mhc
coimisiún meabhair - shláinte
mental health commission

# Mental Health Commission Annual Report 2025

## Including the report of the Inspector of Mental Health Services and the report of the Director of the Decision Support Service

## More Information

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# CHAIRPERSON'S STATEMENT

## DR JOHN HILLERY

**It is my privilege to introduce the Mental Health Commission's Annual Report for 2025, a year in which the role, impact, and responsibilities of the Mental Health Commission (MHC) have continued to expand in line with our mandate to uphold the rights, dignity, and wellbeing of all those who use mental health and decision support services in Ireland.**

During 2025 - the third year of our strategic plan, *Supporting Change 2023-2027* - we further embedded our core objectives and values across every aspect of our strategy and provided a clear and principled framework to guide the MHC through a period of significant legislative reform, service transformation, and rising public expectation. This is reflected across our guidance and policy documents published in 2025 relating to human rights-based care and inclusive mental health service delivery aligned with Ireland's obligations under national and international human rights frameworks.

Across 2025, we continued preparations for the broadening of our statutory responsibilities. At the time of writing, the Mental Health Act 2026 has been enacted. The Board and Executive of the MHC acknowledge the significant leadership of Minister Mary Butler in relation to this reforming legislation, and we look forward to working collaboratively with the Department of Health to fully implement the new Act over the coming months and years. The Act expands regulatory oversight, and aligns mental health legislation with contemporary standards of dignity, autonomy, supported decision-making, and accountability. In this context, the MHC is uniquely positioned to lead the development of clear definitions, standards, safeguards, and reporting requirements, to promote a consistent, human rights-based approach to mental healthcare.

The Decision Support Service (DSS) marked its second full year of operation in 2025, a period which saw it successfully embrace and champion the principles of the Assisted Decision-Making (Capacity) Act 2015, empowering people to make decisions about their lives in a manner that respects their will, preferences, and rights. This service - along with our broader regulatory functions - represents a vital part of a more inclusive, responsive, and accountable system of support. In collaboration with, and supported by, the Department of Children, Disability and Equality, this pioneering service puts Ireland at the forefront of vindicating human rights. The DSS ensures that all people who may need support in making

decisions now have a service that is focused on their will and preferences. I want to acknowledge and thank former and current Ministers of State for Disability, Hildegarde Naughton and Emer Higgins - and officials at the Department - for their support and commitment of, and for, the DSS.

No significant strategic or societal change is achieved in isolation. I would like to extend my sincere thanks to the many service providers; health and social care, legal and financial professionals; and non-governmental organisations who supported the MHC throughout 2025. Your collaboration and shared commitment to service quality and human rights are vital to building a system that meets the needs of all who rely on it.

> The Decision Support Service (DSS) marked its second full year of operation in 2025, a period which saw it successfully embrace and champion the principles of the Assisted Decision-Making (Capacity) Act 2015, empowering people to make decisions about their lives in a manner that respects their will, preferences, and rights.

To implement our expanding statutory mandates, the MHC continues to operate to the highest corporate governance standards. I wish to acknowledge the deep commitment and skill of the MHC executive team and staff, whose tireless work continues to enhance the organisation's regulatory rigour, operational excellence, and public engagement. The MHC is also fortunate to benefit from a capable and experienced Board, whose governance and oversight ensures that the organisation remains strategic, accountable, and effective. I want to thank the members of our Human Rights Committee and our Finance, Audit and Risk committee who assist the Board to both support and hold our Executive to account. This ensures that we are an effective, cohesive and transparently-governed organisation that is independent in function and which acts, at all times, in the public interest.

In closing, I am proud of what the MHC has achieved in 2025, but I am equally mindful of the work that remains. The MHC will continue to play its part, with vigilance, with purpose, and with a deep respect for those we are here to serve.

**Dr John Hillery | Chairperson**

# CHIEF EXECUTIVE'S REVIEW

## JOHN FARRELLY

**Guided by our strategic plan, *Supporting Change 2023–2027*, the MHC has remained steadfast in its mission to promote and uphold the rights of people who use mental health and decision support services. We have seen considerable advancement in the regulation and delivery of mental health and decision support services in Ireland across 2025.**

The DSS has continued to grow in impact and reach since its launch in 2023, offering practical and legal supports to individuals who may face difficulties in making decisions independently, either now or in the future. In 2025, 3,622 enduring powers of attorney were registered (a 156% increase from 2024), 18,637 fully verified 'MyDSS' accounts were created, and 1,875 decision support arrangements were being supervised at the end of the year.

Our 2025 Annual Report also highlights many positive developments in Ireland's inpatient mental health centres, which we should be optimistic about. First, overall compliance levels improved across the 67 approved inpatient centres. Second, eight approved centres achieved 100% compliance with the Regulations, and in so doing demonstrated unwavering commitment to high-quality care. Third, 24 Regulations had a compliance rate of 80% or higher, compared to 22 Regulations with a compliance rate of 80% or higher in 2024. And four - and perhaps most importantly - there was a continued decline in the use of restrictive practices, which represents one of the most notable human rights advances in mental health care in Ireland in recent decades.

However, while there is much to commend, low compliance persisted across several fundamental Regulations such as premises, risk management, staffing, and individual care planning - areas that are essential to delivering safe, person-centred care. The MHC was compelled to take 49 enforcement actions, an increase of 58% from the previous year. These actions reflect our strengthened commitment to regulatory vigilance, but they also highlight actions that must be addressed by the Health Service Executive.

In his report, the Inspector of Mental Health Services points to the increasing complexity of care requirements in inpatient services. He notes that while inpatient care has a significant role; it must not become the default location for care. Much of Irish mental health care should be addressed in the community where primary prevention and recovery are more effectively achieved.

Following the Inspectors 2025 service review, the MHC has increased the standards of medication management, including the need for centres to have an appropriate policy suite, evidence of audit, and regular access to a drugs and therapeutics committee.

Our 2025 Annual Report makes clear, once again, that the role of the MHC continues to evolve from a primarily regulatory function to a broader leadership role in driving standards, quality, safety, service improvement, and human rights-based practice across services.

We continued to contribute to this culture of continuous quality improvement in 2025 by issuing guidance, and developing evidenced-based standards, to improve service delivery and the experience of those accessing services.

We also put a significant level of work into raising awareness of the information we have developed and made available for people who experience involuntary detention, as well as for their friends and family. In 2025, we also created a series of explainer videos to help detained persons understand more about their stay in hospital, and about their rights. We also produced several information leaflets, which are now available in 18 different languages.

> “First, overall compliance levels improved across the 67 approved inpatient centres. Second, eight approved centres achieved 100% compliance with the Regulations, and in so doing demonstrated unwavering commitment to high-quality care. Third, 24 Regulations had a compliance rate of 80% or higher, compared to 22 Regulations with a compliance rate of 80% or higher in 2024. And four - and perhaps most importantly - there was a continued decline in the use of restrictive practices, which represents one of the most notable human rights advances in mental health care in Ireland in recent decades.

At the time of writing, the Mental Health Act 2026 has been enacted. The Executive of the MHC look forward to working collaboratively with the Department of Health to fully implement the new law. This Act, in tandem with proposed safeguarding legislation, sets a strong foundation to build safer and better mental health services across all our communities.

In conclusion, I would like to thank all the staff of the MHC, particularly our Senior Leadership Team; our Board Members, led by our Chairperson, Dr. John Hillery; and all people throughout Ireland who work continually and collaboratively to improve mental health and decision support services at a time of great change in Irish society.

**Mr John Farrelly | Chief Executive**

# 2025 in Brief

**2,612**
registered inpatient beds in 67 approved centres, including two centres newly registered in 2025

**49**
enforcement actions related to 32 approved centres

**8**
centres achieved 100% compliance with all regulations

**11**
Regulations were fully complied with by all 67 approved centres

**24**
Regulations had a compliance rate of 80% or higher compared to 22 Regulations with a compliance rate of 80% or higher in 2024

There was a **11.5%** decrease in the number of reported episodes of physical restraint when compared to 2024

While there was a **1.88%** increase in the number of reported episodes of seclusion when compared to those reported in 2024, overall figures remain lower than previous years

At year end, there were **31** registration conditions attached to 18 approved centres

**5**
instances of overcapacity compared to 7 instances in 2024

**6**
child admission to 5 adult units. This compares to 5 admissions to 5 adult units in 2024

**3,608**
orders for review by Mental Health Tribunals

**1,779**
orders went to a tribunal hearing

**1,985**
admission orders from the community

Applications from An Garda Síochána up by **2%** to **34%**

**16.2%**
of orders revoked at tribunal hearings

**35**
days - average length of involuntary admission

**3,622**
enduring powers of attorney were registered (a 156% increase from 2024)

**18,637**
fully verified MyDSS accounts were created

At year end, there were
**1,875**
decision support arrangements under our supervision

There were
**271**
requests for decision-making representatives from our panel

**84**
complaints received about decision supporters and arrangements

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# Who We Are

# Vision, Mission and Values

The Mental Health Commission is an independent statutory body established under the provisions of the Mental Health Act 2001. The remit of the MHC incorporates the broad spectrum of mental health services for all ages in all settings.

In addition, under the provisions of the Assisted Decision-Making (Capacity) Act 2015, the MHC is responsible for the Decision Support Service to support decision-making by and for adults with capacity difficulties.

## Our Vision 2023-2027

Equity of access to person-centred mental health services and decision support services that deliver high-quality care and support.

## Our Mission 2023-2027

Promotion and vindication of human rights in relation to mental health services and decision support services.

## Our Values 2023-2027

**Person-centred**
We believe in person-centred support; empowering individuals, and their supporters, to be co-creators in their care, recovery and decision-making.

**Human Rights**
Human rights underpin our approach to everything we do, the services we provide and the services we regulate.

**Quality**
We commit to carrying out our functions to the highest standards and in accordance with our legal mandates.

**Independence and Accountability**
To successfully achieve our mission and vision we must be independent, transparent and accountable to our stakeholders and the public on whose behalf we work.

**Dignity and Respect**
Everyone should be treated with dignity and respect. We demonstrate this value through our interactions both within the MHC and with our external stakeholders.

**Expertise**
We value and respect the expertise of our team and those professionals we engage with, thereby ensuring our work is evidence-based and in line with best practice.

# Strategic Priorities 2023-2027

**Strategic Priority 1:**
Continue to be a leading voice in relation to mental health services and assisted decision-making.

**Strategic Priority 2:**
Effective and accessible communication and engagement, emphasising and promoting the voice of the person.

**Strategic Priority 3:**
Continue to drive standards, improve quality and safeguard persons in relation to mental health services that are regulated by the MHC.

**Strategic Priority 4:**
Promote and support assisted decision-making in society by embedding the Decision Support Service as a respected public service.

**Strategic Priority 5:**
Be an effective, cohesive, transparently governed and agile organisation acting in the public interest.

# Mental Health Commission Members April 2022 – April 2027

**The Members of the Mental Health Commission (MHC) are known as the MHC Board and are the governing body of the organisation. The MHC Board has 13 Members, including the Chairperson, who are appointed by the Minister for Health. Section 35 of the Mental Health Act 2001 (the 2001 Act) provides for the composition of the MHC Board. In December 2015, the MHC's remit was extended to include the establishment of the Decision Support Service (DSS) under the provisions of the Assisted Decision-Making (Capacity) Act 2015 (as amended) (the 2015 Act).**

Details of the MHC Board's membership and meeting attendance for 2024 can be found in Appendix 1, 2 and 3 on page 128 and 129.

During 2025, the MHC Board had three standing committees. These were the Finance, Audit and Risk Committee, and the Human Rights Committee.

Details of committees can be found in Appendix 2 and 3 on page 123 and 129.

### John Hillery (Dr)

*First Appointed 02/11/2020*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2027*
**Position Type:** Reappointed as Chairperson
**Basis of Appointment:** Nominated by the College of Psychiatrists in Ireland. Appointed by the Minister of State for Mental Health and Older People.

### Rowena Mulcahy

*First Appointed 26/09/2017*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2025*
**Position Type:** Member
**Basis of Appointment:** Nominated and appointed by the Minister for Health following Public Appointments Service (PAS) Process.

### Michael Drumm (Dr)

*First Appointed 05/04/2017*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2025*
**Position Type:** Member
**Basis of Appointment:** Nominated by the Psychological Society of Ireland. Appointed by the Minister of State for Mental Health and Older People.

### Margo Wrigley (Dr)

*First Appointed 05/04/2017*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2025*
**Position Type:** Member
**Basis of Appointment:** Nominated by the Irish Hospital Consultants Association. Appointed by the Minister for Health.

### Fionn Fitzpatrick

*First Appointed 12/02/2021*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2027*
**Position Type:** Member
**Basis of Appointment:** Nominated by the Voluntary Sector. Appointed by the Minister of State for Mental Health and Older People.

### John Cox (Dr)

*First Appointed 12/02/2021*
*End of Term 04/04/2022*
*Reappointed 05/04/2022*
*End of Term 04/04/2027*
**Position Type:** Member
**Basis of Appointment:** Nominated by the Irish College of General Practitioners. Appointed by the Minister of State for Mental Health and Older People.

**Ray Burke**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by PAS; appointed by the Minister of State for Mental Health and Older People.

**Joseph Duffy (Dr)**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by Jigsaw; appointed by the Minister of State for Mental Health and Older People.

**Tammy Donaghy**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by Spunout; appointed by the Minister of State for Mental Health and Older People

**Orla Healy (Dr)**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by the HSE; appointed by the Minister of State for Mental Health and Older People.

**Martina McGuinness**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by the Psychiatric Nurses Association (PNA); appointed by the Minister of State for Mental Health and Older People.

**Linda Curran**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by the Irish Association of Social Workers (IASW); appointed by the Minister of State for Mental Health and Older People.

**Catherine Cocoman**
*First appointed: 05/04/2022*
*End of Term: 04/04/2027*
**Position Type:** Member
**Basis of Appointment:**
Nominated by Nursing & Midwifery Board of Ireland; appointed by the Minister of State for Mental Health and Older People.

**Joanna Ralston**
*First appointed: 05/04/2025*
*End of Term: 03/04/2030*
**Position Type:** Member
**Basis of Appointment:**
appointed by the Minister of State for Mental Health following a PAS process.

**Mary Davoren (Dr)**
*First appointed: 05/04/2025*
*End of Term: 03/04/2030*
**Position Type:** Member
**Basis of Appointment:**
nominated by the Irish Medical Council; appointed by Minister of State for Mental Health.

**Ian O'Grady**
*First appointed: 05/04/2025*
*End of Term: 03/04/2030*
**Position Type:** Member
**Basis of Appointment:**
nominated by Psychological Society of Ireland; appointed by Minister of State for Mental Health.

### Additional Roles

**Secretary to the MHC Board:** Orla Keane

**Chair of Finance, Audit & Risk Committee (FARC):**
Orla Healy (Dr) (appointed as Chair in May 2022) Resigned 12 March 2025. Dr John Cox appointed Chair on 18 June 2025 until 4 April 2026

**Chair of Legislation Committee and then the Human Rights Committee:**
Michael Drumm (Dr) (appointed as Chair in July 2021) Resigned 4 April 2025 when term with the Board of the MHC ended. Catherine Cocoman was then appointed interim Chair of the HRC. Approval of new interim Chair of HRC was on 26 June 2025 (Catherine Cocoman)

**Chief Risk Officer:** Brian Gillespie

**Note:** Dr Margo Wrigley, Dr Michael Drumm and Rowena Mulcahy's term finished on the Board of MHC on 4 April 2025.

Ian O'Grady, Joanna Ralston and Mary Davoren were appointed to the MHC Board on 5 April 2025

# Senior Leadership Team at the MHC

*Chief Executive*
**John Farrelly**

*General Counsel for the MHC (DSS)*
**Orla Keane**

*Inspector of Mental Health Services*
**Prof Jim Lucey**

*Director, Decision Support Service*
**Áine Flynn**

*Director of Regulation*
**Gary Kiernan**

*Chief Operations Officer*
**Brian Gillespie**

# What We Do

Our work includes regulating inpatient mental health services; protecting the interests of people who are involuntarily admitted; and setting standards for high quality and good practices across mental health services.

In addition, under the provisions of the Assisted Decision-Making (Capacity) Act 2015, the MHC is responsible for the Decision Support Service to support decision-making by and for adults with capacity difficulties.

# Annual Report of the Director of the Decision Support Service

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# Director's Foreword

**This report under section 102(1) of the Assisted Decision-Making (Capacity) Act 2015 (as amended) (the 2015 Act) covers the activities of the Director of the Decision Support service throughout 2025.**

These were a busy and varied 12 months. 2025 presented the first opportunity to compare two successive full calendar years of activity since the Decision Support Service (DSS) began operations on commencement of the 2015 Act in April 2023. During 2025, we saw significant increases in numbers and casework across all our functions.

The DSS is a statutory service within the MHC, delivering the functions assigned to the Director under the 2015 Act.

The service comprises five core teams aligned to these functions:

- Registration
- Supervision
- Complaints and Investigations
- DSS Panels
- Information Services

Each is headed by an Assistant Principal who is a member of the DSS Management Team.

In this report, the Head of each division provides an overview and data on their activities in during 2025 and informative comparisons to 2024 data. The DSS is committed to utilising our data to inform the continuous improvement of the service. This is particularly important to help ensure that our service is scaleable, in response to rising demand for the supports available under the 2015 Act.

The report also summarises the communication and stakeholder engagement activities of the DSS which form a central part of our functions under the Act. The DSS has a statutory function to promote public awareness and confidence around the 2015 Act, to provide information and guidance and to identify and make recommendations for change in organisations and bodies. This report summarises the extensive public-facing awareness-raising work undertaken by the DSS in 2025, including at Bord Bia Bloom with our award-winning garden on the theme of planning ahead, and at the National Ploughing Championships.

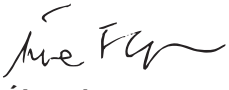
During 2025, work commenced on our next public information campaign. This campaign will also focus on advance planning, which is the part of the 2015 Act that makes it an Act for everyone.

As set out in the report, the DSS continued its engagement with diverse stakeholders from a range of professional backgrounds in the private and public sectors and, most importantly, with the potential users of the service and their families and supporters.

Meetings with our stakeholder forum whose members are all experts by experience continued, facilitated by Inclusion Ireland. These meetings are an invaluable source of feedback and serve as a useful reminder to the DSS of whom we exist to serve.

In our communications as in so many other ways, the work of the DSS is made possible by the support of others. In all our activities we are supported by our colleagues in the wider MHC including the Legal, Financial, HR IT, Operations, Procurement and Communications teams.

I am most grateful to my DSS team, my MHC colleagues, the Senior Leadership Team, the Chief Executive and the Board of the MHC and to our Ministers and their Department officials for their commitment to the DSS and the success of the 2015 Act.



**Áine Flynn**
**Director of the Decision Support Service**

# 2025 by the numbers

**5,329**
arrangement applications submitted
***+2,551 (+92%)**

**84**
complaints received
***+54 (+180%)**

**271**
requests for nominations from the panel of decision-making representatives
***+70 (+35%)**

**137**
acceptance of notification of decision-making assistance agreements
***+88 (+180%)**

**101**
co-decision-making agreements registered
***+41 (+68%)**

**1,113**
decision-making representation orders registered
***+408 (+58%)**

**3,622**
enduring powers of attorney registered
***+2,209 (+156%)**

**170**
enduring powers of attorney notified
***+139 (+448%)**

**1,875**
arrangements under supervision
***+962 (+105%)**

**905**
statutory reports reviewed
***+620 (+218%)**

**29,283**
queries on our dedicated phoneline
***11,194 (+60%)**

**11,017**
queries managed by email
***+ 3065 (+39%)**

**18,637**
verified accounts created on MyDSS
***+3,962 (+27%)**

**273,964**
unique visits to DSS website
***+39,762 (+17%)**

**269**
Renumeration pre-approvals approved
***+211 (+364%)**

**905**
statutory reports reviewed
***+620 (+218%)**

**74**
general visitors requested
***+64 (640%)**

*Change from 2024

# Information services

**During 2025 we answered queries and provided information to the public on a wide range of matters through our dedicated Information Services team. The number of queries managed in 2025 increased by 16,169 (60%) compared to 2024.**

We operated a dedicated free phoneline **01 211 9750** Monday to Friday 9am-4pm.

Our Information Services team provided information on a wide range of matters relating to DSS services and the 2015 Act. The most common queries related to:

- Current arrangement applications
- General information about the 2015 Act
- Requests for information or support for the MyDSS portal
- Information on accessing forms
- Existing registered arrangement
- Requests for stakeholder engagement

In addition, our EPA helpdesk provided support to donors, attorneys and professionals acting on their behalf, providing a comprehensive, responsive, and proactive helpdesk service to address queries, issues and perceived barriers relating to the EPA process. Queries to our EPA helpdesk accounts for 79% of total queries received.

We maintained and updated our website decisionsupportservice.ie with important information about the DSS and how to access our services. We received a total of 273,964 unique visitors to our website throughout 2025.

We maintained our online portal MyDSS, through which members of the public can create an account and access DSS services. While the majority of account holders created and verified their accounts using a MyGovID, we also verified accounts using an alternative process.

**Table 1:** *Queries managed by our Information Services team 2024-2025*

| Queries managed | 2025 | 2024 |
|---|---|---|
| Phone queries | 29,283 | 18,089 |
| Email queries | 11,017 | 7,952 |
| Queries by post | 1,186 | 826 |
| Portal queries* | 1,550 | - |
| **Total queries** | **43,036** | **26,867** |

*New in 2025

A total of 95.5% of all calls made to the DSS in 2025 were answered. In 2024, 79% of calls were answered due to the volume of calls received surpassing the teams available resourcing.

Improvements were made by increasing the team size and establishing our new EPA helpdesk as a permanent service. This helpdesk team was made permanent in August 2025 after its initial establishment in October 2024.

**Table 2:** *Verified MyDSS accounts and method of verification 2024-2025*

| Verification method | 2025 | % | 2024 | % | All time | % |
|---|---|---|---|---|---|---|
| MyGovID | 14,538 | 78 | 10,537 | 72 | 30,469 | 76 |
| Manual (Via DSS) | 4,099 | 22 | 4,138 | 28 | 9,776 | 24 |
| **Total** | **18,637** | **-** | **14,675** | | **40,245** | |

Table 2 shows that the portion of users verifying themselves using MyGovID increased in 2025 versus 2024. Total verified users have also increased across 2025.

## Profile of DSS account holders

A DSS account holder is more likely to be an Irish female over the age of 50 and based in county Dublin. This is consistent with previous annual profiles.

Further detail on the profile of DSS account holders can be found in Appendix 1.

## Accessibility

The DSS have an Accessibility Policy, to ensure people using DSS services and in particular those with specific accessibility requirements interact with us in the way that best meets their needs. During 2025, where a person could not be supported by our helpdesk to complete a digital application, they could request a manual application. This required them to outline the reasons why they needed a manual application form.

During 2025, 242 requests for manual application forms were received and assessed against our Accessibility Policy. 133 were approved and provided with a manual form and the support needed to complete the form. All applicants were offered the necessary support to complete an application.

## Specified forms

During 2025, we specified the following statutory forms, with the consent Minister of Children, Disability and Equality (DCDE):

### Revised Statutory forms

- four forms for registration of enduring powers of attorney
- four forms for registration of co-decision-making agreements
- four forms for notification of decision-making assistance agreements
- two forms for notification of enduring powers of attorney.

### Publication of statutory forms

- three forms for variation and revocation of enduring powers of attorney
- five forms for variation, revocation and partial revocation of co-decision-making agreements
- four forms for variation and revocation of decision-making assistance agreements

## Guidance materials, procedures and forms published

We also updated and published guidance relating to a range of our functions, including how-to guides, guidance materials and videos. Guidance material, procedures and forms can be found in the Resources section of the DSS website.

The following were updated and / published in 2025:

- Annual Report Guidelines for Attorneys
- CDMA Legal practitioner Guide
- CDMA Checklist
- Enduring Power of Attorney Information Pack
  - Booklet 1 – An Introduction to Enduring Powers of Attorney
  - Booklet 2 – Guide for donor: Your Guide to Making your Enduring Power of Attorney
  - Booklet 3 – Guide for Your Attorney
  - Booklet 4 – Start the Conversation
  - Booklet 5 – Steps for Making your Enduring Power of Attorney

- Guidance for Medical and Healthcare Professionals for Completing a Capacity Statement - sample form for recording capacity assessments for registration of CDMAs and EPAs
- Information for decision-making representatives seeking discharge from appointment
- MyDSS step-by-step guide for solicitor (authorised agent) pathway - verify identity, creating and accessing a MyDSS account
- MyExpenses - A user guide to claiming expenses for panel decision-making representatives
- Procedure for processing expedited enduring power of attorney applications or applications that are not on a specified form
- Register materials
  - Getting Register Ready for Your Organisation
  - Guide to Searching the Register
  - User Guidelines (Terms and conditions) for Accessing and Searching Decision Support Service Arrangement Registers for Approved Persons and Organisations
  - Accountable Officer Declaration form
  - Step by Step guide to search the Register
- Revised Complaints and Investigations Procedures
- Revised Complaints forms
  - Complaint Form - Attorney appointed or an Enduring Power of Attorney made under the 1996 Act
  - Complaint Form - Attorney appointed or an Enduring Power of Attorney made under the 2015 Act
  - Complaint Form - Decision-Making Assistant or a Decision-Making Assistance Agreement
  - Complaint Form - Co-Decision-Maker or a Co-Decision-Making Agreement
  - Complaint Form - Decision-Making Representative
  - Complaint Form - Designated Healthcare Representative
- Revised forms
  - Co-decision-making agreement statement of capacity
  - Enduring powers of attorney statement of capacity
  - Enduring power of attorney legal practitioner statement
  - Revocation or partial revocation of a co-decision-making agreement - Statement of capacity
  - Variation or revocation of enduring power of attorney – legal practitioner statement
  - Registered enduring power of attorney – resignation by attorney
- Revised Management of Expense Claims and Remuneration Procedures
- When a panel decision-making representative has been appointed to your family member or loved one - Frequently asked questions

## Publications

During 2025, the Director published articles about the 2015 Act and the role of the DSS in the following:

- St James Hospital Newsletter
- Senior Times
- Law Society Gazette
- Irish Country Living
- HSE Human Rights and Equality Matters Newsletter

# Registration

**During 2025, we registered enduring powers of attorney, decision-making representation orders and co-decision-making agreements. In addition, decision-making assistance agreements were notified to us as required by Regulations and registered enduring powers of attorney were notified to us to become operational.**

The number of arrangements registered and notified to us in 2025 increased across all arrangements, including a 156% increase in registered enduring powers of attorney and 58% increase in registered decision-making representation orders.

**Table 3:** *Number of arrangements registered and notified 2024-2025*

| Arrangements registered and notified | 2025 | 2024 |
|---|---|---|
| Co-decision-making agreements | 101 | 60 |
| Decision-making representation orders | 1,113 | 705 |
| Enduring powers of attorney (registered) | 3,622 | 1,413 |
| Enduring powers of attorney (notified) | 170 | 31 |
| Decision-making-assistant agreements | 137 | 49 |
| **Total arrangements registered or notified** | **5,143** | **2,209** |

Decision support arrangements submitted to us were reviewed to ensure compliance with relevant requirements set out in the 2015 Act and Regulations. Each decision support arrangement has specific requirements relating to:

- Information about the parties
- Content of the arrangement
- Signing and witnessing
- Notice parties
- Supporting statements

**Table 4:** *Number of applications received 2024-2025*

| Submitted applications received | 2025 | 2024 |
|---|---|---|
| to notify decision-making assistance agreements | 141 | 91 |
| to register co-decision-making agreements | 158 | 100 |
| to register an enduring power of attorney | 5,030 | 2,587 |
| **Total applications received** | **5,329** | **2,778** |

Further detail on the number of arrangements submitted and registered or notified by month can be found in **Appendix 1**.

During 2025, we also received and responded to queries by phone and by email and were referred queries from other teams in the DSS.

**Table 5:** *Queries to the Registration team 2024-2025*

| Queries to our Registration team | 2025 | 2024 |
|---|---|---|
| Incoming phone queries | 286 | 2,787 |
| Outgoing phone calls | 3,778 | 5,176 |
| Incoming email queries | 7,463 | 7,099 |
| Outgoing emails | 7,297 | 10,004 |
| Queries referred to the Registration team by other DSS teams | 481 | 512 |

## Profile of applicants and supporters

The most common age range for applicants creating decision-making assistance agreements, co-decision-making agreements and enduring power of attorneys is 80-89. Further detail on the profile of applicants and supporters as well as the current residence of applicants and court location for DMROs can be found in **Appendix 1**.

## Objections

In 2025, we reviewed objections made to the registration of co-decision-making agreements and enduring powers of attorney, as well as to the notification of enduring powers of attorney.

**Table 6:** *Objections received 2024-2025*

| Objections related to | 2025 | 2024 |
|---|---|---|
| Enduring powers of attorney | 78 | 40 |
| Co-decision-making agreements | 29 | 14 |
| **Total** | **107** | **54** |

**Table 7:** *Relationship of objector to the relevant person by percentage*

| Relationship of objector | 2025 | 2024 |
|---|---|---|
| Adult child of relevant person | 75% | 70% |
| Parent of relevant person | 9% | 13% |
| Sibling of relevant person | 7% | 0% |
| Spouse of relevant person | 5% | 4% |
| Other | 4% | 13% |
| Civil partner of relevant person | 1% | 2% |

## DSS Register

During 2025, we maintained a Register of the following decision support arrangements:

- Co-decision-making agreements
- Decision-making representation orders
- Enduring powers of attorney

The Register was searched by prescribed professionals and prescribed organisations as set out in Regulations, as well as by members of the public who demonstrated a legitimate interest in searching the Register.

## Approved organisations and persons

During 2025, we continued to engage with stakeholders in the healthcare sector to provide access to a number of organisations as part of the continued focused launch of the online Register. This focused launch was extended to colleagues in the financial sector, the legal sector and other public bodies.

During 2025 we approved 104 organisations as part of our focused launch of the online Register. These organisations conducted 801 searches on the Register during 2025, of which, 610 were searches related to registered DMROs, 167 related to notified EPAs, and 24 related to registered CDMAs.

The functionality to access the Register as an approved organisation or an approved person became more widely available at the end of 2025 and is now open to any persons specified under regulations who require access to the Register.

## Legitimate interest searches

During 2025 we received 133 Legitimate Interest[2] search requests. Of those, 61 requested information on EPAs; 34 requested all relevant decision support arrangements; 28 requested DMROs, 10 requested CDMAs.

[2] Any person can make a general request to search the Register. This is known as a legitimate interest search request. The request must be made in writing in a form specified by the DSS.

# Supervision

**During 2025, we supervised co-decision-making agreements (CDMAs) and decision-making representation orders (DMROs) that were newly registered or remained registered with the DSS. We also supervised enduring powers of attorney (EPAs) made under the 2015 Act that had been notified and brought into effect.**

Registered CDMAs, DMROs and notified EPAs remain under our supervision until formally revoked, nullified, spent or until the death of the relevant person. The total number of arrangements under supervision at year end increased by 105% in 2025.

**Table 8:** *Total arrangements under supervision at year end 2023-2025*

| Year End | Total CDMAs | Total DMROs | Total EPAs | Total |
|---|---|---|---|---|
| 2023 | 10 | 107 | 1 | **118** |
| 2024 | 69 | 812 | 32 | **913** |
| 2025 | 157 | 1,525 | 193 | **1,875** |

One or more attorneys and decision-making representatives can be appointed to a single arrangement. In 2025, 258 new attorneys were supervised in respect of 170 newly notified enduring powers of attorney and 1,181 new decision-making representatives were supervised in respect of 1,033 newly registered decision-making representation orders.

## First contact supervision calls

In 2025, we attempted to contact all co-decision-makers and decision-making representatives following their appointment and all attorneys appointed under an EPA following the notification of the EPA. We successfully phoned 712 decision supporters. This compares with 467 calls made in 2024; a 52% increase. A first contact was attempted by phone in all cases and followed up by email or post if contact could not be made.

We provided each decision supporter information about:

- their role and function
- relevant Codes of Practice
- relevant guidance material
- their reporting requirements

## Statutory reports

We reviewed the *schedule of assets and liabilities and statement of projected income and expenditure* (the initial report) submitted by decision-making representatives and attorneys authorised to manage property and affairs. This report is a one-time report provided within 3-months of the decision supporter's active appointment. It provides baseline information about the relevant person's financial position.

**Table 9:** *Total initial reports approved 2024-2025*

| Initial Reports | 2025 | 2024 |
|---|---|---|
| Decision-making representative reports | 593 | 258 |
| Attorney initial reports | 33 | 4 |
| **Total intial reports** | **626** | **262** |

We reviewed annual reports, and where relevant annual accounts, submitted by co-decision-makers, decision-making representatives and attorneys. An annual report is provided yearly and contains information on actions taken, decisions supported and financial transactions within the reporting period.

**Table 10:** *Total annual reports approved 2024-2025*

| Annual reports | 2025 | 2024 |
|---|---|---|
| Co-decision-maker annual reports | 41 | 0 |
| Decision-making representative annual reports | 235 | 20 |
| Attorney annual reports | 3 | 0 |
| **Total annual reports** | **279** | **57** |

## Decision-making representative pre-approvals

Decision-making representatives appointed from the DSS panel are entitled to remuneration in the performance of their functions. Remuneration must be pre-approved by the DSS and is subject to maximum annual limits defined in Regulations.

During 2025, we reviewed 269 applications for pre-approval for annual remuneration, excess remuneration and non-travel expenses from decision-making representatives appointed from the DSS panel. This is an increase (364%) from the 58 reviewed in 2024. We also reviewed invoices for decision-making representatives remunerated by the DSS pursuant to section 42(3)(c) of the 2015 Act.

Of the 267 panel members appointed in 2025, 157 (59%) were remunerated by the DSS. This compares with 40% in 2024. One reason for this increase is the increased number of discharged Wards of Court. These cases have a higher proportion of panel members appointed and in most cases are remunerated by the DSS.

Decision-making representatives appointed from the DSS panel can apply for excess remuneration in additional to the annual maximum fee. In 2025, the DSS pre-approved excess remuneration in 53 (25%) cases. The DSS must consider:

- whether circumstances are of such an exceptional nature as to warrant the payment of excess remuneration; and
- the nature and frequency of the particular functions of the decision-making representative; and
- the level of additional work that would be involved in performing such functions.

**Table 11:** *Decision-making representative pre-approvals 2024-2025*

| Pre-approval type | 2025 | 2024 |
|---|---|---|
| Annual fee paid out of assets | 83 | 20 |
| Annual fee paid by DSS | 133 | 27 |
| Excess remuneration | 53 | 11 |
| **Total pre-approvals** | **269** | **58** |

## General and special visitors

In 2025, we requested 74 general visitors to undertake general assurance visits to check in with decision supporters and ensure the decision support arrangement is operating the way it should be. Four were asked to visit decision-making representatives and 70 were asked to visit co-decision-makers as part of the formal review of the co-decision-making agreement.

We requested one special visitor to undertake a capacity assessment to assist with our formal review of a co-decision-making agreement.

## Review of co-decision-making agreements (Section 26)

Under section 26 of the 2015 Act we are required to formally review all co-decision-making agreements within 9-15 months of their registration and then every three years to ensure the agreement remains appropriate. As part of this review we assess:

- The report from a general visitor
- The co-decision-maker's annual report
- An updated capacity assessment for the appointer

In 2025, we formally reviewed 41 co-decision-making agreements. Twenty-five were deemed to continue to meet legislative requirements. Sixteen reviews were not completed due to the death of the appointer, or due to the revocation of the agreement following a preliminary view issued by the DSS that:

- the appointer no longer had capacity to make the decisions in the co-decision-making agreement with the supporter of their co-decision-maker.
- the appointer no longer needed the support of a co-decision-maker
- the decisions in the agreement had been completed.

# Complaints and investigations

**During 2025, we received 84 complaints about decision supporters and decision support arrangements. This represented a 180% increase in the volume of complaints received in 2024 (30 complaints). This ties in with the increased number of arrangements in place and the awareness of the DSS' remit to investigate complaints about EPAs made under the prior legislation, the Powers of Attorney Act 1996. The average time it took to form a view as to whether a complaint was well-founded in 2025 was 152 days, which was a decrease from 168 days on average in 2024.**

Table 17 provides a breakdown of the sources of the 84 complaints received. The highest number of complaints received in 2024 and 2025 was from family members.

**Table 12:** *Source of complaints received 2024-2025*

| Source of complaint | 2025 | 2024 |
|---|---|---|
| Family members | 64 | 16 |
| Nursing homes | 7 | 3 |
| Social workers | 3 | 4 |
| Relevant person | 3 | 2 |
| DSS (Supervision team) | 3 | 3 |
| HSE social workers | 2 | 0 |
| Anonymous | 2 | 0 |
| Independent advocates | 0 | 2 |

Figure 1 provides a breakdown of the 84 complaints received by arrangement type. The highest number of complaints received related to decision-making representation orders and enduring powers of attorney made under the 1996 Powers of Attorney Act.

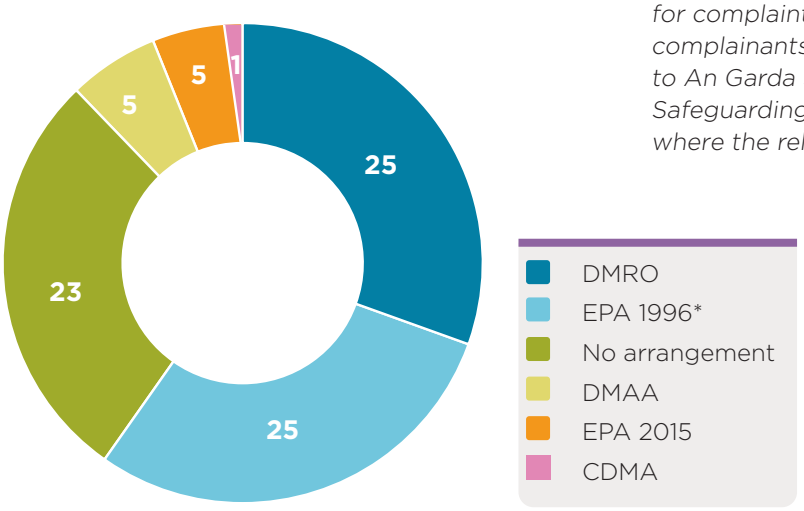



**Figure 1:** *Complaints received by arrangement type 2025*

Table 13 shows the status of complaints active or received during 2025 as of 31 December 2025. Of the 11 complaints that were investigated and considered well-founded in 2025, six were informally resolved and five were referred to court for a determination.

**Table 13:** *Status of complaints received during 2025 as of 31 December 2025*

| Status | Number |
|---|---|
| Investigation stage | 21 |
| Outside remit* | 31 |
| Discontinued (investigation) | 0 |
| Discontinued (screening) | 4 |
| Withdrawn (investigation) | 2 |
| Withdrawn (screening) | 4 |
| Complaint not well-founded | 11 |
| Complaint well-founded | 11 |

**Of the 84 complaints received during 2025, 31 were screened out because there was no decision support arrangement in place or did not meet one or more of the grounds for complaint set out in the 2015 Act. The complainants in these cases were signposted to An Garda Siochana, and/or the HSE Safeguarding and Protection Team in the area where the relevant person lived, as appropriate.*

*The DSS can investigate complaints about attorneys appointed under the Powers of Attorney Act 1996 as well as attorneys appointed under the Assisted Decision-Making (Capacity) Act 2015.

## Ways to make a complaint

Anyone can make a complaint by:

- By completing a Complaint Form for the relevant decision support arrangement from our website and then emailing it to complaints@decisionsupportservice.ie
- By printing off and posting the relevant Complaint Form to us (Decision Support Service, Waterloo Road, D04 E5W7).
- Submitting a complaint through our portal.

During 2025, the highest number of complaints were submitted by email.

## Director's powers when investigating a complaint

As part of the investigation process, we can:

- summon witnesses to attend before us
- examine witnesses under oath
- require a witness to produce any document in their power or control
- by notice, in writing, require any person to provide written information that we consider necessary to enable us to carry out our functions
- seek resolution of complaints informally, as is considered appropriate and reasonable
- investigate using "own initiative" powers
- conduct investigations other than in public

1

### An example of a well-founded complaint that was referred to court

A complaint was received from a HSE Social Worker that joint attorneys appointed under the Powers of Attorney Act 1996 were not making decisions together for the benefit of the donor. Significant differences of opinion had arisen between the attorneys as to how the donor's money should be spent, resulting in the attorneys not speaking to each other. This meant that the donor's money was not being accessed to meet her ongoing needs.

As part of the investigation process, we spoke with the donor and both joint attorneys. Detailed information was gathered about the monies owed to them, and how the conflict between them was impacting the donor. The complaint was considered well-founded, and we held meetings with the joint attorneys separately and together to try to resolve the matter informally. Ultimately, however, we referred the matter to the Circuit Court for a determination, as it was not possible to informally resolve it.

2

### An example of a well-founded complaint that was informally resolved

A Decision-Making Representative had been appointed to make financial and personal welfare decisions for the Relevant Person who was a resident in a nursing home. Complaints were made by the nursing home that the DMR was refusing to pay the Relevant Person's nursing home fees and their medication fees, leading to substantial arrears for both.

When we notified the DMR of the complaints, they responded to say that they were unhappy with the level of care being provided to the RP. As a result, they said that they did not intend to pay the outstanding care or medication costs. We obtained statements from the nursing home and the pharmacy and forwarded them it to the DMR. Following the well-founded outcome to the complaint, we explained that the matter could be resolved if payment was made, and continued to be made, to the nursing home and pharmacy. The alternative would be for us to refer the matter to court, which could result in the removal of the DMR.

The DMR agreed to pay all the outstanding arrears and to continue making payments to ensure that the RP's needs were met. The case was closed as having been informally resolved.

3

## An example of a not-well-founded complaint

A complaint was investigated about a Co-Decision-Maker (CDM) which alleged that the CDM was not suitable for the role, that the Appointer did not have capacity to enter the arrangement, and that the Appointer no longer had capacity to jointly make decisions with the CDM. The arrangement covered decisions about the Appointer's social services, accommodation, and property management.

The Appointer was a resident in a nursing home and admitted to hospital for treatment of an infection.

During the investigation, we reviewed the Statement of Capacity and supporting notes provided by the Appointer's doctor. We also met with the Appointer, his doctor, nursing staff, and the CDM to discuss the complaint. It was noted that the Appointer's ability to jointly make decisions had been temporarily affected by the infection, however, this was expected to improve over time. It was made clear to us that the Appointer was able to tell staff about their wishes and needs and was able to recognise family members, including the CDM who was familiar with their role.

Based on our engagement with the Appointer, CDM and treating team, we formed the view that the complaint was not-well-founded. The Complainant was advised that they could appeal our decision to the Circuit Court within three months.

# DSS Panels

**During 2025, we maintained three panels to support the delivery of a number of our key functions.**

We maintained a panel of:

- Decision-making representatives
- General visitors
- Special visitors

## Decision-making representatives

We maintained a panel of decision-making representatives who were nominated to be appointed by the Circuit Court and Wardship Court to make certain decisions on behalf of a relevant person when there was no other suitable person willing and available and able to do so or where it was the will and preference of the relevant person to have an independent representative.

We expanded our panel by 27 members in 2025; a direct result of the recruitment campaign launched in October 2024. There were 109 members on the panel of decision-making representatives at the end of 2025.

Panel members were appointed to 264 decision-making representation orders at the end of 2025. There was an increase in the number of requests from the panel in 2025, including a 19% increase from the Wardship Court.

During 2025, our panel of decision-making representatives included persons from diverse professional backgrounds including legal, health and social care, medical and finance.

**Table 14:** *Panel of decision-making representatives – number, requests and professions 2024-2025*

| Queries managed | 2025 | 2024 |
|---|---|---|
| Panel members on DMROs at end of 2025 | 264 | 137 |
| Panel members on the panel | 109 | 104 |
| Requests from the panel | 271 | 201 |
| Professions on the panel | 8 | 7 |

**Table 15:** *Panel of decision-making representatives by profession 2025*

| Profession | Number |
|---|---|
| Solicitor | 60 |
| Social worker | 26 |
| Barrister | 13 |
| Nurse | 3 |
| Accountant | 2 |
| Occupational Therapist | 2 |
| Doctor | 2 |
| Physitherapist | 1 |

## Requests from the Circuit Court

- 181 requests for nominations from panel of decision-making representatives
- These accounted for 67% of total requests received by the panels team in 2025
- 210 of the 1,022 (21%) registered DMROs in 2025 from the Circuit Court appointed a panel member

## Requests from Wardship Court

- 90 requests for panel member nominations from panel of decision-making representatives
- These accounted for 33% of total requests received by the panels team in 2025
- 54 of the 91 (59%) registered DMROs in 2025 from the Wardship court appointed a panel member

**Table 16:** *Court requests by area 2024-2025*

| Court | 2025 | 2024 |
|---|---|---|
| Cork Circuit | 16 | 21 |
| Dublin Circuit | 79 | 51 |
| Eastern Circuit | 24 | 9 |
| Midland Circuit | 12 | 17 |
| Northern Circuit | 4 | 2 |
| South-Eastern Circuit | 11 | 11 |
| South-Western Circuit | 15 | 13 |
| Wardship Court | 90 | 67 |
| Western Circuit | 20 | 10 |

## General visitors

During 2025, we requested visitors from our panel of general visitors as part of a programme of general assurance visits as part of our supervisory functions. A general visitor is a person with relevant qualifications or other expertise or experience to assist with these functions.

- 53 members on the panel of general visitors
- 73 requests for general visitors

## Special visitors

During 2025, we maintained a panel of special visitors with knowledge expertise and experience in relation to undertaking a capacity assessment. One special visitor was required to undertake a visit in 2025.

- 32 members on the panel of special visitors
- 1 request for special visitors

## Training and information sharing

Throughout 2025, we kept our panel members informed via a monthly newsletter on the member portal, providing key updates, case law summaries, and practical guidance. To support ongoing professional development, our Moodle platform remains a central hub for training videos and training resources for panel members.

Recognising that the panels' roles are evolving, we identified a growing need for networking and peer-to-peer learning. In response, we launched a new panel member directory on Moodle in 2025 to facilitate direct connection and collaboration between panel members.

In April 2025, we hosted two training events for our decision-making representative panel. The first, an online onboarding session for new members, covered essential operational topics such as the DSS functions, statutory reporting, and expenses and remuneration. The second was an in-person event open to the full panel, featuring a keynote by His Honour Judge O'Connor, legal updates from the MHC, and insights from colleagues in the Courts Service, the banking sector, and the DSS Management Team.

Online training for our general visitor panel took place in September 2025, which included updates from our Complaints and Investigations team, and Supervision team about general assurance visits.

# Stakeholder engagement

## Public information campaign

We ran a comprehensive advertising campaign on advance planning from December 2025 to January 2026. We used regional and national radio, and regional and national press, which our research indicated were the channels most engaged with by our audience cohort. We designed our social campaign around the concept of younger people embracing their 'older selves' with the message 'Make a decision your future self will thank you for'. Overall, the campaign delivered robust results, exceeding the majority of KPIs while maintaining strong cost efficiency.

## General stakeholder engagement

As part of our focus on advance planning, we participated in Bord Bia's Bloom festival by showcasing a show garden titled 'The Support Garden'. The team engaged with thousands of people over the five-days of the festival and outlined the advance planning tools available to them.

We organised a range of roadshows and similar events around the country that gave people an opportunity to start their advance planning journey. These in-person events were held in Cork, Portlaoise, Kildare, Mayo, Cavan and South Dublin with the support of key stakeholders such as the HSE, the Irish Hospice Foundation and Age Friendly Ireland. Such events provide the DSS with the opportunity to give people tools, resources and information about how they can begin to plan ahead to ensure their wishes, beliefs and values are always protected and respected.

During 2025, we focused on the agricultural and farming community by meeting this key cohort in person and urging them to plan for their own future. We participated in the National Ploughing Championships and carried out a sample survey of visitors to the DSS stand. Of the 500 people surveyed at the DSS stand in the Government of Ireland Village, an overwhelming 99% of attendees said more people in Ireland should plan for the future, and 86% said they were now considering doing so themselves following conversations with DSS staff at the event.

We also ran events for regional solicitors' Bar Associations and developed dedicated information leaflets to assist legal professionals to support their clients to register their EPAs online.

We continue to promote the new service across regional and trade media; and by responding to parliamentary questions and public representatives about the growing numbers of people using the new service.

We collaborated on several events to provide information about the 2015 Act and met regularly with our Stakeholder Forum who provided us with important feedback about our services, materials and procedures.

## Events and presentations

During 2025, the DSS met with a range of organisations and provided information sessions about the Assisted Decision-Making (Capacity) Act 2015 and DSS services in-person or online to the following groups:

| | |
|---|---|
| Acquired Brain Injury Ireland | Delegation from Lithuania |
| Active Retirement Group, Kildare | DSS Roadshow - Cork |
| Adult Education Service, Northwest Dublin Dun Laoghaire Education and Training Board, | DSS Roadshow Portlaoise |
| Adult Safeguarding Day Seminar | DSS Roadshow – North Dublin |
| AIB | DSS/BPFI Webinar for Financial Services |
| An Garda Siochana Retired members Association -Dublin West Branch | Family Carers Ireland |
| An Garda Siochana Retired Members Association - Dublin North Branch, | FAS Retirement Group |
| ARC, Cancer Support | FL-EUR Conference -European pathways for supporting and protecting adults: insights and best practices across Europe |
| Courts Service Awareness Raising Exiting Wardship Event | Greystones and District Active Retirement Association |
| Ballinteer Active Retirement Group | Happy Hearts - Active Retirement Group |
| Ballygall Ladies Club | Headway - People with lived experience |
| Banking Payments Federation of Ireland | Headway - Service users |
| Breaking Barriers: Enhancing Cancer Care | Headway, Finglas |
| Central Bank Workshop on Protecting Consumers in Vulnerable Circumstances | Health Research Consent Declarations Committee |
| CESCA Equality Day - Cork | HSE ADM Leads - Learning Event |
| Citizen Information Service (Limerick, Clare, Waterford and Tipperary) | HSE ADM Learning Event - Wardship |
| Clarecare | HSE Mid-West - Public Health Nurses |
| Core Credit Union | IBEC/HSE Webinar |
| Council for Intellectual Disability, New South Wales, Australia | Insurance Ireland |
| Dara Community Living | IRD Duhallow, Cork |

| | |
|---|---|
| Irish Gerontology Society | Safeguarding Adults at Risk - TCD School of Nursing & Midwifery, |
| Irish Hospice Foundation – Compassionate End of Life Care, Nursing Home staff -Ballinasloe | Slane Men's Shed |
| Irish Hospice Foundation- Compassionate End of Life, Cork, | MHC Mental Health Service Providers Engagement event – Athlone and Limerick |
| Joint Oireachtas Committee | St Catherines Association - staff |
| KARE outreach | St Catherines Association- Families |
| Legal Aid Board - Webinar for Legal Profession | St James Hospital, Advance Care Planning Study Day, |
| Live Well Expo Event Portlaoise 2025 | St John of God Community Services, Tallaght |
| Memory Cafe, Connolly Hospital | St John of God, Crumlin |
| Mental Health Services, St Vincent's University Hospital | St John of God, Dementia Cafe, Shankill |
| Monkstown Active Retirement (U3A), | St Lukes Hospital, Kilkenny |
| Office of Public Guardian - Singapore | UCD Staff Wellbeing Seminar |
| Office of the Inspector of Prisons -Aging in Prison | UCD students Advance Healthcare Directives for Mental Health: From Law to Practice |
| Orthopaedic Hospital | Vision Ireland, |
| Peamount Healthcare | VHI Health and Wellbeing |
| National Ploughing Championships | Western Care Alzheimers |
| Prosper Services for people with lived experience | Western Care Association's AGM, Castlebar, |
| Public Health Nurses in Clare | Westmeath Age Friendly |
| Public Information Evening - Talbot Hotel, | Westport Active Retirement Association |
| Rehabcare - Kerry | Women in Farming |
| Retirement Planning Council | |

# Regulatory Process

# Regulatory Process

One of the core functions of the MHC is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services under the Mental Health Act (2001). The MHC strives to ensure its principal legislative functions are achieved through the registration and inspection of approved centres. Our regulatory process includes a cycle of registration, inspection, compliance, monitoring, and enforcement to ensure high standards and good practices in the delivery of care and treatment to people with mental difficulties.

In line with our strategic plan 2023-2027, we:

- Promote high standards, improve quality and safeguard persons in relation to mental health services.
- Promote a rights-based approach to all aspects of service provision.
- Uphold the principles of right-touch regulation of being proportionate, consistent, targeted, transparent, accountable and agile.
- Promote capacity-building and self-assessment within services and aim to use our enforcement powers as a last resort following a stepped approach to escalation.
- Take a risk-based and intelligence-led approach to our regulatory practices.


***Figure 2:*** *MHC model of regulation*

## Key Regulatory Activity in 2025

### Registration

- Two new approved centres were registered in 2025, with 20 centres successfully re-registered.
- In 2025, eight new conditions were attached to the registration of five approved centres, relating to record management, admissions, compliance and quality improvement.
- There were 31 conditions active against registrations at the end of 2025.

### Compliance:

- Seven centres achieved full compliance with all Regulations, Rules and Codes of Practice on annual inspection in 2025, with eight centres found 100% compliant with all Regulations.
- Overall compliance on annual inspection across HSE-funded adult centres increased to 82.66% in 2025 from just under 81% in 2024.
- Overall compliance on annual inspection across independently-run adult centres was 93.01% in 2025, an increase from 88.5% in 2024.
- There was a decrease in the number of critical non-compliances found on annual inspection from 38 found in 17 approved centres in 2024 to 33 found in 18 approved centres in 2025.
- There was an increase in high-risk non-compliances found on annual inspection from 168 in 2024 to 199 in 2025.
- In 2025, 24 of the 31 Regulations on annual inspection had an approved centre compliance rate of 80% or higher. In comparison in 2024, 22 individual Regulations had an approved centre compliance rate of 80% or higher.
- In 2025, eight centres achieved 100% compliance with the Regulations which compares with six in 2024.
- Five Regulations on annual inspection had poor levels of compliance. These were:
  - Regulation 15: Individual Care Plans (58.21%)
  - Regulation 22: Premises (26.87%)
  - Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (53.73%)
  - Regulation 26: Staffing (52.24%)
  - Regulation 32: Risk Management Procedures (44.78%)

### Enforcement:

- The MHC withdrew their prosecution against the Acute Adult Mental Health Unit in Cork University Hospital on 4 November 2025. The case was brought on foot of the annual inspection in April 2024. Following enforcement actions, and ongoing monitoring by the MHC, the HSE took a number of actions, including strengthening the governance and management arrangements in place to monitor and oversee the quality and safety of care. The annual inspection in October 2025 found evidence that the measures taken by the HSE had resulted in improvements in the levels of non-compliance, with no critical non-compliances found. The MHC continues to monitor compliance with Rules, Regulations, Codes of Practice under the Mental Health Acts.
- The MHC took 49 enforcement actions against 32 approved centres in response to incidents, events and serious concerns arising in 2025 in line with our Enforcement Policy. These actions included 27 Immediate Action Notices, 13 Regulatory Compliance Meetings, eight formal warning letters and one formal assurance request.

### Seclusion And Physical Restraint:

- There was an increase of 1.88% in the number of reported episodes of seclusion when compared to those reported in 2024. However, figures remain lower than previous years.
- There was a decrease of 11.5% in the number of reported episodes of physical restraint when compared to those reported in 2024.

### Overcapacity:

- In 2025, there were five instances of overcapacity reported by two approved centres compared to seven reported instances of overcapacity in 2024, and 46 in 2023.

# Registration

**Section 64 of the Mental Health Act requires the MHC to establish and maintain a register of approved centres.**

All approved centres are required to apply to register under the Act for a period of three years. Approved centres must apply to renew their registration after that period if they wish to continue to operate.

As part of a registration application, the MHC considers the following;

- information about how the facility is governed
- the profile of residents
- levels of compliance
- how the approved centre is staffed
- how the staff are recruited and trained

The application also seeks information about the premises and the types of services that are provided.

The MHC registers and regulates a wide range of inpatient services, including:

- Acute adult mental health care
- Continuing mental health care
- Psychiatry of later life
- Mental health rehabilitation
- Forensic mental health care (NFMHS)
- Mental health care for people with intellectual disability (MHID)
- Child and adolescent mental health care (CAMHS)
- Eating disorder treatment care

At the end of 2025, there were 67 approved centres registered with the MHC. During the year there were no closures, there were two new registrations, Brandon Unit in the national Forensic Mental Health Services and Nua Healthcare Services in Gormanston, and 20 applications for renewal of registration were approved.

At the end of 2025, there were 2,612 registered inpatient beds in 67 approved centres across the country. During 2025, 17 approved centres notified the MHC of temporary changes to their operational beds. Approved centres reported that this was necessary due to building and refurbishment works and restriction of admissions.

- There were 96 CAMHS beds nationally, 60 in Dublin, 20 in Galway, and 16 in Cork.
- There were 763 adult beds in the independent sector, of which 690 were in Dublin.
- Of those registered non-forensic adult inpatient beds, 84% were HSE beds and 16% were independent beds.
- There were also 141 registered forensic beds (NFMHS) and 48 mental health intellectual disability (MHID) beds. These beds were located in Dublin, with a national catchment area.

**Table 17:** *Registered Beds per Sector & Region 2025*

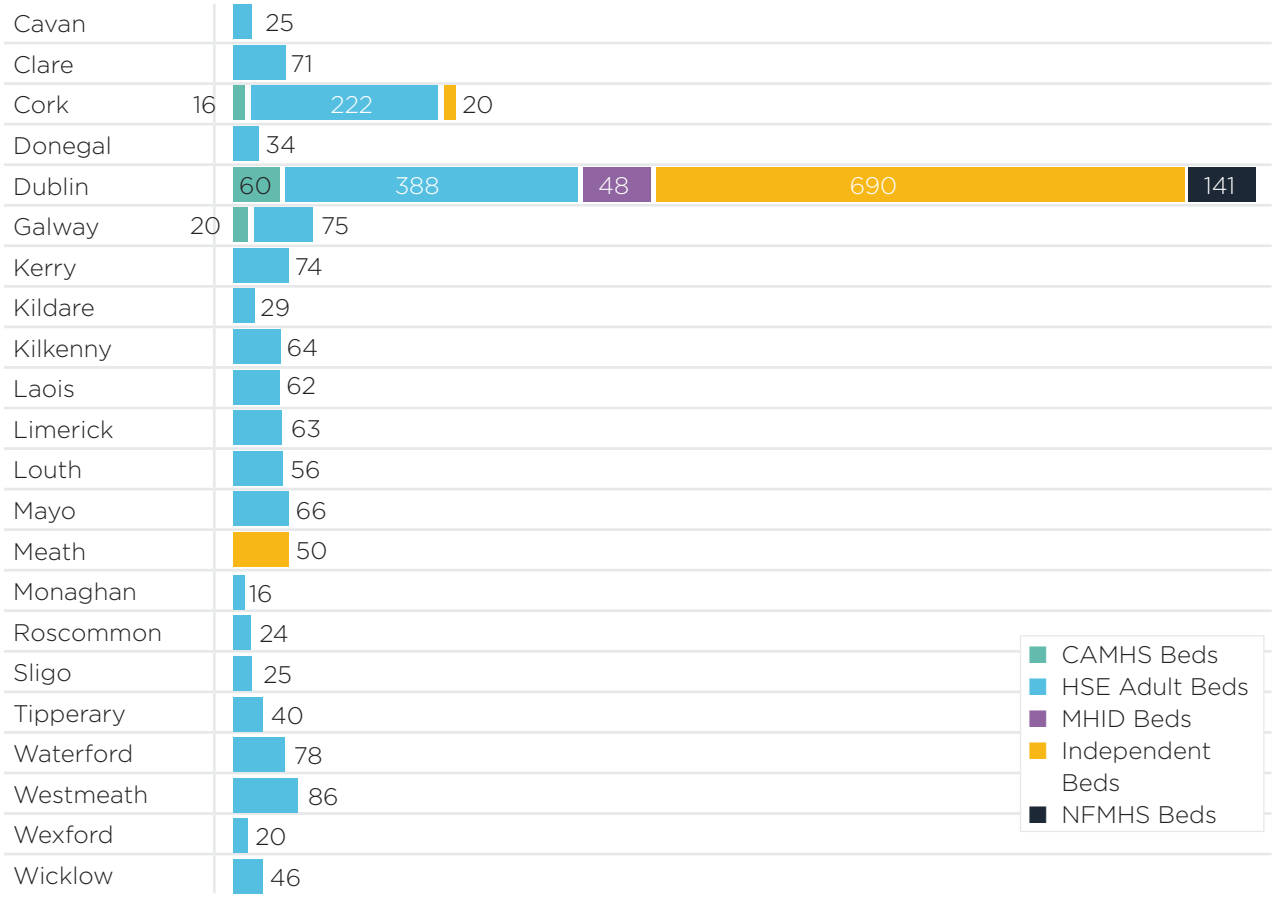
| | Dublin | Cork | Galway | Other Areas | Total |
|---|---|---|---|---|---|
| HSE/HSE Funded Adult Inpatient Beds | 388 | 222 | 75 | 879 | **1,564** |
| CAMHS beds | 60 | 16 | 20 | 0 | **96** |
| Independent beds | 690 | 23 | 0 | 50 | **763** |
| NFMHS Beds | 141 | 0 | 0 | 0 | **141** |
| MHID Beds | 48 | 0 | 0 | 0 | **48** |
| **Total Beds All Areas** | | | | | **2,612** |

**Note that registered beds may change across the year if there is a change to the maximum bed capacity of a centre at re-registration.*

**Table 18:** *Registered Beds by Sector & HSE Health Region 2025*

| HSE HR/Sector | No. of Approved Centres | Max Registered Beds |
|---|---|---|
| HSE Dublin & Midlands | 7 | 276 |
| HSE Dublin & North East | 10 | 321 |
| HSE Dublin & South East | 10 | 313 |
| HSE Midwest | 4 | 134 |
| HSE South West | 8 | 296 |
| HSE West & North West | 10 | 224 |
| Independent | 9 | 763 |
| Forensic | 2 | 141 |
| CAMHS | 6 | 96 |
| MHID | 1 | 48 |

**Figure 3:** *Registered Beds per County 2025*




**Note that registered beds may differ across the year if there is a change to the maximum bed capacity of a centre at re-registration. HSE Dublin & North East includes both St Vincent's Hospital, Fairview, and St Aloysius Ward, Mater Misericordiae University Hospital due to HSE funding.*

*Details of all approved centres and their location are available on the MHC website:* Approved Centres | Mental Health Commission.

# Inspection

**The Inspector of Mental Health Services visits and inspects every approved centre at least once each year. The Inspector prepares a report on their findings following the inspection. Each approved centre is given an opportunity to review and comment on any content or findings prior to publication.**

On inspection, in 2025, the Inspector rated compliance against:

- 31 Regulations
- Three Statutory Rules
  - Rules Governing the Use of Seclusion
  - Rules Governing the Use of Mechanical Means of Bodily Restraint
  - Rules Governing the Use of Electro-Convulsive Therapy (ECT)
- Part 4 of the Mental Health Acts 2001-2018 (Consent to Treatment)
- Four Codes of Practice
  - Code of Practice on the Use of Physical Restraint
  - Code of Practice on the Use of Electro-Convulsive Therapy for Voluntary Patients
  - Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre
  - Code of Practice relating to Admission of Children under the Mental Health Act (2001)

Based on compliance with the relative legislative requirements, the Inspector makes a compliance rating of 'Compliant' or 'Non-Compliant'. Findings of non-compliance are risk-rated as low, moderate, high or critical in order to inform our regulatory activities. Based on the centre's adherence to the criteria set out in the Judgement Support Framework, the Inspector may comment on quality initiatives identified during inspections and in published reports, as a means of recognising and highlighting areas of good practice.

In 2023, the MHC devised and published the National Quality Framework: Driving Excellence in Mental Health Services (2023) facilitating a return to reporting on quality measures across approved centres from 2024. Centres with high levels of compliance can utilise this to continue to drive quality improvement in the services they provide.

# Compliance Monitoring

**The MHC collects, monitors and analyses compliance data by individual approved centre, by sector or HSE Health Region (HR) area, and nationally to identify areas of good practice and areas of concern.**

The Inspector uses the Judgement Support Framework (JSF) as a key document to inform how compliance is assessed on inspection. The JSF is reviewed and updated as required in advance of each annual inspection cycle to provide a consistent and up-to-date inspection framework for assessing compliance. The JSF requires an assessment of compliance against each of the of the Regulations. The MHC inspected 67 of the 67 registered approved centres in 2025, including two approved centres first registered in 2025, Nua Healthcare, Gormanston and a centre registered within the campus of the National Forensic Mental Health Service known as the Brandon Unit, in Portrane.

Compliance data supplied within this chapter relates to the annual inspection cycle only. It is important to note that the MHC also conducts focused inspections in response to specific concerns at any time throughout the year. A focused inspection may also arise to facilitate decisions on registration of approved centres. In 2025, eight focused inspections of eight approved centres were undertaken and enforcement actions taken on foot of these inspections are included in the Enforcement section below.

To access copies of individual approved centre inspection reports please go to the MHC website.

## Key Compliance Findings from the 2025 Annual Inspection Cycle

- Overall compliance figures improved slightly when compared to 2024 (84.35% in 2025 compared to 83.14% in 2024).
- Some centres continue to achieve full compliance with Regulations, with seven centres achieving full compliance with all Regulations, Rules and Codes of Practice in 2025.
- There was a decrease in the number of critical non-compliances, from 38 in 2024 to 33 in 2025.
- There was an increase in high-risk non-compliances in 2025, from 168 in 2024 to 199 in 2025.
- Overall compliance across HSE funded adult centres increased to 82.66% in 2025 from just under 81% in 2024.
- Overall compliance across independently run adult centres was 93.01% an increase from 88.5% in 2024.
- The compliance rate in 2025 with the three statutory Rules, Section 26 Leave, and Part 4 of the Mental Health Act 2001 was 62.43% an increase on an average compliance of 60% in 2024.
- The compliance rate with Codes of Practice in 2025 was 71.67%, an increase on the 69% compliance observed in 2024.

Compliance levels with all legal requirements in 2025 increased slightly overall on the previous year, averaging 84.35% across all centres in 2025, in comparison with 83.14% in 2024. In 2025, eight centres achieved 100% compliance with the 31 Regulations only which compares with six in 2024.

The compliance rate with the 31 Regulations at 86.78% is an increase on the figure reported in 2024 when it was 85%. Approximately 82% of all approved centres achieved an 80% rate of compliance or higher with the Regulations in 2025. This proportion was 71% of approved centres in 2024, and 67% of centres in 2023. A total of 12 approved centres had a compliance rate lower than 80% in 2025, and no centre had a compliance rate lower than 60% with Regulations. In comparison, 19 approved centres had a compliance rate lower than 80% in 2024, and 22 approved centres had a compliance rate lower than 80% in 2023.

Average levels of compliance with the three Statutory Rules, Section 26 Leave, and Part 4 of the Mental Health Act 2001 across all relevant approved centres was 62.43%, which averaged at 60% in 2024. It should be noted that these Rules may not be applicable in all of the approved centres. This is discussed within each inspection report.

Compliance rates with all four Codes of Practice averaged 71.67% in 2025, an increase on the average compliance of 69% reported for 2024.

### Compliance Across HSE Regions and Independent Sector

There were some small differences in levels of compliance achieved across the HSE's Health Regions (HRs) which were established at the end of 2024. Overall average compliance by HSE HR was 83.11% in 2025, an increase on just under 81% by HSE CHO in 2024. HSE Midwest (88.92%) had the highest compliance rate with Regulations, Rules and Codes of Practice on average across each of its approved centres, and HSE Dublin & Midlands had the lowest average compliance rate (79.39%). The average compliance rate across adult approved centres operated by independent providers was 93.01%.

## Areas of Good Practice found on Inspection

- In 2025, 24 of the 31 Regulations had an approved centre compliance rate of 80% or higher. In comparison in 2024, 22 individual Regulations had an approved centre compliance rate of 80% or higher and in 2023, 21 Regulations had a compliance rate of 80% or higher.
- Eleven Regulations were fully complied with by all 67 approved centres in 2025, including Regulation 24: Health and Safety, Regulation 30: Mental Health Tribunals, Regulation 14: Care of the Dying and Regulation 9: Recreational Activities.
- Twenty-nine approved centres achieved 100% compliance with all Codes of Practice representing 43% of all centres inspected under same in 2025.
- Twenty-three approved centres achieved 100% compliance with all Rules, representing 48% of all centres inspected under same in 2025.
- Centres inspected under Section 26 Leave were found 100% compliant and compliance with Part 4 Consent remains high with compliance in 2025 at 87.88%.

The revised Rules Governing the Use of Mechanical Means of Bodily Restraint which came into effect in 2023 differentiates between use for immediate threat of serious harm (Part 3) and for enduring risk of harm (Part 4) mechanical restraint. Compliance on Part 4 in 2025 rose considerably to 76.47% from the figure reported in 2024 of 63.64%.

A total of five approved centres were inspected on the Code of Practice relating to the Admission of Children to adult approved centres in 2025, and of these just one was found to be non-compliant. In 2024 seven centres were inspected under this same Code with all found non-compliant.

## Areas of Concern found on Inspection

A number of Regulations were identified as having poor compliance rates. In 2025, Regulations with compliance rates below 80% included Regulation 16: Therapeutic Services and Programmes (77.61%) and Regulation 21: Privacy (73.13%). However, both Regulations have seen some improvement on compliance noted in 2024: Therapeutic Services and Programmes (73.85%) and Regulation 21: Privacy (67.69%).

A total of five Regulations had compliance rates lower than 60%. These were Regulation 15: Individual Care Plan (ICP) (58.21%), Regulation 22: Premises (26.87%), Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (53.73%), Regulation 26: Staffing (52.24%) and Regulation 32: Risk Management Procedures (44.78%). While the compliance rate for Regulation 26: Staffing has increased in 2025 on the 2024 rate of 50.77% to 52.24%, all four of the remaining low-rated Regulations saw decreases in compliance in 2025. Compliance with the Regulation 22: Premises has continued to be particularly low over the past number of years, with an average compliance rate over the past five years of 29.2%.

In 2025, the revised Judgment Support Framework set out changes in the requirements for the management of high-dose antipsychotic medication (HDAT) in approved centres under Regulation 23 Ordering, Prescribing, Storing and Administration of Medicines. Compliance with Regulation 23 dropped to 53.73% in 2025 from 76.92% in 2024.

Annual reports for the past five years have noted repeated areas of non-compliance across approved centres in four key Regulations: Regulation 15: Individual Care Plans, Regulation 22: Premises, Regulation 26: Staffing and Regulation 32: Risk Management Procedures. The data show that there is considerable variance in compliance levels across the HSE regional areas regarding these four Regulations.

In 2025 the average compliance rate for these four Regulations across adult approved centres in all HSE health regions was 40.49%. By comparison in 2024 this figure was 44%.

As illustrated in **Table 19**, in 2025 HSE Midwest achieved this highest rate of compliance with these four Regulations (62.5%) with HSE West & North West reporting the lowest average rate of compliance at 27.5%. The independent sector compliance-rate across these four Regulations in 2025 was 80.56%.

In relation to Codes of Practice, the compliance rate with the Code of Practice on the use of Electro-Convulsive Therapy for Voluntary Patients has dropped to 84.62% in 2025, compared to 87.5% in 2024, and 100% in 2023.

While compliance with the Rules Governing the Use of Seclusion across all applicable centres in 2025 increased on the 2024 figure of 28.57% in 2024, the figure reported in 2025 of 33.33% remains low.

**Table 19:** *Sector Compliance with ICP, Premises, Staffing and Risk Regulations*

| HSE HR/ Sector | No. of Approved Centres | ICP | Premises | Staffing | Risk | Lowest | Highest | Average |
|---|---|---|---|---|---|---|---|---|
| HSE Dublin & Midlands | 7 | 71.43% | 0% | 14.29% | 28.57% | 0% | 71.43% | 28.57% |
| HSE Dublin & North East | 10 | 60% | 30% | 40% | 40% | 30% | 60% | 42.50% |
| HSE Dublin & South East | 10 | 80% | 20% | 60% | 30% | 20% | 80% | 47.50% |
| HSE Midwest | 4 | 75% | 25% | 75% | 75% | 25% | 75% | 62.50% |
| HSE South West | 8 | 50% | 12.50% | 50% | 25% | 12.50% | 50% | 34.38% |
| HSE West & North West | 10 | 20% | 10% | 40% | 40% | 10% | 40% | 27.50% |
| INDP | 9 | 66.67% | 77.78% | 88.89% | 88.89% | 66.67% | 88.89% | 80.56% |
| Forensic | 2 | 50% | 0% | 0% | 0% | 0% | 50% | 12.50% |
| CAMHS | 6 | 50% | 50% | 83.33% | 66.67% | 50% | 83.33% | 62.50% |
| MHID | 1 | 100% | 0% | 0% | 0% | 0% | 100% | 25% |

## Critical Risks

In 2025, there were 18 approved centres with instances of non-compliance that received a critical risk rating. This means that there was a high likelihood of continued non-compliance and a high impact on the safety, rights, health or wellbeing of residents.

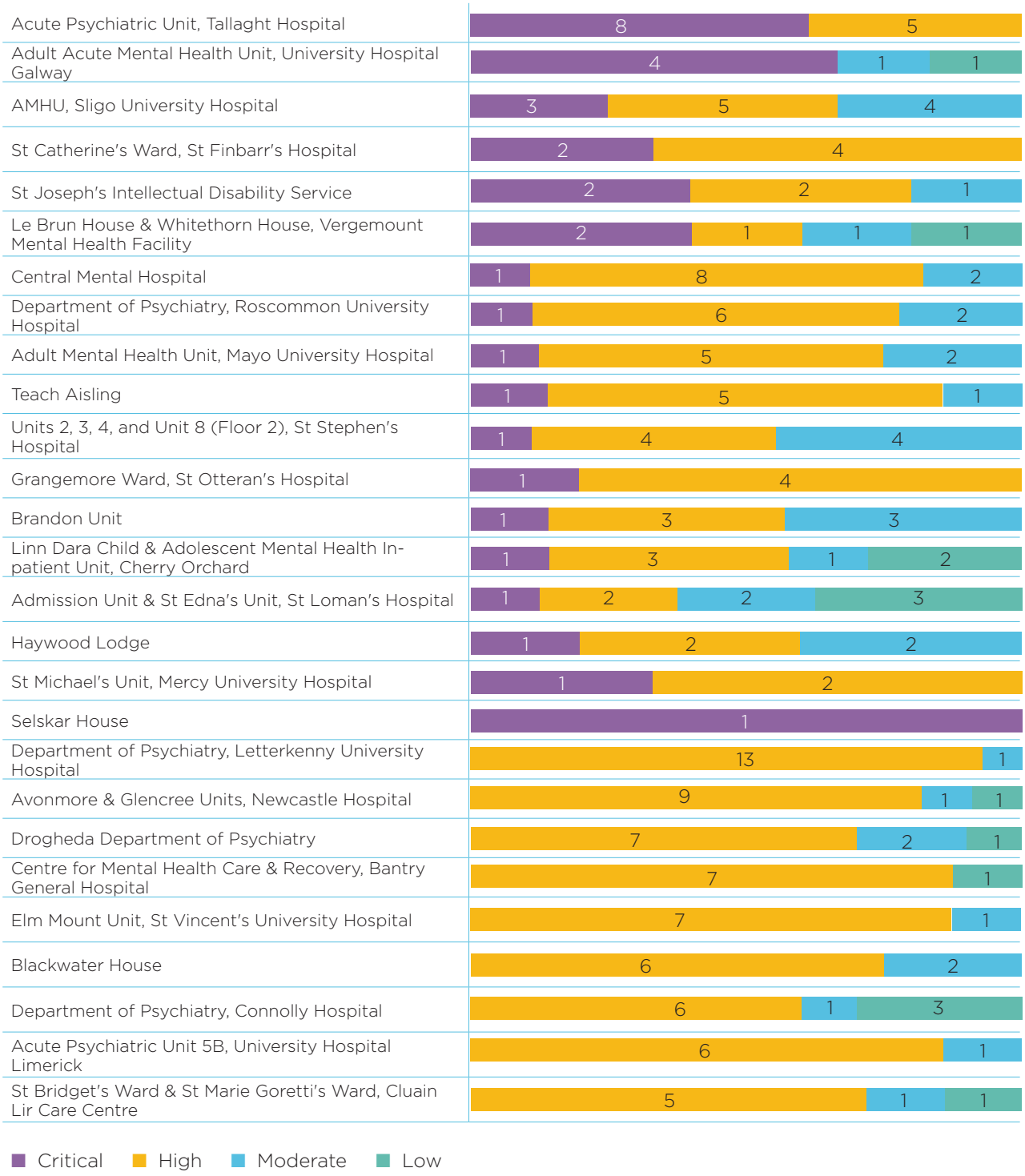
The critical risks included those related to:

- Reguslation 8: Residents' Personal Property and Possessions
- Regulation 15: Individual Care Plan
- Regulation 16: Therapeutic Services and Programmes
- Regulation 19: General Health
- Regulation 21: Privacy
- Regulation 22: Premises
- Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines
- Regulation 26: Staffing
- Regulation 27: Maintenance of Records
- Regulation 32: Risk Management Procedures
- Rules Governing the use of Electro-Convulsive Therapy
- Rules Governing the use of Seclusion
- Code of Practice on the Admission of Children to Approved centres
- Code of Practice on the use of Electro-Convulsive Therapy for Voluntary Patients

Where non-compliance is found, the level of risk is assessed by the Inspector. The risk rating is calculated by assessing the impact of the non-compliance against the likelihood of the non-compliance reoccurring and is assessed to be low, moderate, high or critical risk. In 2025, 6.27% non-compliances were rated as low risk, 27.64% as moderate risk, 56.7% as high risk and 9.4% as critical risk. By comparison in 2024, 9.54% non-compliances were rated as low risk, 33.79% as moderate risk, 46.32% as high risk and 10.35% as critical risk. **Figure 4** below highlights the proportional risk identified on inspection in 2025 by approved centre.

The MHC follows up and monitors all areas of concern and critical risks in line with our enforcement policy. Please refer to the enforcement section of this report for details of actions taken where critical non-compliances were identified.

**Figure 4:** *2025 Proportional Non-Compliance Risk by Approved Centre*



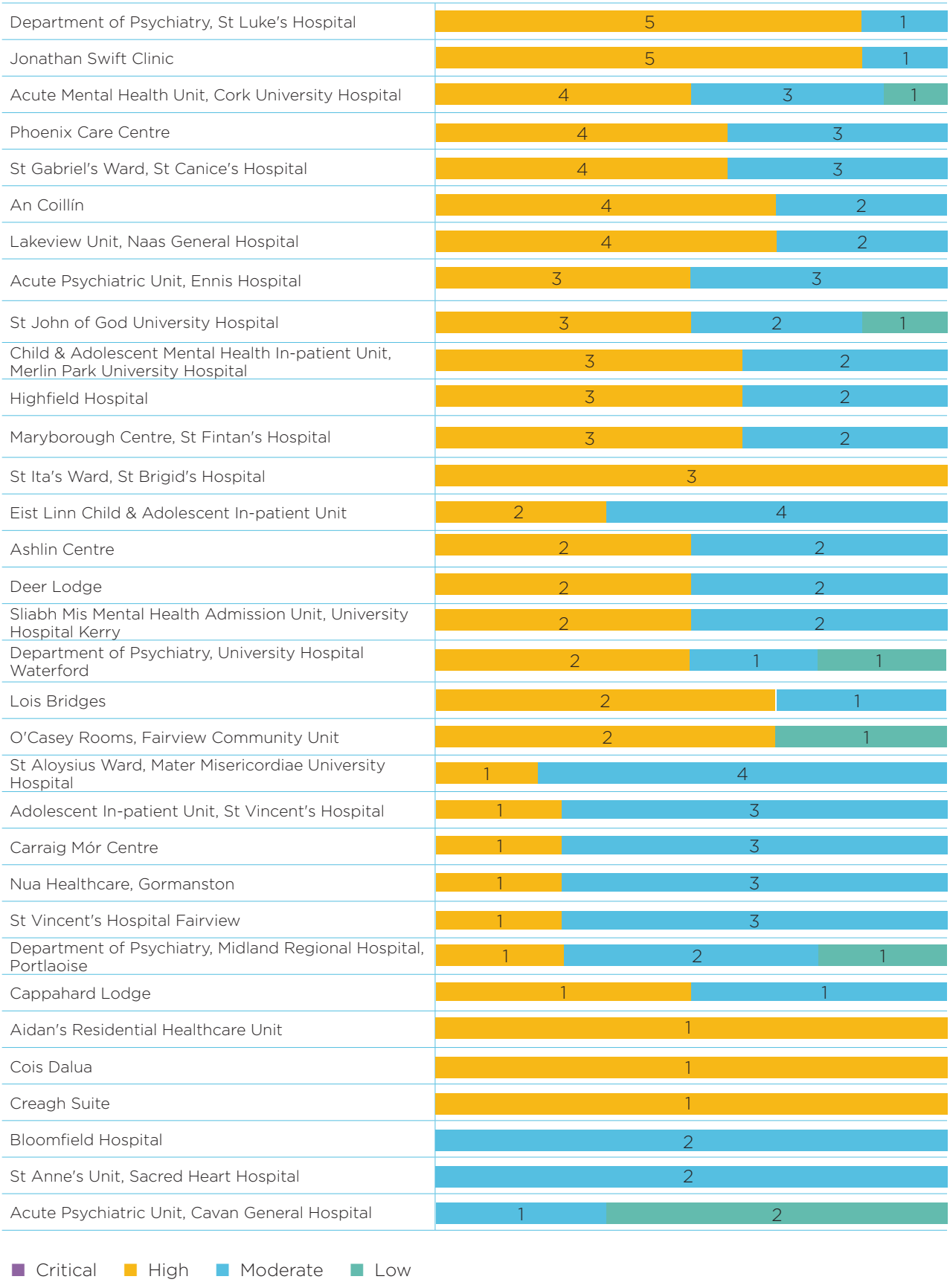

Department of Psychiatry, St Luke's Hospital 5 1
Jonathan Swift Clinic 5 1
Acute Mental Health Unit, Cork University Hospital 4 3 1
Phoenix Care Centre 4 3
St Gabriel's Ward, St Canice's Hospital 4 3
An Coillín 4 2
Lakeview Unit, Naas General Hospital 4 2
Acute Psychiatric Unit, Ennis Hospital 3 3
St John of God University Hospital 3 2 1
Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital 3 2
Highfield Hospital 3 2
Maryborough Centre, St Fintan's Hospital 3 2
St Ita's Ward, St Brigid's Hospital 3
Eist Linn Child & Adolescent In-patient Unit 2 4
Ashlin Centre 2 2
Deer Lodge 2 2
Sliabh Mis Mental Health Admission Unit, University Hospital Kerry 2 2
Department of Psychiatry, University Hospital Waterford 2 1 1
Lois Bridges 2 1
O'Casey Rooms, Fairview Community Unit 2 1
St Aloysius Ward, Mater Misericordiae University Hospital 1 4
Adolescent In-patient Unit, St Vincent's Hospital 1 3
Carraig Mór Centre 1 3
Nua Healthcare, Gormanston 1 3
St Vincent's Hospital Fairview 1 3
Department of Psychiatry, Midland Regional Hospital, Portlaoise 1 2 1
Cappahard Lodge 1 1
Aidan's Residential Healthcare Unit 1
Cois Dalua 1
Creagh Suite 1
Bloomfield Hospital 2
St Anne's Unit, Sacred Heart Hospital 2
Acute Psychiatric Unit, Cavan General Hospital 1 2
Critical
High
Moderate
Low

**Table 20** below demonstrates the levels of risk attributed to non-compliances identified on inspection in 2025.

**Table 20:** *Proportion of Non-Compliance by Area of Concern*

| Reg/COP/Rule/Part 4/Section 26 | Critical | High | Moderate | Low |
|---|---|---|---|---|
| COP: Children | 100% | 0% | 0% | 0% |
| Rules: ECT | 66.67% | 33.33% | 0% | 0% |
| COP: ECT | 50% | 50% | 0% | 0% |
| Rules: Seclusion | 30% | 30% | 25% | 15% |
| Reg 32: Risk Management Procedures | 18.92% | 62.16% | 18.92% | 0% |
| Reg 22: Premises | 12.24% | 65.31% | 22.45% | 0% |
| Reg 21: Privacy | 11.11% | 83.33% | 5.56% | 0% |
| Reg 19: General Health | 11.11% | 22.22% | 55.56% | 11.11% |
| Regulation 8: Residents' Personal Property and Posessions | 10% | 40% | 50% | 0% |
| Reg 27: Maintenance of Records | 9.09% | 45.45% | 36.36% | 9.09% |
| Reg 16: Therapeutic Services | 6.67% | 80% | 13.33% | 0% |
| Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines | 6.45% | 61.29% | 22.58% | 9.68% |
| Reg 15: Individual Care Plan | 3.57% | 50% | 42.86% | 3.57% |
| Reg 26: Staffing | 3.13% | 78.13% | 18.75% | 0% |
| Part 4: Consent to Treatment | 0% | 100% | 0% | 0% |
| Reg 11: Visits | 0% | 100% | 0% | 0% |
| Reg 29: Operating Policies and Procedures | 0% | 100% | 0% | 0% |
| Rules: Part 3 Mechanical Restraint | 0% | 100% | 0% | 0% |
| COP: Admission, Transfer, Discharge | 0% | 60% | 20% | 20% |
| Reg 05: Food and Nutrition | 0% | 50% | 50% | 0% |
| Reg 25: CCTV | 0% | 50% | 25% | 25% |
| Rules: Part 4 Mechanical Restraint | 0% | 50% | 25% | 25% |
| Reg 28: Register of Residents | 0% | 40% | 60% | 0% |
| COP: Physical Restraint | 0% | 40% | 40% | 20% |
| Reg 06: Food Safety | 0% | 33.33% | 33.33% | 33.33% |
| Reg 13: Searches | 0% | 30% | 70% | 0% |
| Reg 12: Communication | 0% | 0% | 100% | 0% |
| Reg 18: Transfer of Residents | 0% | 0% | 100% | 0% |
| Reg 31: Complaints Procedures | 0% | 0% | 50% | 50% |

80+% Compliant
60-80% Compliant
Less than 60% Compliant

**Table 21:** *Approved Centre Compliance with Regulations*

| Approved Centre | HSE HR/Sector | % Compliance |
|---|---|---|
| Cois Dalua | Independent | 100% |
| National Eating Disorders Recovery Centre | Independent | 100% |
| St Patrick's Hospital, Lucan | Independent | 100% |
| St Patrick's University Hospital | Independent | 100% |
| Tearmann Ward, St Camillus' Hospital | HSE Midwest | 100% |
| The Ginesa Centre, St John of God University Hospital | CAMHS | 100% |
| Willow Grove Adolescent Unit, St Patrick's University Hospital | CAMHS | 100% |
| Woodview | HSE West & North West | 100% |
| Bloomfield Hospital | Independent | 96.67% |
| Aidan's Residential Healthcare Unit | HSE Dublin & South East | 96.55% |
| Creagh Suite | HSE West & North West | 96.55% |
| Selskar House | HSE Dublin & South East | 96.43% |
| St Michael's Unit, Mercy University Hospital | HSE South West | 93.33% |
| Acute Psychiatric Unit, Cavan General Hospital | HSE Dublin & North East | 93.10% |
| St Anne's Unit, Sacred Heart Hospital | HSE West & North West | 93.10% |
| Cappahard Lodge | HSE Midwest | 92.86% |
| Ashlin Centre | HSE Dublin & North East | 90% |
| Carraig Mór Centre | HSE South West | 90% |
| Child & Adolescent Mental Health In-patient Unit, Merlin Park University Hospital | CAMHS | 90% |
| Department of Psychiatry, Midland Regional Hospital, Portlaoise | HSE Dublin & Midlands | 90% |
| Nua Healthcare, Gormanston | Independent | 90% |
| Sliabh Mis Mental Health Admission Unit, University Hospital Kerry | HSE South West | 90% |
| Adolescent In-patient Unit, St Vincent's Hospital | CAMHS | 89.66% |
| Maryborough Centre, St Fintan's Hospital | HSE Dublin & Midlands | 89.66% |
| O'Casey Rooms, Fairview Community Unit | HSE Dublin & North East | 89.66% |
| St Joseph's Intellectual Disability Service | MHID | 89.66% |
| Lois Bridges | Independent | 89.29% |
| St Ita's Ward, St Brigid's Hospital | HSE Dublin & North East | 89.29% |
| Department of Psychiatry, University Hospital Waterford | HSE Dublin & South East | 86.67% |
| Eist Linn Child & Adolescent In-patient Unit | CAMHS | 86.67% |
| St John of God University Hospital | Independent | 86.67% |
| Deer Lodge | HSE South West | 86.21% |
| Jonathan Swift Clinic | HSE Dublin & Midlands | 86.21% |
| St Aloysius Ward, Mater Misericordiae University Hospital | HSE Dublin & North East | 86.21% |

| Approved Centre | HSE HR/Sector | % Compliance |
|---|---|---|
| St Vincent's Hospital Fairview | HSE Dublin & North East | 86.21% |
| Le Brun House & Whitethorn House, Vergemount Mental Health Facility | HSE Dublin & South East | 85.71% |
| Acute Psychiatric Unit 5B, University Hospital Limerick | HSE Midwest | 83.33% |
| Acute Psychiatric Unit, Ennis Hospital | HSE Midwest | 83.33% |
| Admission Unit & St Edna's Unit, St Loman's Hospital | HSE Dublin & Midlands | 83.33% |
| Adult Acute Mental Health Unit, University Hospital Galway | HSE West & North West | 83.33% |
| Department of Psychiatry, St Luke's Hospital | HSE Dublin & South East | 83.33% |
| Lakeview Unit, Naas General Hospital | HSE Dublin & Midlands | 83.33% |
| Phoenix Care Centre | HSE Dublin & North East | 83.33% |
| Brandon Unit | NFMHS | 82.76% |
| Grangemore Ward, St Otteran's Hospital | HSE Dublin & South East | 82.76% |
| Haywood Lodge | HSE Dublin & South East | 82.76% |
| Highfield Hospital | Independent | 82.76% |
| St Catherine's Ward, St Finbarr's Hospital | HSE South West | 82.14% |
| St Gabriel's Ward, St Canice's Hospital | HSE Dublin & South East | 82.14% |
| Acute Mental Health Unit, Cork University Hospital | HSE South West | 80% |
| Adult Mental Health Unit, Mayo University Hospital | HSE West & North West | 80% |
| An Coillín | HSE West & North West | 80% |
| Centre for Mental Health Care & Recovery, Bantry General Hospital | HSE South West | 80% |
| Drogheda Department of Psychiatry | HSE Dublin & North East | 80% |
| Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard | CAMHS | 80% |
| Blackwater House | HSE Dublin & North East | 79.31% |
| Department of Psychiatry, Roscommon University Hospital | HSE West & North West | 79.31% |
| Elm Mount Unit, St Vincent's University Hospital | HSE Dublin & South East | 79.31% |
| St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre | HSE Dublin & Midlands | 79.31% |
| Teach Aisling | HSE West & North West | 79.31% |
| Central Mental Hospital | NFMHS | 76.67% |
| Department of Psychiatry, Connolly Hospital | HSE Dublin & North East | 76.67% |
| AMHU, Sligo University Hospital | HSE West & North West | 73.33% |
| Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital | HSE South West | 73.33% |
| Avonmore & Glencree Units, Newcastle Hospital | HSE Dublin & South East | 70% |
| Acute Psychiatric Unit, Tallaght Hospital | HSE Dublin & Midlands | 66.67% |
| Department of Psychiatry, Letterkenny University Hospital | HSE West & North West | 63.33% |

**Table 22:** *Sector Compliance with Regulations in 2025*

| HSE HR/Sector | No. of Approved Centres | Avg. Reg Compliance | Lowest Rate | Highest Rate |
|---|---|---|---|---|
| HSE Dublin & Midlands | 7 | 82.64% | 66.67% | 90% |
| HSE Dublin & North East | 10 | 85.38% | 76.67% | 93.10% |
| HSE Dublin & South East | 10 | 84.57% | 70% | 96.55% |
| HSE Midwest | 4 | 89.88% | 83.33% | 100% |
| HSE South West | 8 | 84.38% | 73.33% | 93.33% |
| HSE West & North West | 10 | 82.83% | 63.33% | 100% |
| INDP | 9 | 93.93% | 82.76% | 100% |
| NFMHS | 2 | 79.71% | 76.67% | 82.76% |
| CAMHS | 6 | 91.05% | 80% | 100% |
| MHID | 1 | 89.66% | 89.66% | 89.66% |

80+% Compliant
60-80% Compliant
Less than 60% Compliant

**Table 23:** *Compliance by Regulation in 2025*

| Regulation | Proportion of centres compliant |
|---|---|
| Reg 24: Health and Safety | 100% |
| Reg 04: Identifiaction of Residents | 100% |
| Reg 34: Certificate of Registration | 100% |
| Reg 07: Clothing | 100% |
| Reg 20: Provision of Information to Residents | 100% |
| Reg 09: Recreation | 100% |
| Reg 33: Insurance | 100% |
| Reg 10: Religion | 100% |
| Reg 14: Care of the Dying | 100% |
| Reg 30: Mental Health Tribunals | 100% |
| Reg 17: Children's Education | 100% |
| Reg 18: Transfer of Residents | 98.51% |
| Reg 29: Operating Policies and Procedures | 98.51% |
| Reg 12: Communication | 98.51% |
| Reg 05: Food and Nutrition | 97.01% |
| Reg 31: Complaints Procedures | 97.01% |
| Reg 11: Visits | 97.01% |
| Reg 06: Food Safety | 95.52% |
| Reg 28: Register of Residents | 92.54% |
| Reg 25: Use of Closed Circuit Television | 88.57% |

| Regulation | Proportion of centres compliant |
|---|---|
| Reg 19: General Health | 86.57% |
| Reg 13: Searches | 85.07% |
| Reg 08: Residents' Property and Posessions | 85.07% |
| Reg 27: Maintenance of Records | 83.58% |
| Reg 16: Therapeutic Services and Programmes | 77.61% |
| Reg 21: Privacy | 73.13% |
| Reg 15: Individual Care Plan | 58.21% |
| Reg 23: Ordering, Prescribing, Storing and Administration of Medicines | 53.73% |
| Reg 26: Staffing | 52.24% |
| Reg 32: Risk Management Procedures | 44.78% |
| Reg 22: Premises | 26.87% |

**Table 24:** *Compliance with Statutory Rules, Part 4 and Section 26 of the Mental Health Act 2001 in 2025*

| Rule | % Compliance |
|---|---|
| Section 26 Leave | 100% |
| Part 4: Consent to Treatment | 87.88% |
| Rules: ECT | 76.92% |
| Rules: Part 4 Mechanical Restraint | 76.47% |
| Rules: Seclusion | 33.33% |
| Rules: Part 3 Mechanical Restraint | 0% |

*Only one centre required inspection in relation to Part 3 Mechanical Restraint in 2025 and was found non-compliant.

**Table 25:** *Compliance with Codes of Practice in 2025*

| Rule | % Compliance |
|---|---|
| COP: ECT | 84.62% |
| COP: Children | 80.% |
| COP: Admission, Transfer, Discharge | 77.61% |
| COP: Physical Restraint | 44.44% |

## Enforcement

Enforcement action is taken when the MHC is concerned that the care and treatment provided in an approved centre may be a risk to the safety, health and wellbeing of residents, or where there has been a failure by the provider to address an ongoing area of non-compliance.

All critical risk issues are considered by the MHC's Regulatory Management Team. Enforcement actions commonly arise from inspection findings, quality and safety notifications, and compliance monitoring.

Enforcement actions available to the MHC are set out under the Mental Health Act (2001), and are outlined in the MHC Enforcement Policy. See **Figure 5**. Enforcement actions range from requiring a corrective and preventative action plan (at the lower end of enforcement) to removing an approved centre from the register and/or pursuing prosecution.

### Enforcement actions

The MHC took 49 enforcement actions in response to incidents, events and inspection findings arising in 2025. These actions related to 32 approved centres, and the maximum number of enforcement actions initiated against any one approved centre was three.

This compares with:

- 31 enforcement actions in 2024
- 52 enforcement actions in 2023
- 45 enforcement actions in 2022
- 42 enforcement actions in 2021

During 2025, enforcement actions included:

- 27 Immediate Action Notices
- 13 Regulatory Compliance Meetings
- Eight formal warning letters
- One formal assurance request

In addition, the MHC requested 60 Corrective and Preventive Action plans on foot of the findings during the inspection cycle.

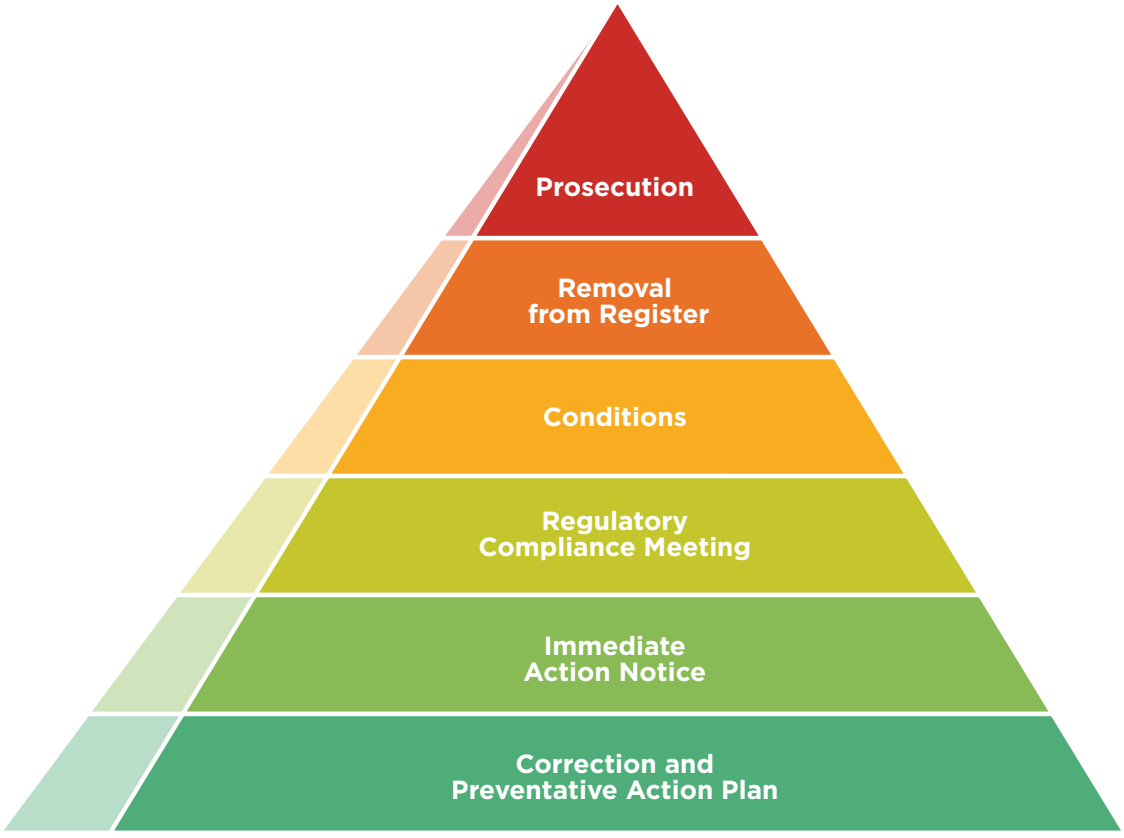



**Figure 5:** *MHC Enforcement Model*

Approximately 50% of the Immediate Action Notices and Regulatory Compliance Meetings in 2025 arose from annual inspections. The remainder were initiated from focused inspections or on foot of quality and safety notifications in approved centres.

Enforcement actions related to core areas of service provision that impacted the safety, wellbeing or human rights of residents.

They included:

- Maintenance of premises at the approved centre
- Risk management procedures at the approved centre
- Appropriate staffing levels at the approved centre
- Compliance with Codes of Practice and Rules
- Other service provision areas

## Registration Conditions

The MHC may attach conditions to an approved centre's registration under Section 64 of the Act. The most common reason to attach conditions to the registration of an approved centre is to address sustained and repeated non-compliance with Rules, Regulations or Codes of Practice. The MHC monitors conditions on a regular basis to ensure that approved centres are implementing actions required. It is an offence to breach a condition of registration.

### Conditions Attached

In 2025, eight new conditions were attached to the registration of five approved centres, relating to record management, admissions, compliance and quality improvement. This compares to four new conditions attached to two approved centres in 2024, and 25 new conditions attached to 13 approved centres in 2023.

At the end of 2025, there were 31 conditions attached to 18 approved centres in total, compared to 36 conditions attached to 20 approved centres at end of 2024, and 39 conditions attached to 25 approved centres at end of 2023. The reduction in the number of conditions in 2025 can be linked to the registration cycle, such that a relatively small number of approved centres applied for re-registration in 2025. The most common matters addressed through conditions are presented in **Table 26**.

- Two new approved centres were registered for the first time in 2025.
- 20 centres applied for re-registration in 2025, compared to 11 in 2024, and 34 in 2023.
- Conditions may remain in place for the duration of the three-year registration cycle, where issues of poor compliance have not been fully addressed.

Approved centres are required to submit registration condition updates to the MHC in a form and frequency set out by the MHC. These are on a monthly or quarterly basis. In 2025, 137 condition-monitoring reports were submitted, compared to 109 condition-monitoring reports submitted in 2024 and 79 in 2023.

**Table 26:** *Registration Conditions in force in 2025*

| Condition Area | Number of conditions Attached |
|---|---|
| Premises | 13 |
| Quality Improvement | 6 |
| Risk Management | 2 |
| Staffing & Staff Training | 2 |
| Others | 8 |

## Quality & Safety Notifications

Approved centres are required to record and submit Quality and Safety Notifications to the MHC via the Comprehensive Information System (CIS). There are a range of Quality and Safety Notification categories, which relate to incidents and adverse events and regulated practices, including:

- Child Admissions
- Deaths
- Electro-Convulsive Therapy
- Incident Reporting
- Overcapacity
- Operational Bed Capacity
- Restrictive Practices
- Serious Reportable Events

All notifications received are reviewed by the Standards and Quality Assurance (S&QA) division of the MHC, to ensure quality, safety of care, dignity and human rights practices are adhered to in the provision of mental health services in approved centres.

The S&QA division monitors and reviews these notifications and may request further information from a service in relation to a notification, to ensure that specific actions have been taken to safeguard the wider resident group or that relevant learnings have been incorporated into service practice.

The MHC analyses notifications for trends and uses these data to inform its regulatory practices. The MHC produces annual activity reports on some regulated practices, which can be found on the MHC's website.

### Adverse Events

#### Deaths

Approved Centres are required to notify the MHC of resident deaths that occur within the centre and those that occur within four weeks post discharge from an approved centre.

The MHC received four notifiable Incidents under the Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023 via the National Incident Management System (NIMS) in 2025. These notifiable incidents relate to deaths of residents or patients associated with medical treatment, medication errors or unintended deaths where the cause is believed to be suicide. The MHC used the information in these Patient Safety Notifications to inform regulatory processes for those approved centres to ensure residents were in receipt of safe and good quality care.

In accordance with Quality and Safety Notification Guidance, in 2025, 147 resident deaths were reported by approved centres to the MHC, via CIS.

This compares to:

- 143 deaths in 2024 relating to residents of approved centres.
- 529 deaths in 2023, 149 related to residents of approved centres and 380 related to other community mental health services.
- 498 deaths in 2022, 147 were residents in approved centres and 351 related to other community mental health services.
- 471 deaths in 2021, 174 were residents in approved centres and 297 related to other community mental health services.

A total of 86 (58.5%) deaths reported by approved centres in 2025 related to males. The average age at death was 66 years. The youngest was 20 years of age, and the oldest was 95 years.

Death by suicide may only be determined by a Coroner's inquest, which may take place several months after the death. However, in 2025, 37 total deaths were reported to the MHC by approved centres as a 'suspected suicide'. This compares to 2024, where 28 related to residents of approved centres.

It should be noted that deaths notified to the MHC include those that are reported within four weeks of a resident's discharge. A breakdown of the deaths reported to the MHC is provided in **Table 27**.

**Table 27:** *Deaths Notified to the MHC*

| Type of Death* | Approved Centre Deaths |
|---|---|
| Death was Sudden | 57 |
| Death was Not Sudden | 87 |
| Death was Suspected Suicide | 37 |
| Cause of Death Unknown | 45 |

**A resident death may be reported under more than one Type of Death category*

## Serious Reportable Events

All approved centres are required to notify the MHC of Serious Reportable Events that occur in their service (Serious Reportable Events (SREs), HSE 2015). There are ten categories of SREs which require notification to the MHC. These are grouped as:

- **Patient Protection Events** relating to death, disability or injury associated with absconsion, or those which occur in an approved centre.
- **Care Management Events** relating to pressure ulcers, injuries following restrictive interventions, or those relating to medication errors in approved centres.
- **Environmental Events** relating to death, disability or other serious injuries relating to burns or falls in approved centres.
- **Criminal Events** relating to alleged or actual sexual assault or physical assault within or on the grounds of the approved centre.

The numbers of SREs received over the past five years are as follows:

- In 2025, 197 SREs were reported to the MHC involving 42 approved centres
- In 2024, 124 SREs were reported to the MHC involving 38 approved centres
- In 2023, 94 SREs were reported involving 30 approved centres
- In 2022, 51 SREs were reported involving 23 approved centres
- In 2021, 42 SREs were reported involving 23 approved centres

**Table 28** shows the number of reported SREs in 2025, broken down by SRE category as reportable to the MHC. The highest reported SRE category was Criminal Events 6C (50.8%), followed by Environmental Events 5D (24.4%), and Other (8.6%). In relation to the Criminal Events 6C (Sexual Assault) category, there was another marked annual increase in the number of approved centre incidents reported in 2025 (100) compared to 2024 (76), 2023 (42) and 2022 (12). The MHC engaged with each approved centre that reported a category 6C Criminal Event to ensure the safety of each resident and to seek assurances regarding the wider safeguarding arrangements in place.

**Table 28:** *Serious Reportable Events Reported in 2025 by Category*

| SRE Category | Description | Number Reported | % |
|---|---|---|---|
| Criminal Events (6C) | Sexual assault* | 100 | 50.76% |
| Environmental Events (5D) | Serious disability or injury that requires medical treatment associated with a fall | 48 | 24.37% |
| Other | Other event | 17 | 8.63% |
| Care Management Events (4I) | Stage 3 or 4 pressure ulcers | 12 | 6.09% |
| Patient Protection Events (3C) | Sudden or unexplained death, disability, or injury that requires medical treatment | 10 | 5.08% |
| Criminal Events (6D) | Serious disability or injury that requires medical treatment resulting from a physical assault | 5 | 2.54% |

| SRE Category | Description | Number Reported | % |
|---|---|---|---|
| Patient Protection Events (3B) | Serious disability or injury that requires medical treatment associated with a patient absconding from a healthcare service | 4 | 2.03% |
| Care Management Events (4A) | Serious disability or injury that requires medical treatment associated with a medication error | 1 | 0.51% |
| | **Total** | **197** | |

**actual or alleged*

**Table 29** provides a breakdown of SRE by HSE Health Region and Sector. HSE Dublin & Midlands (24.9%) reported the highest number of SREs in 2025. The MHID sector reported the lowest proportion of SREs in 2025 at only 1%. It should be noted that some approved centres may be more likely to report a specific type of SRE based on the profile of residents that they support, for example, falls and pressure ulcers are associated with older adults in care.

Fifty-six percent of SREs reported by approved centres related to male residents. The average age of a resident who was the subject of an SRE was 53 years of age. The youngest resident was 15 years old and the oldest was 94 years.

**Table 29:** *Serious Reportable Events Reported by Sector*

| SRE Category | CAMHS | HSE Dublin & Midlands | HSE Dublin & North East | HSE Dublin & South East | HSE Midwest | HSE South West | HSE West & North West | MHID | Independent |
|---|---|---|---|---|---|---|---|---|---|
| **Care Management Events (4A)** | | | 1 | | | | | | |
| **Care Management Events (4I)** | | 2 | | 3 | 2 | | | | 5 |
| **Criminal Events (6C)** | 1 | 36 | 26 | 8 | 1 | 8 | 9 | 2 | 9 |
| **Criminal Events (6D)** | | 3 | | | | 1 | 1 | | |
| **Environmental Events (5D)** | 1 | 3 | 4 | 12 | 2 | 12 | 8 | | 6 |
| **Other** | | 2 | 1 | | | 4 | | | 10 |
| **Patient Protection Events (3B)** | | 2 | | | | 1 | | | 1 |
| **Patient Protection Events (3C)** | | 1 | 1 | 1 | | 6 | | | 1 |
| **Sector Proportional Total** | **2** | **49** | **33** | **24** | **5** | **32** | **18** | **2** | **32** |

## Regulated Practices

The MHC produces annual activity reports on the use of ECT and restrictive practices, the latter of which includes seclusion, physical restraint and mechanical restraint. We provide here a high-level overview of the information which will be presented in greater detail when the 2025 instances of these reports are published later in 2026. The data presented are therefore provisional. The final figures for 2025 and additional information will be included within the 2025 activity reports.

### ECT

Electro-Convulsive Therapy (ECT) is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.

The use of ECT in Ireland is regulated by the 2001 Act and approved centres must notify the MHC of all programmes of ECT.

Notifications reported to the MHC as completed show:

- In 2025 there were 281 programmes of ECT notified for 212 individuals in 14 approved centres
- In 2024 there were 316 programmes of ECT notified for 235 individuals in 16 approved centres
- In 2023 there were 271 programmes of ECT notified for 205 individuals
- In 2022 there were 265 programmes of ECT notified for 206 individuals
- In 2021 there were 296 programmes of ECT notified for 219 individuals

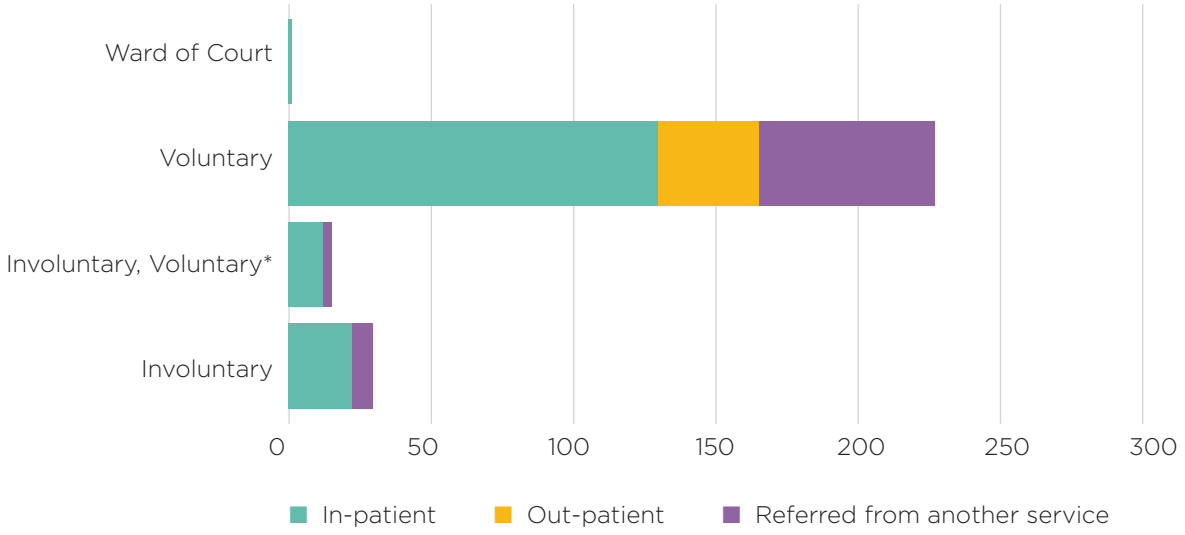
Of the individuals who were administered ECT in 2025, 79.36% were voluntary patients attending an approved centre at the time of commencement of the ECT programme, compared to 85.76% in 2024.

In 2025, 75% of individuals underwent a single programme of ECT, while 24.5% of individuals received two or three ECT programmes. In 2025, 63.2% of ECT recipients were female, compared to 63.6% in 2024. The average age of a patient at initiation of ECT in 2025 was 61 years, in 2024 the average age was 65.2 years. The youngest ECT recipient in 2025 was 18 years of age and the oldest recipient was 91 years at the outset of treatment.

A single ECT programme may involve up to 12 individual treatments. Eighty-five programmes (30.25%) of ECT involved the full 12 treatments in 2025, with an average of 10.7 treatments per recipient. There were administered a total of 2,267 individual ECT treatments in 2025, compared to 2,582 in 2024.

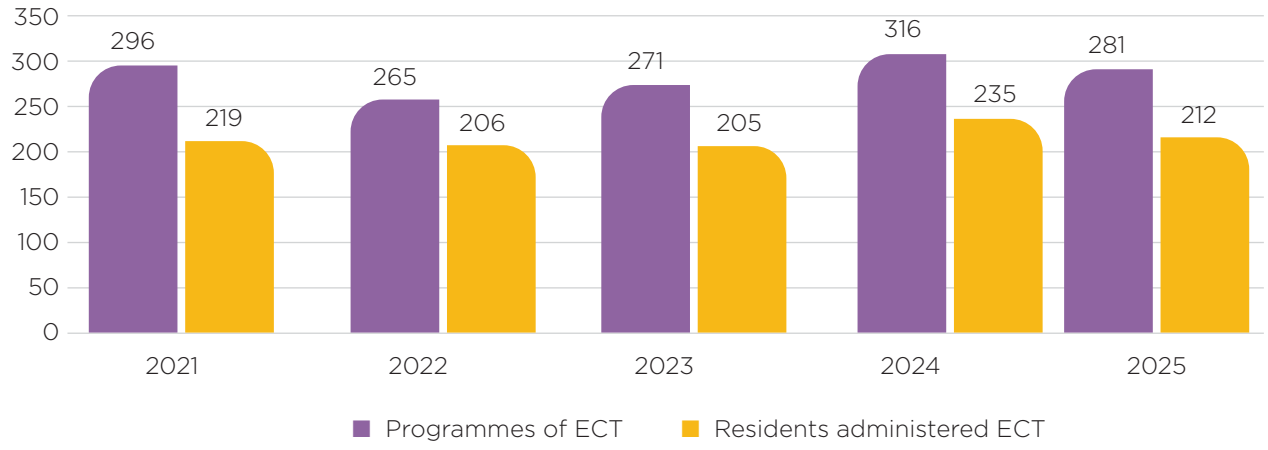
In 2025, 1,907 ECT treatments (84.12%) took place with the recipient's consent, compared to 2,348 (90.9%) in 2024. Fifty programmes of ECT programmes (17.8%) in 2025 included at least one treatment without consent, both a numerical and proportional increase on the figure of 38 (12%) notified in 2024.

**Figure 6:** *2025 ECT Programmes by Patient Legal and Resident Status*




**An individual's legal status may change across the course of a programme of ECT*

**Figure 7:** *ECT Programmes per year 2021-2025*



## Seclusion

Seclusion refers to the placing or leaving of a person in any room, at any time, day or night, such that the person is prevented from leaving the room by any means.

In 2025 there was an increase of 1.88% in the number of reported episodes of seclusion when compared to those reported in 2024. There were 758 episodes of seclusion reported as having concluded in 2025, involving 454 residents in 26 approved centres. The shortest episode reported lasted five minutes, while the longest episode lasted 25,204 hours or 1,050 days. This long-running seclusion, which was in the National Forensic Mental Health Service started in November 2022 and ended in September 2025. Services are required to notify the MHC if a resident is secluded for a period exceeding 72 hours. The MHC received 73 notifications from 14 approved centres of episodes of seclusion that lasted longer than 72 hours in 2025.

In comparison, noted within the 2024 annual activity report there were 744 episodes of seclusion involving 434 residents in 27 approved centres, and reported within the 2023 annual report there were 895 episodes of seclusion involving 473 residents in 27 approved centres.

While there is variance in the both the numbers of centres and numbers of centres with seclusion rooms from sector to sector, HSE Dublin & North East accounted for 22.43% of seclusion episodes notified as ending in 2025, followed by HSE Dublin & Midlands which accounted for 21.37%, and HSE Dublin & South East which accounted for 17.81%. The CAMHS sector reported the lowest number of seclusion episodes in 2025, accounting for 0.66% of 2025 reported episodes.

In 2025, 69.2% of residents who were secluded were male. The average age of secluded residents at start of episode was 35 years. The youngest secluded resident was 16 and the oldest was 86 years. The majority of residents (71.8%) were secluded only once. The average number of episodes per secluded resident was 1.7, the median number of episodes per resident is one.

## Physical Restraint

Physical restraint refers to the use of physical force for the purpose of preventing the free movement of a resident's body.

In 2025 there was a decrease of 11.5% in the number of reported episodes of physical restraint when compared to those reported in 2024. There were 1,851 episodes of physical restraint involving 785 residents in 52 approved centres notified to the MHC in 2025. This compares to annually reported activity figures of 2,092 episodes of physical restraint involving 844 residents in 51 approved centres in 2024, 2,572 episodes of physical restraint involving 879 residents in 52 approved centres in 2023, and 2,945 episodes of physical restraint involving 1,078 residents in 48 approved centres in 2022. The average episode of physical restraint in 2025 lasted for 3.6 minutes. The shortest episode of physical restraint lasted for less than one minute, while the longest duration was 30 minutes.

Renewal orders are required for episodes of physical restraint that last longer than 10 minutes. In 2025, less than 1% of all notified physical restraints were of a duration longer than 10 minutes.

HSE Dublin & Midlands reported the highest number of physical restraints, accounting for 20.75% of all reported episodes in 2025. HSE Dublin & North East accounted for 17.72% of physical restraint episodes in 2025, followed by HSE West & North West at 15.13%, and HSE Dublin & South East at 13.67%. It should be noted that there is a variance in the number of acute centres per sector. The highest number of physical restraint episodes reported by a single approved centre was Linn Dara Child & Adolescent Mental Health In-patient Unit, Cherry Orchard (170), which accounted for just over 9% of all 2025 notified episodes.

Of those residents physically restrained in 2025 55.5% were notified as male. The average age of residents who were physically restrained was 41. The youngest resident who was physically restrained was 10 years old, and the oldest was 90 years. The average number of episodes per physically restrained resident in 2024 was just over two, and the median one.

### Mechanical Restraint Part 3: Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others

Mechanical restraint refers to the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a person's body when they pose an immediate threat of serious harm to themselves or others.

In 2025, there were eight episodes notified of mechanical restraint involving six residents under Part 3 of Rules Governing the Use of Mechanical Means of Bodily Restraint for Immediate Threat of Serious Harm to Self or Others. All eight episodes of mechanical restraint were reported by the Central Mental Hospital. The total duration of mechanical restraint under Part 3 in 2025 was 28 hours and 10 minutes. The average episode of mechanical restraint lasted for three hours and 31 minutes. The shortest episode lasted one hour and 10 minutes, and the longest episode was 11 hours and 40 minutes.

In 2024, 10 episodes of Part 3 mechanical restraint involving five residents were reported to the MHC as outlined in The Use of Restrictive Practices in Approved Centres 2024 activity report.

### Mechanical Restraint Part 4: Use of Mechanical Means of Bodily Restraint for enduring risk of harm to self or others

The use of mechanical means of bodily restraint on an ongoing basis for enduring risk of harm to self or others may be appropriate in certain clinical situations but must be used only to address an identified clinical need and/or risk.

A total of 15 approved centres reported the use of mechanical restraint for the purposes of clinical need as having occurred up to the end of 2025. These notifications reported the use of Buxton chairs for the safety of seven residents, the use of lap belts for 103 residents, and the use of bed rails for the safety of 329 residents. In addition, in 2024, six residents were restrained by other means such as a gait belts or postural positioning and pressure relieving chairs.

## Other Areas the MHC closely monitors

### Overcapacity

An approved centre is at overcapacity if the number of residents accommodated in the unit at 12am on that day exceeds the number of registered number of beds in the approved centre. In 2025, there were five instances of overcapacity reported by two approved centres. There were seven reported instances of overcapacity in 2024, and 46 in 2023.

Overcapacity in 2025 related to the following two approved centres:

- Department of Psychiatry, Letterkenny University Hospital
- Lakeview Unit, Naas General Hospital

The Department of Psychiatry, Letterkenny University Hospital reported the highest number of overcapacity notifications (4) representing 80% of 2025 notifications while the Lakeview Unit at Naas General Hospital reported just one instance of overcapacity in 2025.

The MHC requires additional information and assurances from all centres reporting overcapacity to ensure patient safety and dignity, request evidence of surge management plans and require that they address the systemic causes of overcapacity.

All instances of overcapacity notified in 2025 were reported to have occurred due to emergency admissions.

**Figure 8:** *Overcapacity Reported per annum 2021-2025*

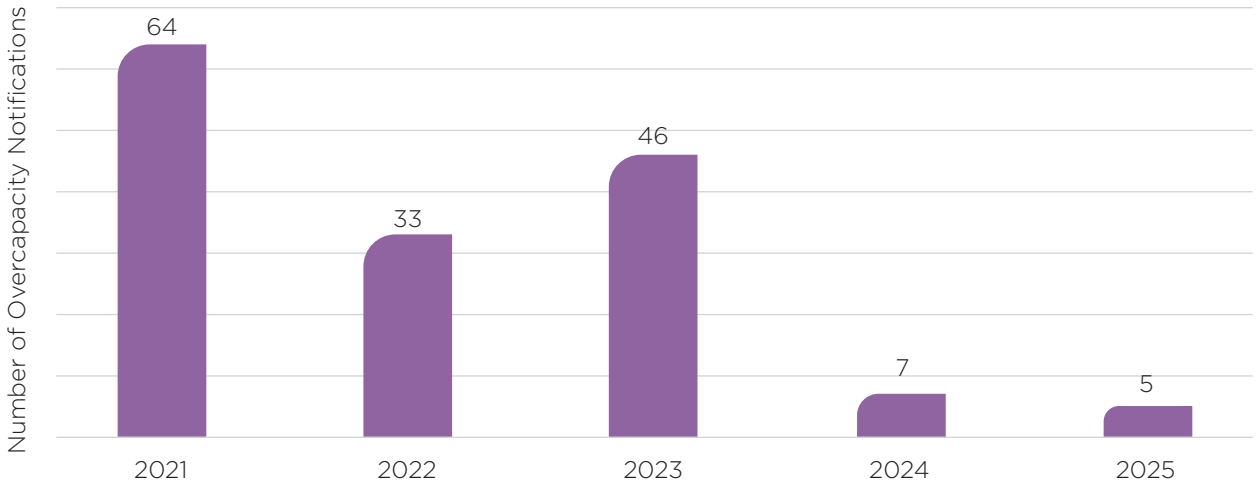
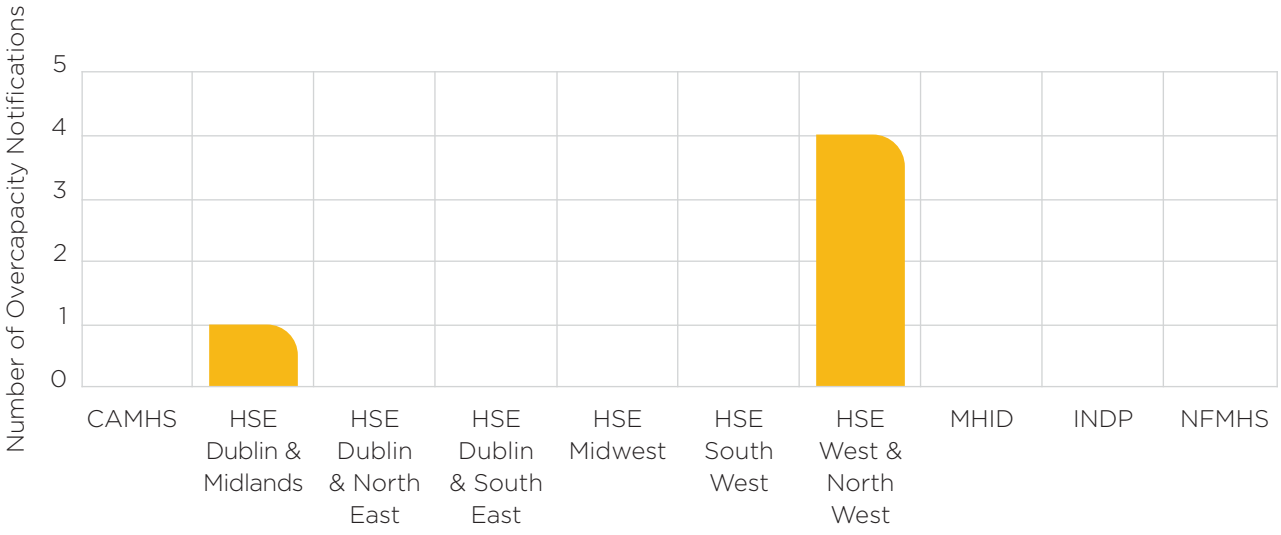



**Figure 9:** *Overcapacity Reported by Sector*



## Child Admissions

The MHC closely monitors the admission of children and young people under the age of 18 to approved centres.

The total number of all admissions of young people to approved centres in 2025 was 342. This compares with a total of 333 admissions in 2024, and 323 admissions in 2023.

### Admissions to adult approved centres

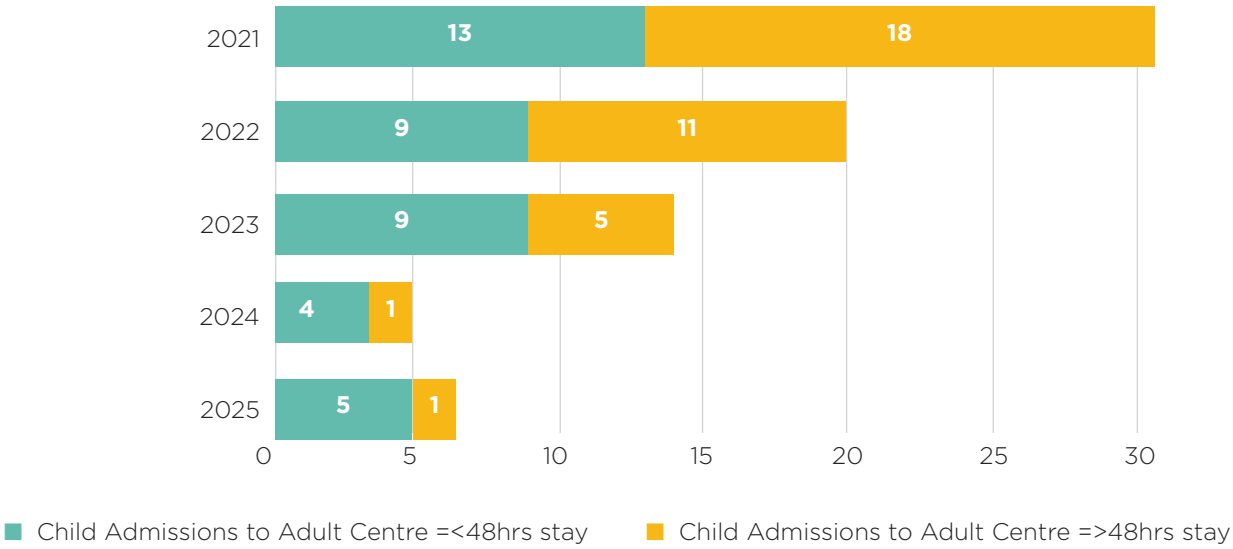
The frequency and duration of the admission of children to adult approved centres continued to remain low in 2025. Children and young people should not be admitted to adult units except in exceptional circumstances. The most common reasons for admissions to adult units are:

- Immediate risk to the young person or others
- Lack of a bed in a specialist CAMHS unit

Residential CAMHS units are located in only three counties nationally. Due to the unavailability of CAMHS beds, children and young people in crisis may be left with the unacceptable 'choice' between an emergency department, general hospital, children's hospital, or an adult inpatient unit.

In 2025, the number of children admitted to adult units were similar to the number in 2024 and shows a decrease when compared to previous years. There were six admissions to five units in 2025. This compares with five admissions to five adult units in 2024 and 14 admissions to 11 adult units in 2023. Five of those admissions of children to adult units in 2025 were for less than 48 hours.

**Figure 10:** *Duration of Stay – Child Admissions to Adult Units*




Children admitted to adult approved centres were generally reported to have been admitted because of immediate risk to themselves or others, or due to no availability of a bed within a CAMHS facility.

In 2025, 1.75% of all child admissions were to adult units. This figure is slightly higher than 2024 when it was reported at 1.5% but lower than in 2023, when 4.3% of child admissions were to adult units, and 2022, when 5.2% of child admissions were to adult units.

**Figure 11** presents child admissions to adult and CAMHS approved centres over the past five years.

**Figure 11:** *Child Admissions to Adult and CAMHS Approved Centres*

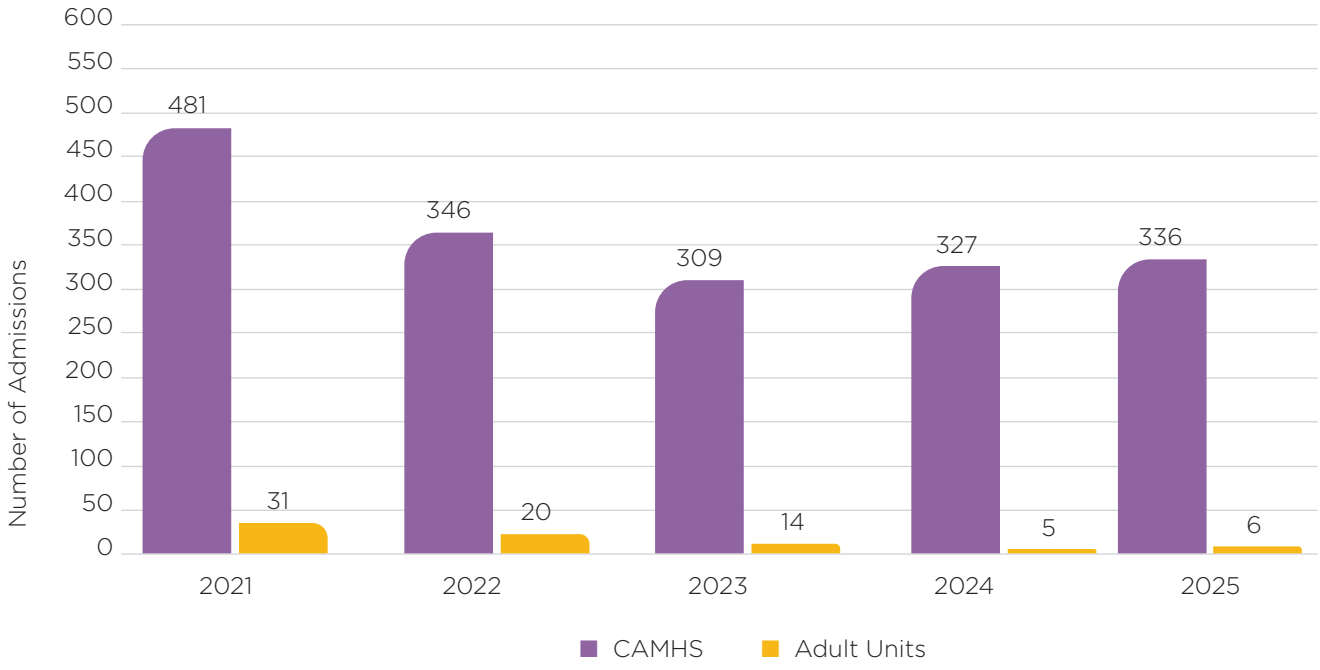



**Table 30:** *Child Admissions to Adult Units 2025*

| Rank | CHO/Sector | No. Admissions |
|---|---|---|
| 1 | HSE Dublin & North East | 4 |
| 2 | HSE Dublin & South East | 1 |
| 2 | HSE West & North West | 1 |
| | **Total** | **6** |

**HSE Dublin North & North East includes both St Vincent's Hospital, Fairview, and St Aloysius Ward, Mater Misericordiae University Hospital due to their being HSE funded.*

## Admissions to child and adolescent approved centres

There are six specialist CAMHS units nationally; four are in Dublin, one in Cork and one in Galway. Of the four CAMHS units in Dublin, two are operated by private providers. In 2025, there were 336 admissions to CAMHS units nationally.

The average duration of stay was 50 days, based on discharge information provided for 331 admissions. The shortest duration was less than one day, and the longest duration was 287 days. These data include admissions that were discharged after 31 December 2025.

### Involuntary child admissions

The District Court is required to authorise the involuntary admission of a child. In 2025, there were 47 involuntary admissions orders of children to approved centres, pursuant to section 25 of the 2001 Act. This included:

- One order to an adult unit
- Forty-six orders to CAMHS units
- In addition, there were:
  - Two admissions of a Ward of Court to a CAMHS unit
  - No admissions of a Ward of Court to an adult unit

## Age and gender of child admissions

In 2025, 74.4% of child admissions to CAMHS units were female. In comparison, 16.67% of child admissions to adult approved centres were female. In 2025, 73.39% of all child admissions related to female residents. The average age of a service user in 2025 was 15.6 years. The youngest resident was 10 years. A breakdown of admission by age is presented in **Table 31**. Eighty-eight percent of children admitted to CAMHS and adult units in 2025 were admitted only once, with 10.3% of residents admitted twice and 1.3% admitted more than twice in that period.

**Table 31:** *Admissions to Adult and CAMHS Approved Centres by Age in 2025*

| Age | Adult | CAMHS |
|---|---|---|
| 17 | 5 | 111 |
| 16 | 1 | 90 |
| 15 | - | 62 |
| 14 | - | 47 |
| 13 | - | 20 |
| 12 | - | 4 |
| 11 | - | - |
| 10 | - | 2 |

# Quality Improvement

# Quality Improvement

**The MHC has a mandate to foster high standards and good practice in the delivery of mental health care. We encourage the delivery of recovery-based, person-centred services which promote and uphold the human rights of those receiving care and treatment.**

We contribute to a culture of continuous quality improvement by conducting analysis, issuing guidance, and developing evidenced-based standards, guidance, Rules, and Codes of Practice to improve service delivery and the experience of those accessing services.

## Publications

The MHC published several documents throughout 2025:

- Guidance for staff working in mental health services on the care and treatment of LGBTQIA+ people
- Guidance for Irish Mental Health Services on the Adoption and Implementation of a Human Rights-Based Approach to Care and Treatment
- The Use of Restrictive Practices in Approved Centres: Activity Report 2024
- The Administration of Electro-Convulsive Therapy in Approved Centres: Activity Report 2024
- Declining restrictive practice in approved centres in Ireland: improving quality of care through the adoption of a human rights-based approach. Irish Journal of Psychological Medicine. Published online 2025: -5. doi:10.1017/ipm.2025.10146

### Guidance for staff working in mental health services on the care and treatment of LGBTQIA+ people

In June, the MHC launched *Guidance for staff working in mental health services on the care and treatment of LGBTQIA+ people* and an accompanying e-learning module, at the LGBT Ireland annual conference in the Royal College of Surgeons Ireland.

The purpose of this guidance is to raise awareness in relation to the rights of LGBTQIA+ people and promote positive and equitable experiences for people identifying as LGBTQIA+ who access mental health services. The MHC hopes that this guidance will support mental health services to provide high quality care to LGBTQIA+ people with a mental difficulties and create a positive change in the way LGBTQIA+ people are cared for within mental health services in Ireland. This guidance aims to address the most common questions and information gaps that mental health staff may have in relation to providing care to LGBTQIA+ people. To achieve these aims, the document provides an overview of the main issues facing LGBTQIA+ people who are accessing mental health services in Ireland and includes good practice in service provision to LGBTQIA+ people.

It was developed following an extensive consultation process which included a public consultation survey, focus groups and interviews with LGBTQIA+ people with a mental difficulties, their family members, staff working in mental health services, the HSE and advocacy organisations and feedback on the draft guidance from key stakeholders including LGBTQIA+ people with a mental difficulties, advocacy organisations, and staff working in mental health services.
An in-depth evidence review of contemporary national and international literature, best practice and policy, undertaken by Trinity College Dublin following a tender process, also informed its content.

The guidance can be found at the link https://www.mhcirl.ie/publications/guidance-staff-working-mental-health-services-care-and-treatment-lgbtqia-people

The 30-minute learning module is available on HSELanD.

***Guidance for Irish Mental Health Services on the Adoption and Implementation of a Human Rights-Based Approach to Care and Treatment***

In October, the MHC published national guidance for all Irish mental health services, setting out how a human rights-based approach must become the foundation of care and treatment across the sector.

The new guidance follows an extensive consultation process involving over 350 people with a mental illness, families, carers, and staff. It presents key concepts, including human rights principles and instruments, as well as practical guidance for embedding a human rights approach in mental health services.

It also introduces the RIGHTS framework, a practical tool that includes key themes such as inclusion, dignity and person-centred care that can be used to explore essential considerations and actions for implementing a human rights-based approach within services.

The guidance can be found at the link: https://www.mhcirl.ie/publications/guidance-irish-mental-health-services-adoption-and-implementation-human-rights-based

The MHC has developed an online training module to reinforce the guidance in this document and support the establishment of a human rights-based approach to mental health service provision which can be accessed on HSELanD.

**Declining restrictive practice in approved centres in Ireland: improving quality of care through the adoption of a human rights-based approach.** *Irish Journal of Psychological Medicine*. Published online 2025: https://orcid.org/0009-0004-9629-4468

In 2025 the MHC published an article in the Irish Journal of Psychological Medicine which detailed that a downward trend in the use of seclusion and restraint, already noted in approved centres over the period 2018 to 2022 inclusive, accelerated in 2023 and 2024 following the introduction of the MHC's revised Rules and Code of Practice and after the implementation of a timely notification system.

The article discussed how the momentum of change towards less restrictive forms of care has increased. The rate of fall in seclusion episodes in 2023 and 2024 was almost twice that seen in the preceding four years. The rate of reduction in the number of people physically restrained was twice that seen in the preceding four years. The number of people subject to seclusion and restraint and the number of seclusion and restraint episodes has fallen. The duration of episodes has also reduced.

The MHC notes that the results could not have been achieved without the enthusiastic participation of the leadership and staff in approved centres throughout Ireland. The reduction of restrictive practices progressed following the successful introduction of policy initiatives in approved centres and the reform of services offered to acutely distressed patients.

The Director of Regulation presented on the decline in the use of restrictive practices at the *Sharing the Vision* Conference in Dublin Castle in April, and at the 'Mental Health Data and Outcomes' conference in Queens University Belfast in May.

## Standards for Development Work

### Standards for Community Residential Mental Health Services

In 2025, the MHC's regulatory remit encompassed 67 approved centres providing inpatient treatment to persons with a mental health difficulty. However, under the Mental Health Act 2026, that remit is expected to significantly expand to include the regulation of community mental health services. In 2025, we progressed the work on the development of standards for community residential mental health services (which are staffed on a 24-hour basis) and expect that they will be published in 2026.

The development of these standards was supported by extensive consultation and engagement with a broad range of participants, including experts by experience, healthcare providers, mental health service professionals, peer supporters, and advocacy organisations. The MHC conducted a public consultation and invited broad input and feedback. It also carried out a programme of site visits to community

mental health centres across the country, complemented by focus groups with residents. The development process was supported by an expert advisory group, which provided guidance and oversight.

Service providers are expected to implement these standards to enhance governance, operational management, and leadership structures, guide staff training and wellbeing initiatives, and integrate care approaches that promote resident health, independence, and active involvement in care planning and decision-making. They highlight the importance of recognising the will and preferences of all residents, cultural diversity, and supporting holistic wellbeing.

The standards call for services that create welcoming, therapeutic environments where residents can pursue recovery and build meaningful social connections, all while honouring their rights, autonomy, privacy, dignity, and individuality. The standards require the mental health teams to develop individual, co-produced care plans and involve residents in all aspects of their care and treatment. They highlight the importance of skilled, compassionate staff who are well supported and work collaboratively across disciplines.

### Code of Practice on the Use of Digital Monitoring Technologies

In 2025 the MHC commenced developing a Code of Practice on the Use of Digital Monitoring Technologies for use by staff working in approved centres. This new Code of Practice, due to be published in 2026, will be inspected on from 1 January 2027.

Following a tender process, the MHC commissioned Queen's University Belfast to undertake an in-depth evidence review of contemporary national and international literature, best practice and policy to inform the development of the Code of Practice. The Evidence Review will be published alongside the Code of Practice when it is launched.

In quarter one, the MHC established an Expert Advisory Group to assist with the development of the Code of Practice. This group will also consider the development of a Code of Practice or Regulations on Individual Care Planning. The Expert Advisory Group met twice in 2025 to discuss the Code of Practice on the Use of Digital Monitoring Technologies.

In quarter two and quarter three, the MHC undertook an extensive public consultation process to inform the document. This included:

- A public consultation survey which received 199 responses from individuals and organisations.
- Focus groups and 1:1 interviews with people receiving mental health services, their family members, staff working in mental health services and relevant organisations.

The purpose of the Code of Practice is to promote good practice and high standards in relation to the safe, transparent and responsible use of digital monitoring technologies. It will expand on the requirements of Regulation 25 of the approved centre Regulations and provide more guidance to services considering technological advancements and moves towards digitalisation of services. It aims to encourage services to adopt a human-rights and evidence-based approach when using digital monitoring technologies.

### Guidance for Persons Working in Mental Health Services with People with Intellectual Disabilities

The MHC initiated work developing guidance for staff providing mental health services to people with intellectual disabilities. The guidance is intended to ensure that staff across the country have access to up-to-date evidence and best practice, supporting them to deliver appropriate, person-centred and human rights-based care to people with intellectual disabilities. Its purpose is to promote equitable access to mental health services; strengthen staff knowledge, skills and competence; support comprehensive, individualised assessment and care planning; enhance interagency collaboration between disability and mental health services; and improve safeguarding, consent, and supported decision-making practices.

Development of the guidance has been informed by an in-depth evidence review, commissioned by the MHC and carried out by Trinity College Dublin, examining national and international research, human rights standards, and relevant legislative requirements. It has also included engagement with more than 300 stakeholders, including

clinicians, service providers, and people with lived experience, as well as expert input from specialists in intellectual disability and mental health.

The guidance and accompanying resources are scheduled for publication in 2026.

### National Standards for Child and Adolescent Mental Health Services

Child and Adolescent Mental Health Services (CAMHS) provide specialist assessment and treatment for children and young people experiencing moderate to severe mental illness. CAMHS operates across a range of settings, including inpatient units, community residences, and community mental health services, and plays a central role in supporting the mental health and wellbeing of young people.

Following a formal request from the Minister of Mental Health, and in preparation for the enactment of the Mental Health Bill 2024, the MHC initiated the development of new National Standards for CAMHS. These standards aim to strengthen the quality, safety, and consistency of care delivered to children and young people across Ireland and represent an important step toward ensuring access to safe, effective, and evidence based mental health services. In parallel, the MHC will also develop Codes of Practice relating to:

- the assessment of capacity of a child aged 16 years or older to consent to admission, care, and treatment
- admission with parental consent of a child aged 16 years or older who lacks the necessary capacity
- criteria for the involuntary admission of a child to a registered acute mental health centre

In 2025, the MHC formally advanced this work, guided by the legal framework of the Mental Health Bill 2024, which seeks to modernise services and ensure that children and young people receive high quality, rights-based care. The MHC's goal is to develop standards that are person-centred, holistic, multidisciplinary, and recovery oriented.

To support this work, the MHC commissioned Queen's University Belfast, following a tender process, to conduct an in-depth evidence review of contemporary national and international literature, best practice, and policy. This work also included analysis of the public consultation survey. The resulting Evidence Review and Consultation Report will be published alongside the Standards at launch.

From 13 October to 28 November, the MHC carried out an extensive public consultation to inform the Standards. This included a public survey that received 670 responses from individuals and organisations, as well as a dedicated survey for children and young people. This scoping consultation sought views from:

- Young people who use or have used CAMHS
- Families
- Professionals
- Service providers
- Advocacy groups

An Expert Advisory Group was established to guide the development of the Standards. The group held its first meeting in November 2025 and will continue to meet at key milestones throughout 2026.

## Collaborative Working

### Participation in Working Groups

During 2025, the MHC participated in several working groups and project groups to promote good practices in services:

The MHC was represented on, and participated in, the following groups:

1. **Sharing the Vision: Recommendation 27 Working Group**

   The MHC was represented on the National Mental Health Strategy's Sharing the Vision Recommendation 27 working group aimed at ensuring the co-production of recovery-focused individual care plans for all users of specialist mental health services.

2. **Sharing the Vision Workstream: Quality Assurance Framework**

   The MHC participated in the Sharing the Vision Workstream: Quality Assurance Framework and the working group pertaining to recommendations 83 and 84.

3. **The National Mental Health Experience Survey**

   During 2025, the MHC participated in a number of meetings and contributed to the development and oversight of the first ever national mental health experience survey which is due to go live in 2026.

   The nationwide survey aims to improve and shape mental health services across Ireland by asking people about their experiences of inpatient mental health care to find out what is working well and what can be improved.

   The survey includes 66 questions and covers all stages of inpatient mental health care, including admission, care and treatment, interactions with staff, and experiences during discharge and follow-up care.

   The survey is a joint initiative between the Department of Health, MHC and the HSE, facilitated by the National Care Experience Programme (NCEP). The final report will be published in 2027 and made available to the public at the link www.yourexperience.ie.

4. **CHUMS Project**

   The MHC also participated in a working group for Dublin City University's CHUMS (Cultural HUmility in Mental health Services) Project. The group aims to co-produce actionable knowledge in support of strengthening cultural humility in Irish mental health services.

5. **HIQA National Guidance for the Responsible and Safe Use of Artificial Intelligence in Health and Social Care Services**

   HIQA has been requested by the Department of Health to develop national guidance to promote a responsible and safe approach to the use of Artificial Intelligence (AI) in the health and social care sector in Ireland. The guidance aims to support services in promoting and driving a responsible, safe approach to AI use. The main purpose of the guidance is to promote awareness and build good practice amongst providers and practitioners. The guidance will also be useful to people using services, educating and empowering them about their expectations regarding how AI can be used safely and responsibly.

6. **HIQA Health Information Standards**

   The MHC participated in HIQA's Standards Working Group to assist with the revision of two sets of health information standards regarding demographic datasets and patient discharge summaries.

7. **HIQA Expert Group: Thematic inspection programme on the use of restrictive practices on children in secure care centres**

   The MHC also attended several meetings of the HIQA Expert Group which developed a thematic inspection programme on restrictive practices in secure care centres for children.

## Stakeholder Engagement

### Service Provider Engagement Days

The Standards and Quality Assurance and Inspectorate Teams hosted two full day in-person service provider engagement days in Limerick and Athlone in October 2025.

Hosted by the Director of Regulation and the Inspector of Mental Health Services, over 400 leaders, managers and staff of approved centres and community mental health services attended these information days. The theme for 2025 was 'Human Rights in Mental Health Services'.

The agenda included the launch of the MHC's Human Rights Guidance, a lived experience perspective on upholding human rights in mental health services, and updates on the Mental Health Bill and associated standards development. Leading experts presented on a human rights-based approach to mental health service provision. Services also presented on areas of good practice including:

- a case study on the reduction of restrictive practices using a human rights approach to care and treatment (Connolly Hospital and Phoenix Care Centre)
- the role of clinical governance in increasing quality and compliance (Adam Kavanagh, St Patrick's Mental Health Services)
- the contribution of pharmacists to mental health care (Professor Dolores Keating, St John of God Hospital)
- the role of governance and management in increasing compliance with MHC Regulations (MidWest Mental Health Services)

# Mental Health Tribunals

# Mental Health Tribunals

## Introduction

There were two main purposes of the Mental Health Act 2001 (as amended) (the 2001 Act); the primary purpose was to ensure that the detention of those involuntarily detained in approved centres would be reviewed by independent persons on a regular basis[3]. The 2001 Act initially provided for orders to be made for periods of up to 21 days, then up to three months and thereafter for periods up to six months or 12 months. In 2018, following a decision of the Court of Appeal[4], the legislation was amended, and a person could no longer be detained on an order for up to 12 months, and if detained on an order up to six months, the detained person could seek a review if still detained after three months. In the new amending legislation[5], a person may only be detained on an order for 21 days and thereafter on an order of up to 3 months.

The independent persons who carry out the review are referred to as a mental health tribunal (tribunal). The tribunal reviews two matters:

1. If the person has a 'mental disorder' as per the test set out in the 2001 Act, and
2. If there has been compliance with all the relevant requirements in the 2001 Act.

Therefore, over a 20-year period, the maximum period for which a person may be detained and be entitled to a review has reduced from up to 12 months to up to 3 months. It might be argued that this should have happened sooner, however, this would not have happened at all without the introduction of the 2001 Act, the vital role played by the mental health tribunals and the courageous people, along with their legal representatives, who challenged the legal system.

## Person-centred actions taken by the Mental Health Tribunals (Tribunals) team in 2025

### Respecting the voting rights of those detained

In 2024, the Tribunals team implemented a system to highlight the right to vote for those involuntarily detained and those residing in 24-hour staffed residences. This was rolled out successfully again for the Presidential Election in October 2025. The Tribunals team want to thank the approved centres for their support and assistance to ensure any person in an acute or residential facility who wanted to vote in this election was supported to do so.

### Stakeholder Engagement

In 2025, the Tribunals team engaged regularly with external stakeholders. This engagement both informs the work of the team and enhances our understanding of the lived experience of individuals who have been involuntarily detained. The Tribunals team participated in a stakeholder forum facilitated by Mental Health Reform that commenced in 2024 and continued throughout 2025. This forum offered an opportunity to meet with individuals with lived experience and discuss the work of the Tribunals team.

Forum discussions informed several initiatives undertaken by the team in 2025. A new leaflet was developed to outline the right to a tribunal hearing after revocation of an order. All correspondence that issues to detained persons was reviewed with all letters rewritten in plain English to make them more accessible and relevant. We wish to acknowledge the assistance of the National Adult Literacy Agency (NALA) in that regard. QR codes and website details were also included to facilitate easy access to online information. Letters were amended to highlight that access to legal representation is free of charge which was an important matter for stakeholders.

[3]The second reason was the establishment of an independent regulator in relation to mental health services.

[4]AB v. The Clinical Director of St. Loman's Hospital, The Health Service Executive, The Minister for Health, The Attorney General, Ireland (Respondents) and The Mental Health Commission, The Irish Human Rights Equality Commission (Notice Parties) [2018] IECA 123

[5]Mental Health Act 2026

Stakeholders were concerned that information provided to detained persons is mostly provided on or shortly after admission. In response to this feedback, the Tribunals team now includes information leaflets with letters issued throughout an individual's period of detention.

A new stakeholder forum will be organised in 2026, and the Tribunals team will participate fully with the expectation that further positive outcomes will be achieved.

### Information and Awareness

The Tribunals team has been actively raising awareness of the information available for people who experience involuntary detention, as well as for their friends, family members, carers and supporters. In 2025, we developed a series of Tribunals explainer videos to help detained persons understand more about their stay in hospital and about their rights as an involuntary detained person. We also provide seven information leaflets which are currently available in 18 different languages. We review and update the range of languages offered each year to ensure they reflect identified needs. In 2025, we translated our information into Czech, Croatian, Hungarian and Italian. This information can be found on our website www.mhcirl.ie/information for patients

## What is a mental health tribunal?

Less than 10% of individuals accessing mental health services receive treatment in an acute inpatient facility either on a voluntary or involuntary basis. According to the Health Research Board[6], there were 15,578 admissions[7] to adult psychiatric units and hospitals in 2025. The percentage of those detained involuntarily (16%) is low. However, given that these individuals are detained against their will, there is an even greater onus on the State to ensure that they are detained in accordance with the law and their rights are respected and vindicated. The MHC, with the mental health tribunals, acknowledge the responsibility that has been vested in them.

As noted above, the 2001 Act sets out a mandatory system of independent review. The independent review must be carried out by a tribunal within **21 days** of the making of the order (not the date of receipt of the order). The tribunal is made up of three people; a solicitor/barrister as chair; a consultant psychiatrist; and another person, often referred to as a lay person.

The issues to be considered by the tribunal are:

1. Whether the person has a mental disorder as of the date of tribunal, and
2. If there has been compliance with certain specified sections of the 2001 Act, or not, and if not, does that non-compliance affect the substance of the order or not.

Having considered the above issues, the tribunal must affirm or revoke the order. Currently, the decision of a tribunal is not published. However, it is proposed under the Mental Health Act 2026, that every tribunal decision will be published in an anonymised version. In preparation for this, all tribunal decisions are now delivered in typed, not handwritten, format.

As part of this process, the MHC assigns each detained person a legal representative (covered by legal aid) but, if they so wish, the person may seek to have another solicitor from the MHC's panel appointed to them and the person may also appoint their own private solicitor (at their own cost).

The MHC also arranges for the detained person to be reviewed by an independent consultant psychiatrist, whose report is provided to their legal representative and the tribunal.

Other people who may attend a tribunal, in addition to the tribunal members, are the detained person (who may not always choose to attend), the person's legal representative (if the person wants them to attend) and the person's treating consultant psychiatrist.

### Involuntary Detention (admission and renewal orders)

A person can only be admitted to an approved centre and detained there if he or she is suffering from a mental disorder (as defined in section 3 of the 2001 Act).

[6] Health Research Board's (HRB) National Psychiatric Inpatient Reporting System (NPIRS)

[7] One person could have several admissions in a year.

An involuntary admission of an adult can occur in two ways: an involuntary admission from the community, or the re-grading of a voluntary patient in an approved centre to an involuntary detained person.

In such cases, the admission order is made by a consultant psychiatrist on a statutory form (Form 6 or 13). If the person is detained on a Form 6, the form must be accompanied by other statutory forms which include an application form (Forms 1, 2, 3A, 3B or 4) and a recommendation form signed by a registered medical practitioner (Form 5).

Please note that admissions (and discharges) represent episodes (or events) of admission rather than persons. Therefore, one person may have several admissions during a year, and each admission is recorded separately as an episode.

The initial order detaining an individual, known as an **admission order**, is for a maximum of **21 days**. As stated above the detention can be extended by a further order, known as a **renewal order**, the first of which can be for a period up to three months (but can be for a lesser period) and the second for a period up to six months (and again this can be for a lesser period).

A renewal order **can only be made** after the consultant who is responsible for the detained person reviews the individual not more than one week before the making of the order that he or she is still suffering from a mental disorder.

A consultant psychiatrist, when making an order for up to three or six months, does not have to make it for the full period and must use their clinical judgement to decide what is the appropriate period. Each of these renewal orders are sent to a tribunal to be reviewed.

In 2025, the following orders were made:

- 1,985 admissions orders from the community
- 570 admissions orders by way of re-grading
- 852 renewal orders for a period up to three months
- 201 renewal orders for a period up to six months

**From 2024 to 2025, there was a 1% increase in admission orders and a 0.5% increase in renewal orders.**

Subsequent to the removal of 12-month renewal orders in October 2018, there has been a 39% decrease in 6 month renewal orders and a 6% decrease in 3 month renewal orders from 2019 to 2025

Figures 1-3 and Table 1 in the Appendices provide detailed information on admission and renewal orders.

## Additional Reviews

As noted above, since October 2018, the maximum period for which an order can be made to involuntarily detain a person is six months. If a person is detained for longer than three months during that six-month order, the person is entitled to an additional review by a tribunal. This is an extra safeguard for detained persons. The additional review only considers the issue of mental disorder; it does not address any issues related to compliance which shall be addressed at the initial hearing for the order.

In 2025, there were 157 detained persons who were eligible to seek an additional review. Of these, 137 did not seek an additional review. Twenty detained persons did seek an additional review of which:

- Two (2) orders were revoked before the hearing took place, and
- Eighteen (18) hearings took place with 17 orders being affirmed and one order being revoked.

The positive message from the above is that 18 detained persons availed of the opportunity to have their detention reviewed before the end of the six month order and three of those had their orders revoked either before or at the hearing as they did not have a mental disorder.

## Tribunal Hearings

3,608 orders were made in 2025 and:

- 1,866 orders were revoked before hearing – 51%
- 1,779 orders went to hearing – 49%

Of the 1,779 orders that went to hearing 289 (16.2%) were revoked at hearing. Please see further information below on this.

*Orders revoked before tribunal:*

A consultant psychiatrist responsible for a detained person must revoke an order if he/she

becomes of the opinion that the person is no longer suffering from a mental disorder.

In deciding whether to discharge a detained person, the consultant psychiatrist must balance the need to ensure that the person is not inappropriately discharged with the need to ensure that the person is only involuntarily detained for so long as is reasonably necessary for their proper care and treatment.

Where the responsible consultant psychiatrist discharges a detained person under the 2001 Act, they must give the person concerned, and his or her legal representative, written notice to this effect. In 2025, it was noted that this was not always done or done promptly. When a detained person's order is revoked, they may leave the approved centre, or they may agree to stay to receive treatment on a voluntary basis. All of this must be explained to the person by the responsible consultant psychiatrist and other members of the person's treating team.

Please refer to **Figure 4** in the Appendices.

*Orders revoked at tribunal:*

A total of 1,779 orders were reviewed by a tribunal, and of those, 289 orders were revoked at hearing. Revocations for **2025 increased to 16.2%. In 2022 it was 13.5%, 2023 it was 12.3% and 2024 it was 13.4%.**

The below table shows the categorisation of the reason for these revocations.

36% of cases were revoked because of mental disorder (i.e. did not meet the criteria for mental disorder in section 3 of the 2001 Act) and 54% solely for reasons of non-compliance with statutory provisions (No. 2-6 below) with 9% being revoked for a combination of both and 1% for other reasons. The number of orders revoked based on non-compliance from 2023 to 2025 is a serious concern given the dedicated training by the MHC and offers to provide further training.

The decision of the Court of Appeal in A.A. v The Ashlin Centre from February 2025, referenced in the 2024 MHC annual report given the High Court decision in July 2024, continues to be the main reason for the high level of non-compliance in 2025. It was either the sole reason or partial reason for revocation in 113 (out of 289) decisions in 2025. The MHC will now proactively address these issues with the HSE and the independent approved centres as non-compliances should be decreasing not increasing. In 2026, the MHC intends to produce a table allocating the non-compliances to each approved centre and then seek for the relevant centres to provide details of the action taken to reduce their levels of non-compliance. The first table will be circulated in June 2026 for Q1 2026.

| No | Issues | Number of Revocations | % of Revocations |
|---|---|---|---|
| 1 | No mental disorder (section 3 not met) | 103 | 35.6% |
| 2 | Errors with sections 9 to 12 (applications and recommendations for involuntary admission) and the related Forms | 23 | 8% |
| 3 | Errors with sections 14 and 15 (admission and renewal orders for involuntary admission) and the related Forms | 94 | 32.5% |
| 4 | Patient Notification Form issues (information to be provided to the detained person from the admission and renewal orders) | 7 | 2.4% |
| 5 | Errors with sections 23 and 24 (admission form where someone is regraded) and the related Forms | 25 | 8.6% |
| 6 | Other non-compliance issues to those referred to above | 10 | 3.5% |
| 7 | No mental disorder (section 3 not met) and non-compliance issues | 25 | 8.7% |
| 8 | Other | 2 | 0.7% |
| | **Total** | **289** | |

In addition to the above, please also note that –

- A number of cases were revoked due to errors by An Garda Síochána in completing the application forms for detention. The MHC is working with An Garda Síochána to address this.
- There were non-compliance issues (other than the AA Case) relating to the completion of the admission (Form 6) and renewal orders (Form 7) and the associated patient notification form (PNF) by the responsible consultant psychiatrist. Separate to the issue in the AA case, non-compliance has continued to improve but the MHC will continue training to address this.

Further information on revoked decisions is provided in Table 2 in the Appendices.

### Length of stay

91.5% of individuals who were involuntarily detained in 2025 also had their order revoked in 2025.

- 14.4% of all revocations in 2025 occurred within one week of admission.
- 56% of revocations occurred between one week and four weeks of admission.
- 27.6% were revoked between 1 month and 6 months of admission.
- 2% of revocations were for individuals detained for 6 months or longer.

The average length of stay for individuals who had their order revoked in 2025 was 35 days. When revocations of one or more years were excluded (1% of revocations), the average length of stay was 29 days.

Figure 5 in the Appendices provides a detailed breakdown of revocations.

### Lapsed Orders

In 2025, 33 orders were allowed to lapse. This occurs where an order is affirmed by a mental health tribunal and subsequently the responsible consultant psychiatrist does not either revoke the order or renew the order before it expires. In 2025, the MHC commenced writing to the approved centres to seek confirmation that the relevant consultant psychiatrist had met with the detained person and explained to them that their order had lapsed or that their change in status had been appropriately explained to them. The number of lapsed orders is significantly lower in 2025, than the 46 orders that were allowed to lapse in 2024.

In most instances, it appears that the detained person was appropriately advised of their change in status. However, in a small number of cases, centres were unclear if this had been done. Where this occurred, the relevant centres noted that following contact from the MHC they had met with the individual to clarify their situation. We are aware that there have been process changes arising from these issues and additional training for staff in some centres. This review also allowed the MHC to identify instances where statutory forms, in particular notification of a revocation, had been completed but not submitted to the MHC.

### Tribunals for transfers to the Central Mental Hospital (CMH)

No proposals were received in 2025 to seek the transfer of a detained person to the CMH in 2025. This had been an ongoing issue due to the lack of beds in the National Forensic Mental Health Service (NFMHS) in Dundrum, Co Dublin. The MHC was hopeful that when the new NFMHS in Portrane, Co. Dublin opened that there would be more beds available to those detained in other approved centres where it would be for the benefit of the detained person or necessary for the purpose of obtaining special treatment for such detained person. Unfortunately, this has not occurred. This is an issue that the MHC shall seek to address with the HSE in 2026.

### Section 28 tribunals:

If an order is revoked before a tribunal, the individual concerned can still proceed to have a tribunal. This is commonly referred to as a *Section 28 tribunal.* Of the 1,866 orders revoked before hearing, there were 34 requests for Section 28 tribunals of which 16 proceeded to an actual hearing. This is a very small percentage (<1%) of the orders revoked before hearing.

The MHC in its submission to the Department of Health in March 2020 sought for Section 28 to be reviewed to assist persons involuntarily detained,

those representing them and the tribunal members. A recent Court of Appeal[9] decision held that in relation to a Section 28 review that *"The patient in question would certainly have an interest in an enquiry into whether or not the relevant sections of the Act had been complied with, and whether or not the process of their involuntary admission to hospital had been done in a proper and legal manner. This legitimate interest would persist notwithstanding the revocation of the original order".*

The Court referred to the peculiarity of the wording in Section 28(5) and, in referring to a review by a mental health tribunal, the Court commented that the Section 28(5) *"mandates the commencement or continuation of a process without taking into account the fact that the conclusion of that process (the affirmation or revocation of the relevant order) can never be reached,"* and that, while the wording is *"less than ideal"*, it is *"workable."*

## Admissions from the community

There were 1,985 admission orders from the community in 2025. One of the issues which the MHC considers each year is who makes these applications.

The key changes in the 2025 figures compared to 2024 are -

- applications by family members are down by 2% to 19%,
- applications by authorised officers (AOs) remain the same as 2024 at 16%,
- applications by An Garda Síochána are up by 2% to 34% and
- applications by 'any other person' remain the same as 2024 at 31%.[10]

Please refer to **Figure 6, Figure 7** and **Table 3** in the Appendices.

It is positive to see that applications by family members have decreased in 2025 as involvement in this process can be difficult and distressing for all parties and may cause conflict within families.

It is disappointing that the number of applications by authorised officers for the HSE has not changed from 2024 given the many discussions over the last number of years. The MHC has reviewed applications made by authorised officers in 2025 and notes the following.

- 102 authorised officers made 316 applications that proceeded to involuntary admission,
- 26 authorised officers made five or more applications. The applications made by these authorised officers accounted for more than half the applications made, and
- 76 authorised officers made less than five applications.

The MHC understands that several hundred individuals have been trained by the HSE as authorised officers. It is disappointing to note that only a small proportion of these appear to be regularly engaged in making applications for involuntary admission.

Of particular concern, is the fact that applications made by An Garda Síochána increased in 2025. The MHC considers that a significant factor in this increased rate is the continuing low number of applications made by the HSE and the limited availability of authorised officers to do this work. This will have to be addressed before the provisions in the new legislation are commenced, which will no longer allow Gardaí to detain persons. It is sincerely hoped that the onus will not shift back to the family members, which has been a concern of the MHC for several years.

It is difficult to assess fully the applications by 'any other person', however, the MHC reviewed all applications in this category and from this analysis estimated that.

[9] H v Mental Health Tribunal [2026] IECA 12

[10] Other person is very wide and can include medical and nursing staff in an emergency department

- 59% were made by staff in Emergency Departments. In many instances, it is not specified how the person was brought in, however,
  - In 16% of these applications, it was noted that the person was brought by ambulance,
  - In 17% of these applications, it was noted that An Garda Síochána either brought the individuals directly to the emergency department or accompanied ambulance staff.
- 16% were made by staff in general hospitals,
- 9% were made by staff in the prison services,
- 5% were made by staff in homeless services, hostels and emergency accommodation,
- 9% were made by professionals working in mental health services, general health settings and other areas, and
- 2% were made by friends, colleagues and other individuals who knew the person subject of the application.

### Voluntary to Involuntary

If a voluntary person accessing mental health services in an approved centre indicates a wish to leave, they can be involuntarily detained, if a specific member of staff is of the opinion that the individual is suffering from a mental disorder. A detailed process must be undergone before this can happen, which includes the fact that the person must be reviewed by the person seeking to detain them, a second consultant psychiatrist and finally their responsible consultant psychiatrist. The order detaining the person will also be reviewed by a tribunal.

As noted above, there were 570 such admissions notified to the MHC in 2025.

### Age and Gender

Analysis of age and gender for episodes of involuntary admission in 2025 can be found at Tables 4, 5 and 6 in the Appendices and four of the key findings are as follows:

- 22% of the admissions related to people in the 35 – 44 age group.
- 54% of the admissions were male.
- 71% of admissions in the 18 – 24 age group were male.
- There were more female admissions than male in the age groups over 45.

## Quality Improvement

The Tribunals team undertakes audits across three main areas –

- The work of the Tribunals team.
- The decisions of the tribunals.
- Issues arising in approved centres of which we are aware.

### Audit on the work of the Tribunals team:

The team conducts 11 audits on the services provided by the team and by panel members who are assigned to tribunals. Some items of interest from these audits are as follows.

From a sample of 180 tribunals:

- 78.5% were scheduled within 12 days of the making of an order.
- Six people chose to be represented by another legal representative from the panel. People may choose a different solicitor from the MHC's panel of legal representatives than the one that was assigned to their case.
- People are also entitled to be represented by their own private solicitor or represent themselves under the Constitution. No-one sought to be represented by their own private solicitor.
- Four people chose to represent themselves (save for those who sought to do so directly at the tribunal and without notice to the MHC).

### Audit of the tribunal decisions:

The audit of tribunal decisions relates to affirmed decisions and covers a number of issues. Some of the key findings are as follows –

1. 120 decisions over a 12-month period were reviewed.
2. In 39 of the 120 (33%) hearings detained persons did not attend the hearing (this does not take into account those who may have attended for some of the hearing but did not attend for the decision).
3. In nine of the 120 decisions the tribunal did not separately address the issues of compliance and mental disorder as required in section 18(1) of the 2001 Act. This will be specifically addressed at training with the panel members in 2026.

### Audit relating to the approved centres:

This audit is done on a quarterly basis, following which reports are sent to the individual approved centres.

86 issues were logged. Of note:

- 60% of the issues were in relation to revocations of orders that were signed and received on the day of the detained person's tribunal hearing, several at the time that the tribunal was due to commence.
- 12.5% related to Forms received later than the statutory 24-hour timeline, with consequences for the validity of the detention in some of those cases.
- Some of the other issues that arose included the receipt of
  a. partial or incomplete orders,
  b. orders with contradictory information,
  c. multiple, overlapping orders for the same individual,
  d. non-tribunal related information,
  e. transfer forms when individuals had not transferred to another approved centre,
  f. unencrypted Forms received by email.

However, it is very important to acknowledge and recognise the work done by approved centres given that the number of issues has reduced from 103 in 2024 to 86 in 2025.

## Circuit Court Appeals

Detained persons can appeal the decision of a tribunal to the Circuit Court. However, the appeal does not consider the decision of the tribunal. The Circuit Court only considers the issue of mental disorder as of the date of the appeal. The role of the Circuit Court will be expanded under the Mental Health Bill to also consider issues of non-compliance.

The Supreme Court held that a renewal order extends the life of an admission order. Therefore, when someone has appealed the decision of a tribunal in relation to an admission order, which is then extended by a renewal order, the appeal can still proceed as the court will consider, whether the detained person is suffering from a mental disorder as of the date of the appeal. If the order is revoked by the court, this will extend to the renewal order even it is not specifically the subject of the appeal to the court, the entire detention shall come to an end.

The MHC was notified of 143 Circuit Court appeals in 2025. This is a decrease from 2024 (167 appeals) and 2023 (152).

Of the 143 appeals received in 2025 –

- 117 appeals did not proceed to full hearing
- 26 appeals proceeded to full hearing
- 26 were affirmed by the Court
- No orders were revoked by the Court

## Other work of the Tribunals Team

### National Mental Health Experience Survey

Work continued in 2025 by the National Care Experience Programme on the National Mental Health Experience Survey – a nationwide survey that offers people the opportunity to share their experiences of Ireland's in-patient services from admission, and discharge through to follow-up care. The Tribunals team are represented on both the Advisory Group and Working Group for the survey. This has ensured that gathering comprehensive feedback on the experience of involuntarily detained persons, regarding the mental health tribunals process, is central to the survey. The survey is expected to proceed in 2026, and it is hoped that the feedback should improve quality, patient experience and outcomes.

### Training

The MHC is committed to maintaining and improving the standard and quality of mental health tribunals and ensuring that the detained person at the centre of the process is detained in accordance with the law and that their rights are vindicated. In this regard, the Tribunals team undertook an extensive programme of training and information sessions for both internal and external stakeholders in 2025. Internally, we meet with the Legal Representatives, Tribunal Chairpersons and Tribunal Lay Members in person. We had an online session for the Tribunal Consultant Psychiatrists and Independent Consultant Psychiatrists. We also arranged bespoke seminars on the following topics.

- Psychiatry, psychiatric diagnoses and drug treatments in psychiatry for non-clinician panel members
- De-escalation and conflict management for all panel members

The MHC also collaborated with the HSE in the provision of information and training sessions for Consultant Psychiatrists, Mental Health Act Administrators and Authorised Officers.

### Engagement with An Garda Síochána

As noted above, there is significant involvement by An Garda Síochána in the application process for involuntary admission. In certain instances, orders have been revoked due to compliance issues arising from these applications. In order to address these matters the MHC now issues quarterly reports to An Garda Síochána, the purpose of which is to provide information on applications made and compliance errors that have led to revocation of orders. Specific detail of the reasons for revocation is given, and our understanding is that this information has been circulated widely to members of An Garda Síochána and informs training delivered to these members.

### Impact of Assisted Decision-Making (Capacity) Act 2015 (as amended)

The relevance of the amendments for tribunals is that if a person is detained under Section 3 (1) (a) or Section 3(1)(a) and (b) of the 2001 Act they are not entitled to the benefits of the 2015 Act. This is to be addressed in the proposed new legislation. If a person is detained under Section 3(1)(b) they are entitled to the benefits of the 2015 Act. Therefore, if they have a decision support arrangement in place, it may be relevant in terms of their detention and /or the mental health tribunal. The arrangements are - Decision-Making Assistance Agreements, Co-Decision-Making Agreements, Decision Making Representation Orders, Enduring Powers of Attorney, and Advance Healthcare Directives. As of 31 December 2025, we have seen a slight increase in the number of tribunals where support arrangements were in place and the relevant representatives sought to attend the tribunal.

Furthermore, from 1 January 2025 to 31 December 2025 the following was noted in relation to the detention orders-

- 5% of orders were made indicating detention based on section 3(1)(a),
- 70% of orders were made indicating section (3)(1)(b), and
- 25% of orders were made indicating section (3)(1)(a) and (3)(1)(b).

Table 7 in the Appendices provides further detailed information.

# Communications and Stakeholder Engagement

# Communications and Stakeholder Engagement

**The key objective of the communications team is to proactively contribute towards the realisation of the organisation's strategic priorities by helping to drive awareness of the MHC, and by effectively communicating about the Assisted Decision Making (Capacity) Act 2015 and the Decision Support Service.**

We realise these objectives through general press and media engagement; engaging with the public and public representatives; the transparent publication of reports; public information campaigns; public consultations, the promotion of our work through a network of digital assets; and via internal communications.

The communications team continued to generate a high volume of traditional media activity during the year. This activity was based upon some key publications, such as the 2024 annual report, guidance for staff working in mental health services on the care and treatment of LGBTQIA+ people, and guidance on the adoption and implementation of a human rights-based approach to care and treatment, and key annual activity reports by the regulatory team, which the communications team published and publicised across the political, media and public arenas.

On the digital front, the team continued to increase engagement across both the MHC and DSS websites, on all social media channels, and generated a significant rise in subscriptions to both the MHC and DSS newsletters.

To further promote the services of the Decision Support Service, we ran a public information campaign that focused on advance planning and engaged with the public on the topic of advance planning with a show garden at the Board Bia Bloom Festival and The Ploughing Championships.

The communications team continued to facilitate stakeholder engagement presentations at MHC Board meetings with Board Members hearing from experts-by-experience with lived experience of illness, including representatives from Community Access Support Team (CAST) Limerick and Prader-Willi Syndrome Association Ireland. The team also organised consultative stakeholder forums for both mental health and decision support services with the objective of engaging with experts-by-experience to inform our ongoing work.

In 2026, the communications team will continue to proactively engage with all stakeholders on issues that concern or relate to mental health and decision support services to help ensure that the strategic priorities of the MHC are being delivered.

**3**
consultations held with the public

**68**
inspection reports published

**2**
activity reports published

**35**
press releases issued

More than
**450,000**
unique visitors to our two websites

Almost
**8,000**
individuals and 150 organisations consulted across events, projects and forums

Over
**20,000**
followers on social media

**8**
external newsletters issued

**4**
editions of staff e-zine circulated

**19**
parliamentary questions responded to

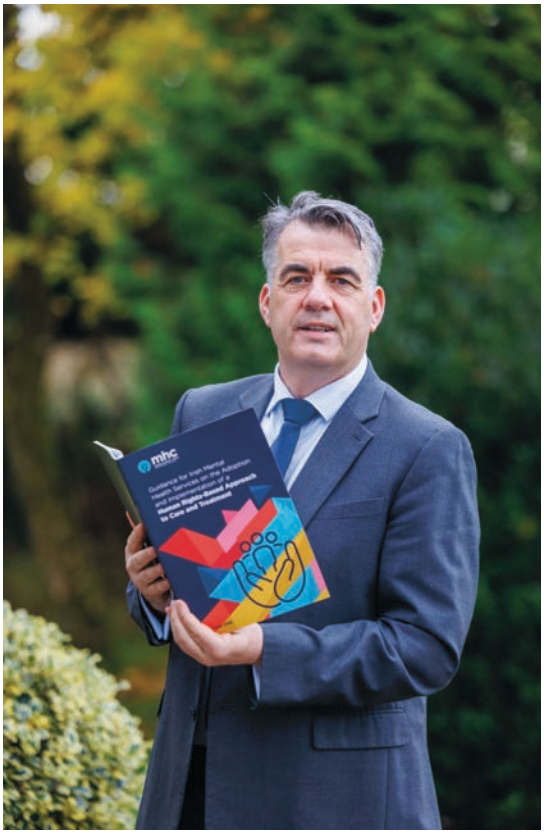
**2**
attendance at Oireachtas Committees (Joint Committee on Health, and Joint Committee on Disablity Matters)

Aoife McMahon, DSS Head of Registration; Joe Eustace, garden designer; Tony O'Connor, DSS service user; and Áine Flynn, Director of the DSS, at the DSS show garden, 'The Support Garden', Bord Bia Bloom 2025.

Áine Flynn, Director of the DSS meeting with Minister for Public Expenditure, Jack Chambers at Bord Bia Bloom

Attendees at the DSS advance planning regional roadshow event for Dubin South and Wicklow.


HR Officer, Órla Gately (right), accepts the WAM Leader Award on behalf of the MHC from Deirdre Moore, AHEAD Ireland




MHC Chief Executive, John Farrelly, launches our *Guidance for Irish Mental Health Services on the Adoption and Implementation of a Human Rights-based Approach to Care.*


Ian Grehan, Head of DSS Information Services, meets with a visitor to the DSS Advance Planning stand at the National Ploughing Championships 2025.

(L-R) Aoife McMahon, Head of Registration DSS; Joe Eustace, designer; Minister for Mental Health, Mary Butler TD; Áine Flynn, Director of the DSS; and John Farrelly, Chief Executive of the MHC, at the DSS advance planning show garden at Bord Bia Bloom 2025.


Members of the DSS Team at a 'Putting Your House in Order' advance planning event, organised by Age Friendly Ireland and the Irish Hospice Foundation.

MHC staff pictured at a 2025 engagement days with service providers in Limerick.


MHC and DSS staff pictured with Minister for Public Expenditure, Jack Chambers TD, at the 2025 Pride Parade in Dublin.


DSS team members meeting with Taoiseach, Micheál Martin TD at the 2025 Ploughing Championships

Ian Grehan, DSS Head of Information Services; Áine Flynn, Director of the DSS; and Aoife McMahon, DSS Head of Registration, who presented to the Joint Oireachtas Committee on Disability Matters


Tánaiste Simon Harris TD meeting DSS Director, Áine Flynn and Communications Officer, Ava McManus, at the 2025 Pride parade


Siobhán Bigley, MHC Communications Manager with DSS stakeholder forum member, Paul Alford, at Inclusion Ireland's 'Paving Our Path Together' event in Athlone

# Governance

# GOVERNANCE

**The MHC is committed to attaining and maintaining the highest standard of corporate governance within the organisation.**

The 2016 Code of Practice for the Governance of State Bodies (the 2016 Code) (as amended) is the definitive corporate governance standard for all commercial and non-commercial State bodies in Ireland. The 2016 Code consists of one main standard and four associated code requirements and guidance documents. The 2016 Code was updated in November 2017 with a Guide for Annual Financial Statements, in September 2020 with an Annex on Gender Balance, Diversity, and Inclusion and in June 2021 in relation to specific superannuation and remuneration proposals.

The MHC has procedures in place to ensure compliance with the provisions of the Code. All reporting requirements for 2025 have been met.

As required under the 2016 Code, the MHC has a formal schedule of matters specifically reserved for decision by the MHC Board to ensure direction and control by the Board. These reserved functions include planning and performance functions, MHC Board committees, financial transactions, internal controls, executive assurances and risk management. The reserved functions are reviewed by the MHC Board every second year or as otherwise required. In addition to this, the MHC Board also has a Scheme of Delegations in place to ensure that the organisation can carry out all its statutory functions effectively and that senior management are confident that they have the delegated authority to carry out their statutory functions and make decisions.

The MHC Board is responsible for the governance of the MHC. In that regard it is supported by the Chief Executive, the Chief Operations Officer and General Counsel / Secretary to the Board.

The following governance matters were addressed by the Board at its meetings in 2025

- Approval of updated Corporate Governance Manual (March 2025)
- Approval of updated Code of Conduct (March 2025)
- Approval of Budget 2025 (March 2025)
- Approval of Corporate Procurement Plan 2025 (March 2025)
- Approval of Business Plan 2025 (March 2025)
- Approval of Bank Mandate Updates (September 2025)
- Approval of Mid-term Review of the Strategic Plan (October 2025)
- Approval of Climate Action Roadmap (October 2025)
- Approval of FARC Workplan 2026 (December 2025)

## Key Governance activities undertaken in line with the 2016 Code

### Board effectiveness

In line with good governance, the MHC Board undertook a self-assessment survey for 2025. This was considered by the MHC Board at its meeting in January 2026.

The Finance, Audit and Risk Committee (FARC) also undertook self-assessments for 2025.

The Human Rights Committee did not undertake a self-assessment in 2025 due to the small number of meetings. However, one is planned to be done for 2026.

### Gender balance in the MHC Board membership

As of 31 December 2025, the MHC Board had 5 male (38%) and 8 (62%) female members. The MHC Board complied with the statutory requirements of the Mental Health Acts, which is

no less than 4 women or no less than 4 men. The MHC Board also meets the Government target of a minimum of 40% representation of women but is just below the 40% requirement for men.

### Code of conduct, ethics in public office, additional disclosures of interest by MHC Board members and protected disclosures

For the year end 31 December 2025, the MHC Board confirms that a code of conduct was in place, updated and adhered to. Furthermore, all MHC Board Members and relevant staff members declared that they were in full compliance with the relevant statutory responsibilities under the Ethics in Public Office legislation.

### Committees

In 2025, the Human Rights Committee, met on two occasions, in March and June.

The core areas of focus for the Human Rights Committee were:

- The Mental Health Bill,
- Adult safeguarding, and
- Protection of liberty safeguards.

The FARC (Finance, Audit and Risk Committee) held five meetings in 2025, and its annual report was provided to the MHC Board in March 2026.

The report considered the following:

- Membership and Meetings in 2025,
- Stakeholder Relationships,
- External Audit (C&AG - Mazars),
- Annual Financial Statements for 2024,
- Internal Audit,
- Management Accounts and Budget for 2025,
- Risk Management System and Strategic Risk and Opportunities Register,
- ICT,
- Governance and Internal Control / Internal Financial Control,
- Protected Disclosures, and
- FARC Performance Management.

There was one internal audit report approved by the FARC in 2025 as follows:

- Review of Fraud Risk

The following internal audits were commenced, but not concluded, in 2025:

- Corporate Governance Review,
- GDPR compliance,
- Strategic and Business Planning.

### Risk Management

The effective management of organisational risk requires robust internal control processes to be in place to support the senior leadership team in achieving the MHC's objectives and in ensuring the efficiency and effectiveness of operations.

In carrying out its risk management responsibilities in 2025, the MHC adhered to three main principles of governance:

1. **Openness**
2. **Integrity**
3. **Accountability**

A significant part of the work programme of the FARC is the oversight role it plays in the risk management process for the organisation.

The Strategic Risk and Opportunities Register ("SROR") was considered quarterly by the senior leadership team, which was in turn reviewed by the FARC, who then presented its report to the MHC Board. Risk was a standing item on the agenda for each Board meeting and the Chief Risk Officer reported on any significant events affecting the working environment of the MHC Board at each meeting.

### Business and financial reporting

The Department of Health's allocation to the MHC for 2025 was €20.656m. The amount drawdown was €20.036m.

Key areas of expenditure related to the statutory functions as set out in the 2001 Act primarily the provision of Mental Health Tribunals and the regulation of approved centres.

The Department of Children, Disability and Equality allocation for the Decision Support Service for 2025 was €10.438m. The amount drawdown was €10.438m. In addition, income in the form of Registration fees of €0.168m was earned in 2025.

The communication costs incurred in 2025 were higher than the previous year and reflect a public information campaign related to raising awareness of the Decision Support Service.

Other expenditure related to staff salaries, rent, professional fees, ICT and related technical support. Third party support contracts continue to be managed to ensure value for money and the achievement of service delivery targets.

The MHC is undergoing its external audit by the Comptroller and Auditor General (C&AG) for 2025 which will review and check that procedures for financial reporting, internal audit, asset disposals and Public Spending Code and Government travel policy requirements were adhered to.

The MHC approved the draft unaudited Annual Financial Statements (AFS) 2025 and agreed that they represent a true and fair view of the MHC's financial performance and position at the MHC Board meeting in March 2026. It is expected that the final audited AFS shall be presented to the MHC Board later in 2026.

The MHC has included a Statement on the System of Internal Control in the format set out in the 2016 Code in the unaudited financial statements for 2025.

The unaudited annual financial statements for 2025 were submitted to the Comptroller and Auditor General (C&AG) as per Section 47 of the Mental Health Acts 2001-2018 and the 2016 Code. The 2025 annual audited financial statements of the MHC will be published on the website as soon as they are available. This will depend on when the C&AG audit is completed.

### Relations with Oireachtas, Minister and Department of Health

Department of Health – Governance meetings between the Department and the Executive took place in March, June, September and December 2025. Oversight and performance delivery agreements were signed for 2025. Minutes of all meetings are recorded and retained.

Department of Children, Equality, Disability, Integration and Youth – Governance meetings between the Department and the Executive took place in March, June, September, and December 2025. An addendum to the Governance and Service Level Agreement signed in 2023 was agreed and signed in 2025.

The MHC had no legal disputes with any other State agency or government body, save in its role as a regulator of approved centres.

## Data Protection

The MHC is fully committed to the protection of the rights and freedoms of individuals whose personal data it holds. Throughout the year, it convened an Information Governance Group to address information matters on behalf of the MHC – including issues pertaining to Data Protection, Freedom of Information and Artificial Intelligence.

### Access Requests

In 2025, 17 Data Subject Access requests were made under data protection legislation. Of the 17 requests received, one was granted, three were part-granted, two were refused and seven were withdrawn. As of 31 December 2025, four were in progress.

## Freedom of Information

Under the Freedom of Information Act 2014, the MHC is designated an FOI body. In compliance with this legislation, it provides its Freedom of Information Publication Scheme on the organisation's website and processes requests for information on a continuing basis.

### Requests

In 2025, the MHC received 59 requests under the Freedom of Information Act 2014.

Of the 59 requests received in 2025, 12 were part-granted, 21 were withdrawn, 16 were refused and two were handled outside of FOI. As of 31 December 2025, eight cases remained open.

Of the 59 requests received in 2025, 36 were personal requests, 20 were non-personal requests and three were a mix of personal and non-personal requests.

Almost all the personal requests under the Freedom of Information Act 2014 were from persons who were seeking medical records or records held by the MHC specifically for themselves or someone on whose behalf they were acting. Many of those requests related to records relating to treatment received in CAMHS.

The details of non-personal requests have been published on the MHC website under the Freedom of Information Publication Scheme.

https://www.mhcirl.ie/freedom-information-publication-scheme

The MHC received 2 notifications of appeal from the Office of the Information Commissioner. At year-end both cases remained open.

## Health Act 2007 (Part 14) and Protected Disclosures Act 2014

Under Section 22 of the Protected Disclosures Act 2014 (as amended), a public body is required to publish an annual report outlining the number of protected disclosures received in the preceding year and any actions taken in response to such disclosures.

For the year ended 31 December 2025, the MHC had procedures in place for the making of protected disclosures in accordance with the relevant legislative requirements.

There were 15 reports made under the MHC's protected disclosure (external) policy to the MHC during 2025 and none under the internal policy.

All reports were assessed under the MHC's Protected Disclosure (external) policy. Eight reports were required to be dealt with under the MHC's Protected Disclosure Policy.

Of the other reports, two were transmitted to another prescribed person or the Protected Disclosures Commissioner, one report was closed because it was a repetitive report containing no meaningful new information, one was referred to a more relevant procedure, one report was closed because of a lack of information, one was assessed as warranting no further follow-up and one was awaiting assessment at the end of the year.

The MHC has published its annal report for 2025 at the link

https://www.mhcirl.ie/about/corporate-operations/protected-disclosures

## Children First

The Children First Act 2015, as amended, was commenced on 11 December 2017. The MHC is not a "relevant service" as defined in the 2015 Act. However, the MHC may still employ "mandated persons" as defined in the 2015 Act. A register of mandated persons within the MHC is maintained and was updated during 2025. The MHC's policy for reporting of child protection and welfare concerns has been in place since January 2018 and has been updated regularly. No events were reported to the MHC during 2025.

## Section 42 of the Irish Human Rights and Equality Act 2014

Section 42(1) of the Irish Human Rights and Equality Act 2014, as amended, places a legal obligation on all public bodies in Ireland to have regard to the need to promote equality, prevent discrimination and protect the human rights of their staff, members and people with lived experience ("Duty").

In addition, all public bodies are obliged to report on their assessment of the human rights and equality issues relevant to its functions and how these issues shall be addressed. In 2023, the MHC included reference to its obligations in its Strategic Plan - "Supporting Change, 2023-2027".

Each Annual Report takes account of this duty and reports on this assessment by way of reference to an annual published MHC Implementation Plan. The plan sets out the issues, actions and progress for the preceding year and has been reviewed by the Senior Leadership Team and published on the MHC website. Implementation plans including the 2025 plan can be viewed at the link:

https://www.mhcirl.ie/about/public-sector-equality-and-human-rights-duty

The MHC set up a Public Sector Duty Working Group in 2019 which was restructured in 2023. The working group is committed to the ongoing implementation by the MHC of its Duty. The working group reports to the MHC's Human

Rights Committee on a quarterly basis, and to the MHC Board bi-annually.

The working group is made up of a representative from each division of the MHC who monitor the ongoing assessment of the relevant human rights and equality issues and report these annually in the Implementation Plan together with the actions that are being taken to address the issues. The working group promotes staff awareness of the Duty, consultations with people with lived experience and staff to inform the issues that may need to be addressed and consideration of the Duty when new policies and procedures are being developed.

## Climate Action

The MHC fulfils its reporting requirements under S.I. 426 of 2014 by reporting through the SEAI Monitoring and Reporting System.

In line with Government guidelines and the obligations on all public bodies, the MHC is fully committed to achieving its targets and reducing its carbon footprint -

- 51% Reduction in greenhouse gas (GHG) emissions by 2030, and
- 50% improvement in energy efficiency by 2030.

The latest results available relate to the provisional 2025 data available from the SEAI M&R system. These indicate that the MHC is on track to achieve the 2030 targets. Please note that these figures are indicative and final figures may be further refined. The Climate Action Roadmap will be updated with this information once available.

The Climate Action Roadmap is a document that communicates how the MHC plans to meet the requirements of the Public Sector Mandate. The first iteration of our Climate Action Roadmap was implemented in March 2023. The Climate Action Roadmap is updated annually in line with the updated Public Sector Climate Action Mandate with the latest update implemented in October 2025.

The Climate and Sustainability Champion of the organisation submitted the Statement on Compliance with the 2024 Climate Action Mandate.

- Actions Implemented – 27
- Partially Implemented – 2
- Not Applicable - 12

The MHC undertook the following sustainability activities.

1. Climate Leadership Training completed by Board members.
2. The Green Team completed various training through the SEAI Energy Academy.
3. Participated in the Green Team initiative introduced by Building Management to promote sustainability and environmental practices within the building.
4. Information and training provided for employees on Green Public Procurement.
5. Education on recycling provided to staff as part of induction.
6. Participated in the Reduce Your Use Campaign.
7. Invited employees to participate in a travel survey.
8. Celebrated World Earth Day, providing information on ways to protect the planet and quizzes to test your knowledge.
9. Paper usage and food waste measured and monitored.
10. SI 426 compliant Energy Audit completed.
11. Arranged an independent review of our electricity bills to confirm the bills were well positioned and no further savings could be achieved currently.

| ENERGY PERFORMANCE | | | | GREENHOUSE GAS EMISSIONS | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2024 energy consumption | | Energy Performance Indicator | | Fossil $CO_2$ emissions | | | | Total $CO_2$ emissions | | | |
| Final GWH | Primary GWH | 2030 target | Change since EE Baseline | GHG baseline $tCO_2$ | 2024 $tCO_2$ | 2030 target $tCO_2$ | Change since GHG baseline | GHG baseline $tCO_2$ | 2024 $tCO_2$ | 2030 target $tCO_2$ | Change since GHG baseline |
| 0.1 | 0.2 | -50% | -70.8% | 23.2 | 14.0 | 11.4 | -39.8% | 59.4 | 31.0 | 19.3 | -47.7% |

In compliance with Circular 1/2020: the MHC makes a payment to the Fund Manager of the statutory Climate Action Fund to offset its greenhouse gas emissions in respect of official air travel.

| Offsetting Emissions Relating to Air Travel | | | | |
|---|---|---|---|---|
| **Year** | **CO2 KG's** | **Tonne** | **Cost per Tonne** | **Cost** |
| 2023 | 1339.6 | 1.3396 | €48.50 | €64.97 |
| 2024 | 3153 | 3.153 | €56.00 | €176.57 |
| 2025 | 589 | 0.589 | €63.00 | €37.40 |

### Prompt payment of account legislation

The MHC complied with the requirements of the Prompt Payment of Accounts legislation and paid 97.62% of valid invoices within 15 days of receipt. To meet this target, strict internal timelines are in place for the approving of invoices. Details of the payment timelines are published on the website.

## Maastricht returns

In 2025, the MHC complied with the requirement to submit Maastricht Returns to the CSO.

## Procurement

In 2025, MHC undertook three EU tendering processes, two mini competitions under OGP Frameworks and 12 competitions that were below €50k plus VAT value thresholds. Eighteen contract extension notices were agreed as permitted under the agreed terms of contract or in accordance with relevant exclusion requirements.

Three EU tendering processes, valued over national procurement threshold limits, incorporated green public procurement criteria (GPP). Two mini competitions, valued over national procurement threshold limits, incorporated GPP criteria. Eight competitions, valued at under national procurement levels, incorporated GPP criteria.

The MHC Corporate Procurement Plan for 2025 was approved by FARC on 12 March 2025. The MHC Procurement and Contracts Manager continues to work with all MHC divisions to ensure forecasting and planning for the procurement of goods and services in line with best practice guidelines and the MHC Procurement & Contracts Policy.

## Information and Communications Technology (ICT)

The key focus for ICT within the MHC is to provide a resilient and secure framework of information services to support all aspects of the MHC's activities. This includes the implementation and configuration of corporate ICT systems, as well as supporting the underlying technology.

ICT has adopted a cloud first approach to systems and in keeping with this approach there has been an increase in Software as a Service (SaaS) systems.

During 2025, the MHC has taken a proactive approach to cybersecurity, engaging with a third-party cybersecurity provider to support the adoption of the European NIS2 Cyber fundamentals Framework (CyFun) which is the standard recommended by the National Cybersecurity Centre (NCSC). MHC is conducting on-going cyber security staff training and will continue to keep MHC systems under review and up to date. MHC is currently upgrading its server systems to further improve the recovery of systems and data in the event of a disaster.

MHC has put in place a secondary fibre failover system to build robustness and reliability into its network infrastructure. Both the primary and secondary fibre lines are connected to and managed by the Government Networks WAN to facilitate secure and reliable communications. This is part of the build to share service offered by the OGCIO.

A new ICT Strategy and roadmap was developed in late 2025 and approved in 2026 for the years 2026 to 2027.

## Human Resources

The Human Resources function plays a role in fostering a positive culture and improving employee engagement and productivity. Treating our employees fairly and providing them with opportunities to grow assists the MHC with the realisation of its strategic objectives.

As of 31 December 2025, the MHC had 182.05 FTEs plus 10 agency staff.

## Performance management

The Performance Management and Development

System (PMDS) was successfully carried out in 2025 with a focus on upskilling people managers to look for opportunities for staff development when conducting performance evaluations.

## Employee Assistance Service

The MHC's Employee Assistance Programme (EAP), provided by an external provider on a 24/7/365 basis offers a free, professional service for employees and their families to resolve personal or work-related concerns.

## Blended Working

The MHC continued with a Blended Working Policy as part of its commitment to embracing opportunities for remote working and to build a more dynamic, agile and responsive organisation, while sustaining strong standards of performance and high levels of productivity. The policy provides a procedure for staff employed by the MHC to apply for blended working arrangements.

## Supports for Employees with Disabilities

The HR team provides an Access Officer to provide a progressive working environment and, in line with equality legislation, promotes equality of opportunity for all employees. The National Disability Authority (NDA) has a statutory duty to monitor the employment of people with disabilities in the public sector on an annual basis. In line with Government commitment to increasing the public service employment target for persons with disabilities on an incremental basis from a minimum of 3% to a minimum of 6% by 2025, HR is responsible for the statutory reporting, both quantitatively and narratively, to the NDA. In 2025, the MHC reported a rate of 9.8 % of their employee base as having a disability.

## Training and development

In 2025, training activities were delivered to build continued improvements in job functions and work practices and to encourage professional development.

## Recruitment

There has been a strong focus on recruitment, including additional staffing for the DSS and Regulation and Standards teams. This has given the MHC the opportunity to attract new talent while also providing further career development opportunities to existing staff. 18 recruitment competitions were run in 2025.

## Acht na dTeangacha Oifigiúla

The MHC comes under the remit of the Official Languages Act 2003 and the Official Languages (Amendment) Act 2021 (the Acts) to provide a statutory framework for the delivery of services through the Irish language.

The MHC continues to work towards fulfilling its obligations under the Official Languages Acts. A senior manager is responsible for overseeing performance of our obligations under the Act, procuring translation services for the organisation and training for senior managers. The MHC submitted its 2025 annual report on the compliance portal on advertising requirements for Section 10A to An Coimisinéir Teanga in line with the legislative timelines.

In accordance with the Acts, this Annual Report is published in both Irish and English.

| Strategic Priorities | Actions achieved during 2025 | Examples of actions achieved |
|---|---|---|
| Strategic Priority 1<br><br>Continue to be the leading voice in relation to mental health services and assisted decision making. | The MHC continues to promote a rights-based approach to service provision and published standards, guidance and data-driven insights in implementing our legislative mandate.<br><br>**Office of the CE:** 7<br><br>**Inspectorate:** 1<br><br>**S&QA:** 11<br><br>**MHT:** 7<br><br>**Regulatory Team:** 2 | We developed a peer-reviewed paper: "Declining restrictive practice in approved centres in Ireland: improving quality of care through the adoption of a human rights-based approach". Published in the Irish Journal of Psychological Medicine.<br><br>We co-hosted the EPSO conference in collaboration with Tusla. The European Partnership for Supervisory Organisations in Health Services and Social Care (EPSO) is an informal group of governmental and government-related organisations involved in law enforcement, supervision, monitoring, and accreditation related to health services and social care in Europe.<br><br>We developed and published "Guidance for Staff working in Mental Health Services on the Care and Treatment of LGBTQIA+"<br><br>We conducted an evidence review to inform the revision of the 2014 MHC Seclusion and Restraint Reduction Strategy.<br><br>We conducted an evidence review to inform the development of standards for Children and Adolescents Mental Health Services (CAMHS).<br><br>Continually updating the Summary of Judgments for both MHA and ADMCA which is available to the public. |

| Strategic Priorities | Actions achieved during 2025 | Examples of actions achieved |
|---|---|---|
| Strategic Priority 2<br><br>Effective and accessible communication and engagement, emphasising and promoting the voice of the person | The MHC continues to include the voice of the person with lived experience using the services across all our work programmes.<br><br>**Office of the CE:** 2 actions<br><br>**Regulatory Team:** 1 action<br><br>**Legal:** 1 action<br><br>**Inspectorate:** 3 actions<br><br>**S&QA:** 1 actions<br><br>**MHT:** 2 actions | Implementation plan published setting out the human rights and equality issues which arise, and how the MHC have addressed these.<br><br>All MHT correspondence reviewed for detained persons in consultation with NALA with appropriate useful information included and further information accessible by QR Codes and weblinks.<br><br>All information for detained persons has been made available in an additional four **(4)** languages increasing the availability of our booklets and online information to **18** languages.<br><br>We developed a series of short information videos on involuntary admission and tribunals for relevant stakeholders.<br><br>We continued our collaboration and consultation with our mental health and DSS stakeholder forums to ensure the voice of the person was incorporated into our work.<br><br>We published material to assist persons accessing DSS services, including the Enduring Power of Attorney Information Pack, revised Complaints forms and a guide for 'When a panel decision-making representative has been appointed to your family member or loved one'.<br><br>We participated in Bord Bia's Bloom festival and the National Ploughing Championships engaging directly with thousands of people on the importance of advance planning.<br><br>We undertook a public consultation to inform the development of guidance for staff providing mental health services to persons with intellectual disabilities, with a strong emphasis on effective, accessible communication.<br><br>We hosted two full-day Service Provider Engagement Days for staff working in mental health services.<br><br>We established an Expert Advisory Group to assist in developing a Code of Practice on the Use of Digital Monitoring Technologies. Membership included people with lived experience of mental health services and a representative from a Disabled Persons' Organisation.<br><br>We continued to utilise Quality and Safety Notification (QSN) data to inform a risk-based approach to regulatory oversight. Monitoring of the Quality and Safety Notification is conducted on an ongoing basis. It initiates the engagement with the regulated services and informs other regulatory activities. The data is used to identify trends, patterns, and regulatory risks.<br><br>We developed and published the 2025 Judgement Support Framework (JSF). The JSF supports service providers in understanding their obligations under the regulatory framework and the compliance criteria set out in the 2006 Regulation. |

| Strategic Priorities | Actions achieved during 2025 | Examples of actions achieved |
|---|---|---|
| Strategic Priority 3<br><br>Continue to drive standards, improve quality and safeguard persons in relation to mental health services that are regulated by the MHC. | The MHC developed and published papers and reports based on evidence, supported by international experience and continued to develop new standards, Codes of Practice and guidance for services.<br><br>**Legal:** 8 actions<br>**Regulatory:** 1 action<br>**S&QA:** 6 actions<br>**MHT:** 5 actions | Recruited additional panel legal representatives in 2025. All panel legal representatives were garda vetted in 2025.<br><br>Continuing to audit panel legal representative's files to ensure all panel legal representatives are audited by Q2 2027.<br><br>Partner in the National Care Experience Programme (NCEP) to support and assist with the development of a national patient survey; this included collaboration on a plan for the promotion and distribution of the survey to relevant stakeholders.<br><br>Audit of tribunal decisions to ascertain areas that required improvement to reduce non-compliance issues, provided training and information to relevant parties where required and ensured ongoing monitoring was in place. |

| Strategic Priorities | Actions achieved during 2025 | Examples of actions achieved |
|---|---|---|
| Strategic Priority 4<br><br>Promote and support assisted decision-making in society by embedding the Decision Support Service as a respected public service. | The DSS continued to engage directly with stakeholders, invested in two public informaiton campagins increasing awareness of assisted decision-making among the general public.<br><br>**Office of the CE** 8 actions<br><br>**DSS** 10 actions<br><br>**Inspectorate:** 1 action<br><br>**Legal:** 3 actions<br><br>**Secretary to the Board** 1 actions | Following the Convention on the International Protection of Adults coming into force in Ireland in 2024 we have engaged with the Hague Conference (HCCH) and Irish stakeholders to ensure the role of the Central Authorities is carried out to a high standard.<br><br>We ran a public information campaign promoting advance planning with the message 'Make a decision your future self will thank you for'.<br><br>We presented to a range if organisations, individuals and professionals at events around the country to provide information and promote awareness of the supports in the 2015 Act and the importance of advance planning.<br><br>We expanded access to our searchable DSS Register so that approved organisations and professionals can immediately search and access relevant information.<br><br>In partnership with key stakeholders, we held specific EPA roadshows and in-person clinics, providing practical supports in Cork, Portlaoise, Kildare, Mayo, Cavan and South Dublin.<br><br>We produced targeted materials for professionals undertaking functions under the 2015 Act including a CDMA legal practitioner guide, guidance for completing a capacity statement and MyDSS authorised agent step-by-step guide. |

| Strategic Priorities | Actions achieved during 2025 | Examples of actions achieved |
|---|---|---|
| Strategic Priority 5<br><br>Be an effective, cohesive, transparently governed and agile organisation acting in the public interest. | The MHC continues to engage with experts by experience at all levles of the organisation and conducted reviews of Governance arrangements and organisations structures<br><br>**Corp Ops**<br>26 actions<br><br>**Legal:** 3 actions<br><br>**Inspectorate:**<br>2 action<br><br>**Secretary to the Board** 10 actions<br><br>**Regulatory Team:**<br>10 actions | We completed all actions required by the 'Climate Action Plan', including the updating of our climate action roadmap.<br><br>We updated the MHC Business Continuity Plan.<br><br>We participated in the Willing, Able, Mentoring programme.<br><br>The MHC Health and Safety Committee met quarterly and considered any health and safety matters.<br><br>The Board reviews its governance documents over a two-year period which involves incorporating all updates to the Code of Practice on the Governance of State Bodies and otherwise to ensure effective and efficient governance.<br><br>We developed a generative AI solution for regulatory reporting and enforcement activities.<br><br>We contributed to the implementation of the NIS2 Directive. The NIS Directive is a legal instrument aimed at improving the resilience of network and information systems in the EU against cybersecurity risks. |

**Note:** Mental Health Tribunals (MHT), Decision Support Service (DSS) Standards and Quality Assurance (S&QA), Office of the Chief Executive (Office of the CE), Regulatory (combined S&QA and Inspectorate teams) and Corporate Operations (Corp Ops)

# 2025 ANNUAL REPORT OF THE INSPECTOR OF MENTAL HEALTH SERVICES

**Prof Jim Lucey**
MD (Dub) PhD (Lond) FRCPI FRCPsych

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# INTRODUCTION

**The Inspector of Mental Health Services, together with a team of assistant inspectors, completed the full inspection of 67 approved centres throughout Ireland. All inspections in 2025 were unannounced and on-site. Inspection teams spent an average of four days in each centre gathering data by means of direct observation combined with document evaluation and triangulated with interviews involving staff and residents. The result is a time-specific indication of compliance with all Regulations, Rules and Codes of Practice. This year, we also completed eight focused inspections in approved centres operated by the HSE and independent providers.**

## Unannounced Inspection Process

On-site unannounced inspections are an important element of the regulatory framework. They also represent a substantial burden on service providers, staff and residents. I am grateful to the providers of our acute mental health services for their cooperation and support. I extend my sincere thanks and appreciation to all of them for their work in mental health care and for their patient facilitation of the inspection process. By collaborating in this way, we are helping to ensure the best possible service is provided for the most vulnerable members of our society.

## Service Provider Feedback

Feedback from approved centres, their residents and their staff regarding the inspection process is overwhelmingly positive. This feedback is constructive and welcome. Open and transparent dialogue between service users, service providers and the MHC is a strategic goal and an important regulatory resource. This year, this communication was enhanced in various ways. The Inspectorate attended a series of service provider engagement days hosted by the MHC Regulatory Team held in Athlone and Limerick. These national meetings were very well attended. They provided opportunities for mutual understanding of the complex challenges facing service providers and their residents. I was pleased to observe the increasing desire for human rights-based mental health services and a growing appreciation of the value of a robust regulatory framework.

## Compliance with Minimum Standards

Annual inspections examine compliance with minimum standards on any given day. This data gives an indication of service quality, but it is not a guarantee that such service will be maintained.

On-site annual inspection provides a single point of observation, a timebound window onto care which continues long after the inspection is over, 24 hours of the day, seven days of the week and 365 days of the year.

Areas of non-compliance are routinely addressed through corrective and preventative action plans implemented by the approved centre in the weeks or months following an inspection. Progress towards human rights-based mental health care requires this reinforcement, helping to build a culture of quality based on trust as well as control.

It is pleasing to see evidence of this culture of quality increasing in most, if not all, of our approved centres. Non-compliance with Regulations at critical levels fell in 2025 and this is to be commended. Five issues of non-compliance represent challenges which still require greater leadership attention and more effective problem solving.

Levels of Compliance with Minimum Standards in Approved Centres in Ireland 2025

- Regulation 15: Individual Care Plan (58.21%)
- Regulation 22: Premises (26.87%)
- Regulation 23: Ordering, Prescribing, Storing and Administration of Medicines (53.73%)
- Regulation 26: Staffing (52.24%)
- Regulation 32: Risk Management Procedures (44.78%).

## Regulation 22: Premises

The most persistent areas of non-compliance relate to Regulation 22: Premises. Many approved centres are still operating in premises which are outdated, unsuitable or unsafe. This

is unacceptable. The perennial nature of this deficit is my real concern. Much needed capital investment is being provided in some areas, but not in others. The MHC has called year-on-year for a more substantial increase in capital funding for our acute mental service. Poor quality of therapeutic environment contributes to the difficulties which staff and residents experience daily. Centres do all they can to mitigate these risks, but the failure to resolve this challenge is beyond their control. It has consequences far beyond a narrow definition of compliance, impacting on the centres' risk management procedures (Regulation 32) and staffing (Regulation 26).

## Restrictive Practice

Approved centres continue to make substantial progress in quality of care, compliance and human rights. I am referring particularly to the continued fall in the use of restriction in approved centres throughout Ireland. The sustained reduction in the use of physical restraint is especially heartening.

Restrictive practices are never in themselves therapeutic, so their reduction is to be welcomed. The scale of reform achieved over a short space of time is commendable, especially since it has occurred in the increasingly challenged context of the Irish acute mental health care sector.

In 2018, there were 2,608 episodes of restriction of children in approved centres in Ireland. In 2025, this number fell to less than 250 episodes in the whole year. A reduction of more than 90% in the restriction of children suggests a cultural shift, which is inspiring (1).

Restriction remains a challenging issue, which is why the MHC will remain vigilant and continue to work with service providers and service users to ensure these practices, when used, are safe, compliant and rare.

## The Inspector's Thematic Report

This year, the Inspector's 'thematic' report related to the issue of 'access' to mental health services through Emergency Departments (EDs) in general hospitals throughout the country (2,3).

An estimated 51,000 persons per year present to EDs in general hospitals seeking acute mental health care. The Inspector's thematic report revealed evidence of widespread regional variability in the distribution and content of mental health supports throughout EDs in Ireland. Some EDs provide 24/7 mental health response with dedicated mental health spaces for assessment in parallel with medical and surgical care, but many others do not.

A provider-based confidential survey was sent to each HSE hospital or area manager with responsibility for an ED or a minor injury unit. This thematic enquiry received a 100% response rate. These responses consistently highlighted the need for better access to community mental health care to reduce the need for attendance at general hospital EDs. Respondents described an imbalance between growing mental health demands and increasingly limited mental health response provision. They highlighted risks for vulnerable adults with acute mental health problems and frustrations associated with delays especially for young people presenting to EDs.

The thematic report also acknowledged the variety of good work being done to address many of these challenges. This work includes standards setting by the National Clinical Programme for Self-Harm and Suicide-related Ideation Implementation Advisory Group (NCPSH/SRI). The Inspector's thematic report recognised that persons have the right to attend ED whether their need arises from mental health difficulty or a combination of problems. In keeping with the standards set by the NCPSH/SRI, a more timely, safe and effective mental health response is required 24/7 in ED throughout Ireland.

The Inspector's thematic report encouraged all parties to work collaboratively to enhance community services and provide alternatives to ED presentation. Standards of mental health care in the ED need to align with NCPSH/SRI standards, including the introduction of a 24/7 mental health nursing presence in all EDs. The report recommends an immediate enhancement of mental health nursing staff in all 24/7 EDs. Enhancement of this resource would reduce clinical risk by augmenting liaison with local mental health teams and alleviating pressure on Level 4 Hospitals where rising numbers of mental health presentations compete with other emergency demands.

## Positive Reponses to the Inspector's Thematic Report

The response to the Inspector's thematic report was swift and decisive. As Inspector, I was invited to participate in a multidisciplinary forum at RCSI entitled 'The 'Open Door.' This brought together a full range of stakeholders, including acute care providers, mental health care providers and users of mental health services. Speakers at the event hosted by Professor Rosa McNamara, Clinical Lead at the National Programme for Emergency Services, acknowledged the challenges involved in delivering mental health care in emergency settings and considered the best ways to address these challenges in present circumstances. The 'Open Door' concluded by affirming the equal right of every person to access modern health care via the ED (4).

A rising tide of public awareness also led to a Dáil Debate in which Minister Mary Butler (Minister with Responsibility for Mental Health) welcomed the Inspector's thematic report and responded by making a commitment to introduce 24/7 mental health nursing in EDs as quickly as possible and on a phased basis (5). I wish to commend the Minister for her timely therapeutic response. Further evaluation of this service development will help to inform mental health service leadership and guide future investment.

## The Inspector's Service Review 2025

The Inspector's service review for 2025 examined the ordering, prescribing, storage and administration of medications in approved centres in Ireland (Regulation 23). Public concern regarding medication monitoring in Irish mental health services is understandable. These concerns were reiterated in July 2023 by my predecessor, Dr. Susan Finnerty, in her independent review of the provision of Child and Adolescent Mental Health Services (CAMHS) and amplified by the Halpin Report into medication management in CAMHS services in Kerry (6,7).

All 67 approved centres were visited and inspected under Regulation 23. A declining level of compliance was noted, falling from 77% compliance in 2022 to only 54% in 2025. Some of this decline can be attributed to the introduction of higher standards, required since 2024, regarding antipsychotic polypharmacy and the use of high dose antipsychotic therapy (HDAT). However, as Inspector, I recognised the need to understand more fully the reasons for poor compliance with this vital therapeutic standard.

All 67 approved centres were invited to complete a focussed questionnaire. This was developed by the Inspectorate for the purpose of understanding the processes and practices in approved centres regarding medication management. The response rate from the approved centres was 100%. We proceeded to examine the response data and correlate these with findings under Regulation 23. The results were highly significant.

Approved centres which were compliant with Regulation 23 in 2025 were compared to those which were not. Significant differences emerged in three areas of medication management. These were policy formation, medication safety audits and access to a Drugs and Therapeutics Oversight Committee (DTC). Approved centres with sufficient and appropriate policies, regular medication audits and access to a DTC were significantly more likely to be compliant with Regulation 23.

**Figure 1:** *Number of approved centres with the specified written policies/guidelines*

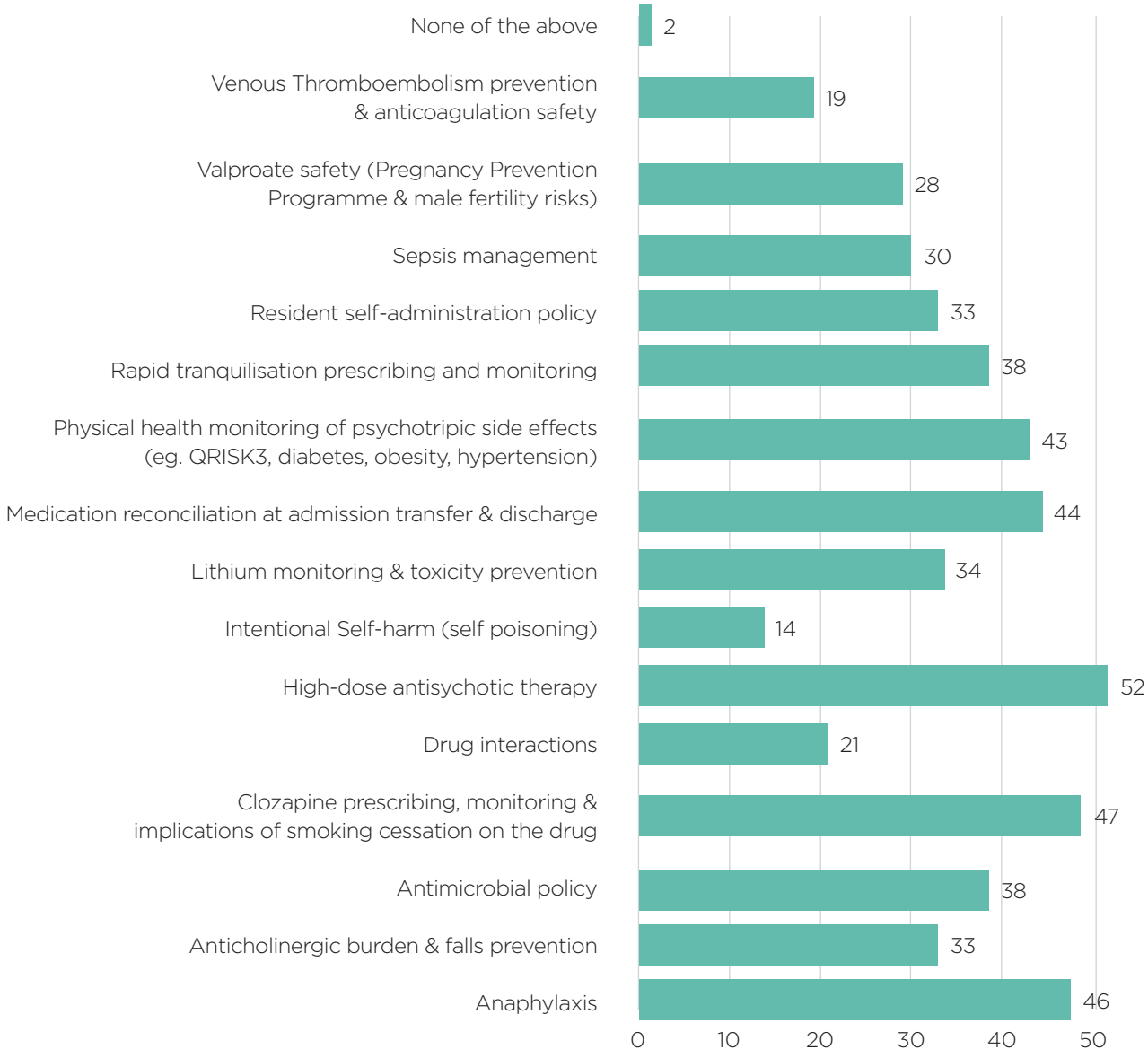



**Table 1:** *Association between compliance with Regulation 23 and medication practices conducted in approved centres*

| Approved Centre Practices | OR* (95% CI**) | p-value (p<0.05) |
|---|---|---|
| Access to a DTC | 9.35 (1.88, 46.6) | 0.004 |
| Written policies and guidelines (≥10) | 4.66 (1.54, 14.1) | 0.005 |
| Internal medication safety audits | 15.15 (0.80, 286.02) | 0.02 |

*OR=Odds Ratio; **CI=Confidence Interval

The differences are not only statistically significant, but they are also practically important. The propriety and safety of medication use is an aspect of care especially important in acute mental health care. The Inspector's service review points to a better way forward, one which will help to ensure best practice across all the approved centres throughout Ireland.

For this reason, the most recent Judgement Support Framework – the JSF 2026 - upon which next year's inspection will rest, includes as a minimum requirement under Regulation 23 that each approved centre has sufficient medication policy in place, each engages in regular audit of its medication practices, and each maintains access to oversight from a local or regional DTC.

These operational processes are already well established in centres which are compliant with Regulation 23. Leadership throughout the regions is required to ensure this same standard is upheld in every approved centre.

## Unsolicited Communication to the Inspector of Mental Health Services

As Inspector at the MHC, I do not have the legal power to investigate complaints regarding mental health services. However, I feel obliged to listen and to acknowledge whenever an unsolicited communication is received.

Any member of the public may contact the Inspector on matters relating to the health, wellbeing or safety of a person in receipt of mental health services. Each communication is referred to the Submitted Issues Committee (SIC) and reviewed weekly along with members of the MHC team. The source of a communication may be identified or unknown. The communication may come from a resident of an approved centre, their relative or advocate, from a third party or other source. Where communication derives from a staff member, they may be treated as protected disclosures.

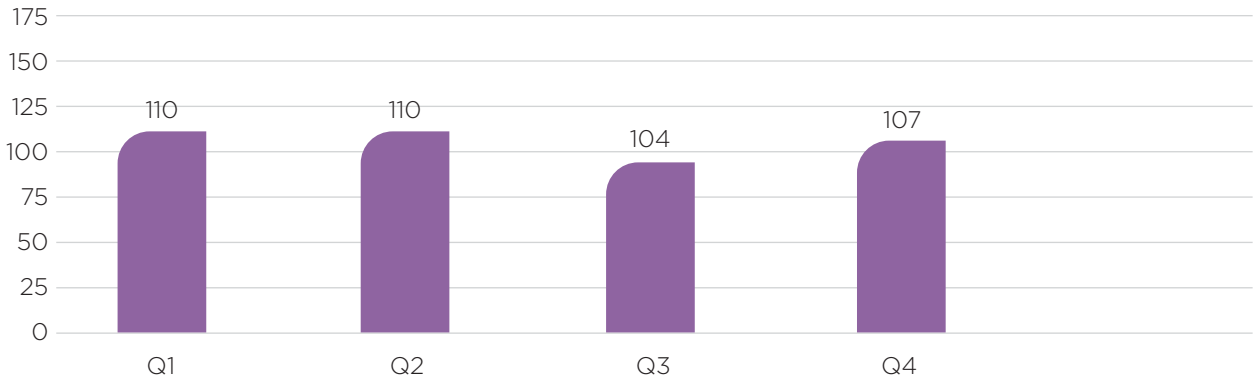
The SIC consists of the Inspector of Mental Health Services, the Director of Regulation or his nominee and an administration team. People may submit issues through any communication medium, and each communication is noted and acknowledged by the SIC. I am grateful to the members of the SIC for the work that they do in this area.

Each communication is treated with respect, in compliance with the law (including GDPR) and in accordance with our remit. Where appropriate, the information may be taken under consideration during the next service inspection or used to inform other regulatory processes.

The SIC logged more than 431 communications in 2025, of which, 380 were new communications received from members of the public who contacted the MHC for the first time. The total number of correspondences received by the Inspector in 2025 (for example, by email, letter, voicemail) arising from members of the public and other key stakeholders was 1,017.

The Inspector's response to any communication may involve a request for information from the relevant mental health service, or information as to where and how the person may make an official complaint, or signposting information regarding potential support organisations or other regulatory bodies.

**Figure 2:** *Number of Unsolicited Communications to the Inspector Per Quarter 2025*



There has been a notable increase in unsolicited communications into the MHC over the past three years. The fact that these numbers are rising is not surprising. Mental health is, after all, our largest unmet health need, and a substantial concern for every family in the land.

Common themes included miscellaneous enquiries regarding services, follow-up issues from previous years, communications from family members or friends and experiences with approved centres.

| Key Theme | Overall* | Individual** |
|---|---|---|
| 24-hour Residence | 2 | 2.00 |
| Access to Mental Health Care | 16 | 14 |
| Access to Records | 8 | 5 |
| ADHD | 4 | 4 |
| Approved Centre | 115 | 58 |
| Care and Treatment | 4 | 2 |
| CAMHS | 2 | 2 |
| Community Mental Health | 10 | 6 |
| Concern for Family/ Friend | 142 | 99 |
| Doctors/Nurses | 26 | 19 |
| Follow Ups (from previous years) | 204 | 62 |
| GP | 3 | 3 |
| Medication | 12 | 7 |
| Mental Health in Ireland | 9 | 8 |
| Mental Health Tribunals | 25 | 14 |
| Miscellaneous | 209 | 126 |

*Overall refers to the total count of communications, including instances where the MHC was contacted multiple times regarding the same issue.

**Individual refers to the number of distinct individuals who raised an issue with the MHC.

We welcome all views and comments about mental health services and the process for contacting us is set out on our website www.mhcirl.ie

## Management Action and Response Template (MART) by Approved Centres

Previous annual reports produced by this Inspector identified several approved centres with persistent levels of non-compliance rated 'critical.' This year, non-compliances rated 'critical' were found in 18 approved centres in Ireland. In some of these centres, non-compliances are persistent, and this is concerning. Levels of enforcement action have increased in 2025, and some services have suspended specific activities in the interest of patient safety.

Thankfully, these issues are rare, and most centres in Ireland continue to make progress towards quality standards consistent with human rights. I have been heartened by developments in some approved centres over the past year where leadership, management and clinical staff within the approved centre have come together to resolve critical deficits in care.

Some of these dynamic centres have adopted a so-called Management Action and Response Template, or MART (or equivalent) developed by the National Office for Mental Health at the HSE and this may have been helpful. Early data suggests that enhanced management processes such as MART are effective, resulting in substantial progress. My hope is that ongoing restructuring of leadership and management in the HSE will enable more widespread targeted adoption of processes such as MART. Effective governance such as this will become standard across all approved centres. Approved centres which have taken similar steps this year were those with the largest positive turn around in performance.

## Conclusions

This is my third annual report as Inspector of Mental Health Services at the MHC. The impact of positive developments identified is balanced by perennial deficits found on inspection. A hopeful analysis is called for. A more sanguine approach is justified by our witness of services in 67 approved centres throughout Ireland.

Recognition of the value of regulation in mental

health care is increasing. Cooperation with the Inspectorate is almost universal and there is a growing integration of management and clinical response to compliance and non-compliance. These data would be evidence enough to justify hope, but there is more.

The lived experience voice is increasingly being heard as awareness increases of human rights and the importance of mental health care to the wellbeing and prosperity of the nation.

Compliance with minimum standards still falls below minimum acceptable levels, but signs of progress are demonstrated by the decline in the number of non-compliances rated 'critical' and by falling rates of restriction. Both are indicative of a growing culture of quality in most of our acute mental health centres.

Investment in Irish mental health care still falls far short of international comparison and promised norms, but the absolute volume of money is increasing year-on-year. The Inspector will continue to listen to the voice of lived experience and hear their concerns. Mental health care regulation is more effective when dialogue between people with mental difficulties and providers is maintained consistent with our mandate. Reliable services become sustainable when the balance of regulation relies less exclusively on control and more on trust. In my view, more enlightened leadership and more effective management is emerging along with increasing respect for the lived experience voice.

Complexity of demand is also increasing rapidly, and so are the expectations of service users in the acute mental health care sector. Growing challenges include difficulties related to suicide and self-harm, substance misuse disorders, eating disorders, brain injuries and a range of needs impacted by neurodiversity.

Approved centres have a role in some of these challenges, but they must not become the default locations for increasing challenges in our society. Much of Irish mental health care service is better placed elsewhere. Common difficulties and needs should be addressed in the community where primary prevention and recovery are more effectively achieved. Availability of specialist in-patient care is a vital part of any functioning community mental health service, including psychiatric intensive care, rehabilitation and child and adolescent mental health. Modern in-patient mental health care facilities should be fit for purpose and well maintained. Greater investment in this capital is necessary to ensure that community services are available for those who need them. I have been encouraged by the positive response to calls for improved mental health services in EDs. Targeted investments in this and in other community mental health initiatives need sustained support and greater evaluation.

Issues related to the monitoring of medication in Irish mental health care remain a continued cause for concern. This year's review of services confirmed the need for more consistent medication management. Resolution of this issue is essential to restore public trust and confidence. As a result of our overview, we have been able to give services clearer guidance. Henceforth, approved centres must ensure that where medication is prescribed, it is administered and monitored to ensure appropriate reliability and safety.

Medication is only one part of multidisciplinary mental health care. A prescription may be necessary, but it is not sufficient. Approved centres which are compliant in this area will respond to residents' needs more consistently within their duty of care and this must be included in the resident's care plan and updated regularly. Such a plan, when used collaboratively, can both provide and guide.

Consequently, we have introduced new requirements under Regulation 23 for the coming year. These are applicable to all approved centres. Each approved centre must have an appropriate policy suite to ensure consistency, evidence of audit to ensure compliance and regular access to a DTC to ensure best practice.

Finally, this report is the last issued by the Inspector at the MHC under the Mental Health Act 2001. The new Mental Health Act passed all stages of the Oireachtas in April 2026. Whether its implementation is incremental and stepwise, or swift and comprehensive, all stakeholders will be hoping that standards are raised and maintained. In this regard, we will learn from the experience of previous generations just as we prepare for the mental health challenges of the next.

There is no mystery about quality mental health care. All that is required is the coherence of those concerned to ensure human rights-based care and best practice is delivered everywhere. This Inspector's report is clear about two things when it comes to mental health care in Ireland; although there is still much to do, there is much more to be hopeful about.

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7. Halpin, C. Report on the Recall Stage of the Look Back Review into CAMHS County MHS Area B Phase 1. HSE South West; 2025 Nov.

# Appendices

# APPENDIX 1
# Decision Support Service Information

**Figure 1:** *Volume of query by source 2025*

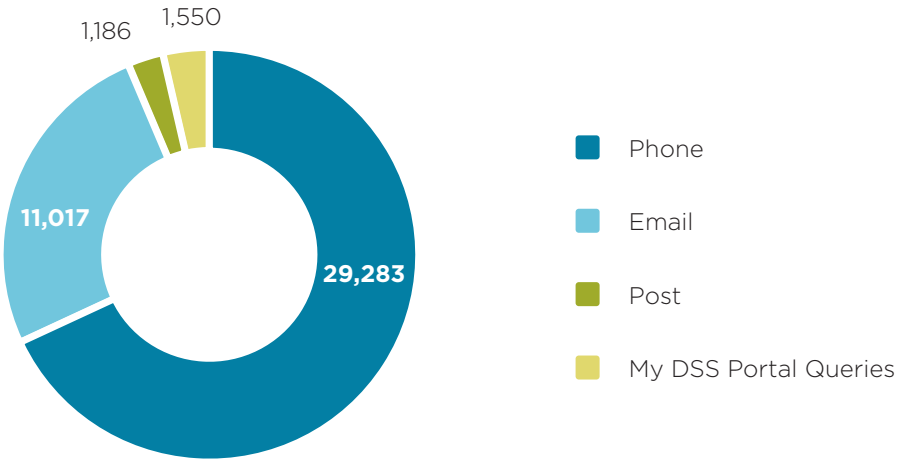
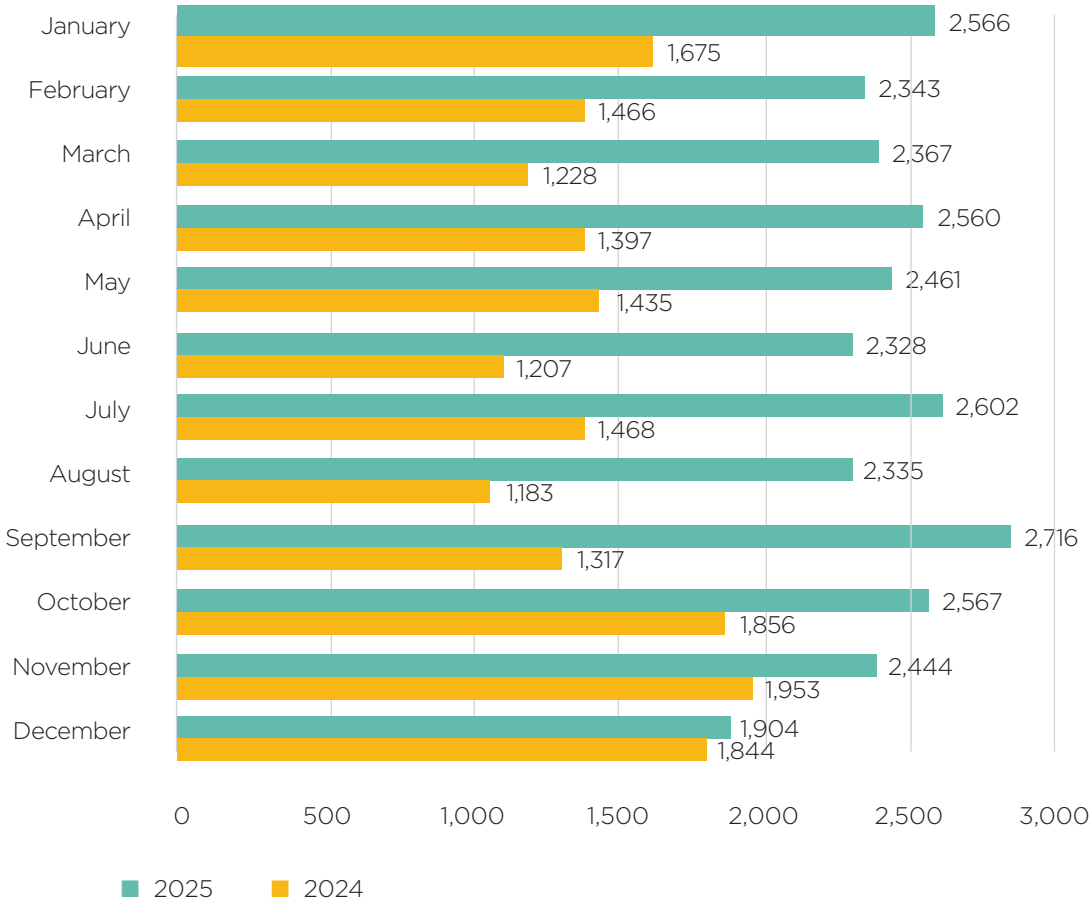



**Figure 2:** *Calls answered by DSS information services per month in 2025 v 2024*



## Profile of DSS account holders

**Table 23:** *Gender of persons who have completed identity verification and have a DSS account*

| Gender | 2025 | % | 2024 | % | All time | % |
|---|---|---|---|---|---|---|
| Female | 7,903 | 42 | 6,146 | 42 | 19.075 | 43 |
| Male | 5,688 | 31 | 4,626 | 31 | 14,114 | 32 |
| Not given | 5,037 | 27 | 3,906 | 27 | 11,190 | 25 |
| Other | <10 | 0 | <10 | 0 | <10 | 0 |

**Table 24:** *Age profile of persons who have completed identity verification and have a DSS account*

| Age range | 2025 | % | 2024 | % | All time | % |
|---|---|---|---|---|---|---|
| Over 90 | 764 | 4 | 688 | 5 | 2159 | 5 |
| 80-89 | 3627 | 19 | 2872 | 20 | 8717 | 20 |
| 70-79 | 3302 | 18 | 2638 | 18 | 7745 | 17 |
| 60-69 | 2896 | 16 | 2290 | 16 | 7044 | 16 |
| 50-59 | 3894 | 21 | 3070 | 21 | 9212 | 21 |
| 40-49 | 2704 | 15 | 2063 | 14 | 6203 | 14 |
| 30-39 | 931 | 5 | 731 | 5 | 2175 | 5 |
| Under 30 | 417 | 2 | 281 | 2 | 914 | 2 |
| Not stated | 102 | 1 | 58 | 0 | 231 | 1 |
| | 18,637 | | 14,691 | | 44,400 | |

**Table 25:** *Top 10 countries of current residence for DSS account holders*

| Country | 2025 | 2024 | All time |
|---|---|---|---|
| Ireland | 17,941.00 | 14102 | 42776 |
| United Kingdom (others) | 255 | 167 | 555 |
| England | 147 | 166 | 379 |
| United States of America | 59 | 56 | 143 |
| Northern Ireland | 30 | 34 | 91 |
| Australia | 39 | 30 | 83 |
| Scotland | 21 | 12 | 44 |
| Germany | 19 | 15 | 39 |
| Spain | 18 | 7 | 38 |
| France | 15 | 12 | 37 |

**Table 26:** *Irish counties of current residence for DSS account holders*

| Country | 2025 | 2024 | All time |
|---|---|---|---|
| Dublin | 6,834.00 | 5515 | 16592 |
| Cork | 1819 | 1414 | 4340 |
| Galway | 886 | 758 | 2188 |
| Kildare | 1120 | 727 | 2420 |
| Wicklow | 782 | 608 | 1816 |
| Meath | 791 | 549 | 1792 |
| Limerick | 652 | 430 | 1405 |
| Kerry | 528 | 389 | 1205 |
| Tipperary | 407 | 377 | 1051 |
| Waterford | 326 | 370 | 907 |
| Wexford | 424 | 344 | 1046 |
| Louth | 401 | 354 | 995 |
| Clare | 395 | 308 | 930 |
| Mayo | 361 | 288 | 862 |
| Donegal | 328 | 253 | 816 |
| Kilkenny | 329 | 214 | 744 |
| Westmeath | 270 | 205 | 643 |
| Offaly | 218 | 150 | 489 |
| Sligo | 176 | 145 | 442 |
| Laois | 194 | 158 | 462 |
| Roscommon | 171 | 123 | 403 |
| Cavan | 121 | 112 | 309 |
| Carlow | 190 | 108 | 398 |
| Monaghan | 94 | 97 | 253 |
| Longford | 80 | 71 | 183 |
| Leitrim | 71 | 42 | 153 |
| **Total** | **17,968** | **14,109** | **42,844** |

**Table 27:** *Ethnicity of new DSS account holders per year and cumulative*

| Ethnicity | 2025 | 2024 | All time |
|---|---|---|---|
| Irish | 12,940.00 | 10016 | 30078 |
| Any other white background | 455 | 374 | 1091 |
| Other | 35 | 39 | 111 |
| African | 18 | 24 | 70 |
| Indian | 17 | 12 | 53 |
| Any other Asian background | 13 | 14 | 44 |
| Arab | 7 | 14 | 34 |
| Pakistani | 11 | 13 | 38 |
| Mixed | 17 | 15 | 46 |
| Irish traveller | 6 | 4 | 15 |
| Bangladeshi | <5 | <5 | <10 |
| Any other black background | <5 | <5 | <10 |
| Chinese | <5 | <5 | <10 |
| Roma | <5 | <5 | <10 |
| Not Given | 5,108 | 4,764 | 12,796 |

## Profile of DSS account holders

**Table 28:** *Age profile of appointers for decision-making assistance agreements by percentage 2024-2025*

| Age range | 2025 | 2024 |
|---|---|---|
| Over 90 | 7% | 20% |
| 80-89 | 45% | 33% |
| 70-79 | 19% | 19% |
| 60-69 | 9% | 7% |
| 50-59 | 8% | 11% |
| 40-49 | 3% | - |
| 30-39 | 4% | - |
| Under 30 | 6% | - |

**Table 29:** *Age profile of appointers for co-decision-making agreements by percentage 2024-2025*

| Age range | 2025 | 2024 |
|---|---|---|
| Over 90 | 7% | 7% |
| 80-89 | 26% | 33% |
| 70-79 | 13% | 13% |
| 60-69 | 11% | 15% |
| 50-59 | 13% | 10% |
| 40-49 | 6% | 7% |
| 30-39 | 4% | 7% |
| Under 30 | 20% | 8% |

**Table 30:** *Age profile of donors for registration of enduring powers of attorney by percentage 2024-2025*

| Age range | 2025 | 2024 |
|---|---|---|
| Over 90 | 9% | 7% |
| 80-89 | 44% | 40% |
| 70-79 | 32% | 34% |
| 60-69 | 11% | 14% |
| 50-59 | 3% | 4% |
| 40-49 | <1% | <1% |
| 30-39 | <1% | <1% |
| Under 30 | <1% | - |

**Table 31:** *Age profile of donors for registration of enduring powers of attorney by percentage 2024-2025*

| Age range | 2025 | 2024 |
|---|---|---|
| Over 90 | 21% | 0% |
| 80-89 | 60% | 0% |
| 70-79 | 19% | 42% |
| 60-69 | 0% | 55% |
| 50-59 | 0% | 3% |
| 40-49 | 0% | 0% |
| 30-39 | 0% | 0% |
| Under 30 | 0% | 0% |

**Table 32:** *Supporter profile of registered DMROs by percentage*

| Relationship of supporter | 2025 | 2024 |
|---|---|---|
| Non-panel member DMR | 82% | 83% |
| Panel member appointed DMR | 18% | 17% |

**Table 33:** *Supporter profile of registered DMROs by percentage*

| Relationship of supporter | 2025 | 2024 |
|---|---|---|
| Adult child of appointer | 39% | 22% |
| Spouse of appointer | 5% | 13% |
| Sibling of appointer | 26% | 27% |
| Parent of appointer | 15% | 13% |
| Niece or Nephew of appointer | 5% | 10% |
| Aunt or Uncle of appointer | >1% | 5% |
| Grandchild of appointer | >1% | 2% |
| Friend of appointer | 2% | 2% |
| Other | 7% | 7% |

## Current residence for applicants

**Table 34:** Applicant residence for a decision-making assistance agreement, co-decision-making agreement and enduring power of attorney by county

| County | DMMA 2025 | DMAA 2024 | CDMA 2025 | CDMA 2024 | EPA 2025 | EPA 2024 |
|---|---|---|---|---|---|---|
| Dublin | 51 | 41 | 41 | 38 | 1,963 | 1040 |
| Cork | 14 | <5 | 18 | 7 | 497 | 276 |
| Galway | 8 | <5 | 9 | 7 | 274 | 128 |
| Kildare | 6 | <5 | 6 | <5 | 232 | 128 |
| Meath | <5 | <5 | <5 | <5 | 146 | 104 |
| Kerry | <5 | <5 | 8 | <5 | 174 | 97 |
| Limerick | 5 | <5 | 9 | <5 | 190 | 78 |
| Waterford | <5 | <5 | <5 | <5 | 117 | 78 |
| Tipperary | 7 | <5 | 9 | <5 | 126 | 74 |
| Wicklow | 6 | <5 | 10 | 5 | 236 | 73 |
| Mayo | <5 | <5 | <5 | <5 | 120 | 57 |
| Louth | 5 | <5 | <5 | <5 | 127 | 54 |
| Clare | 5 | <5 | <5 | <5 | 107 | 54 |
| Wexford | <5 | <5 | 7 | <5 | 111 | 53 |
| Donegal | 7 | 5 | 4 | 7 | 85 | 51 |
| Kilkenny | <5 | <5 | <5 | <5 | 81 | 45 |
| Westmeath | <5 | <5 | <5 | 6 | 63 | 42 |
| Offaly | <5 | <5 | <5 | <5 | 65 | 36 |
| Sligo | <5 | <5 | <5 | <5 | 59 | 22 |
| Laois | 5 | <5 | <5 | <5 | 52 | 22 |
| Cavan | <5 | 8 | <5 | <5 | 33 | 20 |
| Carlow | <5 | <5 | <5 | <5 | 44 | 17 |
| Roscommon | <5 | <5 | 5 | <5 | 47 | 14 |
| Longford | <5 | <5 | <5 | <5 | 34 | 10 |
| Monaghan | <5 | <5 | <5 | <5 | 25 | 7 |
| Leitrim | <5 | <5 | <5 | <5 | 14 | 6 |
| Other | <5 | <5 | <5 | <5 | 8 | <5 |

**Table 35:** Registered decision-making representation orders by court 2024-2025

| Circuit | 2025 | 2024 |
|---|---|---|
| Dublin Circuit | 443 | 279 |
| Eastern Circuit | 174 | 88 |
| Cork Circuit | 98 | 59 |
| High Court | 91 | 88 |
| South Western Circuit | 84 | 43 |
| Midland Circuit | 77 | 37 |
| South Eastern Circuit | 62 | 51 |
| Western Circuit | 58 | 38 |
| Northern Circuit | 26 | 22 |

**Figure 1:** *Number of co-decision-making agreements registered and submitted by month*

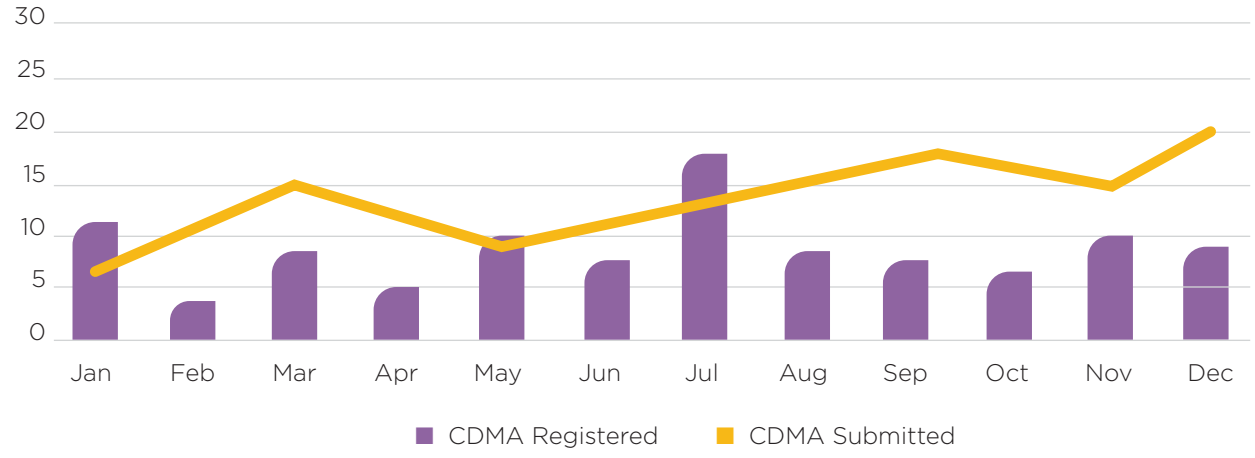



**Figure 2:** *Number of decision-making representative orders registered by month – Total and Wardship Court*

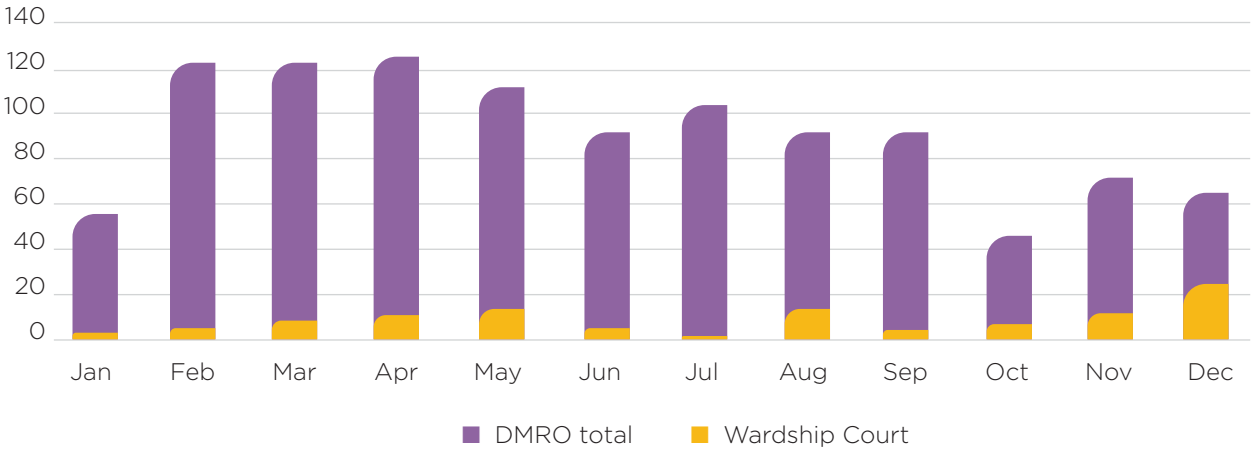


**Figure 5:** *Number of enduring powers of attorney registered and submitted by month*

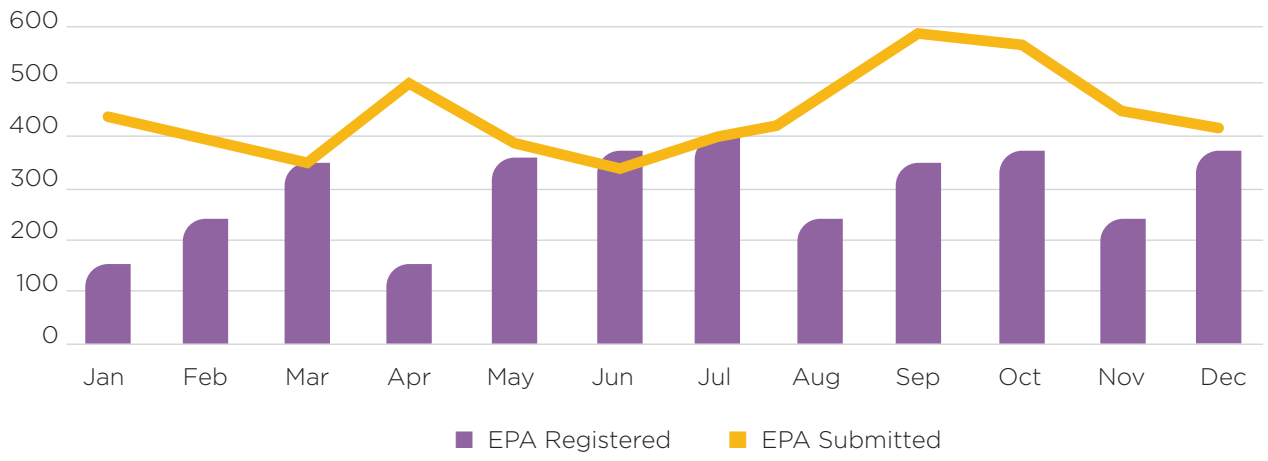
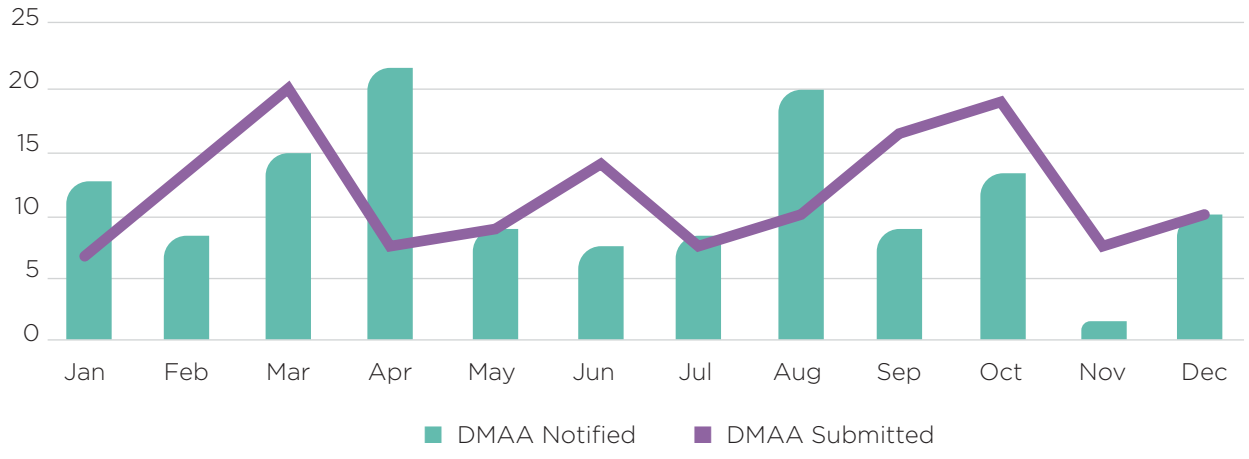



**Figure 6:** *Number of decision-making assistance agreements submitted and notifications accepted by month*



# APPENDIX 2

## Mental Health Tribunals Statistics

**Figure 1:** *Monthly Involuntary Admissions 2025*

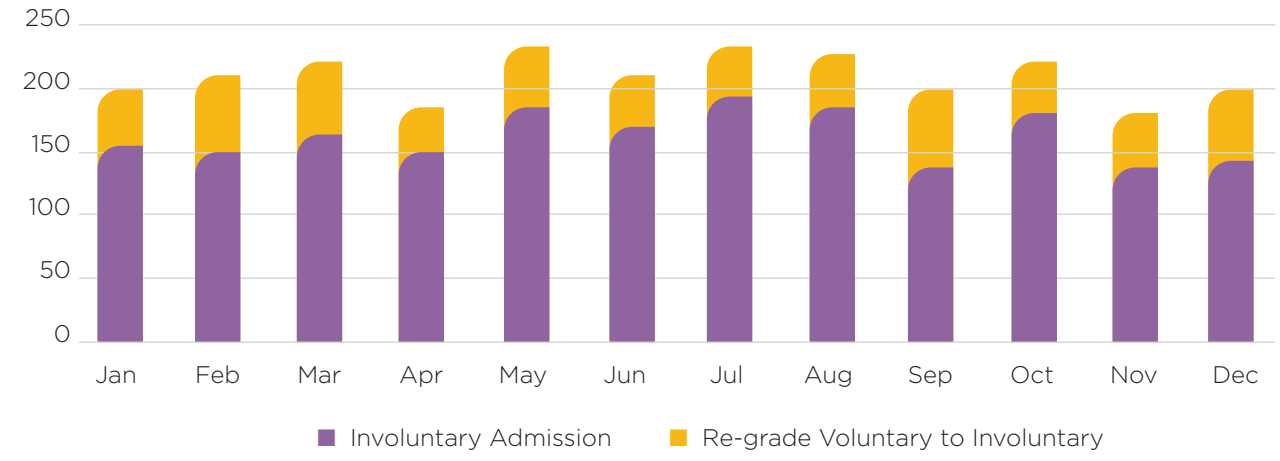



**Figure 2:** *Comparisons of total involuntary admissions 2021-2025*

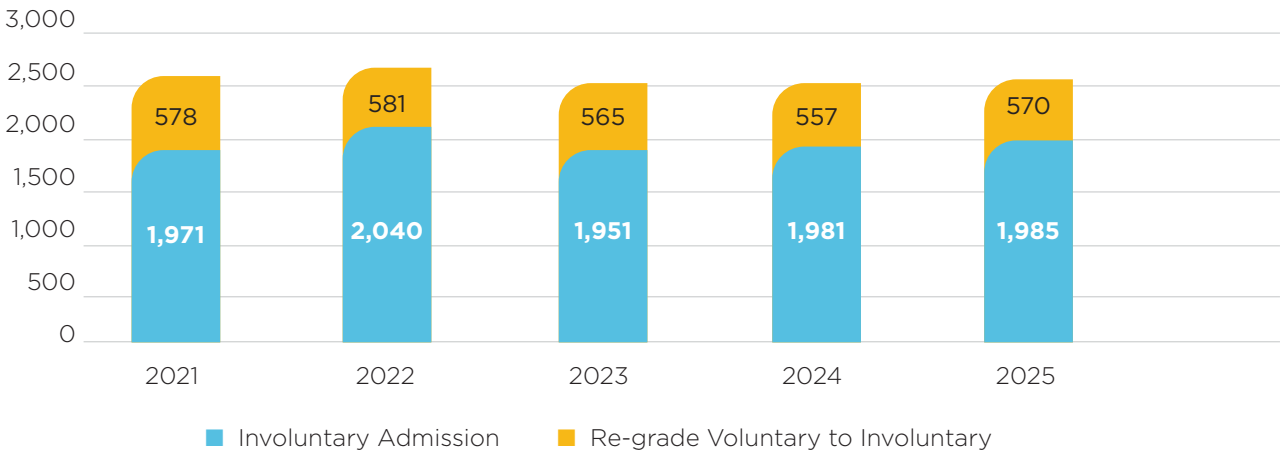


**Figure 3:** *Comparison of renewal orders 2021-2025*

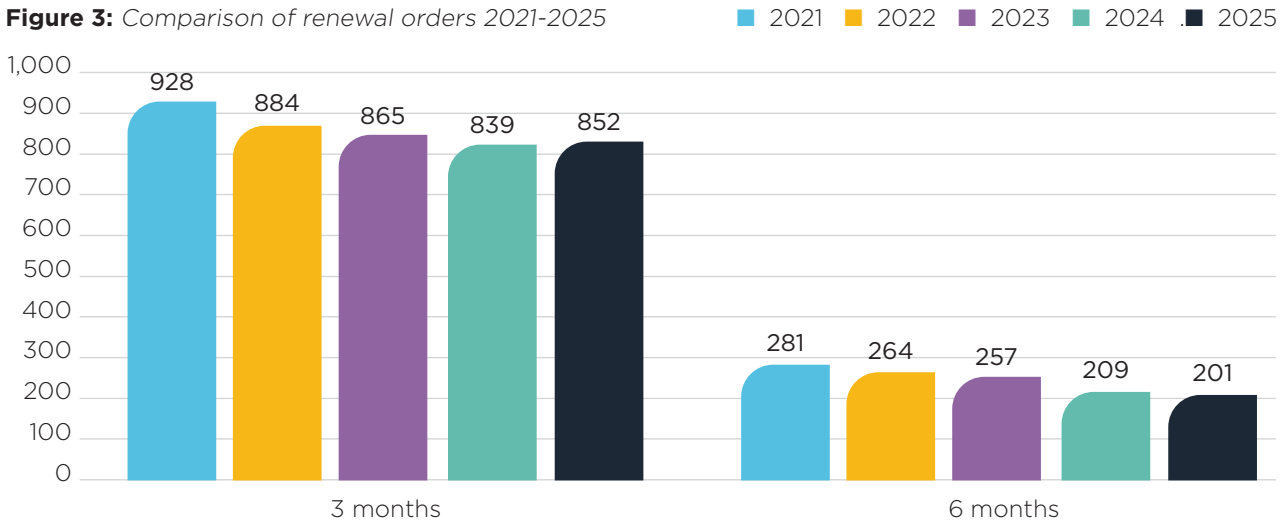



**Table 1:** *Involuntary Admission Rates for 2025 (Adult) by CHO Area and Independent Sector*[11]

| | Involuntary Admissions | Re-grade Voluntary to Involuntary | Total Involuntary Admission Rate |
|---|---|---|---|
| **HSE Dublin and Midlands** | 429 | 90 | 519 |
| **HSE Dublin and North East** | 448 | 105 | 553 |
| **HSE Dublin and South East** | 326 | 89 | 415 |
| **HSE Mid West** | 126 | 23 | 149 |
| **HSE South West** | 277 | 110 | 387 |
| **HSE West and North West** | 286 | 88 | 374 |
| **Independent Sector**[12] | 93 | 65 | 158 |
| **TOTAL (Exclusive of Independent sector)** | 1,892 | 505 | 2,397 |
| **TOTAL (Inclusive of Independent sector)** | 1,985 | 570 | 2,555 |

[12] There are nine independent approved centres

**Figure 4:** *Number of Orders Revoked before Hearing by Responsible Consultant Psychiatrists for Years 2021 to 2025*

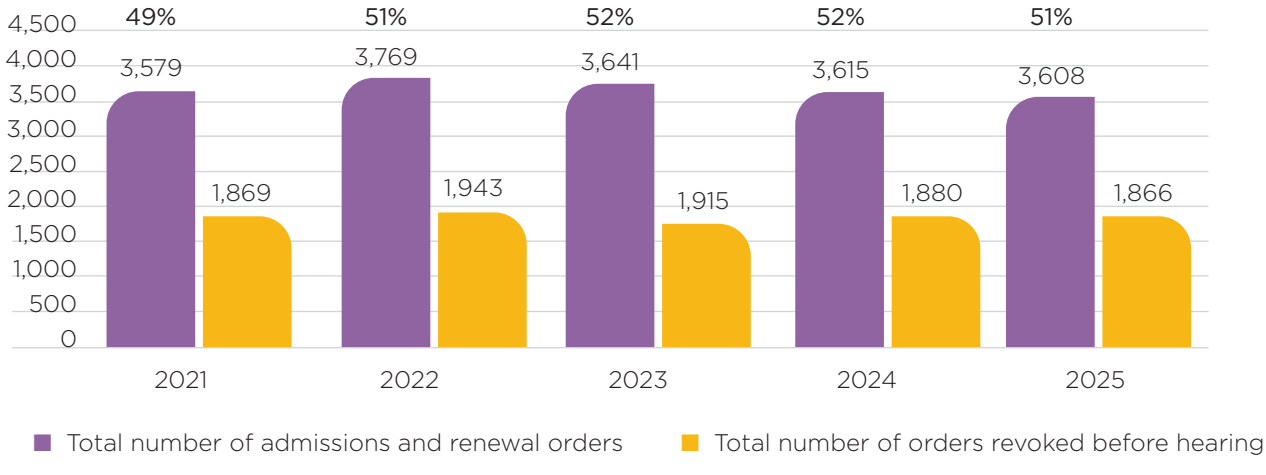


**Table 2:** *Summary of Revoked Decisions*

| No | Issues | Number of Revocations | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | No mental disorder (section 3 not met) | 103 | 16 | 7 | 5 | 9 | 6 | 10 | 8 | 14 | 11 | 3 | 6 | 8 |
| **2** | Errors with sections 9 to 12 (applications and recommendations for involuntary admission) and the related Forms | 23 | 6 | 1 | 2 | 2 | 2 | 3 | 2 | 2 | 1 | 1 | 0 | 1 |
| **3** | Errors with sections 14 and 15 (admission and renewal orders for involuntary admission)) and the related Forms | 94 | 2 | 3 | 9 | 12 | 10 | 8 | 9 | 14 | 3 | 7 | 5 | 12 |
| **4** | Patient Notification Form issues (information to be provided to the patient from the admission and renewal orders) | 7 | 2 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| **5** | Errors with sections 23 and 24 (admission form where someone is regraded) and the related Form | 25 | 0 | 2 | 5 | 2 | 0 | 4 | 2 | 2 | 1 | 4 | 0 | 3 |
| **6** | Other non-compliance issues to those referred to above | 10 | 1 | 0 | 2 | 0 | 0 | 1 | 0 | 1 | 1 | 1 | 3 | 0 |
| **7** | No mental disorder (section 3 not met) and non-compliance issues | 25 | 4 | 3 | 0 | 4 | 2 | 0 | 2 | 1 | 0 | 5 | 1 | 3 |
| **8** | Other | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 |
| | **Total** | **289** | **31** | **18** | **25** | **29** | **20** | **26** | **23** | **34** | **18** | **21** | **16** | **28** |

**Figure 5:** *Length of stay for individuals revoked in 2025*

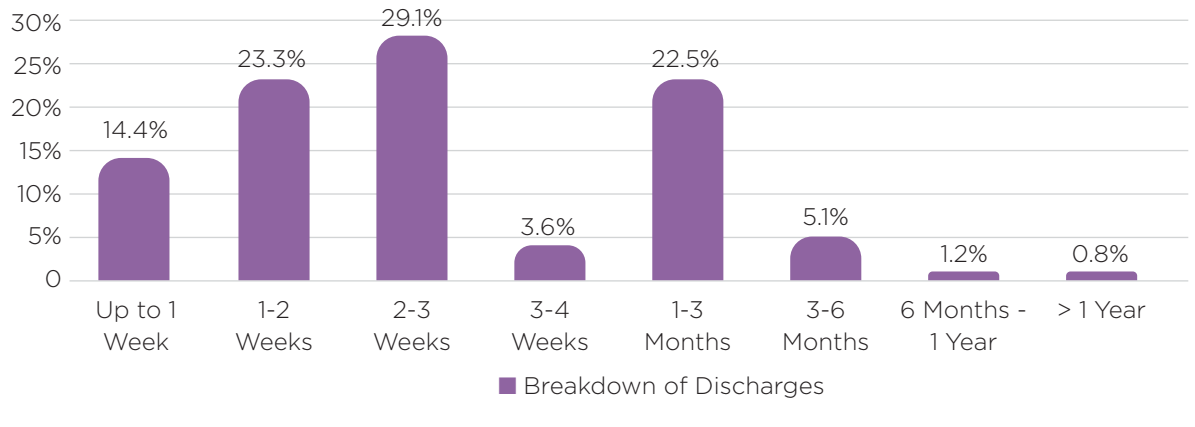


**Figure 6:** *Analysis of Applicants for Involuntary Admissions from the Community in 2025*

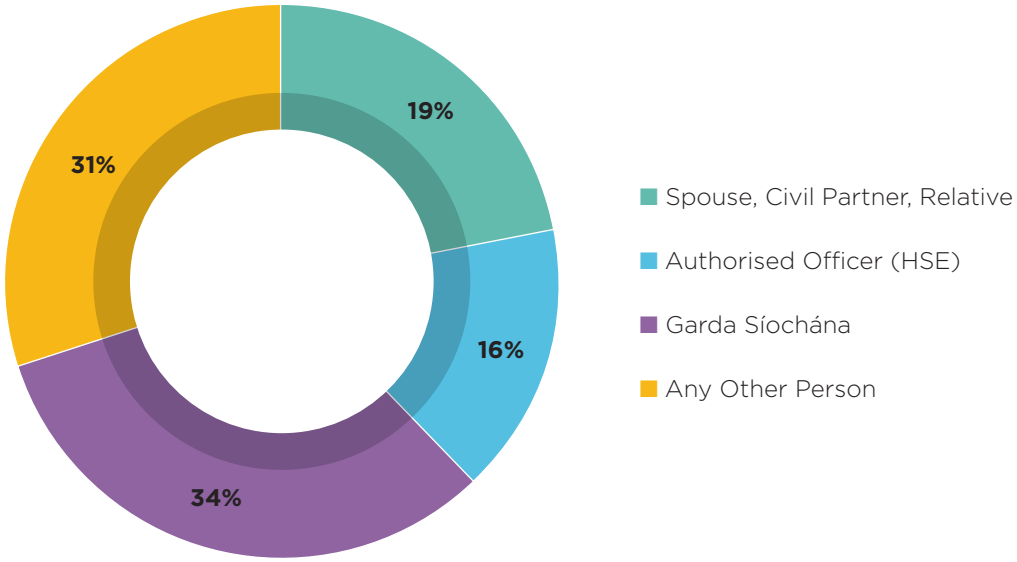



**Figure 7:** *Analysis of Applicants of Involuntary Admissions from Community from 2016 to 2025*

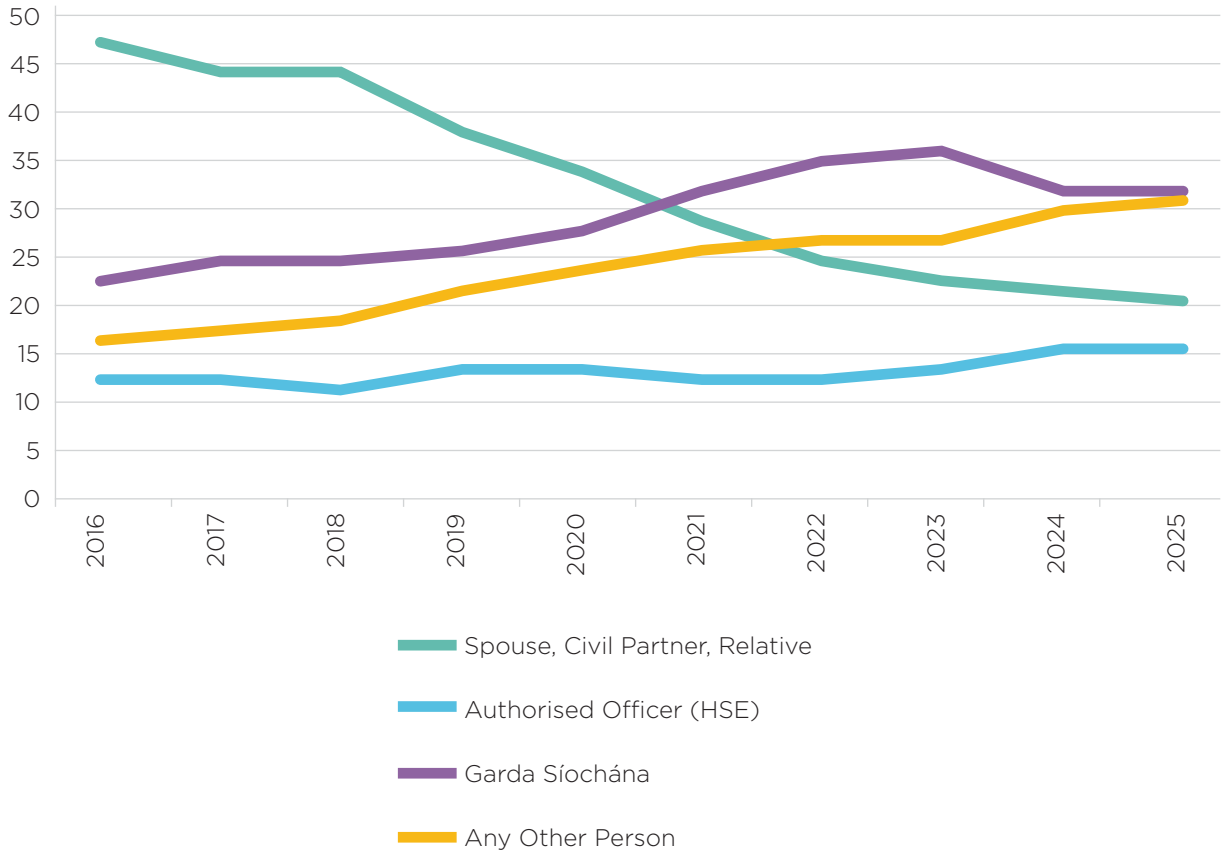


**Table 3:** *Analysis of Applicants of Involuntary Admissions from the Community by Approved Centre*

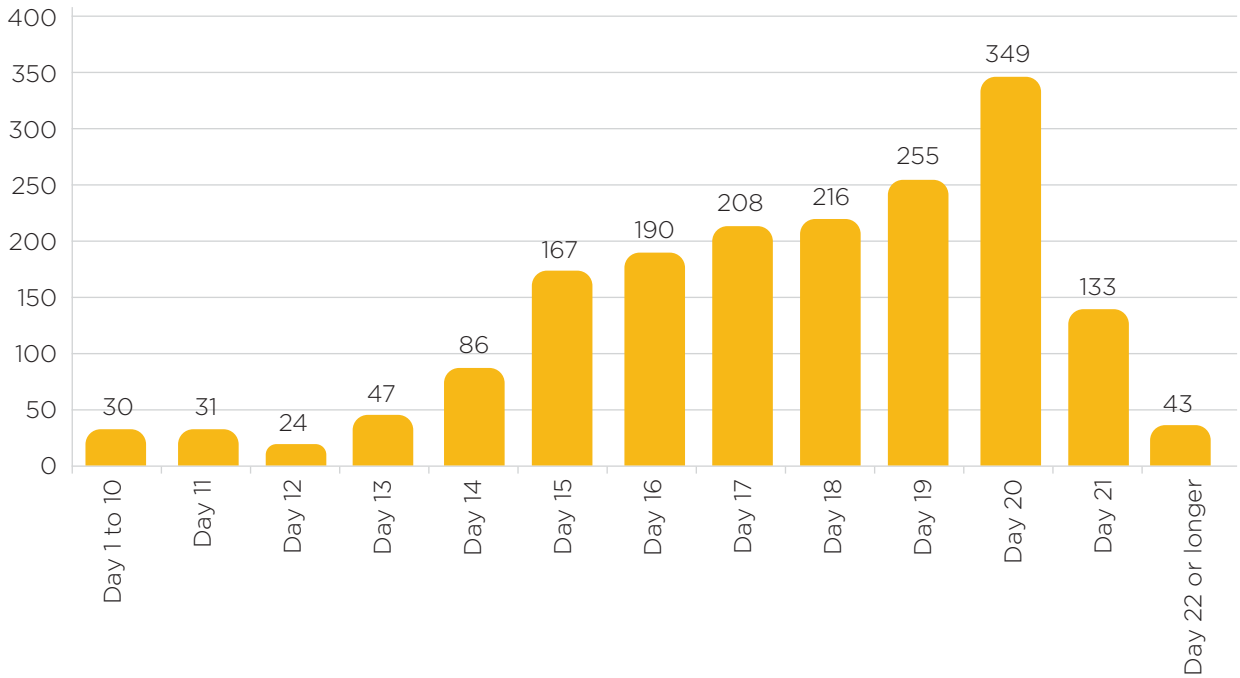
| Approved Centre | Maximum number of beds* | Form 1 | Form 2 | Form 3A/3B | Form 4 | Total |
|---|---|---|---|---|---|---|
| **HSE Dublin and South East** | | | | | | |
| Aidan's Residential Healthcare Unit | 20 | 0 | 2 | 0 | 0 | 2 |
| Avonmore & Glencree Units, Newcastle Hospital | 46 | 3 | 10 | 22 | 27 | 62 |
| Department of Psychiatry, St Luke's Hospital | 44 | 10 | 23 | 24 | 14 | 71 |
| Department of Psychiatry, University Hospital Waterford | 44 | 17 | 11 | 59 | 26 | 113 |
| Elm Mount Unit, St Vincent's University Hospital | 39 | 7 | 17 | 19 | 35 | 78 |
| **Sub-Total** | | **37** | **63** | **124** | **102** | **326** |
| | | **11.4%** | **19.3%** | **38%** | **31.3%** | |
| **HSE Dublin and Midlands** | | | | | | |
| Acute Psychiatric Unit, Tallaght Hospital | 52 | 20 | 22 | 36 | 43 | 121 |
| Admission Unit & St Edna's Unit, St Loman's Hospital | 44 | 6 | 15 | 14 | 5 | 40 |
| Department of Psychiatry, Midland Regional Hospital, Portlaoise | 46 | 25 | 12 | 37 | 20 | 94 |
| Jonathan Swift Clinic | 47 | 6 | 24 | 21 | 47 | 98 |
| Lakeview Unit, Naas General Hospital | 29 | 15 | 17 | 25 | 12 | 69 |
| Maryborough Centre, St Fintan's Hospital | 16 | 0 | 1 | 0 | 0 | 1 |
| St Bridget's Ward & St Marie Goretti's Ward, Cluain Lir Care Centre | 42 | 3 | 0 | 0 | 3 | 6 |
| **Sub-total** | | **75** | **91** | **133** | **130** | **429** |
| | | **17.5%** | **21.2%** | **31%** | **30.3%** | |
| **HSE Dublin and North East** | | | | | | |
| Acute Psychiatric Unit, Cavan General Hospital | 25 | 4 | 10 | 9 | 5 | 28 |
| Ashlin Centre | 46 | 36 | 7 | 36 | 50 | 129 |
| Department of Psychiatry, Connolly Hospital | 47 | 16 | 8 | 19 | 37 | 80 |
| Drogheda Department of Psychiatry | 46 | 26 | 12 | 35 | 25 | 98 |
| Phoenix Care Centre | 54 | 2 | 2 | 3 | 4 | 11 |

| Approved Centre | Maximum number of beds* | Form 1 | Form 2 | Form 3A/3B | Form 4 | Total |
|---|---|---|---|---|---|---|
| St Aloysius Ward, Mater Misericordiae University Hospital | 13 | 3 | 0 | 9 | 12 | 24 |
| St Vincent's Hospital Fairview | 45 | 15 | 5 | 21 | 37 | 78 |
| **Sub-total** | | **102** | **44** | **132** | **170** | **448** |
| | | **22.8%** | **9.8%** | **29.5%** | **37.9%** | |
| **HSE Mid West** | | | | | | |
| Acute Psychiatric Unit 5B, University Hospital Limerick | 50 | 12 | 9 | 26 | 20 | 67 |
| Acute Psychiatric Unit, Ennis Hospital | 39 | 5 | 19 | 28 | 6 | 58 |
| Tearmann Ward, St Camillus' Hospital | 13 | 0 | 1 | 0 | 0 | 1 |
| **Sub-total** | | **17** | **29** | **54** | **26** | **126** |
| | | **13.5%** | **23%** | **42.9%** | **20.6%** | |
| **HSE South West** | | | | | | |
| Acute Mental Health Unit, Cork University Hospital | 50 | 39 | 7 | 19 | 32 | 97 |
| Carraig Mor Centre | 18 | 1 | 0 | 2 | 3 | 6 |
| Centre for Mental Health Care & Recovery, Bantry General Hospital | 18 | 9 | 0 | 8 | 8 | 25 |
| Sliabh Mis Mental Health Admission Unit, University Hospital Kerry | 34 | 2 | 20 | 14 | 5 | 41 |
| St Michael's Unit, Mercy University Hospital | 46 | 22 | 5 | 27 | 24 | 78 |
| Units 2, 3, 4, and Unit 8 (Floor 2), St Stephen's Hospital | 69 | 19 | 1 | 5 | 5 | 30 |
| **Sub-Total** | | **92** | **33** | **75** | **77** | **277** |
| | | **33.2%** | **11.9%** | **27.1%** | **27.8%** | |
| **HSE West and North West** | | | | | | |
| Adult Acute Mental Health Unit, University Hospital Galway | 50 | 14 | 10 | 26 | 27 | 77 |
| Adult Mental Health Unit, Mayo University Hospital | 32 | 16 | 15 | 34 | 11 | 76 |
| AMHU, Sligo University Hospital | 25 | 3 | 4 | 27 | 9 | 43 |
| Department of Psychiatry, Letterkenny University Hospital | 34 | 7 | 14 | 37 | 11 | 69 |
| Department of Psychiatry, Roscommon University Hospital | 24 | 1 | 7 | 4 | 6 | 18 |
| St Anne's Unit, Sacred Heart Hospital | 8 | 2 | 0 | 0 | 0 | 2 |
| Woodview | 15 | 0 | 1 | 0 | 0 | 1 |
| **Sub-total** | | **43** | **51** | **128** | **64** | **286** |
| | | **15%** | **17.8%** | **44.8%** | **22.4%** | |

| Approved Centre | Maximum number of beds* | Form 1 | Form 2 | Form 3A/3B | Form 4 | Total |
|---|---|---|---|---|---|---|
| **Independent** | | | | | | |
| Bloomfield Hospital | 131 | 0 | 1 | 1 | 1 | 3 |
| Highfield Hospital | 116 | 1 | 1 | 0 | 1 | 3 |
| Nua Healthcare | 50 | 0 | 1 | 0 | 2 | 3 |
| St John of God University Hospital | 168 | 6 | 1 | 24 | 34 | 65 |
| St Patrick's University Hospital | 208 | 12 | 1 | 3 | 3 | 19 |
| **Sub-total** | | **19** | **5** | **28** | **41** | **93** |
| | | 20.4% | 5.4% | 30.1% | 44.1% | |
| **TOTAL** | | **385** | **316** | **674** | **610** | **1985** |
| | | 19.4% | 15.9% | 34.1% | 30.7% | |

*Registered beds may change across the year if there is a change to the maximum bed capacity of a centre at re-registration.

**Figure 8:** *Breakdown of Hearings in 2025 over 21 day period*[8]




1. In relation to the hearings heard after the 21 days these relate to hearings that were extended (as allowed under the Act) or relate to section 28 hearings after an order is revoked.

**Figure 9:** *Number of hearings and % of orders revoked at hearing 2025*

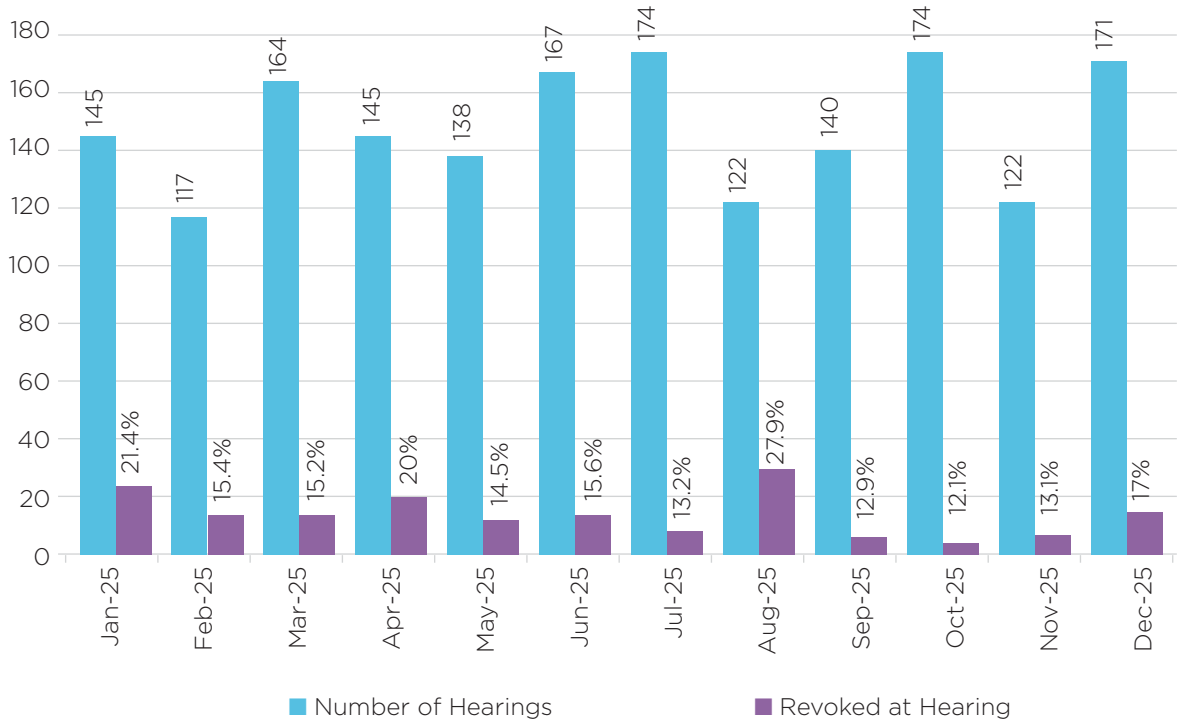



**Table 4:** *Analysis by Gender and Age of 2025 Involuntary Admissions*

| Age | Male | Female | % Gender |
|---|---|---|---|
| 18 – 24 | 234 | 95 | 71% male |
| 25 – 34 | 326 | 220 | 60% male |
| 35 – 44 | 295 | 266 | 53% male |
| 45 – 54 | 248 | 245 | 50% male/female |
| 55 – 64 | 128 | 160 | 56% female |
| 65 + | 144 | 194 | 57% female |
| **Total** | **1,375** | **1,180** | **54% male** |

**Table 5:** *Analysis by Gender and Admission type of 2025 Involuntary Admissions*

| Gender | Form 6 | Form 13 | Total | % |
|---|---|---|---|---|
| Female | 893 | 287 | 1,180 | 46% |
| Male | 1,092 | 283 | 1,375 | 54% |
| **Total** | **1,985** | **557** | **2,555** | **100%** |

**Table 6:** *Analysis by Gender, Age and Admission type of 2025 Involuntary Admissions*

| Age | Form 6 | Form 6 Female | Form 6 Male | Form 13 | Form 13 Female | Form 13 Male | Total | % |
|---|---|---|---|---|---|---|---|---|
| 18 – 24 | 252 | 67 | 185 | 77 | 28 | 49 | 329 | 12.9% |
| 25 - 34 | 406 | 156 | 250 | 140 | 64 | 76 | 546 | 21.4% |
| 35 - 44 | 442 | 203 | 239 | 119 | 63 | 56 | 561 | 21.9% |
| 45 - 54 | 401 | 201 | 200 | 92 | 44 | 48 | 493 | 19.3% |
| 55 - 64 | 227 | 122 | 105 | 61 | 38 | 23 | 288 | 11.3% |
| 65 and over | 257 | 144 | 113 | 81 | 50 | 31 | 338 | 13.2% |
| **Total** | **1,985** | **893** | **1092** | **557** | **287** | **283** | **2,555** | **100%** |

**Table 7:** *Breakdown of Mental Disorder on admission/renewal as defined in section 3 of the 2001 Act for the period 1 January 2024-31 December 2024*

| Category | Form 6 | % | Form 13 | % | Form 7 | % | Total | % |
|---|---|---|---|---|---|---|---|---|
| 3(1)(a) only | 121 | 6% | 45 | 8% | 13 | 1% | 179 | 5% |
| 3(1)(b) only | 1,321 | 67% | 336 | 59% | 868 | 83% | 2525 | 70% |
| 3(1)(a) and 3(1)(b) | 543 | 27% | 189 | 33% | 172 | 16% | 904 | 25% |
| **Total** | **1985** | | **570** | | **1053** | | **3608** | |

The Consultant Psychiatrist gives their opinion that the patient continues to suffer from a mental disorder where:

3(1)(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,

OR

3(1)(b)(i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an Approved Centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission,

AND

3(1)(b)(ii) the reception, detention and treatment of the person concerned in an Approved Centre would be likely to benefit or alleviate the condition of that person to a material extent.

OR 3(1)(a) (as above) and 3(1)(b) (as above).

# APPENDIX 3

## Mental Health Commission Membership and Meeting Attendance 2025

| Name | 23/1 | 20/2 | 20/3 | 15/05 | 26/06 | 17/07 | 18/09 | 16/10 | 11/12 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Dr John Hillery | Y | Y | Y | Y | Y | Y | Y | N | Y | 8/9 |
| Dr Margo Wrigley | Y | Y | N | N/A | N/A | N/A | N/A | N/A | N/A | 2/3 |
| Dr Michael Drumm | Y | Y | Y | N/A | N/A | N/A | N/A | N/A | N/A | 3/3 |
| Dr Orla Healy | Y | Y | Y | Y | N | Y | Y | Y | Y | 8/9 |
| Martina McGuinness | N | Y | Y | Y | Y | Y | Y | Y | Y | 8/9 |
| Linda Curran | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9/9 |
| Dr Joseph Duffy | Y | Y | N | Y | Y | Y | Y | Y | Y | 8/9 |
| Rowena Mulcahy | Y | Y | Y | N/A | N/A | N/A | N/A | N/A | N/A | 3/3 |
| Dr John Cox | Y | N | Y | Y | Y | Y | Y | Y | Y | 8/9 |
| Catherine Cocoman | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9/9 |
| Tammy Donaghy | N | Y | Y | Y | Y | N | Y | N | Y | 6/9 |
| Ray Burke | Y | Y | N | Y | Y | Y | Y | Y | Y | 8/9 |
| Fionn Fitzpatrick | N | N | Y | Y | N | N | N | N | N | 2/9 |
| Ian O'Grady | N/A | N/A | N/A | Y | Y | Y | N | Y | N | 4/6 |
| Joanna Ralston | N/A | N/A | N/A | Y | Y | N | Y | Y | Y | 5/6 |
| Mary Davoren | N/A | N/A | N/A | N | Y | Y | Y | Y | Y | 5/6 |

# APPENDIX 4

## FARC Membership and Meeting Attendance 2025

| Committee Member | 12/3 | 18/6 | 14/7 | 08/09 | 01/12 | Total |
|---|---|---|---|---|---|---|
| Dr Orla Healy (Chair) (CM) | 1 | N/A | N/A | N/A | N/A | 1/1 |
| Dr John Cox (CM) | Y | Y | Y | Y | Y | 5/5 |
| Ray Burke | N/A | Y | N | N | Y | 2/4 |
| Martina McGuinness (CM) | Y | Y | Y | Y | Y | 5/5 |
| Kevin Roantree (EM) | Y | Y | Y | Y | Y | 5/5 |
| Audrey Houlihan (EM) | N | Y | Y | Y | N | 3/5 |
| Cliff O'Keeffe (EM) | N | Y | Y | Y | Y | 4/5 |
| Dearbhla Fitzsimons (EM) | N | Y | Y | Y | Y | 4/5 |
| Josephine O'Reilly (EM) | Y | N | Y | Y | Y | 4/5 |

(CM = Commission Member and EM = External Member)

# APPENDIX 5

## Human Rights Committee Membership and Meeting Attendance 2025

| Committee Member | 3/3 | 14/6 | Total |
|---|---|---|---|
| Dr Michael Drumm (Chair) (CM) | Y | N/A | 1/1 |
| Catherine Cocoman (CM) | Y | Y | 2/2 |
| Linda Curran (CM) | Y | Y | 2/2 |
| Joanna Ralston | N/A | Y | 1/1 |
| Mary Davoren | N | N/A | 0/1 |
| Catherine Carty (EM) | Y | N | 1/2 |
| Mary Donnelly (EM) | N | N/A | 0/1 |
| Blezzing Dada (EM) | Y | Y | 2/2 |
| Charles O'Mahony (EM) | Y | Y | 2/2 |
| Claire Hendrick (EM) | N | N | 0/2 |

(CM = Commission Member and EM = External Member)

# Notes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