everyone trusts one another. Overall, the group felt that digital monitoring technologies can keep staff and people receiving care and treatment safe.

Participants raised concerns about privacy and emphasised the importance of safeguards to protect people receiving care and treatment. Most participants were against the use of digital monitoring technologies in private spaces such as bedrooms and bathrooms. One participant was in favour of digital monitoring technologies being used in bedrooms if a person is at risk of harm. They spoke about their experience of night observations and feeling frightened at times when woken from their sleep to staff members standing over them with flashlights. When asked about the impact on the therapeutic relationship, one participant alluded to the power imbalance when they spoke about "feeling watched".

Regarding consultation and consent, one participant believed that people should be asked if they want digital monitoring technologies to be used in their care. Others suggested that people should be told about the use of digital monitoring technologies at a time where they can absorb the information rather than at admission when they may be distressed or confused. Participants highlighted that it might be difficult to obtain consent if a person is unwell. It was suggested that staff should have ongoing discussions with people receiving care and treatment. Participants believed that staff should explain what technology is being used and what its purpose is. In terms of communal areas – participants mentioned it would be helpful if staff explained that CCTV is not just focused on one person and that it is monitoring everyone for their safety.

Overall, participants were not against recording as they believed data could be used as evidence if something occurred. However, they believed that data should be deleted when it is no longer required after a set period of time. One participant suggested that if footage is required for evidence, the clip should be shortened so only the necessary footage is handed over. Participants expressed concerns over cyber security and hacking and how services would keep information safe and prevent data breaches. In terms of what the Code should focus on, participants would like to see consultation, consent, and privacy addressed.

2.4.2 Perspectives of family members/ friends/ carers

Participants had significant reservations about the increased use of digital monitoring technologies in mental health services. They believed that this represents a move away from person-centered care and would negatively impact on the therapeutic relationship between staff and people receiving care and treatment. Participants emphasised that digital monitoring technologies cannot be used as a method of reducing staff numbers and highlighted that people benefit most from 1:1 interactions with staff in a therapeutic environment. One participant stated that people need to be treated as individuals with rights and their dignity needs to be respected. Most participants who attended this focus group believed that the use of digital monitoring technologies in mental health services is an invasion of privacy. They considered that any decision on whether to use digital monitoring technologies within a service should primarily focus on how introducing the technology would benefit people receiving care and treatment.

It was highlighted that often people are not aware of what technology is being used within a service, including CCTV. One participant mentioned that they only became aware that CCTV was being used in the service caring for their family member upon reading an MHC inspection report. Participants strongly believed that services should have to inform people receiving care and treatment and their family members when this technology is being used, where it is being used and for what purpose it is being used. In terms of consent, participants raised the difficulty of obtaining consent from people who are very unwell, where capacity fluctuates, as decision-making arrangements may not be in place. Participants were strongly against the use of digital monitoring technologies in bedrooms and bathrooms. They believed it should only be in communal areas such as entrance ways, over medicine cupboards, hallways and gardens. They were less supportive of its use in dining rooms and sitting rooms as they believed that staff observations are sufficient in these areas.

As above, participants expressed serious concerns when it comes to data protection and data security. One participant highlighted that not all services are technologically advanced and may not have the appropriate measures in place. One participant queried what would happen when digital monitoring technology stops working. If footage through CCTV is recorded in the future, participants believed that services should not have direct access to the footage, and it should be stored with an independent external provider to prevent misuse and access should be granted as appropriate. One participant noted that it is pointless to have CCTV cameras that are not capable of recording because they can go unmonitored. Most participants specifically mentioned that they would be opposed to the use of body worn cameras in services.

2.4.3 Perspectives of staff, organisations and other interested parties

Over 40 staff working in mental health services and representing organisations took part in focus groups and 1:1 interviews. A wide range of MDT staff participated including mental health nurses, consultant psychiatrists, psychologists, social workers and support workers. The majority of participants categorised as organisations were representatives of professional organisations with some advocacy groups also participating. Most focus groups took place online with the exception of three focus groups that took place in-person in Galway with HSE staff. These were organised in conjunction with the HSE Galway Roscommon Mental Health Services following contact from their Practice Development Facilitator.

Owing to the number of participants, and the diversity of views expressed, not all points raised by individuals can be set out in full. Below, we detail some of the feedback received from staff regarding the development of the Code by theme:

1. **General views on digital monitoring technologies:** There were mixed views on whether digital monitoring technologies should be deployed in mental health services. Overall participants were not in favour of the blanket use of such technologies and cautioned against a one size fits all approach given the variety in mental health services. Some participants suggested that whether it is appropriate depends on the level of acuity in the service, the patient cohort and whether there are a large number of incidents. Participants mostly agreed that digital monitoring technologies have the potential to keep staff and people receiving care and treatment safe. Those who were against its use in services cited concerns about the negative impact on the therapeutic relationship. Only a small number of staff were completely against the use of digital monitoring technologies in mental health services.
2. **Level of detail in Code:** Many participants cautioned against developing a Code that is too vague as this would result in inconsistency, however, participants differed on how detailed the Code should be. Most argued that the MHC should take a high-level approach, identifying principles and key requirements that services should abide by, while allowing services flexibility when it comes to determining when or how technology should be used and whether certain technologies should be introduced following their own risk assessments. A small number of participants preferred the idea of a very detailed Code where the MHC identifies specific types of technologies that are permitted to avoid too much discretion being granted to services. Most participants were against detailed reporting requirements or approval processes to the MHC as they believed that the MHC inspection process would be sufficient to monitor compliance.
3. **Staffing:** The vast majority of participants emphasised that the Code should make it clear that digital monitoring technologies should not replace staff or result in a reduction in staff numbers. Most believed that digital monitoring technology cannot replace therapeutic engagement and should only be used to enhance, rather than replace, the provision of direct care and treatment. A small number of participants felt that digital monitoring technologies could free staff up to spend more time engaging directly in a meaningful way with people receiving care and treatment, instead of constant monitoring. Participants felt strongly that digital monitoring technologies should only be monitored by healthcare staff, not security personnel, with the exception of external perimeters.

4. **Person-centred care:** The majority of participants expressed that digital monitoring technology must not negatively impact the delivery of person-centred care or replace human interaction. A few participants mentioned that a lot would be missed if there is reduced human monitoring as technology cannot read body language and cannot replace staffs' instincts. Many participants stated that there should not be blanket use of digital monitoring technologies as they can be detrimental to the recovery of some individuals, such as those experiencing paranoia, psychosis, trauma, and may exacerbate symptoms. Particular concerns were raised regarding its use in high observation/ seclusion rooms where some participants felt that people would feel isolated if physical observations were replaced with technology.
5. **Training and development:** Several participants noted that digital monitoring technologies may be used to support training and development and can be used as a reflective tool, for example, footage could be used to look back on incidents where restrictive practices were used and what could be done differently. One participant noted that oftentimes staff have very different views on how incidents unfolded even if they were all present in the same room at the same time – they believed that objective footage would give a clear picture and help staff reflect, learn and improve practices. Others were concerned about this as they felt it could result in staffs' decisions being questioned and could be used as part of disciplinary actions. Some participants mentioned that staff would interact differently with people receiving care and treatment if CCTV was recorded because they would be worried about what could be misinterpreted which may result in more detached and robotic care.
6. **Governance:** Many participants believed that services should be required to justify why they are using digital monitoring technology and demonstrate how it will improve therapeutic outcomes. One participant noted that they reviewed the use of CCTV within their services and determined that considering their patient cohort and level of acuity, CCTV was not justified, and they discontinued its use. This service also carried out a review to assess whether a new form of technology, that is used to a large extent in the UK, should be introduced and it determined that there was not enough evidence to support its introduction. Other suggestions in terms of governance were transparent documentation of rationales, records of consent status, time-limited authorisations, and appointment of designated person responsible for digital monitoring technologies.
7. **Consent, consultation and information:** There were different views expressed about consent across the focus groups. Many participants expressed concerns around the practicalities of obtaining consent if a person is very unwell and their capacity fluctuates, or where digital monitoring technologies are used in communal areas. Some contended that this would result in a huge amount of paperwork for staff. Some participants believed people receiving care and treatment should be able to opt into the use of digital monitoring technologies as part of their care and treatment, while others believed it should be viewed as implicit consent on admission. Overall, most staff believed it would be unworkable to seek consent, especially in communal areas as people will have different views on its use and a consensus would be required. However, many believed consent should be required if digital monitoring technologies are used in bedrooms and/or bathrooms. Many participants highlighted the importance of accessible information through signage and information leaflets to explain what technology is used and how it is used. One participant suggested it would be helpful to physically show people the technology, how it works, who monitors it and how information is stored as this would allow them to understand how it functions meaning it may be more acceptable to them.
8. **Communal areas versus private areas:** Most participants were against the use of digital monitoring technologies given the impact on service users' right to privacy. However, a handful of participants felt that it may be beneficial where a person is at very high risk of suicide or otherwise at high risk of harm as staff could have access to vitals and

additional imagery which could facilitate quicker interventions in emergency situations.[6] Other benefits put forward were the reduction in disruptive nighttime observations and the potential for technology to alert staff to serious incidents. Some participants felt that digital monitoring technologies should only be used where the person consents or prefers to be monitored in this way. One participant believed it would be too difficult to have technology in some rooms and not others if you are not able to switch it on and off. Another participant believed it should be considered part of the fixtures and fittings and therefore consent should not be required. If technology is used in bedrooms and bathrooms, participants believed that this should be subject to strict approval processes and regulatory oversight to ensure safe practices. Several participants mentioned that it should be prescribed and approved by the consultant psychiatrists and MDT team responsible for the person's care, and only where it is deemed to be necessary and proportionate. It was suggested that it should be time-limited and reviewed regularly to ensure that people are not under continuous observation for extended periods of time. In terms of communal areas, some participants noted that where an approved centre is situated in a hospital, people will be monitored as they make their way to the approved centre and it needs to be clear when the Code applies. One participant contended that the Code needs to address the use of CCTV outside of or at the point of entry for general security purposes and that security personnel should be able to monitor this.

9. **Data protection and recording:** Participants expressed concerns about the privacy rights of both staff and service users and data protection if data or footage is recorded and stored. Many believed that data protection procedures would need to be in place to prevent unauthorised access and misuse. When asked if CCTV recording should be permitted, several participants expressed concerns about who would have access to recordings, how they can be used and where they would be stored and there were queries regarding how services would manage data of this nature. A few participants mentioned that it would not be appropriate to record people who are unwell as they may regret what occurred and it would not be fair to keep recordings of incidents on file. Some participants mentioned that contractual changes and disclaimer forms may be required when staff are recorded. Other participants were supportive of recordings and noted it can be useful for Garda investigations, serious incident reviews and learning. Many staff who participated were emphatic that IT/ data protection personnel would be required if data was capable of being recorded as clinical staff would not have the skills or the time to manage data access requests and delete data.
10. **Notifying or reporting to MHC:** A number of participants expressed concern about the potential for overly onerous reporting requirements to the MHC in relation to the use of digital monitoring technologies. It was suggested that if the requirements in the Code are clear and unambiguous, they should be capable of being applied without administratively burdensome reporting requirements being placed on services. Other participants believed there should be reporting requirements as it would allow the MHC to have oversight over the level of use across services and consider whether it is appropriate to be used in individual services.

6. One participant mentioned that for people in treatment for their eating disorder, it may be useful to have sensor technology in bedrooms to alert staff as they may exercise at nighttime when they are not under observation by staff and this can impact recovery. Another participant gave the example of a person appearing to be asleep during 15 minute observations but they could have a dangerous apparatus that is not in view of staff.

Appendices

Appendix A: Membership of the project team

Gary Kiernan	Director of Regulation
Pawel Stepala	Head of Standards
Katey Tolan	Policy and Research Manager
Anne Marie Ryan	Policy and Research Officer
Ciara Cady	Policy and Research Officer
Ciarán Lee	Policy and Research Officer
Sarah Garrett	Clerical Officer

Appendix B: Membership of Expert Advisory Group

George Bridges	Expert by lived experience
Fiona Anderson	Expert by lived experience
Thom Stewart	Independent Living Movement Ireland Disabled Persons' Organisation representative
Catherine Gibson	Assistant Principal, Department of Health
Lucia Power	Regional Manager, Health Information and Quality Authority
Daráine Murphy	Senior Business Analyst, Health Information and Quality Authority
Karen Murphy	CRPD/IMM Manager, Irish Human Rights and Equality Commission
Dr Louise Rooney	Policy and Research Manager, Mental Health Reform
Jim Walsh	Training and Development Manager, Peer Advocacy in Mental Health
James McQuirk	Senior Operations Manager, Peer Advocacy in Mental Health
Dr Patricia Isobel Walsh	Consultant Psychiatrist, Irish College of Psychiatrist representative
Helen Earley	Area Director of Nursing, Area Director of Nursing Group representative
Aishat Sansui	Social worker, Irish Association of Social Workers representative
Niamh Quinlivan	Speech and Language Therapist, Irish Association of Speech and Language Therapists
Dr Michael Drumm	Principal Psychology Manager, Psychological Society of Ireland
Carla Johnston	Registered Proprietor Nominee, National Eating Disorder Clinic
Aoife Gallaher	Assistant Inspector, MHC
Shayne Wilson	Assistant Inspector, MHC

Appendix C: Organisations or professionals that attended focus groups, one-to-one interviews or meetings to inform the development[7]

Care Quality Commission (CQC)
Data Protection Commission (DPC)
Dr Owen O'Sullivan, Staff Psychiatrist, Forensic Division, Centre for Addiction and Mental Health & Assistant Professor, University of Toronto, Canada
HSE Data Protection Office
Irish Association of Social Workers (IASW)
Irish Council for Psychotherapy
Nua Healthcare
Psychiatric Nurses Association (PNA)
Psychological Society of Ireland (PSI)
Shine

Appendix D: Organisations or professionals who completed a response to the public questionnaire

Abilitywest New Directions
BodyWhys
Dr Owen O'Sullivan, Staff Psychiatrist, Forensic Division, Centre for Addiction and Mental Health & Assistant Professor, University of Toronto, Canada
Health Information and Quality Authority (HIQA)
Independent Living Movement Ireland
Irish Association of Social Workers (IASW)
Irish Deaf Society (IDS)
Mental Health First Aid Ireland (NTMA)
Mental Health Nursing Discipline, Trinity College Dublin
Nursing and Midwifery Board of Ireland (NMBI)
Psychological Society of Ireland (PSI)
Shine
St Patrick's Mental Health Services

7. Many people with lived experience, family members and staff working in mental health services also attended focus groups and one-to-one interviews. To ensure confidentiality, the MHC only acknowledges organisations by name, or people who indicated that they would be happy to be personally acknowledged.

Appendix E: Organisations that provided written observations on the Code

Chief Technology and Transformation Office
Data Protection Commission
Department of Health
HSE Data Protection Office
HSE National Quality and Patient Safety Directorate
HSE Mental Health Engagement and Recovery Office
College of Psychiatrists

Mental Health Commission
Coimisiún Meabhair-Shláinte
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YouTube Channel: Mental Health Commission - YouTube