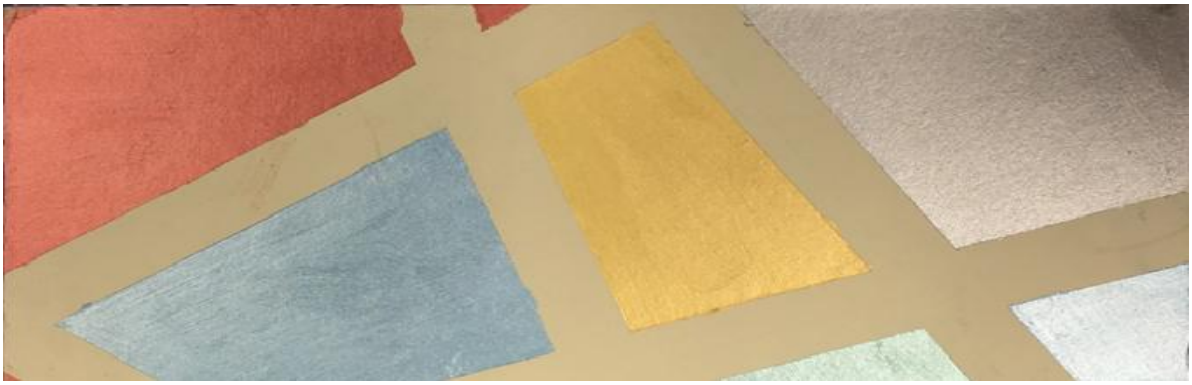

Welcome to the July 2026 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: Permission to appeal granted in *Townsend*; post-AGNI guidance; and a new Guidance Note on Capacity for Care Providers

(2) In the Property and Affairs Report: Statutory wills; charging for being an appointee; and guidance on assessing financial capacity

(3) In the Practice and Procedure Report: Court of Protection and child deprivation of liberty statistics; court fees rising; reasons challenges in the Court of Protection; medical treatment cases – whether to issue, and the consequences of waiting too long

(4) In the Mental Health Matters Report: EU Recommendation of the Committee of Ministers to member States on respect for autonomy in mental healthcare

(5) In the Children's Capacity Report: A CAMHS psychiatrist's view on child deprivation of liberty cases – and what interventions can help to break the 'vicious cycle' of restrictions and institutionalisation

(6) In the Wider Context Report: Adult social care reform; the Muckamore Abbey Inquiry Report is published; and what becomes of solicitors whose clients lacked capacity

(7) In the Scotland Report: Circumvention and undue influence

A reminder that that whilst Chambers have launched a new and zippy version of our website which may look unfamiliar, all the content that you might need – our Reports, our case-law summaries, and our guidance notes – can still be found via here.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

Deprivation of Liberty or Initiation of Institutionalisation? A view from CAMHS Psychiatrist, Dr Girish Vaidya[1]

Whilst Deprivation of Liberty is necessary, it is often not inevitable

As a Consultant Child and Adolescent Psychiatrist, I predominantly work with young people often identified as 'Complex Needs' in professional jargon. In clinical practice, it often indicates needs that are usually difficult to safely 'categorise' within existing legal, educational and social services' frameworks.

Let us examine the story of Jess – a 16-year-old who came into care following an adoption breakdown. The adoption breakdown was preceded by multiple requests for assistance from child and adolescent mental health services (CAMHS) and from children's social services. Jess came to be adopted after the courts accepted that she had been neglected by her alcoholic mother who had separated from her birth father who had a long career in crime. Jess' two half-siblings from other fathers lived in their fathers' families.

Assessments focussed on her trauma, not her neurodiversity. Solutions proposed were a failure since the diagnosis was rational – but flawed. Jess moved rapidly from foster families to residential care to secure care. A return to the community did not last long. Lack of spaces in secure children's homes meant that a bespoke placement authorised in which her deprivation of liberty was authorised under the inherent jurisdiction was the only option left.

Speak to Jess and she tells you that she actually '*loves*' the bespoke placement. It enables her to feel 'wanted'. She can't see herself living in the community since there is now no-one 'left' for her. She is without roots having moved so frequently that she barely got to know the building she was living in. She is without anchors since those who she had thought of her had long 'disconnected' from her. She never returned to her mother who is now sadly dead. Her adoptive parents are scarred from their experience of parenting her, have separated and have new families where she does not have a place. She had a string of social workers – too many to remember. She never had any school friends or friends in the 'community' since she was never part of either.

As her Deprivation of Liberty order was in the process of being renewed, Jess absconded – stabbed a random person and was convicted for murder. She is expected to spend a majority of her life in prison.[2]

There are a number of Jess' in prison. Yet, the ending need not be so stark.

In this article, I will analyse five aspects where interventions may have yet changed the trajectory.

1 https://www.expertwitness.co.uk/expert/67da97a1bc96b45a97508122

2 Details have been changed to protect confidentiality.

1. Disability and distress vs diagnosis: Clinicians often focus on getting the 'diagnosis' right. Unfortunately, in clinical practice, it is at the cost of not recognising the distress and disability that accompanies clinical presentations. *Diagnosis in mental health is dimensional, not categorical*. A focus on defining categories accurately, can sometimes miss the subtle dimensions that may yet contribute to the disability and resulting distress. Psychiatry is not alone in taking a 'dimensional' approach. Indeed, most of medicine (excluding infectious diseases and trauma) takes a dimensional approach where disability or distress underpin the need for treatment. For example, a shepherd in a developing country may not experience the disability arising from his deteriorating vision for a long time. Yet, a lawyer would notice the impairment associated with deteriorating vision much earlier due to the nature of the work undertaken. The reluctance to embrace a diagnosis despite evidence of distress and/or disability does more harm to the child in the short, medium and long-term.

2. Medications treat symptoms – not the underlying cause: A reluctance to use medication – alongside other psychological interventions – is another factor that can impair a child's ability to sustain and succeed in school. Medication – particularly for ADHD, a common neurodevelopmental disorder – is known to be effective across numerous studies. Folkins and colleagues[3] reported on the use of long-acting stimulant (LAS) medications in school children. They found '*LAS treatment was associated with improved report card and provincial assessment exam scores among grades 9 to 12, reduced absences among grades K-12 and increased likelihood of graduation and transition to post-secondary education.*' Concerns over substance abuse associated with stimulant medication is not borne by research. Baweja and colleagues [4] analysed the impact of ADHD medication on those abusing substances. They concluded '*stimulant treatment was associated with fewer hospitalizations, accidental overdoses, and suicidal ideation/attempts. Overall, ADHD treatment was associated with a 30% lower risk of mortality.*' Conversely, lack of treatment for ADHD is associated with increased criminality [5] and an early death[6]. In summary – long acting stimulant medication has a strong evidence basis for improved outcomes in those with ADHD. Denying treatment or,

[3] Chris Folkins et al., 'Academic Outcomes in Primary and Secondary School Students Prescribed Long-Acting Stimulants for ADHD Management', *Journal of Attention Disorders* 30, no. 4 (2026): 493–505, https://doi.org/10.1177/10870547251378169.
[4] Raman Baweja et al., 'Attention-Deficit/Hyperactivity Disorder Treatment Patterns and Association With Clinical Outcomes in Adolescents and Young Adults with Co-Occurring Attention-Deficit/Hyperactivity Disorder and Substance Use Disorder: A Retrospective Analysis', *Journal of the American Academy of Child & Adolescent Psychiatry*, December 2025, S0890856725022324, https://doi.org/10.1016/j.jaac.2025.12.003.
[5] Martina Nicole Modesti et al., 'ADHD in Adults and Criminal Behavior: The Role of Psychiatric Comorbidities and Clinical and Sociodemographic Factors in a Clinical Sample', *International Journal of Law and Psychiatry* 101 (July 2025): 102088, https://doi.org/10.1016/j.ijlp.2025.102088.
[6] Søren Dalsgaard et al., 'Mortality in Children, Adolescents, and Adults with Attention Deficit Hyperactivity Disorder: A Nationwide Cohort Study', *The Lancet* 385, no. 9983 (2015): 2190–96, https://doi.org/10.1016/S0140-6736(14)61684-6.

at the very least, a therapeutic trial, does deserving patients a great disservice.

3. Loss of 'institutional memory[7]': In children living within families, it is the families themselves, the schools and the community which provide an ongoing repository of the child's information. For children who come into care, it is the State that is expected to hold the child in its mind – the 'institutional memory'. Yet, multiple placement breakdowns often lead to changes in therapeutic teams and systems. Each new CAMHS team is typically unaware of the young person's prior experience in care to the same extent as someone who has known the person over the years. Every new social worker is a new leaf in the child's memory book, but is not able to hold the narrative of the child in the same way that a parent/grandparent does. Such loss of institutional memory leaves the system around the child repeating errors from the child's past.

4. Absence of an Always Available Adult: Children in care are often surrounded by adults. For those who are violent or abusive or absconding, the number of adults is higher. It is not uncommon to come across a child being on 3:1 continuous observations due to their risks. Yet, none of these adults could be understood as being always available for the child. An always available adult is not someone who needs to be physically close to the child. It is usually an adult who the child regards as being supportive *despite* their physical separation. It is typically an adult who has believed in the child's potential or seen a positive aspect of their emerging personality which has got buried in the multiple incident reports and risk assessments. Yet – and this is an important *yet,* research[8] shows that a child requires one – just one – adult to believe in their potential to succeed. Such belief is often able to help the child overcome the most severe adverse childhood experiences. Such an adult can have positive consequences not just for mental health but also physical health.

5. *ACEs to PACES[9] – from deficit to strengths*: Most of the professional conversations around 'complex' young people is around their deficits. This also involves an understandable emphasis on 'trauma' and the need for healing the trauma. An increasingly restrictive regime however tends to simply reinforce the trauma. In clinical practice, within multiprofessional meetings, it is often interesting to observe the response from professionals when the issue of a child's strengths is brought up. Well meaning professionals frequently overlook the child's strengths to the detriment of the child. In some cases, it may be due to the ignorance of those strengths on behalf of the workforce[10] or the paucity of information on supporting an autistic young person's obvious tech talent[11]. Frustrated at being forced to communicate through the spoken word, these young people – often on the autistic spectrum – are then subject to

[7] t.ly/aaWFv
[8] Mark A. Bellis et al., 'Does Continuous Trusted Adult Support in Childhood Impart Life-Course Resilience against Adverse Childhood Experiences - a Retrospective Study on Adult Health-Harming Behaviours and Mental Well-Being', *BMC Psychiatry* 17, no. 1 (2017): 110, https://doi.org/10.1186/s12888-017-1260-z.
[9] https://www.linkedin.com/pulse/paces-aces-rethinking-childhood-girish-vaidya/
[10] https://www.linkedin.com/feed/update/urn:li:activity:7468176303054225408/
[11] https://www.linkedin.com/pulse/from-self-taught-coder-tech-visionary-what-can-support-girish-vaidya-owhef/

Deprivation of Liberty Orders with escalating restrictions. Their ACEs (Adverse Childhood Experiences) are then amplified. Services should start to focus on a child's strengths – the PACES (Positive Assessment of Childhood Experiences and Strengths) approach. Doing so helps to reduce the trauma of ACEs, presents children with tools for recovery, helps them to identify their Always Available Adult (AAA) and thereby also discover their ability to monetise their skills.

To contextualise for Jess, a focus on her impulsivity, distractibility and hyperactivity would have been accurately identified as ADHD. It would have led to treatment with methylphenidate which would have allowed her to stay in one placement. Being in a single placement would have helped develop institutional memory. It would have also facilitated developing relationships which could have identified her match with an Always Available Adult. The latter would have facilitated developing her strengths in sports (she was an excellent footballer) which would have led to a career in coaching.

Jess needed to ascend the 'Virtuous Spiral' wherein those around her identified her strengths and enabled her to take risks with activities that would have gained positive attention. Such positive attention would have further cemented her self-esteem leading to self-belief. Unfortunately, Jess ended up in a 'Vicious Spiral' where her traumas were the main focus, leading her to feel a passive recipient of support that was transitional since she would be moving placements rapidly. As people around her stopped believing in her possibilities, Jess did so too ending up in behavioural dysregulation that spiralled downwards into a long prison sentence. With a reported million children referred for anxiety[12], the need for a different approach is all the more crucial.

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[12] https://www.bbc.co.uk/news/articles/cwyd1l0lge8o

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex also does a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Neil's training dates are available on his website.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in September. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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