The Fonagy Review asks some right questions – inside a framework that risks real harm

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neurobetter's response to the interim report of the Independent Review into Mental Health Conditions, ADHD and Autism, and to Professor Peter Fonagy's commentary in The Times (31 March 2026)

Professor Fonagy writes that "the question we face is not whether we should care more about mental health and neurodiversity. We should. It is whether we are responding in the right way."

We agree with the second sentence. But we are concerned that this review – and the way it is already being reported – is not responding in the right way either.

What the review gets right

There are points in this interim report that neurobetter has been making from the start. Support should not be gatekept behind diagnosis. Early, accessible help matters. Systems that force people to wait years for an assessment before they can access any meaningful support are failing everyone – the people waiting, the clinicians assessing, and the public purse.

Professor Fonagy is right that "when support is tied tightly to diagnostic labels, demand for diagnosis will rise." That is not a revelation. It is a description of a system that successive governments have chosen to maintain. The question is not why people seek diagnosis. It is why diagnosis remains the only key that opens the door.

We also want to be clear: the panel leading this review brings decades of distinguished clinical and academic expertise. Professor Fonagy, Sir Simon Wessely, and Professor Gillian Baird have each made substantial contributions to their fields. Our concern is not with their credentials or their intentions. It is with the framing of the review itself, and how that framing will be received.

What concerns us

The review frames rising diagnoses as a problem to be explained. It uses language like "medicalisation of distress", "self-identify" (in quotation marks), and "incentivised". The Times headline goes further: children are '"incentivised' to get ADHD and autism diagnoses."

This language does real damage. It implies that neurodivergent people – many of whom have spent years fighting to be taken seriously – are somehow gaming a system. That the increase in recognition, particularly among girls and women, reflects not decades of under-diagnosis finally being corrected, but a fashionable overcorrection.

The report itself acknowledges that "the best population data suggests relatively stable underlying prevalence" for ADHD and autism. But it then sets this against dramatically rising diagnoses and referrals, and invites the reader to conclude that something has gone wrong. An equally valid reading – and one more consistent with the lived experience of the people we work with – is that something is finally going right. People who were previously missed, masked, or misdiagnosed are now being recognised.

What the evidence actually shows

The seven-fold increase in autism diagnoses among girls between 2010 and 2022 is not evidence of overdiagnosis. It is evidence of how profoundly girls were overlooked before.

A Swedish longitudinal study published in the BMJ in February 2026, tracking 2.7 million children born between 1985 and 2020, found that the male-to-female ratio for autism diagnosis was 3:1 in childhood but narrowed rapidly from age 10 onwards. By age 20, the researchers projected the cumulative ratio would reach parity. The gap does not widen with age. It closes. That is not a pattern consistent with overdiagnosis. It is a pattern consistent with girls being systematically missed, diagnosed later, and forced to mask their way through childhood without support.

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The picture for ADHD is strikingly similar. A systematic review published in the Journal of Attention Disorders found that boys are diagnosed at roughly 3:1 compared to girls in childhood – but by adulthood, the ratio narrows to near parity. Girls with ADHD are more likely to present with inattentive symptoms, which are less disruptive in a classroom and therefore less likely to be noticed. They are more likely to be misdiagnosed with anxiety or depression. They are more likely to develop compensatory strategies that mask their difficulties until those strategies collapse – often in adolescence or early adulthood, at precisely the point where the review notes a surge in referrals.

In experimental vignette studies, when teachers and parents were presented with identical symptom profiles differing only in the child's name, they were significantly less likely to recommend ADHD assessment for girls than for boys. This is not demand rising because of TikTok. It is demand rising because half the population was being missed, and some of them have now found the language to describe what they experience.

The human cost of getting this wrong

The stakes of this conversation are not abstract. Up to 35% of autistic people have considered suicide, and up to 25% have attempted it. Autistic people are up to seven times more likely to attempt suicide than non-autistic people. Around eight in ten autistic people will experience a mental health problem during their lifetime, compared to one in four in the general population.

Only 31.4% of autistic people are in employment, according to the most recent ONS data – compared to around half of all disabled people and eight in ten non-disabled people. The Buckland Review of Autism Employment, published in 2024, set out 19 recommendations to address this gap. Progress has been slow.

Masking – the very strategy that causes so many neurodivergent people, particularly women and girls, to be missed by diagnostic services – is itself associated with higher rates of depression, burnout, and suicidality. When we frame rising diagnoses as a problem, we risk reinforcing the conditions that lead to these outcomes. People who are identified and supported earlier do better. People who are missed do not.

The missing perspective

"Nearly one in ten young adults 'self-identify' as autistic," the report notes. The quotation marks around "self-identify" are telling. For many people, self-identification is not a casual label adopted from social media. It is the result of years of research, reflection, and recognition – often because the formal diagnostic pathway was inaccessible, unaffordable, or had a waiting list measured in years. There are currently over 562,000 open referrals for ADHD assessment in England alone. To frame self-identification as a symptom of the problem, rather than a rational response to a broken system, is to misunderstand the people you are trying to help.

We recognise that the review has engaged with lived experience organisations and recruited lived experience partners into its topic groups. That matters, and we welcome it. But engagement is not the same as influence. The framing of this interim report – the language it uses, the questions it centres, the narrative it invites – does not read as though it was shaped by the people it describes. Lived experience is not a substitute for clinical expertise, but it is not subordinate to it either. A review of this significance – one that will shape policy for years to come – should reflect both in its conclusions, not only in its consultation process.

The wider context

This review does not exist in a vacuum. It sits alongside broader policy conversations about welfare reform, economic inactivity among young people, and the rising cost of disability benefits. We recognise that these are legitimate areas of public concern, and that government has a responsibility to ensure systems are sustainable and well-targeted.

But the language of "overdiagnosis" and "incentivisation" carries risks in that context. It can too easily become a justification for tightening access rather than improving services – for treating rising demand as the problem rather than the decades of unmet need that generated it.

It has been reported that almost 95,000 people now claim Personal Independence Payments for ADHD, up three and a half times since before the pandemic. We would encourage a different reading: these are people whose needs were always there, who are now – finally – able to name what they experience and

access the support they are entitled to. The challenge for policymakers is to ensure that support is well-designed, not to question whether it should exist.

What we would rather see

Professor Fonagy calls for "a system that is more proportionate, more responsive and less dependent on diagnosis alone." We agree, but with an important qualification: the answer to a system that gates support behind diagnosis is not to question the validity of diagnosis. It is to build support that does not require one.

neurobetter exists because we believe people should not have to be in crisis to deserve support. We believe that neurodivergent people's distress is real, that it is shaped by systems and environments as much as by neurology, and that earlier, affirming support can prevent the escalation this review describes.

We would welcome a final report that:

- centres neurodivergent voices and lived experience in its evidence base and recommendations
- distinguishes clearly between the increase in recognition (which is welcome) and any genuine concerns about diagnostic quality (which require better training and resourcing, not suspicion)
- resists the framing of rising diagnoses as inherently problematic, and instead examines the decades of under-recognition that preceded them
- addresses the structural reasons support is tied to diagnosis, rather than implying that the people seeking diagnosis are the problem
- considers how its findings and language will be received by policymakers, the media, and – most importantly – the neurodivergent people whose lives will be affected by the policy decisions that follow

A final thought

Professor Fonagy writes that "we have encouraged people to recognise distress and seek help. We have been less clear about how to stay well."

We would put it differently. We have encouraged people to recognise distress. We have then made them wait years for help. We have built systems that require a clinical label before they will listen. And now we are asking whether too many people are seeking that label.

The answer is not fewer diagnoses. It is better systems.

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neurobetter is a UK registered charity (1210347) working to improve the mental health and wellbeing of neurodivergent people through understanding, connection, and earlier support. We are not a crisis service and do not provide diagnosis or therapy. Learn more at neurobetter.org.

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