

Original Research

Exploring service user attitudes towards mental health technologies

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Abstract

Objectives: Understanding service users' knowledge of and attitudes towards the rapidly progressing field of mental health technology (MHT) is an important endeavour in clinical psychiatry.

Methods: To evaluate the current use of and attitudes towards MHT (mobile apps, online therapy and counselling, telehealth, web-based programmes, chatbots, social media), a 5-point Likert-scale survey was designed based on previous studies and distributed to attendees of an adult community mental health service in Ireland. Chi-square tests were used and corrected for multiple comparisons.

Results: 107 mental health service users completed the survey (58% female, aged 18–80). 86% of respondents owned a smartphone. 27.1% reported using a mental health application, while 33.6% expressed interest in using one in the future. 61.7% reported they had not used and were not interested in using AI for their mental health, and 51.4% indicated they would not feel comfortable using it. 46.8% were not comfortable with psychiatrists utilising AI in their care. The majority (86.9%) preferred face-to-face appointments, while 52.6% would consider using MHT while on a waiting list. Younger participants reported significantly greater comfort using mental health apps and higher self-rated knowledge of AI.

Conclusion: There were low levels of knowledge about and comfort using MHT, accompanied by concerns about confidentiality and privacy. Younger service users tended to be more comfortable with and knowledgeable about MHT. Despite the growing interest in digital approaches, there remains a clear preference for face-to-face appointments, underscoring the importance of addressing privacy and safety concerns, together with training and education.

Keywords: Artificial intelligence; community mental health services; digital health; mobile applications; telehealth

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Introduction

Mental health technology (MHT) encompasses various digital tools used in mental health, including applications, social media, artificial intelligence (AI), telehealth, online therapy, and chatbots. These technologies allow digital platforms, devices, and software to deliver mental health services and resources, potentially making them more accessible, affordable, convenient, efficient, and personalised for individuals seeking mental health support.

This rapidly expanding field presents new opportunities, but also significant challenges, for delivering personalised mental health interventions at scale (Richards & Richardson, 2012, Torous *et al.* 2019).

The COVID-19 pandemic accelerated the use of various components of MHT (O'Brien & McNicholas, 2020, Twomey

et al. 2013, Wright & Caudill, 2020). Many approaches, including video-enabled psychology sessions, telehealth for outpatient appointments via conferencing software, and digital cognitive behavioural therapy (CBT), were scaled up to meet large-scale public demand (Corruble, 2020). Significant demand on limited resources has also increased the popularity of such platforms, allowing many service users to access mental health supports without limitations based on geography or lack of staffing (Timulak *et al.* 2022).

In the wake of the pandemic, there is an ongoing appraisal of the balance between traditional models of care, such as face-to-face consultation, and the integration of complementary digitally enabled solutions, especially in the context of increased demand and growing waiting lists (HSE, 2025c, Ndayishimiye *et al.* 2023).

Accumulating evidence suggests that internet-based CBT, including virtual/digital therapists, may be helpful for a range of mild to moderate mental health conditions (Carl *et al.* 2020, Hedman-Lagerlöf *et al.* 2023, Lee *et al.* 2024, Lee *et al.* 2023, Loveys *et al.* 2021, Zhang *et al.* 2024). Furthermore, regulators are starting

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to approve digital therapeutics for mental health purposes (Assmann *et al.* 2025, Phan *et al.* 2023). Recently, the Food and Drug Administration approved the first prescription of a “digital therapeutic” app as an adjunct to clinician-managed outpatient care for major depressive disorder (Rejoyn, 2024).

In the UK, the National Institute for Health and Care Excellence (NICE) recently published early value assessment guidance on MHT, including virtual reality (VR) technology for managing psychosis symptoms in adults and young people (Freeman *et al.* 2022, Freeman *et al.* 2023, NICE, 2024).

Ireland’s national mental health policy, “Sharing the Vision,” recommends that “evidence-based digital and social media channels should be used to the maximum to promote mental health and to provide appropriate signposting to services and supports and develop the potential for digital health solutions to enhance service delivery and empower service users” (HSE, 2024, 2025b).

The adoption of MHT unfolds within a broader conversation about how service delivery models adapt to evolving technological, social, and demographic realities. According to established technology acceptance frameworks such as the Technology Acceptance Model (TAM) and the Unified Theory of Acceptance and Use of Technology (UTAUT), user uptake is shaped by factors including perceived usefulness, ease of use, trust, social influence, and accessibility (Alojail, 2024, Lee *et al.* 2025).

Attitudes towards MHT are further influenced by perceived benefits, perceived barriers, and external cues (Muruganantham *et al.* 2024). Digital literacy, age, and socio-economic status contribute to the digital divide, requiring equitable implementation strategies that address both structural and attitudinal barriers. Age also plays a moderating role, with older users particularly affected by perceptions of ease of use and vulnerability (Muruganantham *et al.* 2024).

Other influential variables include technology anxiety, resistance to change, and concerns about data privacy (Rajak & Shaw, 2021). To address these concerns and promote adoption, stakeholder readiness and targeted educational interventions are critical components of a comprehensive implementation strategy (Lee *et al.* 2025).

Opinions among service users/patients and the public are mixed. In general, there is openness to implementation provided it is accompanied by regulation, data security, and transparent human oversight, particularly in relation to decision-making processes (Hoffman *et al.* 2024, IPPOSI, 2025, Kim *et al.* 2024, Miller *et al.* 2020, Robertson *et al.* 2023, Young *et al.* 2021).

A survey of individuals with severe mental health problems ($n = 447$) in an outpatient setting in Beijing, China, found that despite high ownership and use of digital technologies, fewer than half used these platforms frequently for health-related purposes. This may be partly due to limited knowledge in using MHT (Zhang *et al.* 2023).

A similar study conducted in Ireland among patients ($n = 61$) at a general practice found that only 39% of participants were aware of technology-based resources to support their mental health, and only 11% had ever used them. Interestingly, 72% reported that they would find it helpful if their general practitioner (GP) recommended digital resources for mental health issues (Finucane, 2019).

Given the rapid advance of MHT, understanding mental health service user attitudes may help to identify barriers to successful adoption and facilitate assessment of accessibility and effectiveness. This paper sought to explore the use of and attitudes towards MHT technologies among attendees of a public community mental health service in Ireland.

Methods

Ethical approval

Tallaght University Hospital/St. James’s Hospital Joint Research Ethics Committee approved this study (Project ID:3669).

Survey design

A questionnaire was designed, informed by previous studies (Nogueira-Leite *et al.* 2023, Nogueira-Leite *et al.* 2024) and structured to reflect constructs found in technology acceptance frameworks such as TAM and UTAUT, including perceived knowledge, comfort, and interest in digital tools.

Basic demographic details, including age, gender, educational level, employment status, marital status, and nationality, were collected. The diagnoses of the participants were also recorded.

A 5-point Likert scale (strongly agree, somewhat agree, neither/neutral, somewhat disagree, and strongly disagree) was used to capture attitudes about MHT in several domains, including (1) mobile apps, (2) online therapy and counselling, (3) telehealth, (4) web-based programmes, (6) chatbots, and (7) social media. The Likert-scale items were designed to assess respondents’ perceived knowledge, comfort, past usage, and willingness to engage with each MHT modality.

Participants were asked to rank their preferences for mental health appointments and what technological resources they would prefer to use to manage their mental health between appointments/on waiting lists. See the supplementary materials for the survey and the participant information leaflet.

Participants and procedure

The sample of service users was selected using convenience sampling at outpatient appointments between January 2024 to July 2024. Prior to commencement of the survey, an information leaflet was given to participants, and informed consent was signed.

Inclusion Criteria: Adult (≥ 18 years) service users attending the Dublin South Central Community Mental Health Service and diagnosed with a mental health condition.

Exclusion Criteria: Service users with cognitive impairment or learning disability interfering with the ability to consent or understand the survey, service users with active mental health crises, service users with active psychotic symptoms, and any service users who could not provide informed consent to participate.

Data analysis

Data analysis was conducted using IBM SPSS Statistics Version 29.0.2.0 (20) for Mac. Frequencies of responses to questions were examined (Supplementary Tables S1, S2, S3), and the non-parametric Chi-square test was used to compare answers between age groups (Supplementary Table S4). For detailed analysis, survey responses on the Likert scale were recoded to yes, no, or neutral. Secondary analyses examined outcomes stratified by age group (divided into <30 , $30-49$, and ≥ 50). The Benjamini–Hochberg false discovery rate correction was used.

Results

A total of 107 participants completed the questionnaire. Demographics are shown in Table 1.

Table 1. Demographic information of participants

Characteristic	Total <i>n</i> = 107 <i>n</i> (%)
Gender	
Male	44 (41.1%)
Female	62 (58.0%)
Other	1 (0.9%)
Age	
Under 20	4 (3.7%)
20–29	21 (19.6%)
30–39	28 (26.2%)
40–49	17 (15.9%)
50–59	23 (21.5%)
60–69	12 (11.2%)
Over 70	2 (1.9%)
Education level	
Left before 16 without qualification	10 (9.3%)
Junior certificate	19 (17.8%)
Leaving certificate	29 (27.1%)
University or equivalent	25 (23.4%)
Bachelor's	15 (14.0%)
Post-graduate	9 (8.4%)
Employment status	
Student	14 (13.1%)
Unemployed	39 (36.4%)
Part-time	5 (4.7%)
Full-time	27 (25.2%)
Retired	11 (10.3%)
Full-time carer	5 (4.7%)
On disability	6 (5.6%)
Nationality	
Irish	95 (88.8%)
Other European	5 (4.7%)
Asian	5 (4.7%)
African	1 (0.9%)
South American	1 (0.9%)
Diagnosis	
Depression	36 (33.6%)
Bipolar affective disorder	11 (10.3%)
Psychotic disorder (schizophrenia, schizoaffective, delusional disorder)	23 (21.5%)
Generalised anxiety disorder	11 (10.3%)
Obsessive-compulsive disorder	6 (5.6%)
Emotionally unstable personality disorder	17 (15.9%)
Alcohol addiction	1 (0.9%)
ADHD	1 (0.9%)
Autism spectrum disorder	1 (0.9%)

(Continued)

Table 1. (Continued)

Characteristic	Total <i>n</i> = 107 <i>n</i> (%)
Marital status	
Single	56 (52.3%)
Married	23 (21.5%)
Separated	7 (6.5%)
In a relationship/living with partner	16 (15.0%)
Divorced	2 (1.9%)
Widowed	3 (2.8%)

Technology device ownership and use

The majority of participants 92 (86%) owned a smartphone, more than half 63 (58.9%) had a desktop or laptop computer, under a third 33 (30.8%) had a tablet, 11 (10.3%) had a non-smartphone mobile phone, 18 (16.8%) reported owning a wearable device such as a smart watch, and 6 (5.6%) denied owning any of these devices (Figure 1A).

Of 107 participants, 30 (28%) reported using the internet almost constantly, 31 (29%) many times a day, 14 (13.1%) occasionally, 21 (19.6%) a few times a day, 2 (1.9%) weekly, 1 (0.9%) monthly, and 8 (7.5%) never (Figure 1B).

Previous psychotherapy (with a human)

14 participants (13.1%) reported never attending psychological therapy, 55 (51.4%) reported having previously attended, 32 (29.9%) reported currently attending, and 6 (5.6%) reported being currently on a waitlist.

Mental health apps

Among those who reported using a mental health app, 8 (7.5%) used Headspace, 7 (6.5%) used CALM, 1 used YouTube, and 13 did not specify the app. 52 (48.6%) participants disagreed or strongly disagreed that they were knowledgeable about mental health apps, while over a third, 42 (39.3%), agreed or strongly agreed that they would feel comfortable using these apps (Figure 2A).

Fifteen service users shared additional details about their app usage, highlighting benefits such as providing helpful information, aiding meditation, reducing anxiety, offering support, or improving sleep. One service user described their app as “too hard to use when anxious.”

There was no significant difference in reports of feeling knowledgeable about apps by age ($\chi^2 = 12.06$, $df = 4$, $p = 0.32$). Still, significantly more participants aged over 50 reported not being comfortable using apps ($\chi^2 = 25.97$, $df = 4$, $p < 0.01$) compared to younger participants. In contrast, a larger proportion of those aged 30–49 were neutral or positive about using apps (see Supplementary Table S4).

Internet-delivered therapy

44 (41.1%) participants reported not having used internet-delivered therapy, such as CBT, and not being interested in it. 42 (39.3%) reported not having used but being interested in internet-delivered therapy. 16 (15%) reported having used it in the past, and 5 (4.7%) reported currently using such therapy

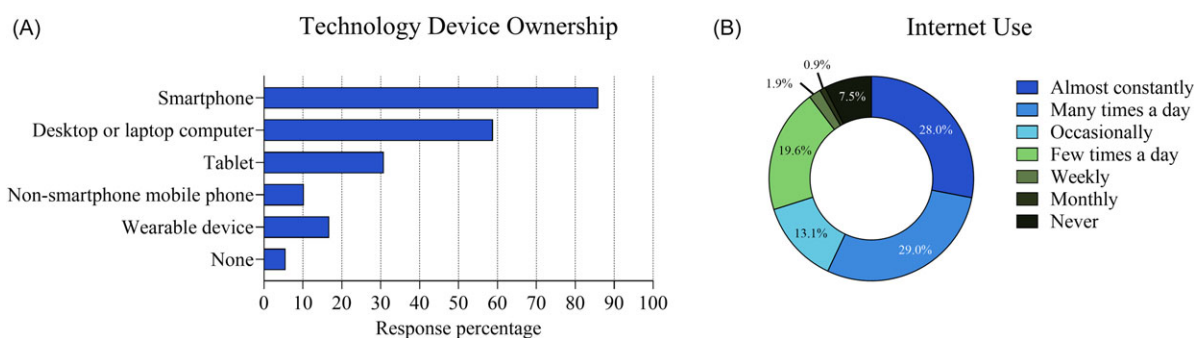


Figure 1. Technology device ownership and internet use. **A.** The majority of participants, 86% owned a smartphone, 58.9% had a desktop or laptop computer, 30.8% had a tablet, 10.3% had a non-smartphone mobile phone, 16.8% reported owning a wearable device such as a smart watch, and 5.6% did not own any of these devices. **B.** 28% reported using the internet almost constantly, 29% many times a day, 13.1% occasionally, 19.6% a few times a day, 1.9% weekly, 0.9% monthly, and 7.5% never.

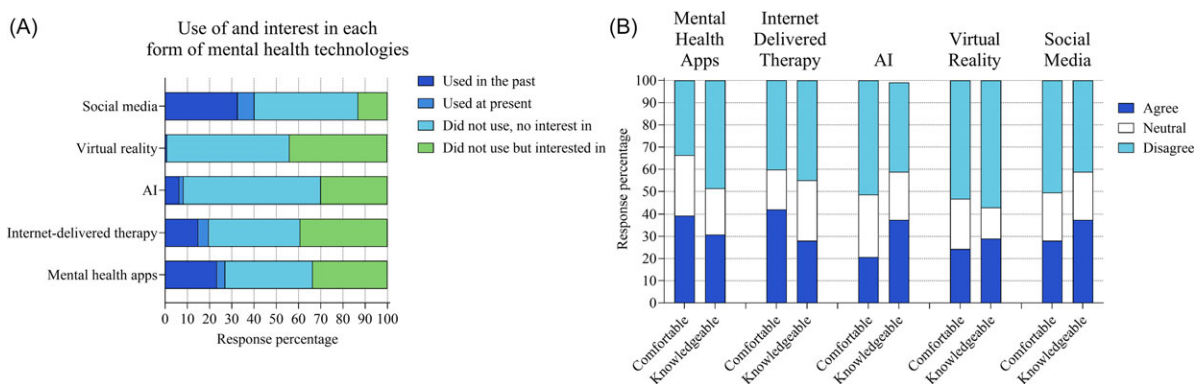


Figure 2. Attitudes towards mental health technologies. **A.** Use of and interest in social media, VR, AI, internet-delivered therapy, and mental health apps. **B.** Knowledge and comfort using the various mental health technologies.

(Figure 2A). Of those who had used internet-delivered therapy, 10 reported having used SilverCloud (digital CBT service that the HSE provides in Ireland), and 6 reported having used another form of remote therapy, while 5 participants did not answer.

Some users reported that internet-delivered therapy was beneficial due to its convenience, the scarcity of specialists in Ireland, and the flexibility it offers. However, one participant described internet-delivered therapy as impersonal.

Additionally, 48 participants (44.9%) disagreed or strongly disagreed that they were knowledgeable about internet-delivered therapy, while 45 participants (42.1%) agreed or strongly agreed that they would feel comfortable using it (Figure 2).

There was no significant difference between participants feeling knowledgeable about ($\chi^2 = 8.27$, $df = 4$, $p = 0.88$) or comfortable with ($\chi^2 = 6.85$, $df = 4$, $p = 0.88$) internet-delivered therapies between age groups (see Supplementary Table S4).

Artificial intelligence

See Figure 3A for attitudes to AI. There was no difference between comfort using AI for mental health between age groups ($\chi^2 = 3.11$, $df = 4$, $p = 0.88$), but significantly more service users between 30–49 and under the age of 30 reported feeling knowledgeable about AI ($\chi^2 = 24.63$, $df = 4$, $p < 0.01$). No other item differed significantly by age group (see Supplementary Table S4).

Virtual reality

10 (9.3%) participants strongly agreed that they were knowledgeable about VR technology, 21 (19.6%) agreed, 15 (14%) felt neutral,

31 (29%) disagreed, and 30 (28%) strongly disagreed that they were knowledgeable about VR. Four (3.7%) participants strongly agreed that they would feel comfortable using VR for their mental health, 22 (20.6%) agreed, 24 (22.4%) felt neutral, 27 (25.2%) disagreed, and 30 (28%) strongly disagreed.

There were no significant differences in feeling knowledgeable about ($\chi^2 = 7.03$, $df = 4$, $p = 0.88$) or comfortable with ($\chi^2 = 6.23$, $df = 4$, $p < 0.88$) VR by age group (see Supplementary Table S4).

Social media

8 (7.5%) participants said they were currently using social media as a resource for managing their mental health, 35 (32.7%) said they were not at present but had in the past, 14 (13.1%) reported not having done so but being interested in doing so and 50 (46.7%) reported not having done so and not being interested in doing so. Those who had used social media reported using Facebook (16 participants), TikTok (9 participants), and Instagram (10 participants) (Figure 2A).

Of the 43 participants who had used social media, 2 participants strongly agreed that using social media for their mental health was beneficial, 20 agreed that it was beneficial, 12 were neutral, and five disagreed that it was beneficial. Four did not answer. Those who said it was beneficial described using social media to “answer questions” or because it was “educational” or “informative,” or to seek out peer support “connect with others,” “listen to others’ stories” and “learn about others’ experiences,” or to use it as a “distraction.”

8 (7.5%) participants strongly agreed that they were knowledgeable about mental health resources on social media, 32 (29.9%)

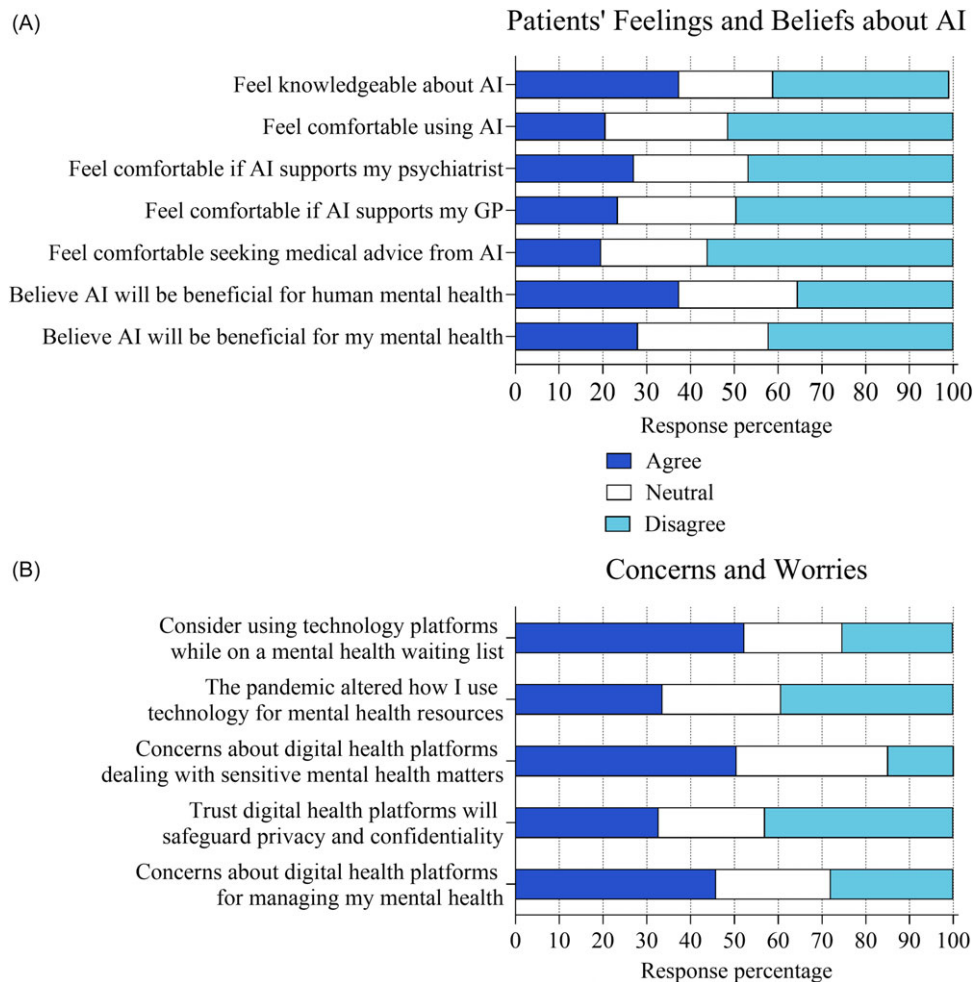


Figure 3. Attitudes to AI and concerns about mental health technologies. **A.** Participants' feelings and beliefs about AI. **B.** Concerns and worries about mental health technologies.

agreed, 23 (21.5%) were neutral, 25 (23.4%) disagreed, and 19 (17.8%) strongly disagreed. Three (2.8%) participants strongly agreed that they felt comfortable using mental health resources on social media, 27 (25.2%) agreed, 23 (21.5%) felt neutral, 29 (27.1%) disagreed, and 25 (23.4%) strongly disagreed (Figure 2B).

There were no significant differences in feeling knowledgeable about ($\chi^2 = 9$, $df = 4$, $p = 0.88$) or comfortable with ($\chi^2 = 8.22$, $df = 4$, $p = 0.88$) social media by age group (see Supplementary Table S4).

Concerns and worries about technology use

The majority of participants reported at least one concern about using digital platforms for managing their mental health. Slightly more than half the participants, 56 (52.6%), would consider using technology for mental health while on a waiting list, but half the participants, 54 (50.4%), also endorsed having concerns about these platforms dealing with sensitive mental health matters (Figure 3B).

Appointment delivery preference

93 (86.9%) participants ranked mental health appointments that were face-to-face with a person as most preferable, 8 (7.5%) would most prefer online with a person, 2 (1.9%) most preferred

telephone appointments with a person, and 2 (1.9%) most preferred online with an AI chatbot (Figure 4A).

First preferences for which technological resources participants would most prefer to use to manage their mental health between appointments were split, with 33 (30.8%) most preferring websites or online forums or communities, 28 (26.2%) most preferring AI chatbots, 25 (23.4%) preferring mental health apps, and 19 (17.8%) preferring social media (Figure 4B).

Discussion

This study provided further insights into the attitudes of mental health service users towards the rapidly evolving field of MHT. Overall, there were low levels of knowledge about and comfort using MHT. Younger participants were generally more comfortable with and knowledgeable about mobile apps and AI-based interventions.

Notably, nearly half of the total sample reported concerns regarding confidentiality and privacy when using MHT. These reservations underscore the need to address issues of privacy and security and highlight the importance of providing appropriate education and training to support the safe and effective integration of MHT into clinical practice.

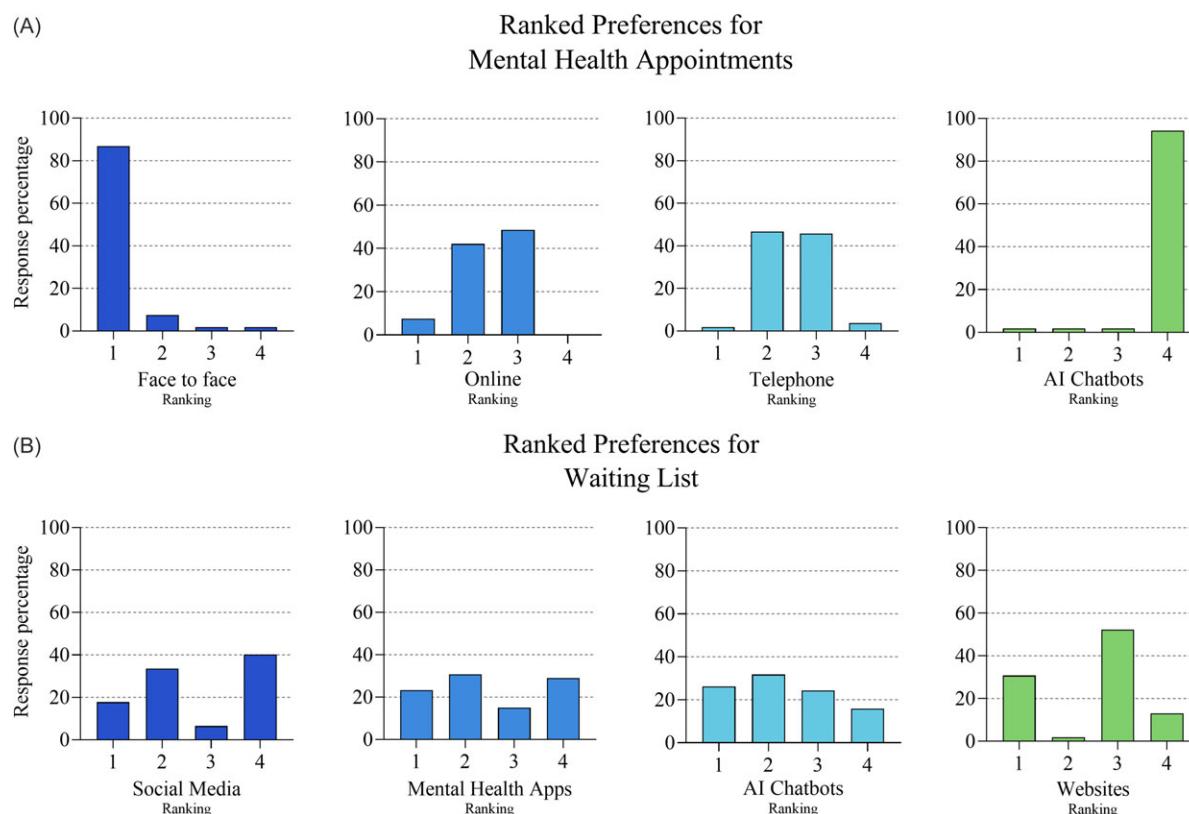


Figure 4. Preferred options for mental health appointments and while on the waiting list. **A.** The majority of mental health service users preferred face-to-face mental health appointments (86.9%), whereas 7.5% would most prefer online with a person, 1.9% would most prefer telephone appointments with a person, and 1.9% would most prefer online appointments with an AI chatbot. **B.** First preferences for technological resources participants would most prefer to use to manage their mental health between appointments were split, with 30.8% most preferring websites or online forums or communities, 26.2% most preferring AI chatbots, 23.4% preferring mental health apps, and 17.8% preferring social media.

The findings reinforce key concerns outlined in national strategy documents, particularly the call for digital mental health solutions that are evidence-based, person-centred, and adaptable to diverse user needs (HSE, 2025a, b).

While there is clear interest in digital mental health interventions, especially among younger service users, the data also highlight persistent concerns around trust, accessibility, and acceptability. These align with constructs from the TAM and UTAUT, which emphasise perceived usefulness, ease of use, and social influence as critical drivers of adoption (Alojail, 2024).

Empirical evidence suggests that perceived usefulness and trust strongly predict young people's intention to use digital interventions, whereas ease of use is less influential (Sawrikar & Mote, 2022). For adults with intellectual disabilities, usability factors such as visual design, support needs, and basic digital skills are crucial to meaningful engagement (Vereenoooghe *et al.* 2021).

Similar themes emerge in research on mobile health apps, where user trust and social cues significantly shape adoption patterns (Russell *et al.* 2018). These findings underscore the importance of designing digital mental health interventions that are not only technically sound but also responsive to users' lived contexts and varying levels of digital confidence.

Our findings of low levels of knowledge about MHT are in line with previous studies in Ireland (Finucane, 2019). Similarly, concerns around confidentiality, privacy, and trust when using MHT echo previous studies of service users, psychiatrists, and psychologists (Carlbring *et al.* 2023, Cummins & Schuller, 2020,

Sunarti *et al.* 2021). Indeed, there have been notable data protection issues. For example, in the United States, controversy has surrounded a popular mental health app following allegations that it sold users' data to third parties (Neporent, 2024).

Surprisingly, social media was the most used platform for mental health purposes. This may also raise concerns about the underlying quality of evidence and broader worries about people, especially younger people, navigating potential misinformation (Hudon *et al.* 2025).

The second most commonly used platform was mental health apps. In our sample, 86% of participants owned a smartphone, slightly below the reported national ownership rate of 95% in Ireland (Deloitte Ireland LLP, 2024). Despite this high level of access, only a quarter of our participants reported current or previous use of mental health apps. This proportion is even lower than that reported in a previous study of individuals with mental health disorders in Beijing, where fewer than half frequently used such platforms for health-related purposes (Zhang *et al.* 2023).

Notably, over one-third expressed interest in using such apps in the future. However, it should also be noted that relatively few digital mental health apps have received formal approval (Rejoyn, 2024) and many have limited scientific validation, regulatory oversight, or robust evidence supporting their effectiveness (Anthes, 2016, Neary & Schueller, 2018).

AI has the potential to transform multiple facets of healthcare, ranging from risk prediction and patient monitoring to non-clinical administrative tasks (Eisemann *et al.* 2025, Ginder *et al.*

2023, Johri *et al.* 2025, Moritz *et al.* 2025, Osipov *et al.* 2024). AI-assisted therapeutic chatbots are progressing at a rapid pace, and their ability to emulate empathy seems to be improving (Boucher *et al.* 2021, Carlbring *et al.* 2023, Heinz *et al.* 2025, Kuhail *et al.* 2024, Raile, 2024). This raises interesting issues for personalised preferences for non-human therapeutic approaches for those individuals who may feel more at ease sharing their experiences with AI-based therapists (Hoffman *et al.* 2024) and cultural differences (Chin *et al.* 2023).

While some studies report generally open attitudes and acceptance among service users (Abd-Alrazaq *et al.* 2021, Limpanopparat *et al.* 2024), significant gaps remain in the standardisation of reporting and evaluation frameworks. There is a need for greater transparency, methodological consistency, and replicability in chatbot research (Vaidyam *et al.* 2019), and many service users, psychiatrists, and other mental health professionals maintain a cautious stance (Blease *et al.* 2024, Siddals *et al.* 2024, Sweeney *et al.* 2021).

A study of mental health professionals ($n = 160$) in Portugal showed that less than half (43.6%) of the respondents planned to prescribe or recommend digital mental health apps to their patients, with psychologists holding slightly more favourable attitudes than psychiatrists (Nogueira-Leite *et al.* 2023).

Additionally, almost half of our respondents were not comfortable with their psychiatrist or GP utilising AI in supporting decisions about their care. In a survey of 138 psychiatrists affiliated with the American Psychiatric Association, approximately 40% reported using ChatGPT to assist in answering clinical questions, and 70% agreed that generative AI will help with documentation and reducing administrative burden (Blease *et al.* 2024). Interestingly, GPT-4 outperformed both psychiatry residents and open-source models in diagnostic and knowledge tasks (Bang *et al.* 2025).

The majority of participants in our study voiced discomfort utilising AI in any aspect of their lives, rising to almost 60% about healthcare specifically. The scepticism went even further, as less than 40% of the participants believed that AI would benefit human mental health over the next two decades, dropping to below 30% when applied to beliefs around their own mental health.

Younger respondents, as expected, felt more knowledgeable about AI than their older peers. This highlights the age divide in digital literacy and comfort. Previous literature has theorised that AI chatbots may be appealing to younger people in general due to their familiarity with existing online platforms (Koulouri *et al.* 2022). It also emphasises that for AI to be widely adopted in psychiatry, substantial efforts must be made to educate and support older service users.

Notwithstanding the advancing competencies of AI, the majority of participants in our study expressed a clear preference for face-to-face mental health appointments. However, just over half of the participants said they would consider using MHT while on a waiting list. This suggests its potential as a complementary tool to clinician-led conventional care and a possible support within the HSE's Waiting List Action Plan – *Beyond the Wait* (HSE, 2025c).

Our study, in line with previous research, highlights the need for a guided approach and associated training if MHT is to be successfully delivered in a public psychiatric clinic (Breedvelt *et al.* 2019, McCausland *et al.* 2023, Nogueira-Leite *et al.* 2023).

To advance the implementation of MHT, it is essential to co-design digital care pathways with service users, recognising both demographic differences and varying levels of attitudinal

readiness. As Ireland progresses towards its Digital for Care 2030 goals, translating high-level policy into equitable and effective practice demands sustained engagement with the lived realities of front-line mental health services. Co-design has been shown to improve user engagement, tailor interventions to individual needs, and empower participants in the therapeutic process (Veldmeijer *et al.* 2023).

However, challenges persist in sustaining meaningful participation and balancing service user insights with clinical frameworks. Research suggests that digital innovation in mental health care requires systemic adjustments, such as revised clinical roles and the introduction of digital navigators to support users (Smith *et al.* 2023).

Collaborating with people who have lived experience can help address concerns around stigma, disempowerment, and access, while also enhancing agency and self-monitoring (Patrickson *et al.* 2023). Nonetheless, successful adoption is influenced by practical factors including IT infrastructure, staff capacity, training, and concerns about how technology may affect therapeutic relationships (Pithara *et al.* 2020).

Findings from our study reflect the tension between innovation and inclusion, emphasising the importance of participatory approaches that are sensitive to the complex contexts in which digital tools are implemented.

Of course, any advance in MHT must occur alongside the Irish Digital for Care 2030 framework and the long-overdue implementation of the national electronic health record system in Ireland, which according to the European Union, must be accessible to all citizens by 2030 (eMHIC, 2024, EU, 2024, HSE, 2024, 2025a). To ensure that digital interventions are both practical and equitable, we recommend (1) targeted digital literacy initiatives, especially for older service users; (2) regulatory frameworks that ensure privacy, transparency, and clinical validation; and (3) the incorporation of service user perspectives into the design and implementation of MHT tools.

Conclusions

This study underscores both the promise and complexity of integrating technology into mental health care. Digital tools have the potential to improve access and complement traditional services, but key challenges, particularly around regulation, privacy, and proven effectiveness, remain. Future efforts should prioritise robust evaluation frameworks, comprehensive education and guidance for users and providers, and ethical, evidence-based implementation, especially when supporting vulnerable populations (Kelly, 2024, McCradden *et al.* 2023, Redahan & Kelly, 2024).

Our findings also reveal a clear age divide, with younger users demonstrating greater comfort and familiarity with mental health technologies. These results emphasise the importance of targeted education and training to ensure that technological interventions are equitably and effectively integrated into routine psychiatric practice.

Alongside the need for robust evidence demonstrating the efficacy of these novel MHT approaches, the challenge ahead lies in striking a balance between innovation and trust, ensuring that technological advancements genuinely serve and support mental health service users.

Limitations

This survey did not permit the calculation of response rate and may not be fully representative of all service users in Ireland. Convenience sampling was used to select participants for this

survey, which may have introduced selection bias into the pool of respondents.

Exploration of attitudinal variations according to demographics and diagnoses would be interesting, but subgroup analyses lack sufficient power to derive meaningful interpretations.

Participants were recruited from community mental health teams in the Community Healthcare Organisation 7 area. The teams that participated in this survey are located in the Dublin South Central Community Mental Health Service. These public teams predominantly serve urban areas. It would be beneficial to replicate this study in both rural and private settings to allow for further generalisation of results.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/ipm.2026.10170>.

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Ethical standards. Tallaght University Hospital/St. James's Hospital Joint Research Ethics Committee approved this study (Project ID:3669). The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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