

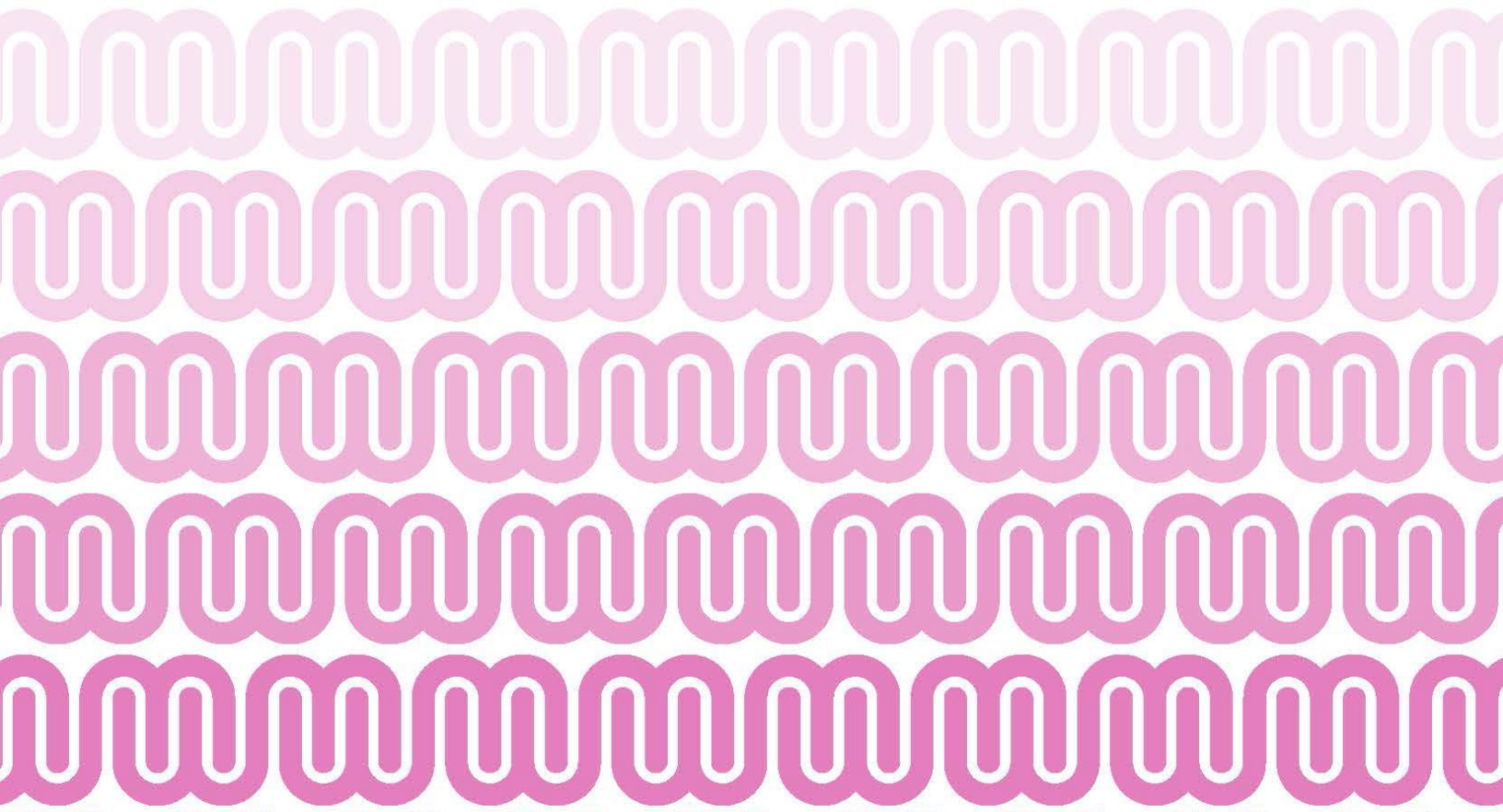


mental welfare
commission for scotland

Decisions about technology

Good practice guide

October 2026



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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1. Introduction

We first published guidance on the use of technology in 2007 as *Safe to wander*. Since then, there has been a significant increase in the availability, affordability and sophistication of technologies that can support people in their care and treatment.

Reflecting these developments, the Mental Welfare Commission for Scotland published *Decisions about technology* in 2015. That guidance focused primarily on the use of telecare to support people affected by dementia, although many of the principles were relevant to a wider range of people with mental illness, learning disability, autism, dementia and related conditions. The guidance was updated in 2020 with minor revisions and again in 2025.

Technological developments have continued at pace and the Commission has seen a growing number of enquiries from individuals, families, carers and professionals about the appropriate use of technology in health and social care. This revised edition reflects those developments by updating the legal and policy context, incorporating current legislation, case law and good practice, and broadening the scope of the guidance to address a wider range of technologies and the human rights issues they may raise.

This guide sets out the principles and considerations that should inform decisions about the use of technology when supporting people with mental illness, learning disability, dementia, autism and related conditions. Throughout, the emphasis is on ensuring that technology is used in a way that promotes independence, respects autonomy and dignity, and protects the rights of the individual.

2. About this guidance

This guidance is intended for individuals, families, carers and professionals who are considering the use of technology to support people with mental illness, dementia, learning disability, autism or related conditions. It aims to support decision-making where technology may promote independence, safety and wellbeing, while respecting the rights, wishes and preferences of the individual.

The Commission has a statutory role in protecting and promoting the rights of people with mental illness, learning disability, dementia and related conditions. Many people are able to make their own decisions about the use of technology and should be supported to do so. Others may have impaired decision-making ability or lack capacity to make particular decisions. In some circumstances, lawful restrictions on an individual's rights or freedoms may be necessary to provide appropriate care, treatment or support. Where this is the case, decisions should be informed by the relevant legal framework, human rights principles and the views, wishes and preferences of the individual.

As technology continues to evolve, the principles set out in this guidance are intended to assist decision-making across a wide range of settings, including hospitals, registered care services, supported accommodation and people's own homes. The guidance is intended to remain relevant regardless of the specific technology being considered.

The Commission does not seek to provide technical advice on the suitability or operation of particular technologies. Rather, this guidance focuses on the legal, ethical and human rights considerations that should inform decisions about their use. Sources of further information are provided at the end of this document.

This guidance does not constitute legal advice. The Commission's expertise lies in promoting rights-based decision-making and supporting the lawful and ethical use of technology where decisions may be affected by mental disorder or impaired decision-making ability. Individual cases may require specific legal advice.

3. Digital health and assistive technologies – what's available?

Throughout this guidance we use the terms *digital health care* and *assistive technology*. These are broad terms encompassing a wide range of digital, electronic and other technologies used to support communication, assessment, treatment, care and independent living. They may promote health, wellbeing, safety, participation and autonomy, and may be used in hospitals, registered care services, supported accommodation and people's own homes.

The examples below illustrate some of the technologies currently in use. They are not intended to be exhaustive. Technology continues to evolve rapidly, and the principles set out in this guidance are intended to apply equally to existing technologies, emerging innovations and future developments.

3.1. Mobile phones

Mobile phones and tablets have become an integral part of everyday life and are increasingly used to support health, wellbeing and independent living. They provide opportunities to communicate with others, access health and social care services, obtain information, and support individuals to manage their care and treatment.

Modern mobile devices incorporate a wide range of accessibility features that may benefit people with mental illness, learning disability, dementia, autism and related conditions. These include voice activation, speech recognition, text-to-speech and speech-to-text functions, visual and hearing accessibility features, prompts and reminders, location services and emergency assistance.

Mobile devices can also support individuals through a wide range of applications, including medication reminders, digital safety plans, wellbeing and relaxation tools, symptom monitoring, appointment management, video consultations, communication aids and health management applications. Where appropriate and with the individual's agreement or other lawful authority, they may also enable location-sharing or the remote sharing of health information with family members, carers or healthcare professionals.

The increasing use of mobile devices also raises important issues relating to privacy, confidentiality and information governance. Decisions about their use should take account of the individual's wishes, decision-making capacity, privacy, dignity and human rights, together with the purpose for which information is collected, shared or stored.

When used appropriately, mobile devices may promote independence, communication and participation, while reducing the need for more restrictive interventions. Their use should always be proportionate to the individual's needs and supported by appropriate safeguards where information is shared or monitoring functions are used.

3.2. Remote monitoring

Remote monitoring uses a wide range of technologies to collect and transmit information about an individual's health, wellbeing, safety or location to family members, carers or health and social care professionals. Information may be monitored in real time or reviewed periodically to support assessment, treatment, care planning and early intervention.

Examples include:

- Mobile applications, as discussed above.
- Wearable devices such as community alarm pendants, fall detectors, seizure detection devices and personal emergency response systems that can actively or automatically summon assistance.
- Medical devices capable of securely transmitting clinical information to healthcare professionals. Examples include continuous glucose monitoring systems, insulin pumps and CPAP devices that share information with healthcare services to support monitoring, treatment and ongoing care.
- Wearable devices that monitor physiological measures such as heart rate, physical activity, sleep patterns and other health indicators.
- Boundary or location-monitoring technologies, such as wearable devices that alert others if an individual moves beyond a predetermined area.
- Smart home technologies that use sensors to detect movement, sound, door opening, environmental changes or other indicators that may suggest an individual requires assistance.
- Global Positioning System (GPS) technologies incorporated into mobile devices, watches, shoe insoles, key fobs or other equipment, allowing location information to be shared where appropriate.
- Video consultation and communication systems that enable remote assessment, welfare checks and communication between individuals, families, carers and professionals.

Remote monitoring may promote independence, improve access to health and social care, support earlier intervention and provide reassurance to individuals and those involved in their care. However, it may also involve the collection, storage and sharing of sensitive personal information and, in some circumstances, the monitoring of an individual's activities or movements.

The use of remote monitoring should always be based on a clear benefit to the individual and should take account of their wishes, decision-making capacity, privacy, dignity and human rights. Where information is shared or monitoring functions are used, there should be appropriate consent or other lawful authority together with suitable arrangements for information governance, security and regular review.

Case example - Mrs J: drop in technologies (registered care settings)

Mrs J is an 80-year-old woman with dementia who lives in a care home. Her daughter lives overseas and holds a welfare power of attorney that has been activated following an assessment that Mrs J lacks capacity to make certain welfare decisions. To help them stay in contact, Mrs J has been provided with a tablet that allows video calls. The device also has a feature that allows her daughter to connect directly to the tablet without Mrs J having to answer the call.

What should be considered in Mrs J's case?

- *What are Mrs J's wishes and feelings about receiving video calls in this way? Is she able to accept or decline contact when she wishes?*
- *What support has been provided to help Mrs J understand and express her views about the technology? Has supported decision-making been maximised?*
- *Is the proposed arrangement consistent with the principles of the Adults with Incapacity (Scotland) Act 2000? In particular, does it provide a clear benefit and represent the least restrictive option?*
- *Does Mrs J understand when someone is connecting to the device? Does she find the experience reassuring, confusing or distressing? How have staff assessed this over time?*
- *How will the privacy and dignity of Mrs J, other people living in the care home and members of staff be protected during video calls?*
- *Are there appropriate arrangements for when and how the technology will be used, who may initiate calls and how any concerns will be addressed?*

Is there a care or support plan that records the purpose of the technology, the anticipated benefits, any risks identified, and arrangements for regular review?

3.3. Sensor-based technologies

Sensor-based monitoring technologies, including infra-red and other contact-free systems, are increasingly used to support health, wellbeing and safety. They may monitor movement, breathing, pulse, sleep patterns or other physiological indicators without requiring the individual to wear a device. Some systems can also generate images or short video clips, particularly in low-light conditions, or transmit information to family members, carers or healthcare professionals.

These technologies are increasingly used in hospitals, registered care services and people's own homes to support assessment, monitoring and care. The legal, ethical and human rights considerations arising from their use are discussed later in this guidance.

3.4. Closed-circuit television (CCTV)

Video monitoring systems, including closed-circuit television (CCTV), are used in a variety of settings, including hospitals, registered care services and private homes. They may be used for security purposes, to control access to buildings, to support the care of individuals where there are concerns about safety or significant distress, or to enable remote assessment and observation.

Video monitoring may assist staff to assess situations remotely, support timely intervention and, in some circumstances, reduce the need for more intrusive observation. It may also form part of wider sensor-based monitoring systems.

Video monitoring may take place in communal areas or, in some circumstances, private spaces such as bedrooms. The legal, ethical and human rights considerations arising from its use are discussed later in this guidance.

3.5. Video consultations

Video consultation services, such as NHS Scotland's Near Me, enable individuals to attend health and social care appointments remotely using a secure video connection. Video consultations may be appropriate where they are clinically suitable and reflect the needs and preferences of the individual.

Video consultations can improve access to care by reducing travel, enabling family members, carers or advocates to participate where appropriate, and supporting access for people who might otherwise experience barriers to attending appointments. They can also support communication between professionals and contribute to more flexible models of care.

Near Me can be accessed using a smartphone, tablet, laptop or desktop computer with a camera, microphone and internet connection. The appropriate method of consultation should be determined by the nature and purpose of the appointment, clinical considerations, and the individual's needs and preferences. Video consultation should not be regarded as the default where face-to-face interaction is more appropriate.

Further guidance on the appropriate use of video consultations is available from [NHS Scotland](#).

4. Assess and plan

Digital health care and assistive technology should be considered where they have the potential to promote an individual's independence, wellbeing, safety or access to care.

Technology may support communication, improve the monitoring of health conditions, reduce identified risks or enable an individual to remain living in their preferred environment.

However, technology should not be introduced simply because it is available or because it makes care more convenient for others. Decisions should always be centred on the needs, wishes, rights and preferences of the individual.

Where the proposed use of technology has the potential to restrict an individual's liberty, privacy, autonomy or dignity, or involves monitoring or surveillance, a structured, outcome-focused assessment should be undertaken before it is introduced.

The individual should be fully involved in that assessment wherever possible, with appropriate support to participate in decision-making. Family members, carers, welfare attorneys, welfare guardians, independent advocates and others with an interest in the person's welfare should be involved where appropriate and consistent with the relevant legal framework.

The assessment should identify the individual's strengths, needs and desired outcomes, together with the potential benefits, risks and burdens associated with the proposed use of technology.

It should also consider the range of reasonable options available to achieve those outcomes, including whether technology represents the least restrictive and most appropriate approach in the individual's particular circumstances.

Before introducing digital health care or assistive technology, consideration should be given to factors that may be contributing to the presenting concerns. These include, but are not limited to:

- **Physical health** – Has an appropriate physical health assessment been undertaken? This should include consideration of pain, delirium, sensory impairment, medication review, adverse drug effects and untreated physical illness.
- **Psychological and emotional wellbeing** – Has the individual experienced recent psychological distress, trauma, bereavement, relationship difficulties or deterioration in their mental health? Are they able to communicate these experiences, and have they had access to appropriate psychological or psychiatric assessment?

- **Environmental and social factors** – Does the individual's environment meet their needs? Are they able to participate in meaningful activity, maintain relationships and opportunities for social interaction? Could changes to the environment reduce the need for technological intervention?
- **Communication and supported decision-making** – Has the individual been given appropriate support to understand the proposed technology and express their wishes and preferences? Has supported decision-making been maximised?
- **Positive Behavioural Support and specialist assessment** – Where stress and distress may relate to mental disorder, learning disability or autism, consideration should be given to Positive Behavioural Support, psychological formulation and other specialist assessment before relying on technological solutions.

Every assessment should include an analysis of potential risk. This should focus primarily on the risks and benefits for the individual rather than the convenience of the organization or service provider. Positive risk-taking should be supported so that individuals are not subjected to unnecessary or disproportionate restrictions in the name of safety.

Where technology is introduced, it should form part of a wider care or support plan rather than being viewed as an intervention in isolation. The support plan should clearly record:

- the purpose of the technology;
- the expected benefits for the individual;
- any risks or restrictions arising from its use;
- the legal authority, where required;
- who is responsible for monitoring its use;
- arrangements for review; and
- the circumstances in which the technology should be reduced, discontinued or replaced.

The continued use of technology should be reviewed regularly to ensure that it remains necessary, proportionate and continues to benefit the individual. If the intended outcomes are no longer being achieved, or if less restrictive alternatives become available, its continued use should be reconsidered.

5. Legal context

Individuals with mental illness, learning disability, dementia, autism and related conditions may, but do not necessarily, lack decision making capacity about the use of digital health care and assistive technology. In law, there is a presumption that adults have capacity unless it is established otherwise. Individuals who have capacity to decide should be free to determine whether or not they wish to use a particular technology.

Disagreeing with a proposed intervention, or making a decision that others consider unwise, does not in itself mean that a person lacks capacity. Capacity is decision-specific and should always be assessed in relation to the particular decision under consideration.

Before concluding that a person lacks capacity, every practicable step should be taken to support them to make their own decision. This may include providing information in an accessible format, allowing additional time for discussion, using communication aids, involving speech and language therapists or other specialists where appropriate, and offering the support of an independent advocate or trusted person. For further information, see the Commission's good practice guide on supported decision making, [Supported decision making good practice guide 2024](#)¹.

When considering whether an individual has capacity to decide about the use of digital health care or assistive technology, the following questions may assist:

- Does the individual understand, retain, use or weigh the information relevant to the decision, and are they able to communicate their decision?
- Does the individual understand what the proposed technology does, what information it collects, who may have access to that information, and how it may affect their privacy, autonomy and daily life?
- Is the individual making the decision freely, without coercion or undue influence from others?
- Has the individual been given appropriate support to understand the proposed intervention and express their wishes and preferences?
- Have the individual's past and present wishes, values and preferences been explored and taken into account?

Where an individual lacks capacity to make the decision, any intervention should be authorised through the appropriate legal framework and should reflect the principles of benefit, least restriction and respect for the individual's rights, wishes and preferences.

¹ Supported decision making good practice guide: <https://www.mwcscot.org.uk/node/503>

5.1 The Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000 provides a framework for supporting adults to make their own decisions wherever possible and, where they lack capacity to make a particular decision, for making decisions on their behalf.

Before relying on substitute decision-making, every practicable step should be taken to support the individual to make their own decision. Capacity is decision-specific and should always be assessed in relation to the particular decision under consideration.

Where an individual lacks capacity to make a particular decision, the Act makes several provisions for substitute decision-making. While they have capacity, an individual may grant a welfare power of attorney (PoA) authorising another person to make specified welfare decisions should capacity be lost. Where no such arrangement exists, the sheriff may appoint a welfare guardian to make decisions on the individual's behalf. The views of welfare attorneys and welfare guardians should always be sought and taken into account when making welfare decisions within the scope of their authority.

Where there is no welfare attorney or welfare guardian with the necessary authority, consideration should be given to whether an application for welfare guardianship or another intervention under the AWI Act is required.

Where a valid welfare power of attorney or guardianship order exists, those responsible for an individual's care should be familiar with the extent of the powers granted. Not all welfare powers of attorney or guardianship orders will authorise decisions relating to digital health care, assistive technology or surveillance. Where technology has the potential to restrict liberty, privacy, autonomy or dignity, or involves monitoring or surveillance, consideration should be given to whether specific authority is required. Legal advice should be sought where there is uncertainty.

The principles of the AWI Act should guide all decisions regarding the use of digital health care and assistive technology:

1. The intervention must provide a benefit that cannot reasonably be achieved without it.
2. The intervention must be the least restrictive option in relation to the individual's freedom, rights and autonomy.
3. The past and present wishes and feelings of the individual should be taken into account.
4. The views of relevant others should be sought and taken into account.
5. The intervention should encourage the individual to exercise existing skills and develop new ones wherever possible.

The application of these principles is an ongoing process. Decisions should be reviewed regularly to ensure that the use of technology continues to provide benefit, remains the least restrictive option available and reflect the individual's current circumstances, wishes and needs.

The Commission is sometimes asked whether an AWI Act section 47 certificate should authorise the use of digital health care or assistive technology. In our view, a section 47 certificate is not the appropriate mechanism for authorising the routine use of digital health care, assistive technology or surveillance. The assessment supporting the use of technology, the reasons for its introduction, any associated restrictions, the legal authority relied upon and arrangements for review should instead be clearly documented within the individual's care or support plan.

Technology should support the individual's independence and participation wherever possible, rather than replacing human contact or unnecessarily restricting the person's freedom.

Health and social care organisations should have clear policies governing the use of digital health care and assistive technology for adults who lack capacity to consent. Those policies should promote rights-based decision-making, ensure compliance with the principles of the AWI Act and relevant human rights obligations, and provide appropriate arrangements for governance, oversight, review and accountability.

Further guidance on the use of the AWI Act can be found at:

- Commission's website
www.mwcscot.org.uk
- Scottish Government
<https://www.gov.scot/policies/social-care/adults-with-incapacity>
- Office of the Public Guardian (OPG)
www.publicguardian-scotland.gov.uk
- NHS Scotland, [NHS Education for Scotland](#)
[Adults With Incapacity \(AWI\) | Turas | Learn \(nhs.scot\)](#)

5.2 Mental Health (Care and Treatment) (Scotland) Act 2003

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides the legal framework for the compulsory assessment, care and treatment of people with a mental disorder.

The Act applies to people with a mental illness (including dementia), personality disorder, learning disability or related condition, which are collectively referred to in the Act as *mental disorders*. It provides powers for compulsory assessment,

detention, care and treatment in hospital and, in certain circumstances, compulsory treatment in the community.

The use of digital health care and assistive technology does not, in itself, require or authorise compulsory measures under the Mental Health Act. However, where technology is used in a way that restricts an individual's liberty, freedom of movement, privacy or autonomy, consideration should be given to whether the Mental Health Act provides the appropriate legal framework.

For example, where technology is used to prevent an individual from leaving hospital, restrict their movement or otherwise impose restrictions that amount to compulsory care or treatment, consideration should be given to whether detention under the Mental Health Act is required. Formal detention provides important legal safeguards, including access to independent advocacy, rights of appeal to the Mental Health Tribunal for Scotland and regular review of compulsory measures.

Technology should never be used to avoid, replace or circumvent the legal safeguards provided by the Mental Health Act.

Professionals exercising functions under the Mental Health Act should have regard to the principles of the Act when considering the use of digital health care and assistive technology. These include:

1. **Participation** – Individuals should be involved, as far as practicable, in decisions about the use of technology affecting their care and treatment.
2. **Least restrictive alternative** – Technology should only be used where it represents the least restrictive means of achieving the intended therapeutic or care objective. Less restrictive alternatives should always be considered.
3. **Benefit** – The use of technology should provide a clear therapeutic or welfare benefit to the individual. It should not be introduced primarily for the convenience of services or to compensate for deficiencies in staffing or resources.

Where digital technology forms part of compulsory care or treatment, its purpose, anticipated benefits, associated risks, legal authority and arrangements for review should be clearly documented within the individual's care or treatment plan.

The Commission recognises that developments in technology, including electronic location monitoring and other forms of remote monitoring, may increasingly be considered in relation to individuals subject to compulsory measures, including those subject to restriction orders. Where such technology is used, there should be clear legal authority for its use. It should be necessary and proportionate to the risks identified, represent the least restrictive option available and be subject to regular multidisciplinary review. Technology should support, and never replace, clinical judgement, therapeutic engagement and individualised risk management.

For individuals detained in hospital, the Mental Health Act permits restrictions to be placed on access to telephones and other communication devices where an individual has been designated a Specified Person. These powers may include restrictions on the use of mobile phones and other electronic devices capable of communication, recording or accessing the internet where authorised under the Specified Persons Regulations. These provisions apply only to individuals detained in hospital and do not apply to voluntary inpatients or to those subject to compulsory treatment measures in the community.

The Commission's [good practice guide on specified persons](#)² and [easyread version](#)³ are available for more information.

Further guidance on the use of the Mental Health Act can be found on [our website](#)⁴ and the [Scottish Government website](#)⁵.

5.3 Human rights and the legal framework

Human rights are central to decisions about the use of digital health care and assistive technology. In Scotland, the rights contained in the European Convention on Human Rights (ECHR) form an important part of the legal framework governing health and social care.

The Human Rights Act 1998 gives effect to Convention rights in domestic law, while the Scotland Act 1998 requires Acts of the Scottish Parliament and the actions of Scottish Ministers to be compatible with those rights. Consequently, legislation including the Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007 must be interpreted and applied in a manner that is compatible with Convention rights.

The following Convention rights are particularly relevant when considering the use of digital health care and assistive technology:

- **Article 2** – The right to life.
- **Article 3** – The right to be free from torture and inhuman or degrading treatment.
- **Article 5** – The right to liberty and security.
- **Article 6** – The right to a fair hearing.
- **Article 8** – The right to respect for private and family life, home and correspondence.
- **Article 14** – The right to enjoy Convention rights without discrimination.

² Specified persons good practice guide: <https://www.mwcscot.org.uk/node/512>

³ Easyread: specified persons: <https://www.mwcscot.org.uk/node/418>

⁴ Mental Welfare Commission website: <https://www.mwcscot.org.uk>

⁵ Scottish Government mental health legislation: <https://www.gov.scot/policies/mental-health/legislation-and-guidance/>

Any decision to introduce digital health care or assistive technology should be lawful, pursue a legitimate aim, be necessary and proportionate, and interfere as little as possible with the individual's rights and freedoms. Particular consideration should be given to Article 8, as many technologies involve the collection, storage or sharing of personal information, the monitoring of an individual's activities or movements, or surveillance within private living spaces. Different Convention rights may point in different directions in individual cases. Decisions should therefore seek to achieve an appropriate balance between protecting the individual's rights, promoting their autonomy and ensuring their safety and wellbeing.

The use of technology may, in some circumstances, contribute to a deprivation of liberty. Where technology forms part of care arrangements that amount to, or may amount to, a deprivation of liberty, there must be appropriate legal authority and procedural safeguards. Further guidance on deprivation of liberty and relevant case law is provided later in this chapter.

Human rights considerations should not be viewed solely as restrictions on the use of technology. Appropriate technology may itself promote Convention rights by supporting independence, facilitating communication, improving access to healthcare, reducing unnecessary restrictions and enabling individuals to participate more fully in decisions about their care and treatment.

Where technology forms part of an individual's care or treatment, consideration should be given to whether the person's wishes and preferences regarding its use should be recorded in an advance statement where appropriate. An advance statement allows a person, while they have capacity, to record how they wish to be treated should they become subject to compulsory treatment under the Mental Health Act in the future. Although advance statements relate to treatment under the Mental Health Act, they may assist future decision-making where digital technology forms part of that treatment or care.

The Commission encourages individuals to prepare an advance statement where they wish to do so and to be supported in doing so. Further information is available in the Commission's [guidance on advance statements](https://www.mwcscot.org.uk/law-and-rights/advance-statements)⁶.

⁶ Advance statements guidance: <https://www.mwcscot.org.uk/law-and-rights/advance-statements>

5.4. United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) ⁷

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) provides an important international human rights framework for disabled people, including many people with mental illness, learning disability, autism, dementia and related conditions.

The Convention is binding on the United Kingdom in international law and has significantly influenced the development of legislation, policy and practice in Scotland.

Although the substantive rights contained within the Convention have not been incorporated generally into Scots law, the Convention may assist courts in interpreting domestic legislation and Convention rights.

The UNCRPD places particular emphasis on equality, non-discrimination, autonomy, participation and respect for the rights, will and preferences of disabled people. These principles are especially relevant when considering the use of digital health care, assistive technology and surveillance.

Particularly relevant provisions include:

- **Article 5** – Persons with disabilities are entitled to equal protection and equal benefit of the law without discrimination.
- **Article 12** – Persons with disabilities have the right to equal recognition before the law. Measures relating to the exercise of legal capacity should include appropriate safeguards and should respect the person's rights, will and preferences.
- **Article 14** – Persons with disabilities have the right to liberty and security on an equal basis with others. The existence of a disability must never, of itself, justify a deprivation of liberty.
- **Article 16** – States should take appropriate measures to protect persons with disabilities from all forms of exploitation, violence and abuse.
- **Article 17** – Every person with disabilities has the right to respect for their physical and mental integrity on an equal basis with others.

The concept of legal capacity used in Article 12 reflects the language of the UNCRPD and should be understood within the context of the Convention. Decisions about whether an individual has capacity to make a particular decision, and the arrangements for making decisions on behalf of those who do not, continue to be governed in Scotland by the Adults with Incapacity (Scotland) Act 2000.

⁷ Ibid fn 1

The principles of the UNCRPD reinforce the importance of supported decision-making, maximising autonomy and ensuring that technology is used to promote, rather than unnecessarily restrict, the rights and participation of disabled people. Decisions about digital health care and assistive technology should therefore seek to empower individuals, respect their wishes and preferences wherever possible, and ensure that any restrictions are lawful, necessary and proportionate.

5.5 United Nations Convention on the Rights of the Child (UNCRC)

The United Nations Convention on the Rights of the Child (UNCRC) sets out the civil, political, economic, social and cultural rights of children and young people. In Scotland, the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024 incorporates the UNCRC into Scots law, within the limits of devolved competence. Public authorities exercising devolved functions must therefore act compatibly with the incorporated UNCRC requirements.

The UNCRC is relevant whenever digital health care or assistive technology is being considered for a child or young person. Decisions should respect and promote the child's rights, recognise their evolving capacities and ensure that they are able to participate, as far as possible, in decisions affecting them.

Particularly relevant provisions include:

- **Article 2** – Children should enjoy their rights without discrimination.
- **Article 3** – In all actions concerning children, the best interests of the child should be a primary consideration.
- **Article 12** – Children capable of forming their own views have the right to express those views freely in all matters affecting them, with those views being given due weight according to their age and maturity.
- **Article 16** – Children have the right to privacy.
- **Article 17** – Children have the right to access information from a diversity of sources appropriate to their age and development, while being protected from material that may be harmful to their wellbeing
- **Article 23** – Children with disabilities have the right to enjoy a full and decent life in conditions that ensure dignity, promote self-reliance and facilitate active participation in the community.
- **Article 24** – Children have the right to the highest attainable standard of health.

When considering the use of digital health care, assistive technology or surveillance involving a child or young person, particular attention should be given to:

- the child's wishes and feelings;
- their age, maturity and evolving capacities;
- their ability to participate in decision-making;
- the impact of technology on their privacy, development and family life; and whether the proposed intervention is lawful, necessary, proportionate and in the child's best interests.

Technology should be used to support children and young people to participate as fully as possible in decisions about their care and treatment, while ensuring that any restrictions on their rights are lawful, necessary and proportionate.

5.6. Developments in case law

The law relating to deprivation of liberty continues to develop. The Supreme Court's decision in *P v Cheshire West and Chester Council* [2014] UKSC 19⁸ established that a person is generally deprived of their liberty where they are subject to continuous supervision and control and are not free to leave. The Court emphasised that the purpose of the arrangements, the person's compliance or lack of objection, and the relative normality of the placement were not, of themselves, determinative. This became known as the 'acid test' for deprivation of liberty.

In 2026, the Supreme Court revisited these principles in *Reference by the Attorney General for Northern Ireland* [2026] UKSC 16⁹. The Court held that Cheshire West had placed too much emphasis on the absence of mental capacity as automatically preventing valid consent for the purposes of Article 5 of the European Convention on Human Rights. The Court confirmed that the assessment of deprivation of liberty requires consideration of the Strasbourg jurisprudence as a whole and that, in appropriate circumstances, a person may express sufficient acceptance of their care arrangements to constitute valid consent, even where they lack decision-making capacity under domestic law. The assessment therefore requires consideration of all the relevant circumstances and should not rely solely on the 'acid test'.

The implications of this decision for Scotland continue to evolve. The Scottish legal framework differs from that operating in England and Wales, and the interaction between the developing case law, the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 will require careful consideration. The Scottish Mental Health Law Review recommended reform of the

⁸ <https://www.supremecourt.uk/cases/uksc-2012-0068>

⁹ <https://supremecourt.uk/cases/press-summary/uksc-2025-0042>

law relating to deprivation of liberty, and the Scottish Government has indicated that reform of incapacity legislation remains a priority.

In the meantime, services should continue to operate within the existing statutory framework while remaining informed by developments in the law. Where care arrangements, including the use of digital technology, monitoring or surveillance, may amount to a deprivation of liberty, there should be clear legal authority for those arrangements together with appropriate safeguards and regular review.

The Commission considers that the principles of the Adults with Incapacity (Scotland) Act remain central to good practice. Decisions should be supported by a transparent and auditable decision-making process, should reflect the individual's rights, wishes and preferences wherever possible, and should ensure that any restrictions are lawful, necessary and proportionate.

Where an application for welfare guardianship or another legal intervention is required, it is important to identify any measures that may constitute or contribute to a deprivation of liberty and to ensure that they are clearly justified and, where appropriate, specifically authorised. Such measures may include restraint, preventing a person from leaving or requiring them to return to their place of residence, continuous supervision, or intrusive monitoring and surveillance, whether undertaken in person or through technology.

6. Benefits, risks and safeguards

Digital health care and assistive technology have transformed the way people receive care, treatment and support. When used appropriately, technology can promote independence, improve access to healthcare, enhance communication, support clinical decision-making and enable people to remain safely in their preferred environment for longer.

Technology can also assist professionals to identify changes in an individual's health or wellbeing, facilitate earlier intervention and reduce the need for more restrictive forms of care. In many situations, technology may enhance rather than diminish a person's autonomy by enabling them to exercise greater choice and control over their daily lives.

However, technology also presents ethical, legal and practical challenges. Some technologies collect, store or share highly personal information, while others involve monitoring, surveillance or restrictions on movement. If introduced without appropriate safeguards they may interfere with an individual's privacy, dignity, autonomy or liberty.

Technology should never be viewed as a substitute for therapeutic relationships, skilled clinical judgement or adequate staffing. It should complement person-centred care and should only be used where it provides a clear benefit to the individual. Decisions about its use should always reflect the principles described throughout this guidance, including supported decision-making, respect for the individual's wishes and preferences, proportionality, least restriction and regular review.

The following sections consider some of the technologies and situations that most commonly give rise to ethical or legal questions.

6.1 Restraint

The use of digital health care and assistive technology may, in some circumstances, amount to restraint or contribute to restrictions on an individual's liberty or freedom of movement. This applies whether the technology is used in hospitals, registered care services or an individual's own home.

The Commission defines restraint in its [Rights, risks and limits to freedom](#) good practice guide as:

"Restraint is taking place when the planned or unplanned, conscious or unconscious actions of care staff prevent a resident or patient from doing what he or she wishes to do and as a result are placing limits on his or her freedom."

Technology may constitute restraint where, for example, it is used to prevent an individual from leaving a particular area, continuously monitor their movements or activities, or impose restrictions that they are unable to consent to. Examples may include electronic door controls linked to wearable devices, location-monitoring systems, remote surveillance or other technologies that limit an individual's freedom of movement or decision-making.

Whether a particular technology amounts to restraint depends on its effect on the individual rather than the technology itself. In some circumstances, technology may reduce the need for more restrictive interventions and promote independence. In others, it may increase restrictions on an individual's liberty, privacy or autonomy. Decisions should therefore be based on an individual assessment of the likely benefits, risks and impact on the person's rights and freedoms.

Where technology may constitute restraint, there should be:

- a clear assessment of the individual's needs, wishes and desired outcomes;
- a clear rationale for the use of the technology;
- consideration of the range of reasonable options available, including whether the proposed technology represents the least restrictive and most appropriate approach;
- appropriate legal authority where required;
- a documented care or support plan describing the purpose of the intervention and arrangements for review; and
- regular multidisciplinary review to ensure that the intervention continues to provide benefit and remains necessary and proportionate.

Technology should never be introduced solely because it is more convenient for services or as a substitute for adequate staffing, professional judgement or therapeutic engagement. Even where technology is appropriately used, meaningful human contact remains central to high-quality care.

Where restraint is required, it should always be lawful, proportionate, represent the least restrictive option available and continue only for as long as it is necessary to achieve the intended benefit.

Case example - Ms. S: Video monitoring (own home)

Ms S is a 35-year-old woman with a learning disability who recently moved from hospital into her own home with 24-hour support from a care provider. During the night, staff remain awake in another room. Following a review, it has been suggested that overnight staff are no longer required. Ms S's parents are concerned about this proposal and suggest that a video monitor should be installed in Ms S's bedroom so that she can be observed remotely during the night.

What should be considered in Ms S's case?

- Has an outcome-focused assessment been completed to identify Ms S's strengths, needs, desired outcomes and any risks associated with changing the current support arrangements?*
- What is the purpose of introducing video monitoring? Is it intended to address an identified need or risk, or is it being proposed as an alternative to overnight staffing?*
- What are Ms S's wishes and preferences? What support has been provided to enable her to understand the proposal and express her views?*
- Does Ms S have capacity to decide about the proposed monitoring? If not, what legal authority exists to make this decision on her behalf?*

6.2. Video monitoring

Video monitoring systems, including closed-circuit television (CCTV), are increasingly used in hospitals, registered care services and, in some circumstances, private homes. They may be used for security purposes, to control access to buildings, to support the care of individuals where there are concerns about safety, significant distress or risk of serious harm, or to assist in the assessment and management of clinical risk.

The Commission recognises that, in carefully defined circumstances, video monitoring may provide a less restrictive alternative to more intrusive interventions. It may support timely intervention, reduce the need for frequent direct observation in some situations and contribute to the safe delivery of care. However, decisions about its use should always be based on the needs, rights and interests of the individual rather than the convenience of the service.

The continued use of video monitoring should be reviewed regularly to ensure that it remains necessary, proportionate and continues to provide benefit to the individual. Consideration should always be given to whether the level of monitoring can be reduced or discontinued as the individual's circumstances change.

Organisations using video monitoring should ensure that staff receive appropriate training and that local policies are consistent with current data protection legislation and relevant guidance issued by the Information Commissioner's Office and, where appropriate, the Care Inspectorate. Information obtained through video monitoring

should be accessed only by those with a legitimate need to do so and retained only for as long as is necessary for the purpose for which it was obtained.

Case example – Mr C: Video monitoring in hospital

Mr C is a 25-year-old man with autism who is detained in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003. At times he experiences significant stress and distress, which may result in aggression towards staff or damage to the ward environment. To reduce the risk of harm, he is cared for in a separate area of the ward where staff use video monitoring to observe him and respond when required.

What should be considered in Mr C's case?

- *Has a comprehensive assessment been undertaken to understand the factors contributing to Mr C's stress and distress, including physical health, communication, environmental and psychological factors?*
- *What is the purpose of the video monitoring? Is it intended to improve Mr C's care and safety, or is it being used as a substitute for direct observation or therapeutic engagement?*
- *What are Mr C's wishes and preferences regarding the use of video monitoring? What support has been provided to help him understand the proposed arrangements and express his views?*
- *Does the use of video monitoring represent the least restrictive and most appropriate approach to meeting Mr C's needs? What alternative interventions have been considered?*
- *What legal authority supports the use of the monitoring? If it contributes to restrictions on Mr C's liberty or privacy, have the relevant legal safeguards been considered?*
- *Is there a clearly documented care and treatment plan describing the purpose of the monitoring, the anticipated benefits, any associated risks, who has access to the recordings, and how the arrangements will be reviewed?*
- *What plans are in place to reduce or discontinue the monitoring if Mr C's circumstances change or less restrictive approaches become appropriate?*

6.3 Hidden surveillance

Hidden surveillance is the use of hidden cameras, audio recording equipment or other recording devices to monitor the actions of staff or others in their interactions with someone under their care. This may include equipment installed specifically for surveillance as well as devices such as mobile phones, tablets, internet-connected cameras, smart speakers and other technology capable of recording images or sound.

The Commission is aware that recording devices are increasingly being used to monitor care provided in hospitals, registered care services and people's own homes. Hidden surveillance may be undertaken by family members, carers, organisations or, in some circumstances, public authorities exercising statutory

functions. In some cases this reflects genuine concerns about the safety or quality of care. Hidden surveillance has, on occasion, played an important role in exposing serious abuse of vulnerable people.

However, it represents a significant intrusion into privacy and raises complex legal, ethical and human rights issues. Its use therefore requires careful justification.

We would always expect concerns about care, treatment or support to be addressed through the least intrusive means available. Wherever possible, concerns should be raised with the staff involved or the manager of the service. Advice and support may also be sought from an independent advocate, ward staff, the person's social worker, the Care Inspectorate or through the organisation's complaints procedure. Where there are concerns that an adult may be at risk of harm, consideration should be given to referral under adult support and protection legislation.

The Commission considers that hidden surveillance should be regarded as a measure of last resort. It should only be considered where there are clear, evidenced reasons why it is necessary, where reasonable alternatives have been explored or are unlikely to provide the necessary protection, and where its use is lawful, necessary and proportionate. It should never become a routine response to concerns about care.

When considering the use of hidden surveillance, particular attention should be given to the following. The decision-making process, the reasons for the decision and the legal authority relied upon should all be clearly documented.

Capacity and supported decision-making

People who have capacity to decide whether they wish to be recorded have the right to refuse. Capacity is decision-specific and should not be assumed simply because a person lacks capacity in another area of decision-making. Every practicable step should be taken to support the individual to make their own decision before concluding that they are unable to do so. Where the individual cannot consent, any decision must have an appropriate legal basis and reflect the principles of the Adults with Incapacity (Scotland) Act 2000.

Where a welfare attorney or welfare guardian has authority to make decisions about welfare, their views should be sought and taken into account as part of the decision-making process.

Human rights and legal authority

Hidden surveillance interferes with an individual's right to privacy under Article 8 of the European Convention on Human Rights and therefore requires proper legal justification.

Decisions should be demonstrably necessary, proportionate and directed towards a legitimate aim. Consideration should also be given to the principles of the United Nations Convention on the Rights of Persons with Disabilities, particularly respect for dignity, autonomy and participation in decision-making. The rights of staff, visitors, other people receiving care and anyone else who may be inadvertently recorded must also be taken into account.

Current data protection legislation, including the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018, should be considered together with relevant guidance issued by the Information Commissioner's Office. Public authorities should also consider the requirements of the Regulation of Investigatory Powers (Scotland) Act 2000 where applicable.

Necessity and proportionality

The use of hidden surveillance should always be capable of objective justification. Decision-makers should be satisfied that:

- there is a clearly identified risk or concern;
- the purpose of the surveillance is clearly defined;
- surveillance is likely to reduce or address the identified risk;
- less intrusive measures have been considered and would not achieve the intended purpose;
- the anticipated benefit outweighs the intrusion into privacy; and
- the arrangements will be reviewed regularly and discontinued when they are no longer required.

Practical arrangements

If hidden surveillance is used, careful consideration should be given to:

- the location of recording devices and the extent of any intrusion into private activities;
- whether video alone or video with audio recording is necessary;
- who will have access to recordings and under what circumstances;
- secure storage, retention and disposal of recordings;
- whether recordings are accurately date and time stamped;
- the circumstances in which recordings may be disclosed to others; and
- how and when the surveillance will cease once its intended purpose has been achieved.

Only the minimum recording necessary to achieve the intended purpose should be obtained. Consideration should also be given to whether the proposed recording may capture information about individuals other than the intended subject of the surveillance and how this will be managed.

Where an organisation becomes aware that hidden surveillance has been installed without its knowledge, it should consider the circumstances carefully, preserve any potential evidence where appropriate, and consider whether safeguarding procedures, the police or other regulatory authorities should be involved, depending on the circumstances.

The Commission considers that hidden surveillance raises particularly complex legal, ethical and professional issues. Organisations should ensure that any proposal to introduce hidden surveillance is subject to appropriate governance, legal advice and multidisciplinary discussion before implementation. Organisations should also have clear arrangements for considering requests to use hidden surveillance and for managing any recordings obtained.

Registered care services should seek advice from the Care Inspectorate where appropriate. Healthcare professionals should also have regard to relevant professional guidance, including the General Medical Council's guidance *Making and using visual and audio recordings of patients*¹⁰, [which advises that covert recording should normally be](https://www.gmc-uk.org/cdn/documents/making-and-using-visual-and-audio-recordings-of-patients_pdf-58838365.pdf) undertaken only where there is no less intrusive means of preventing serious harm or investigating serious crime.

Where hidden surveillance is introduced, it should continue only for as long as it remains necessary to achieve its intended purpose and should be discontinued as soon as that purpose has been achieved.

6.4. Sensor-based monitoring

Sensor-based monitoring technologies, including infra-red and other contact-free systems, may provide a less intrusive means of monitoring an individual's health, wellbeing or safety than continuous direct observation. In appropriate circumstances they may support earlier intervention, reduce unnecessary disturbance and promote independence.

However, these technologies may also collect information about an individual's movements, activities or physiological state within private living spaces. Their use

¹⁰ https://www.gmc-uk.org/cdn/documents/making-and-using-visual-and-audio-recordings-of-patients_pdf-58838365.pdf

should therefore be supported by an individual assessment, a clear clinical or care rationale and appropriate legal authority where required.

The Commission considers that sensor-based monitoring should only be used where it provides a clear benefit to the individual, represents the least restrictive option available and is proportionate to the risks identified. Its use should be documented within the individual's care or support plan, reviewed regularly and discontinued when no longer necessary.

Sensor-based monitoring should complement, and never replace, therapeutic relationships, direct human observation or person-centred care.

6.5 Digital communication and social media

Digital communication and social media have become an integral part of everyday life. They provide opportunities for individuals to communicate with family and friends, access health information and services, participate in education and employment, and maintain social connections. For many people, they can promote independence, reduce isolation and support wellbeing.

At the same time, digital communication presents important risks. Information shared online may remain accessible indefinitely, be copied or redistributed without consent, and compromise an individual's privacy, dignity or personal safety. Images, video and audio recordings may be shared rapidly and widely, sometimes without the knowledge or consent of the individual concerned. Developments in technology, including live streaming, cloud storage and artificial intelligence, mean that information shared digitally may be difficult or impossible to remove once it has entered the public domain.

The regulation of children's access to social media and other online services continues to evolve. Decisions about access should take account of the individual's age, maturity, capacity where relevant, and the potential benefits and risks of digital participation.

Where restrictions are considered necessary, they should be proportionate, kept under regular review and consistent with the relevant legal framework, including the rights of children and young people.

Individuals should be supported, wherever possible, to make informed decisions about their use of digital communication and social media. This should include supported decision-making, discussion of online privacy, digital security, the potential consequences of sharing personal information, and strategies for maintaining personal safety. The aim should be to enable individuals to participate safely rather than unnecessarily restricting access to digital technologies.

Where an individual lacks capacity to make decisions about their use of digital communication or social media, any decisions should reflect the principles of the Adults with Incapacity (Scotland) Act 2000. Consideration should be given to the benefit of the proposed intervention, whether it represents the least restrictive option available, and the individual's past and present wishes together with the views of those with an interest in their welfare. Where necessary, consideration may need to be given to welfare guardianship or an intervention order.

Some individuals generate income through social media or other online platforms. Where a person lacks capacity to manage these activities, consideration may need to be given to financial guardianship or other legal measures to protect their financial interests and reduce the risk of exploitation or financial harm.

The Commission is aware that mobile phones, tablets and other digital devices can be used to make visual or audio recordings of others without their knowledge or consent. Such recordings may subsequently be shared through social media, messaging applications or other online platforms. These situations may arise in hospitals, registered care services, educational settings or private homes and raise important legal, ethical and professional issues.

Organisations should have clear policies governing the use of personal recording devices and the making or sharing of recordings within care settings. Consideration should also be given to the rights of individuals who may be recorded, including people receiving care, staff, visitors and other service users. Where concerns arise, reference should be made to local policies, current professional guidance, the Specified Persons provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 where applicable, data protection legislation and, where necessary, legal advice.

6.6. Artificial intelligence

Artificial intelligence (AI) is increasingly incorporated into digital health care and assistive technology. AI may be used to support clinical decision-making, analyse information from monitoring devices, identify patterns or changes in health, assist with communication, summarise information, recognise speech or images, and support the operation of assistive technologies.

AI has the potential to improve access to care, support earlier intervention and enhance an individual's independence. However, it also raises important legal, ethical and human rights considerations. AI systems may process large volumes of personal information, make predictions about an individual's health or behaviour, or influence decisions about care and treatment. It is therefore important that

individuals understand, wherever possible, when AI forms part of the technology being used and how it may affect decisions about their care.

The Commission considers that AI should support, and not replace, professional judgement, therapeutic relationships or person-centred decision-making. Decisions affecting an individual's care, treatment, risk or liberty should not be based solely on automated systems. Health and social care professionals remain responsible for exercising their own judgement and ensuring that decisions are lawful, evidence-based and in the best interests of the individual.

Where AI forms part of digital health care or assistive technology, organisations should ensure that its use is transparent, appropriately governed and subject to regular review. Consideration should be given to the quality of the information on which AI systems rely, the potential for bias or discrimination, the security of personal information and the continuing need for human oversight.

As with all forms of digital health care and assistive technology, the use of AI should promote the rights, dignity, autonomy and participation of the individual. Its use should be proportionate, represent a clear benefit to the individual and comply with the relevant legal and ethical framework.

Ultimately, technology should always serve the person, and never the other way round.

7. Further information

Technology and the law continue to evolve rapidly. Readers should ensure that they are consulting the most up-to-date versions of legislation, statutory guidance and professional guidance referred to in this publication.

- [*Risks, rights and limits to freedom*](#)
- [*Care Inspectorate contact details*](#)
- European Convention on Human Rights, Article 8 (Right to respect for private and family life)
<https://www.legislation.gov.uk/ukpga/1998/42/schedule/1/part/I/chapter/7>
- Information Commissioner's Office. *Video surveillance (including guidance for organisations using CCTV)* <https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/cctv-and-video-surveillance/guidance-on-video-surveillance-including-cctv/>
- UK General Data Protection Regulation (UK GDPR)
<https://www.legislation.gov.uk/eur/2016/679/contents>
- The Data Protection Act 2018
<https://www.legislation.gov.uk/ukpga/2018/12/contents>
- Adults with Incapacity (Scotland) Act 2000
- Adult Support and Protection (Scotland) Act 2007
- Regulation of Investigatory Powers (Scotland) Act 2000
<https://www.legislation.gov.uk/asp/2000/11/section/1>
- Covert Surveillance and Property Interference: Revised Code of Practice (Scottish Government)
<https://www.legislation.gov.uk/ssi/2018/54/contents/made>



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