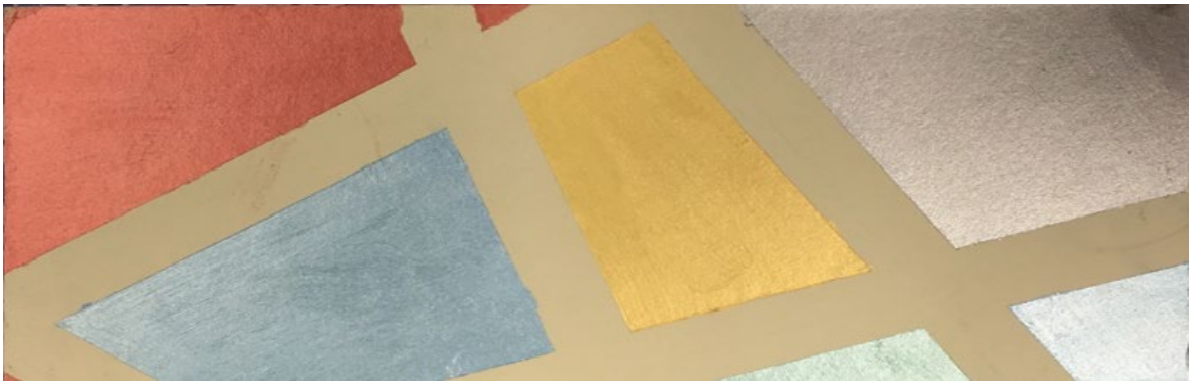
MENTAL HEALTH MATTERS
November 2026 | Issue 165



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

(1) In the Health, Welfare and Deprivation of Liberty Report: key themes from post-AGNI caselaw to date, and two medical treatment decisions showing doctors getting it right;

(2) In the Property and Affairs Report: self-dealing in the rearview mirror, dismay at deputy delegation and blithe ignorance of the obligations on a deputy as regards settlement of monies;

(3) In the Practice and Procedure Report: personal welfare orders after HB;

(4) In the Mental Health Matters Report: the Mental health conditions, ADHD and autism prevalence review; and Royal College of Psychiatrists on coercion and human rights;

(5) In the Children's Capacity Report: information-sharing as regards children, and new procedural rules relating to children in ECtHR cases;

(6) In the Wider Context Report: deprivation of liberty before Strasbourg, guidance on eating and drinking at acknowledged risk, and an important change of position relating to Jehovah's Witnesses;

(7) In the Scotland Report: the death of a Bill that never was, and a new appointment for the Mental Welfare Commission.

With huge thanks to Neil Allen, we have set up a running table of post-AGNI cases allowing rapid identification of the types of scenarios being considered, and the results. The case-tracker can be found here, a page where we also host an 'AGNI annex' summarising and commenting on the cases decided in October.

All our other content that you might need – our Reports, our case-law summaries, and our guidance notes – can be found via here.

Editors
Alex Ruck Keene KC (Hon)
Victoria Butler-Cole KC
Neil Allen
Nicola Kohn
Katie Scott
Arianna Kelly
Annabel Lee
Alex Cisneros

Scottish Contributors
Adrian Ward
Jill Stavert

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.

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Mental health conditions, ADHD and autism prevalence review

The long-trailed review report was published on 9 October. It is a long, detailed, and nuanced report. Of particular importance are its conclusions (taken here from the executive summary) in relation to diagnosis:

> *Public debate is often reduced to a single question: is there too much diagnosis or too little? Underdiagnosis, misdiagnosis and overdiagnosis are different problems, and all 3 can occur within the same system at the same time. They occur across many areas of medicine and are not unique to ADHD, autism or mental health conditions.*
>
> *Diagnosis is often complex, and in mental health and neurodevelopmental care there is no biological test that provides a simple 'yes or no' answer. What matters is:*
>
> - *whether people receive an accurate and comprehensive assessment that identifies the causes of their difficulties and the degree of functional impairment they are experiencing*
> - *appropriate diagnosis where needed and that this informs the right support that improves their functioning, participation and quality of life*
>
> [...] *Overdiagnosis, misdiagnosis and underdiagnosis are all system failures.*
>
> *Both misdiagnosis and overdiagnosis are harmful. They may delay appropriate support, lead to unnecessary or inappropriate treatment, or focus attention on the wrong solutions. People understandably ask whether 'ordinary' stress, worry and low mood are increasingly being classified as disorders. That may happen because the threshold between normal variation or having certain traits and having a clinical condition or disorder can be difficult to define in practice and is a clinical judgement. But over-medicalisation specifically occurs when every difficulty is assumed to require a medical response. For example, a young person who is lonely but not clinically depressed may benefit more from rebuilding social connection and participation than from antidepressant medication.*
>
> *Misdiagnosis is an unwelcome but inescapable fact of modern medicine, including psychiatry and psychology. However, we are confident that the rapid increases in administrative prevalence and demand for diagnostic assessments, together with the system failures in responding to this, are creating the conditions for increasing risk of misdiagnoses. As was noted above, recorded diagnoses in some younger age groups are now exceeding older population prevalence estimates (chapters 7 and 8).*

> *On the basis of evidence available to us we cannot conclude that overdiagnosis is occurring at scale, particularly given the gaps in population prevalence data and data reporting. However, if present trends continue we are clearly entering a phase in which the balance of risks is changing, from previous merited concerns with under recognition and underdiagnosis, towards an increased risk of misdiagnosis and overdiagnosis, which are becoming increasingly important considerations for policy and service delivery.*
>
> *Under-recognition nevertheless continues for some groups. The increasing risk of overdiagnosis or misdiagnosis cannot mean neglecting those often overlooked. The requirement is for comprehensive, high-quality assessment and timely diagnosis where needed, while making practical and clinical support available according to need rather than diagnosis alone.*
>
> *None of this should be taken to suggest that people's distress or difficulties are not real. If anything, the evidence points the other way: the rising numbers coming forward for assessment have not been accompanied by any fall in severity or impairment - those now presenting are no less affected than those identified before. People are seeking answers and support for very real problems, and they are not the problem. <u>The problem is a system that leans too heavily on diagnosis as the route to help and cannot keep pace</u>* (emphasis added)

The system's reliance on diagnosis, rather than need, is a feature of the report more broadly,[1] the report earlier emphasising:

> *There should be a fundamental shift from a 'diagnosis-dependent' system to a 'needs-led plus diagnosis' system. The heated debate about whether there is too much diagnosis or too little risks reinforcing the centrality of diagnosis rather than need and timely access to support and treatment. The government must address 2 failures at the same time:*
>
> 1. *People wait far too long for support, diagnosis and treatment.*
> 2. *Diagnosis has become the primary gateway to support that could and should be available earlier.*
>
> *These failures sit alongside insufficient capacity for people with the most severe, enduring and complex needs.*

As the report makes clear:

> *Diagnosis matters but is not without risks. For many people it is clinically necessary, personally meaningful and essential to treatment. It can help explain and address difficulties that significantly impair a person's functioning, participation and quality of life. People with significant functional impairment should be able to access diagnostic assessment within a reasonable timeframe and specialist care should reach those who need it most. Support should be available according to a person's needs before, during and after assessment, and not be withheld while waiting for a diagnosis.*

[1] Similar issues were highlighted by the Law Commission in its report on Disabled Children's Social Care.

> *Diagnosis can also do harm when it is inaccurate or used poorly. It can direct someone towards the wrong treatment and obscure co-occurring conditions or the social and environmental causes of their difficulties. A diagnosis can inform practical support people need to remain in education, participate in work, sustain relationships and live well. But those same outcomes can also be delayed or denied if a diagnostic label defines a person by their difficulties rather than by their strengths, circumstances and potential.*

Royal College of Psychiatrists' position statement on coercion and human rights

Responding to guidance issued by the World Health Organisation, suggesting (in effect) that any form of non-consensual admission and treatment is always unlawful, the Royal College of Psychiatrists published in October 2026 a position statement entitled: *Coercion and other forms of restrictive practices: compliance with human rights*.[2] As the covering webpage identifies:

> *The statement sets out the College's position on coercion and other forms of restrictive practice in mental healthcare. It emphasises dignity, autonomy and the need to minimise these interventions, while arguing that their use may sometimes be necessary as a last resort to prevent serious harm. Responding to WHO–UN guidance, it explains the College's view that carefully justified interventions can be compatible with human rights, drawing particularly on the European Convention on Human Rights.*
>
> *The College states that care should be based on informed consent wherever possible. Any involuntary treatment or restrictive measure must be lawful, necessary, proportionate and subject to rigorous safeguards, including individual assessment, clear documentation, regular review, access to advocacy and independent oversight. The statement also supports advance care planning to preserve patients' wishes and preferences, and highlights additional safeguards for children and young people.*
>
> *Its recommendations extend beyond individual clinical decisions to the organisation of care. The College calls for stronger community services alongside appropriate inpatient provision, research into alternatives to coercion, and coordinated action on housing, education, employment and social inclusion. It also advocates continued work on capacity-based mental health law across the UK, robust accountability, and meaningful involvement of patients and families in care, research and policy.*

[2] Full disclosure, Alex was one of the authors, in his role as a member of the College's Special Committee on Human Rights.

Editors and Contributors



Alex Ruck Keene KC (Hon): alex.ruckkeene@39essex.com
Alex has been in cases involving the MCA 2005 at all levels up to and including the Supreme Court and European Court of Human Rights. He also writes extensively, has numerous academic affiliations, including as Professor of Practice at King's College London, and created the website www.mentalcapacitylawandpolicy.org.uk. To view full CV click here.



Victoria Butler-Cole KC: vb@39essex.com
Victoria regularly appears in the Court of Protection, instructed by the Official Solicitor, family members, and statutory bodies, in welfare, financial and medical cases. She is a former Chair of the Court of Protection Bar Association and a member of the Nuffield Council on Bioethics. To view full CV click here.



Neil Allen: neil.allen@39essex.com
Neil has particular interests in ECHR/CRPD human rights, mental health and incapacity law and mainly practises in the Court of Protection and Upper Tribunal. He trains health, social care and legal professionals through his training company, LPS Law Ltd. When time permits, Neil publishes in academic books and journals and created the website www.lpslaw.co.uk. To view full CV click here.



Arianna Kelly: Arianna.kelly@39essex.com
Arianna practices in mental capacity, community care, mental health law and inquests. Arianna acts in a range of Court of Protection matters including welfare, property and affairs, serious medical treatment and in inherent jurisdiction matters. Arianna works extensively in the field of community care. She is a contributor to the Court of Protection Practice (LexisNexis). To view full CV, click here.



Nicola Kohn: nicola.kohn@39essex.com

Nicola appears regularly in the Court of Protection in health and welfare matters. She is frequently instructed by the Official Solicitor as well as by local authorities, ICBs and care homes. She is a contributor to the 5th edition of the *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (BMA/Law Society 2022). To view full CV click here.



Katie Scott: katie.scott@39essex.com

Katie advises and represents clients in all things health related, from personal injury and clinical negligence, to community care, mental health and healthcare regulation. The main focus of her practice however is in the Court of Protection where she has a particular interest in the health and welfare of incapacitated adults. She is also a qualified mediator, mediating legal and community disputes. To view full CV click here.



Annabel Lee: annabel.lee@39essex.com

Annabel has a well-established practice in the Court of Protection covering all areas of health and welfare, property and affairs and cross-border matters. She is ranked as a leading junior for Court of Protection work in the main legal directories, and was shortlisted for Court of Protection and Community Care Junior of the Year in 2023. She is a contributor to the leading practitioners' text, the Court of Protection Practice (LexisNexis). To view full CV click here.



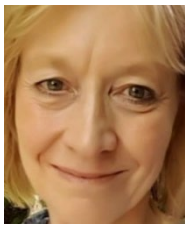
Alex Cisneros: alex.cisneros@39essex.com

Alex regularly appears in health and welfare and property and affairs cases in the Court of Protection. He has appeared in leading cases to do with deputyship and published a textbook about LPAs. His recent doctoral thesis explores the impact of changes to mental capacity law in England and Wales. To view a full CV, click here.



Adrian Ward: adrian@adward.co.uk

Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.



Jill Stavert: j.stavert@napier.ac.uk

Jill is the inaugural Executive Director (Law and Policy) at the Mental Welfare Commission, having previously been Professor of Law, Director of the Centre for Mental Health and Capacity Law and Director of Research, as well as a long-standing member of the Law Society of Scotland's Mental Health and Disability Committee. To view full CV click here.

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.

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 December. 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.

Sheraton Doyle
Director of Clerking
sheraton.doyle@39essex.com

Peter Campbell
Director of Clerking
peter.campbell@39essex.com

Chambers UK Bar
Court of Protection: Health & Welfare
Leading Set

The Legal 500 UK
Court of Protection and Community Care
Top Tier Set

clerks@39essex.com • DX: London/Chancery Lane 298 • 39essex.com

LONDON
81 Chancery Lane,
London WC2A 1DD
Tel: +44 (0)20 7832 1111
Fax: +44 (0)20 7353 3978

MANCHESTER
82 King Street,
Manchester M2 4WQ
Tel: +44 (0)16 1870 0333
Fax: +44 (0)20 7353 3978

SINGAPORE
Maxwell Chambers,
#02-16 32, Maxwell Road
Singapore 069115
Tel: +(65) 6634 1336

KUALA LUMPUR
#02-9, Bangunan Sulaiman,
Jalan Sultan Hishamuddin
50000 Kuala Lumpur,
Malaysia: +(60)32 271 1085

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