INSIGHTS ON INSIGHT: THE LIMITS OF INSIGHT IN ASSESSING MEDICAL TREATMENT DECISION-MAKING CAPACITY

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Questions around medical treatment decision-making capacity ('DMC') arise commonly in clinical practice, requiring medical practitioners to assess an individual's DMC. The test for DMC is generally well established across Australia and is derived from legislation and the common law from the United Kingdom. However, the application of the test can be challenging when the individual ostensibly lacks insight into their diagnosis or need for treatment. This article examines the use of insight in the assessment of DMC by medical practitioners and, on appeal, courts, and argues that focusing on insight leads to an improper application of the DMC test. The consequence is a higher than intended threshold for DMC, resulting in a finding of incapacity where there legally should not be and thereby depriving the individual of their decisional autonomy.

CONTENTS

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I Introduction

All individuals have a fundamental right to make their own medical treatment decisions.[1] This freedom to choose is premised on the presumption that individuals who have attained adulthood have the requisite decision-making capacity ('DMC') to make their own decisions.[2] When doubts arise about DMC, often in the context of a mental illness or neurocognitive disorders, it can present significant medical, legal and ethical challenges for all those involved.[3] The biggest impact is on the individual whose decisional autonomy is under threat.

[1] *Schloendorff v Society of New York Hospital*, 105 NE 92, 93 (Cardozo J) (NY, 1914), quoted in *Secretary, Department of Health & Community Services v JWB* (1992) 175 CLR 218, 234 (Mason CJ, Dawson, Toohey and Gaudron JJ), 310 (McHugh J) ('*Marion's Case*'); *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] AC 871, 882 (Lord Scarman); *Airedale NHS Trust v Bland* [1993] AC 789, 816 (Butler-Sloss LJ), 826–7 (Hoffman LJ); *Re T* [1993] Fam 95, 115 (Lord Donaldson MR), 116–17 (Butler-Sloss LJ), 120–1 (Staughton LJ); *Heart of England NHS Foundation Trust v JB* (2014) 137 Butterworths Medico-Legal Reports 232, 235 [1]–[2] (Peter Jackson J) ('*Heart of England*'); *PBU v Mental Health Tribunal* (2018) 56 VR 141, 183 [137] (Bell J) ('*PBU*'); *Falconer v Commissioner of Police [No 2]* [2024] WASCA 47, [111]–[116], [118] (Buss P and Vaughan JA). See also *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) arts 3(a), 12.

[2] The focus on this article is decision-making capacity ('DMC') in relation to adults (ie those over the age of eighteen). There are different considerations when dealing with minors: see below n 14. Notably, unlike competent adults, who have an absolute right to consent or refuse medical treatment, courts have an inherent (*Parens Patriae*) jurisdiction over minors to override their decision even if they are competent to make legally valid treatment decisions: see Malcolm Smith and Ben Mathews, 'Children and Consent to Medical Treatment' in Ben White et al (eds), *Health Law in Australia* (Lawbook, 4th ed, 2024) 165, 187–8, 200–7. See also, eg, *Minister for Health v AS* (2004) 29 WAR 517; *X v The Sydney Children's Hospitals Network* (2013) 85 NSWLR 294; *H v AC* (2024) Aust Torts Reports ¶83-026; *Re AC* [2026] NSWSC 236.

[3] Scott Lamont, Cameron Stewart and Mary Chiarella, 'Decision-Making Capacity and Its Relationship to a Legally Valid Consent: Ethical, Legal and Professional Context' (2016) 24(2) *Journal of Law and Medicine* 371, 372; Sandip Talukdar, 'Undisclosed Probing into Decision-Making Capacity: A Dilemma in Secondary Care' (2021) 22(1) *BMC Medical Ethics* 100:1–14, 12; Nuala B Kane et al, 'Difficult Capacity Cases: The Experience of Liaison Psychiatrists' (2022) 13 *Frontiers in Psychiatry* 946234:1–12, 9–10; Chloe Beale et al, 'Mental Capacity in

The legal test for determining DMC in relation to medical treatments is generally well-established across all the states in Australia, the origins of which can be traced back to the development of the common law and legislation in the United Kingdom ('UK'). The DMC test focuses on the individual's functional ability to make the decision, rather than the prudence of the decision or the status of any illness or disability they may have.

Uncertainties around medical treatment DMC arise frequently, requiring medical practitioners to assess the individual's DMC in relation to specific treatment decisions.[4] Whilst the DMC test appears simple and easy to comprehend, its application can present significant challenges when the individual ostensibly lacks *insight*[5] into various facets of the decision, including insight into their diagnosis or need for treatment. Although the exact definition of insight in the medical context can be complex and nuanced,[6] it remains a commonly used concept by medical practitioners to generally signal the extent to which the individual accepts, believes and applies the relevant information to their circumstances in arriving at a treatment decision.[7] Insight is not a criterion of the DMC test.[8] Despite this, medical practitioners continue to place emphasis on it in their DMC assessments as it is a convenient and familiar clinical concept, especially in psychiatry.[9] Where there is a lack of insight, it can form a core tenet of the medical practitioner's reasoning of their determination on the

Practice Part 2: Capacity and the Suicidal Patient' (2024) 30(1) *BJPsych Advances* 11 ('Mental Capacity in Practice Part 2'); Roshen John et al, 'Ethical Challenges in the Treatment of Psychotic Pregnancy Denial' (2024) 15 *Frontiers in Psychiatry* 1337988:1–7, 1, 3. See, eg, *St George's Healthcare NHS Trust v S* [1999] Fam 26, 36, 43–4 (Butler-Sloss LJ).

4 This article refers specifically to medical practitioners; however, there are other professional craft groups that also play a pivotal role in the assessment of medical treatment DMC such as neuropsychologists: Nicola Mooney et al, 'Decision-Making Capacity Assessments in New Zealand and Australia: A Systematised Review' (2024) 31(5) *Psychiatry, Psychology and Law* 816, 830–1. Courts and tribunals may also look at other sources of information in determining DMC: *KH v Nottinghamshire Healthcare NHS Foundation Trust* [2025] 1 WLR 4263, 4279 [73]–[74] (Upper Tribunal Judge Church); Alex Ruck Keene (ed), *Assessment of Mental Capacity: A Practical Guide for Doctors and Lawyers* (Law Society, 5th ed, 2022) 55.

5 There are numerous other terms used in this context that signal the same meaning as *insight*. These include terms such as 'appreciate', 'believe' and 'understand': see below Part III(A).

6 See Genevra Richardson, 'Mental Capacity at the Margin: The Interface between Two Acts' (2010) 18(1) *Medical Law Review* 56, 65.

7 See ibid 65–6, 68.

8 See below n 15.

9 The concept of 'insight' has a long-standing history with psychiatry: Aubrey Lewis, 'The Psychopathology of Insight' (1934) 14(4) *British Journal of Medical Psychology* 332; Anthony S David, 'Insight and Psychosis: The Next 30 Years' (2020) 217(3) *British Journal of Psychiatry* 521, 521; Sarah R Kamens et al, 'Enhancing Insight into Clinical Insight: An Investigation of Conceptual Variations' (2025) 12(1) *Psychology of Consciousness: Theory, Research, and Practice* 68, 69–74. See also below n 195.

individual's DMC.[10] Their findings on insight then inform their expert evidence, forcing the court or tribunal,[11] as the final arbiter of DMC, to consider and rely on notions of insight in making its decision.[12]

In this article, it is argued that the use of insight distracts, rather than assists, with the DMC assessment and there is a danger that it will lead courts astray, causing them to falsely find incapacity. By examining UK and Australian jurisprudence, Part II outlines the current legal test for determining DMC as well as some important principles that underpin the DMC assessment. Part III discusses the development of the law as it relates to insight in determining DMC. Concerns around the impact of insight on the DMC assessment have been recognised in the UK,[13] and Part IV specifically details the problems that insight causes in applying the DMC test. It is argued that focusing on insight leads to an improper application of the DMC test. The consequence of this may be a higher than intended threshold for DMC and less transparent decision-making around DMC. Part V considers what role there is, if any, for insight in the assessment of DMC. Part VI concludes that both medical practitioners and courts should use insight with caution.

[10] See below nn 123, 195.

[11] Matters on DMC in many states and territories in Australia are heard in administrative or specially constituted tribunals in the first instance. This article will generally refer to courts, but this should be taken to include tribunals. In the United Kingdom ('UK'), the Court of Protection hears matters on DMC: Alex Ruck Keene et al, 'Taking Capacity Seriously? Ten Years of Mental Capacity Disputes before England's Court of Protection' (2019) 62 *International Journal of Law and Psychiatry* 56, 59–63; Janet Weston, 'Managing Mental Incapacity in the 20th Century: A History of the Court of Protection of England & Wales' (2020) 68 *International Journal of Law and Psychiatry* 101524:1–12, 1.

[12] See, eg, Kate Diesfeld, 'Insight: Unpacking the Concept in Mental Health Law' (2003) 10(1) *Psychiatry, Psychology and Law* 63, 64–5; Susanna Radovic, Lena Eriksson and Moa Kindström Dahlin, 'Absence of Insight as a Catch-All Extra-Legislative Factor in Swedish Mental Health Law Proceedings' (2020) 27(4) *Psychiatry, Psychology and Law* 601, 601–2, 608, 611–12. See also below n 195 and accompanying text.

[13] See especially Paula Case, 'Dangerous Liaisons? Psychiatry and Law in the Court of Protection' (2016) 24(3) *Medical Law Review* 360, 378; Neil Allen, 'Is Capacity "In Sight"?' [2009] (Winter) *Journal of Mental Health Law* 165, 167–70.

II Decision-Making Capacity

A *The Decision-Making Capacity Test*

Before examining the role of insight in assessing DMC, it is important to understand the elements of the DMC test, including their interpretation and application. By doing so, it will become apparent how incorporation of insight into the DMC assessment distorts the application of the test to the detriment of the individual being assessed.

Where legislation exists, the test for medical treatment DMC for adults across Australia,[14] though worded differently between the states and

[14] Whether the adult DMC test applies to minors remains unclear. Unlike adults, minors are not presumed to have DMC, rather they are required to demonstrate *Gillick* competence. (Although some jurisdictions have statutorily lowered the age at which the DMC presumption applies in relation to some decisions: see, eg, *Consent to Medical Treatment and Palliative Care Act 1995* (SA) s 3(a) ('*Consent to Medical Treatment Act* (SA)').) The concept of *Gillick* competence is derived from *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] 1 AC 112, where Lord Scarman noted that a minor may be able to provide valid consent, a prerequisite of which is DMC, when the minor 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed': at 189, quoted in *Marion's Case* (n 1) 237 (Mason CJ, Dawson, Toohey and Gaudron JJ). There remains uncertainty as to whether the adult DMC test applies in determining *Gillick* competence. In *Re CD* (2024) 75 VR 559, Richards J held that the adult legislative DMC test 'is similar to the common law test of *Gillick* competence': at 566–7 [29(a)]. Although, the need to understand *fully* would be at odds with the adult DMC test: see below Part II(C)(A). In the UK, there are conflicting accounts as to the relationship between the adult DMC test and *Gillick* competence. In *An NHS Trust v X* [2021] 4 WLR 11, Sir James Munby, sitting as a High Court judge, held that the legislative DMC for adults was 'in the realm of psychiatry' whereas *Gillick* competence was concerned with 'child and adolescent psychology': at 19 [73]; therefore the two concepts were 'both historically and conceptually quite distinct': at 20 [75]. Conversely in *Re S* [2019] Fam 117, 185 [15], Cobb J observed:

> [T]he approach of the courts to decision-making by adults and children ought (with appropriate adjustments to reflect age and maturity) in my judgment to be complementary. Therefore, in applying the *Gillick* test in the context of determining the competence of a child to make decisions, I regard it as appropriate, and indeed helpful, to read across to, and borrow from, the relevant concepts and language of the [legislative DMC test used for adults].

Sir James Munby rejected this approach: *An NHS Trust v X* (n 14) 20 [75]. However, Cobb J's position was seemingly accepted recently by the England and Wales Court of Appeal: *Re S* [2026] 1 FLR 73, 84–5 [44] (Andrew McFarlane P, Baker LJ agreeing at 88 [54], Arnold LJ agreeing at 88 [60]) (note that despite the same case name, they are unrelated cases).

territories,[15] is generally modelled after the test contained in s 3(1) of the *Mental Capacity Act 2005* (UK) ('*Mental Capacity Act* (UK)'):[16]

[15] Australian Capital Territory: *Mental Health Act 2015* (ACT) s 7 ('*Mental Health Act* (ACT)'). But see *Medical Treatment (Health Directions) Act 2006* (ACT) Dictionary (definition of 'decision-making capacity'); *Powers of Attorney Act 2006* (ACT) s 9. New South Wales does not have a legislative definition for DMC and relies on the common law: NSW Government, *Capacity Toolkit* (Toolkit, April 2020) 10, 18, archived at <https://perma.cc/6PM8-CBD5> ('*NSW Capacity Toolkit*'). Northern Territory: *Health Care Decision Making Act 2023* (NT) s 8(2) ('*Health Care Decision-Making Act* (NT)'); *Advance Personal Planning Act 2013* (NT) s 6A(2) ('*Advance Personal Planning Act* (NT)'). The *Mental Health and Related Services Act 1998* (NT) is concerned with the minimum requirements for informed consent rather than defining the test for DMC: at s 7. Queensland: *Mental Health Act 2016* (Qld) s 14(1) ('*Mental Health Act* (Qld)'). The Queensland legislation does not contain the use/weigh criterion nor the retain criterion, but arguably this is implied by the requirement that the person 'is capable of making a decision': at s 14(1)(b). See also Queensland Government, *Queensland Capacity Assessment Guidelines 2020* (Guidelines, 7 April 2021) 5, archived at <https://perma.cc/H444-6VHN>. Cf *Guardianship and Administration Act 2000* (Qld) sch 4 (definition of 'capacity' para (b)) ('*Guardianship and Administration Act* (Qld)'). South Australia: *Consent to Medical Treatment Act* (SA) (n 14) s 4(2)(a); *Advance Care Directives Act 2013* (SA) s 7(1)(a); *Mental Health Act 2009* (SA) s 5A(2)(a) ('*Mental Health Act* (SA)'). Tasmania: *Mental Health Act 2013* (Tas) s 7(1)(b) ('*Mental Health Act* (Tas)'); *Guardianship and Administration Act 1995* (Tas) s 11 ('*Guardianship and Administration Act* (Tas)'). Victoria: *Medical Treatment Planning and Decisions Act 2016* (Vic) s 4(1) ('*Medical Treatment Planning Act* (Vic)'); *Mental Health and Wellbeing Act 2022* (Vic) s 87(1) ('*Mental Health and Wellbeing Act* (Vic)'). Western Australia ('WA'): *Mental Health Act 2014* (WA) ss 15(1), 18 ('*Mental Health Act* (WA)'). See also *PBU* (n 1) 190 n 188.

[16] The same test is also applied to a broad range of non-medical decisions in the UK: (UK) Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (Code of Practice, 23 April 2007) 16 [1.8], archived at <https://perma.cc/3LKP-AWPB>. The same cannot be said for non-medical decisions around Australia. For example, in Victoria, the same DMC test is replicated in legislation dealing with medical treatment decisions, including in a mental health context, and in non-medical DMC in relation to guardianship and powers of attorney: *Medical Treatment Planning Act* (Vic) (n 15) s 4(1); *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(1); *Guardianship and Administration Act 2019* (Vic) s 5(1) ('*Guardianship Act* (Vic)'); *Powers of Attorney Act 2014* (Vic) s 4(1) ('*Powers of Attorney Act* (Vic)'). In WA, the *Mental Health Act* (WA) (n 15) ss 15(1), 18 provide a similar test to that of the *Mental Capacity Act 2005* (UK) s 3(1) ('*Mental Capacity Act* (UK)'). However, the *Guardianship and Administration Act 1990* (WA) ('*Guardianship and Administration Act* (WA)') frames DMC as being able to make 'reasonable judgments': at ss 4(3)(b), 4(3)(d), 43(1)(b)(ii), 64(1)(a), 110F. Guardianship laws in WA, including the DMC test, have undergone review by the Law Reform Commission of Western Australia ('LRCWA'), with the LRCWA recommending that a similar definition of DMC to that used in other states be adopted in WA: Law Reform Commission of Western Australia, *Project 114: Guardianship and Administration Act 1990 (WA)* (Final Report, December 2025) 83–4 [6.50]–[6.57] ('*LRCWA Guardianship and Administration Report*'), archived at <https://perma.cc/T7W3-7WAT>. See also Sam Boyle, 'Medical Evidence of Capacity in a Legal Setting: To What Extent Do Courts and Tribunals Make Their Own Decisions?' (2018) 25(2) *Journal of Law and Medicine* 572, 574–5 ('Medical Evidence of Capacity'). The focus of this article is on medical treatment decision-making.

> For the purposes of section 2, a person is unable to make a decision for himself if he is unable —
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).[17]

Section 2(1) relevantly notes:

> For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Therefore, to find a lack of DMC, a court must be satisfied, on a balance of probabilities,[18] that the individual is unable to carry out one or more of the DMC criteria. This inability must then be shown to be a consequence of an

[17] The *Mental Capacity Act* (UK) (n 16) s 3(1) frames the capacity criteria in the negative ('unable'). Other jurisdictions frame it in the positive ('ability to'): see, eg, *Medical Treatment Planning Act* (Vic) (n 15) s 4(1). This likely has no impact on the interpretation of the legislation. Although, given that there is a presumption of DMC, a negative framing of the test is technically more accurate as the burden is on proving an inability to carry out one of the four criteria (rather than proving that the individual can carry out all four): see below Part II(B)(1); *LRCWA Guardianship and Administration Report* (n 16) 84 [6.52]. However, for simplicity, this article will refer to the positive framing ('ability to').

[18] *Mental Capacity Act* (UK) (n 16) s 2(4); *Evidence Act 2011* (ACT) s 140(1); *Evidence Act 1995* (Cth) s 140(1); *Evidence (National Uniform Legislation) Act 2011* (NT) s 140(1); *Evidence Act 1995* (NSW) s 140(1); *Evidence Act 2001* (Tas) s 140(1); *Evidence Act 2008* (Vic) s 140(1). Whilst the balance of probabilities standard also applies in Australia, the 'nature of the issue necessarily affects the process by which reasonable satisfaction is attained': *Briginshaw v Briginshaw* (1938) 60 CLR 336, 363 (Dixon J). This means that 'the strength of the evidence necessary to establish' incapacity on the balance of probabilities must be commensurate with the seriousness of finding incapacity and potentially subjecting an individual to non-consensual treatment: *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449, 450 (Mason CJ, Brennan, Deane and Gaudron JJ). See also *PBU* (n 1) 204–5 [204]–[205] (Bell J); Jeremy Gans, Andrew Palmer and Andrew Roberts, *Uniform Evidence* (Thomson Reuters, 4th ed, 2025) 525–7. Daniel Shipsides, Alex Ruck Keene and Wayne Martin term this as 'a risk-evidence sliding scale' where 'more compelling evidence should be required where consequences are potentially "grave"': Daniel Shipsides, Alex Ruck Keene and Wayne Martin, 'Risk and Capacity: Does the Mental Capacity Act Incorporate a Sliding Scale of Capacity?' (2024) 30 *International Journal of Mental Health and Capacity Law* 10, 20. However, such an approach appears to have been rejected in the UK: at 21–3.

'impairment of, or a disturbance in the functioning of, the mind or brain'.[19] Where such a connection cannot be drawn, the inability to satisfy the DMC criteria may stem from the '[undue] influence of someone else, threat, coercion or fear of the consequences of a decision'.[20] However, it may be that in some Australian jurisdictions, factors such as undue influence and coercion are considered to deprive an individual of DMC rather than being treated as independent factors that vitiate a treatment decision.[21]

Section 2(1) of the *Mental Capacity Act* (UK) is not uniformly mirrored in Australian states and territories that have legislated a DMC test,[22] but it is likely immaterial in the interpretation and application of the DMC test itself and establishing incapacity. The DMC test must be carried out with regard to the DMC criteria and the information relevant to the decision to determine whether there is sufficient impairment to prove incapacity. In addition to this evidence, a court or tribunal would also require sufficiently well-reasoned admissible expert evidence as to the cause of any incapacity before making such a finding.[23] Ordinarily, the impairment would arise from some form of 'an

[19] *Mental Capacity Act* (UK) (n 16) s 2(1). See also *York City Council v C* [2014] Fam 10, 32–3 [57]–[60] (McFarlane LJ, Lewison LJ agreeing at 33 [62], Richards LJ agreeing at 34 [65]). Cf below n 25.

[20] *Mental Capacity Act 2005 Code of Practice: Including the Liberty Protection Safeguards* (Draft Code of Practice, 2022) 58 [4.49], archived at <https://perma.cc/S3BZ-5ULT> ('*Draft Code of Practice*'). See, eg, *Re T* (n 1) 104–6, 113 (Lord Donaldson MR), 117–18 (Butler-Sloss LJ), 121 (Staughton LJ); *Application of a Local Health District; Re a Patient Fay* [2016] NSWSC 624, [39]–[42], [79]–[86] (Sackar J) ('*Re Fay*').

[21] See, eg, *Guardianship and Administration Act* (Qld) (n 15) sch 4 (definition of 'capacity' para (b)), where free and voluntary consent is a requirement for DMC. See also Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws* (Report No 67, September 2010) vol 1, 281–4 [7.172]–[7.184], 290 [7.208]–[7.210], archived at <https://perma.cc/6J95-GPJ6>. On the vitiation of consent: *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88, 94–5 [26]–[30] (McDougall J) ('*Hunter*').

[22] For example, in Tasmania, the *Mental Health Act* (Tas) (n 15) replicates s 2(1) of the *Mental Capacity Act* (UK) (n 16): at s 7(1)(a). However, the *Guardianship and Administration Act* (Tas) (n 15) does not, even though the legislation deals with medical treatment decisions outside of the mental health context: at s 11. This appears to be an intentional choice based on the recommendations from the Tasmania Law Reform Institute: Tasmania Law Reform Institute, *Review of the Guardianship and Administration Act 1995 (Tas)* (Final Report No 26, December 2018) 92. See *LRCWA Guardianship and Administration Report* (n 16) 87 [6.78]. See also below n 25.

[23] See below n 56 and accompanying text. See also *CT v Lambeth London Borough Council* [2025] 4 WLR 46, [59]–[60] (Theis J) ('*CT*'); *AMDC v AG* [2020] 4 WLR 166, [28] (Poole J); *Dasreef Pty Ltd v Hawchar* (2011) 243 CLR 588, 638 [129] (Heydon J). But see at 604 [37] (French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ).

impairment of, or a disturbance in the functioning of, the mind'.[24] It is doubtful whether an Australian court or tribunal would accept a finding of incapacity based solely on the testing of the DMC criteria without linking this to an underlying cause.[25]

The UK common law has developed in tandem with the legislative DMC test and is mirrored in the seminal decision of *Re MB*:

> A person lacks capacity if some impairment or disturbance of mental functioning renders the person unable to make a decision whether to consent to or to refuse treatment. That inability to make a decision will occur when:
>
> (a) the patient is unable to comprehend and retain the information which is material to the decision, especially as to the likely consequences of having or not having the treatment in question;
>
> (b) the patient is unable to use the information and weigh it in the balance as part of the process of arriving at the decision.[26]

Re MB has been cited with approval in Australia,[27] indicating that this reflects the common law position in Australia in those jurisdictions that have not

[24] *Mental Capacity Act* (UK) (n 16) s 2(1). The 'impairment' or 'disturbance' need not be a 'specific diagnosis': *North Bristol NHS Trust v R* [2023] EWCOP 5, [47] (Macdonald J). See also at [48]. The impairment may be the result of a combination of factors: see, eg, *Blackpool Teaching Hospitals NHS Foundation Trust v GWS* [2025] EWCOP 23, [127]–[128] (Theis J) ('*GWS*').

[25] But see *LRCWA Guardianship and Administration Report* (n 16), where the LRCWA cautioned against the 'inclusion … of a causative connection between a person's lack of decision-making capacity and a mental disability': at 89 [6.96]. The LRCWA argued that such a requirement may 'be both over and under inclusive' in determining DMC: at 89 [6.96]. Over inclusive because focusing on a person's disability may 'unfairly' lead to a finding of incapacity, and conversely, it may be under inclusive by finding capacity in those 'who do not have a cognitive impairment diagnosis': at 89 [6.97] (citation omitted). See also *A Review of Queensland's Guardianship Laws* (n 21) vol 1, 267 [7.111]; *Review of the Guardianship and Administration Act 1995 (Tas)* (n 22) 89–92 [6.2.6]–[6.2.18]. Whilst the LRCWA's concerns are legitimate, finding a causative connection between a person's lack of DMC and a mental disability or impairment can serve as an evidentiary safeguard in ensuring that sufficient reasons are given for a finding of incapacity. It can also assist in distinguishing between other vitiating factors which may impact on DMC which are not related to a person's functional abilities in relation to their DMC, such as undue influence or coercion: see above n 20 and accompanying text. Any assessment and determination of DMC must be cognisant of the dangers noted by the LRCWA.

[26] [1997] 2 FLR 426, 437 (Butler-Sloss LJ for Saville and Ward LJJ).

[27] See eg, *Krnjic v Bunnings Group Ltd [No 2]* (2018) 334 FLR 168, 177 [43] (Judge Wilson), quoting *Masterman-Lister v Brutton & Co [Nos 1 and 2]* [2003] 1 WLR 1511, 1533 [57] (Chadwick LJ, Potter LJ agreeing at 1532 [55]) ('*Masterman-Lister*'); *Hunter* (n 21) 93 [23]–[25] (McDougall J); *Brightwater Care Group (Inc) v Rossiter* (2009) 40 WAR 84, 90 [23] (Martin CJ).

legislated a DMC test.[28] Therefore, the judicial interpretation of the DMC test in the *Mental Capacity Act* (UK) has direct relevance to Australia, both for those jurisdictions that have a legislative DMC test and those that rely on the common law.

There has been limited case law in Australia dealing with the interpretation of the DMC test. *PBU v Mental Health Tribunal* ('*PBU*') is the most recent decision to consider in detail the interpretation and application of the DMC test.[29] *PBU* concerned the appeal to the Supreme Court of Victoria by two separate applicants, PBU and NJE, of decisions of the Victorian Civil and Administrative Tribunal ('VCAT').[30]

PBU was diagnosed with treatment-resistant schizophrenia and it was the opinion of his treating team that he required electroconvulsive therapy ('ECT').[31] PBU did not accept this diagnosis and refused ECT, prompting his treating team to seek permission from the Mental Health Tribunal to administer ECT against his wishes.[32] The Mental Health Tribunal could only permit ECT if it was satisfied that PBU lacked DMC to consent/refuse ECT,[33] which it was.[34] PBU subsequently sought review of this decision by VCAT.[35] In affirming the original decision of the Mental Health Tribunal, VCAT found that PBU did 'not have capacity to give informed consent to … [ECT] in circumstances where he did not accept the diagnosis for which the treatment was intended to be given'.[36]

NJE came before VCAT in similar circumstances.[37] NJE was also diagnosed with treatment-resistant schizophrenia and sought review of the decision of the Mental Health Tribunal granting an application for ECT by her treating team.[38] VCAT found that NJE had an 'understanding about ECT treatment';[39] however,

[28] See *NSW Capacity Toolkit* (n 15) 18.

[29] *PBU* (n 1).

[30] Ibid 145 [1] (Bell J).

[31] *PBU v Mental Health Tribunal* [2017] VCAT 781, [7] (Senior Member Dea) ('*PBU VCAT Decision*').

[32] *PBU* (n 1) 146–7 [10]–[11], 154–5 [44]–[45] (Bell J).

[33] *Mental Health Act 2014* (Vic) ss 96(1)(a)(i), 98(1) ('*Mental Health Act* (Vic)'). Similar provisions are also present in the current mental health legislation in Victoria: *Mental Health and Wellbeing Act* (Vic) (n 15) ss 99(1)(a), 100(a)(i), 102(2)(d).

[34] *PBU VCAT Decision* (n 31) [14]–[16] (Senior Member Dea).

[35] Ibid [5] (Senior Member Dea).

[36] Ibid [82] (Senior Member Dea).

[37] *NJE v Mental Health Tribunal* [2017] VCAT 1070, [4]–[9] (Member Hoysted).

[38] Ibid [1]–[12] (Member Hoysted).

[39] Ibid [63] (Member Hoysted).

she was found to not be able to '*use and weigh* the information'.[40] In coming to this conclusion, VCAT observed:

> To use and weigh requires a person to *carefully consider the advantages and disadvantages* of a situation or proposal before making a decision. NJE could not apply herself in that way. Her decision to refuse ECT was made without prior consideration of the advantages or disadvantages. NJE could not use and weigh the information because she could not conceive that it applied to her situation because it was her belief that she did not have a mental illness.[41]

In allowing the appeal of both of these VCAT decisions for PBU and NJE, Bell J found that, in relation to PBU, VCAT erred in law because it had 'based its finding that PBU lacked capacity upon his non-acceptance of the diagnosis for schizophrenia'.[42] In relation to NJE, Bell J found that VCAT had applied 'too high' a standard for determining DMC.[43] VCAT fell into error because the focus of the DMC enquiry is on 'the ability to "use or weigh" relevant information' as a 'functional assessment', and 'not [on] whether the person has actually done so, to a careful-consideration standard or at all'.[44] In coming to these decisions in relation to PBU and NJE, Bell J provided important insights into the interpretation and application of the DMC test.

In considering the application of *PBU* more broadly across Australia in determining medical treatment DMC, three observations are made. First, *PBU* was concerned with legislation that required *actual* understanding, rather than the *ability* to understand.[45] This is not material for the purposes of this article or the broader implications of the *PBU* decision on the DMC test.[46] Second, *PBU* dealt with the interpretation of the DMC test within a mental health legislative framework; regardless, what was said in *PBU* likely has broad relevance. It is hard to see why a uniformly worded DMC test would be interpreted differently under different legislation when the core question is identical: does the

[40] Ibid (emphasis in original) (Member Hoysted).

[41] Ibid (emphasis altered) (Member Hoysted).

[42] *PBU* (n 1) 213 [233].

[43] Ibid 214–15 [238].

[44] Ibid 215 [239] (Bell J).

[45] *Mental Health Act* (Vic) (n 33) s 68(1)(a); ibid 190 [161] (Bell J).

[46] The legislation considered in *PBU* (*Mental Health Act* (Vic) (n 33)) has since been replaced; the new legislation changes the actual knowledge requirement to 'able to understand': *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(1)(a).

individual have DMC in relation to the decision?[47] Third, Bell J was influenced by the *Charter of Human Rights and Responsibilities Act 2006* (Vic),[48] which does not have an equivalent in all states and territories.[49] Whether another state or territory, without equivalent human rights legislation would interpret the DMC test differently is an open question.[50] It would be an odd outcome for an individual to have DMC in one state and not another in relation to the same treatment decision.[51]

B *Important Principles in Assessing Decision-Making Capacity*

In applying the DMC test, there are numerous important principles that provide the backdrop to the assessment.[52] Three in particular are discussed below because the use of insight has the potential to significantly undermine these

[47] In Victoria: see, eg, *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(1); *Medical Treatment Planning Act* (Vic) (n 15) s 4(1); *Guardianship Act* (Vic) (n 15) s 5(1); *Powers of Attorney Act* (Vic) (n 16) s 4(1). In the NT: *Health Care Decision-Making Act* (NT) (n 15) s 8(2); *Advance Personal Planning Act* (NT) (n 15) s 6A(2); *Guardianship of Adults Act 2016* (NT) s 5A(2).

[48] *PBU* (n 1) 181 [132]. See also at 172–81 [105]–[128].

[49] However, the ACT and Qld have similar human rights legislation: *Human Rights Act 2004* (ACT); *Human Rights Act 2019* (Qld).

[50] Much of what Bell J considered under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) is important aspects of preserving personal autonomy and dignity, which are core values of the common law itself: *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 248 [88]–[89] (Gummow, Hayne and Heydon JJ); *PBU* (n 1) 184 [141] (Bell J). His Honour also considered international human rights treaties to which Australia is a party: at 163–72 [83]–[104]. In *TSC v Department for Health and Wellbeing* [2021] SASCA 93, the Court of Appeal of South Australia also endorsed the approach taken by Bell J in *PBU* to determining DMC despite SA not having human rights legislation: at [22]–[35] (Doyle, Livesey and Bleby JJA). The Court was influenced by the 'fundamental common law right to bodily integrity' in adopting the approach in *PBU*: at [33] (Doyle, Livesey and Bleby JJA). See also *UI* [2020] TASGAB 48, [83]–[84] (President Holder, Members Lee and Fasnacht); *SI* [2023] TASCAT 168, [60] (Presiding Member Locke, Ordinary Members McArthur and Hale); *SI* [2025] TASCAT 29, [143] (Deputy President Mollross, Senior Member Chaperon and Ordinary Member Morrissey).

[51] A changing legal threshold for DMC (in relation to a specific decision) across state/territory lines would make it a challenging task for medical practitioners (and others) to assess DMC, especially as their knowledge of the legal test may already be limited: see below n 193. See also Julia P Duffy, Sam Boyle and Casey M Haining, 'When May an Adult Woman with Cognitive Impairment Still Have Capacity To Consent to an Abortion?' (2025) 223(3) *Medical Journal of Australia* 127, 130.

[52] See, eg, *Mental Health Act* (ACT) (n 15) s 8; *Guardianship and Administration Act* (Qld) (n 15) s 11(1), 11B(3); *Consent to Medical Treatment Act* (SA) (n 14) s 4(3); *Mental Health Act* (SA) (n 15) ss 5A(1), (3); *Guardianship and Administration Act* (Tas) (n 15) ss 12, 35B; *Medical Treatment Planning Act* (Vic) (n 15) ss 4(4), 5; *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(2), (3); *Mental Capacity Act* (UK) (n 16) s 1.

principles, thereby risking an incorrect finding of incapacity. The three principles considered include:

- a presumption of DMC ('Presumption Principle');
- a focus on function in assessing DMC ('Functional Principle'); and
- a low threshold for finding DMC ('Low Threshold Principle').

Another important principle that is not discussed further is that DMC is *decision specific*:[53] an individual may have DMC in relation to some decisions but not others.[54] So where reference is made to DMC in this article, it must be remembered that it is in relation to a specific decision, rather than DMC at large.

1 *Presumption Principle*

All adults are presumed to have DMC 'unless and until that presumption is rebutted'.[55] The onus is on those alleging a lack of DMC to rebut the presumption with 'cogent and well-reasoned analysis'.[56] Some doubt about capacity is

[53] *Mental Health Act* (ACT) (n 15) s 8(1)(a); *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(2)(a); *PBU* (n 1) 186–7 [148] (Bell J), quoting *N v A Clinical Commissioning Group* [2017] 1 AC 549, 564 [25] (Baroness Hale DPSC, Lords Wilson, Reed, Carnwath and Hughes JJSC agreeing); *Gibbons v Wright* (1954) 91 CLR 423, 437–8 (Dixon CJ, Kitto and Taylor JJ).

[54] *Medical Treatment Planning Act* (Vic) (n 15) s 4(4)(a); *Mental Health Act* (ACT) (n 15) s 8(1)(e)(ii); *Health Care Decision-Making Act* (NT) (n 15) s 8(5).

[55] *Re MB* (n 26) 436 (Butler-Sloss LJ), quoted in *PBU* (n 1) 186 [146] (Bell J). See also *Re T* (n 1) 112 (Lord Donaldson MR, Butler-Sloss LJ agreeing at 116); *Mental Health Act* (ACT) (n 15) s 8(1)(b); *Health Care Decision-Making Act* (NT) (n 15) s 5; *Mental Health Act* (Qld) (n 15) s 11(1); *Guardianship and Administration Act* (Tas) (n 15) s 35B(c); *Mental Health Act* (SA) (n 15) s 5A(1); *Mental Health Act* (Tas) (n 15) s 7(1); *Medical Treatment Planning Act* (Vic) (n 15) s 4(2); *Mental Health and Wellbeing Act* (Vic) (n 15) s 85(2); *Mental Health Act* (WA) (n 15) s 13(1); *Mental Capacity Act* (UK) (n 16) s 1(2); *Hunter* (n 21) 93 [23] (McDougall J). This presumption does not generally apply to minors: see above n 14.

[56] *Tower Hamlets London Borough Council v PB* [2020] 4 WLR 94, [51] (Hayden J) ('*Tower Hamlets*'). Although there is a presumption of DMC, the assessment undertaken by a medical practitioner is often framed from a position of finding evidence to show the individual meets (or fails to meet) the threshold of capacity: see, eg, *SS v Richmond upon Thames London Borough Council* [2021] Court of Protection Law Reports 612, 616 [11]–[12] (Hayden J); *Heart of England* (n 1) 240 [26], 242 [39] (Peter Jackson J); *FX v A Local Authority* [2017] EWCOP 36, [43] (Judge Bell). This may be due to the assessment taking place in a context where there are doubts about the DMC of the individual, so the medical practitioner starts their assessment from the premise that the person does not have the capacity to make the decision and then seeks evidence to counter that. This is obviously improper as it seemingly reverses the onus onto the individual to demonstrate DMC. For example, in a NSW discussion paper on the *Mental Health Act 2007* (NSW), it was noted that 'a decision on medical treatment likely to have a serious and permanent impact on a person is likely to require greater certainty that the person can comprehend the consequences of the decision than a decision regarding a simple medical

not sufficient to rebut the presumption. This presumption is an important protection for individuals who might otherwise have their DMC questioned based on their appearance or their status of having a particular diagnosis (eg schizophrenia or dementia).[57]

The presumption may not obviate the need to assess DMC if there is 'good reason for concern that [the individual] might lack capacity'.[58] Where there is 'legitimate doubt' about an individual's DMC, 'the presumption cannot be used to avoid taking responsibility for assessing and determining capacity'.[59] This responsibility to assess DMC may fall within the scope of a medical practitioner's

procedure': Mental Health & Drug and Alcohol Office (NSW), *Issues Arising under the Mental Health Act 2007* (Discussion Paper, September 2012) 19, archived at <https://perma.cc/FB5Z-CSVS>. Irrespective of the seriousness of the decision, an individual is presumed to have DMC. It is not certainty as to their DMC that must be proved, but sufficient evidence to rebut the presumption of DMC to make that decision (when there is doubt about their ability to make that decision): see below n 82. Where *certainty* as to DMC may play a role is in the discharge of the medical practitioner's *duty of care* to their patient: see below n 82. In relation to a medical practitioner's *duty of care*, see *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 492–3 (Gaudron J) ('*Rogers*'). If an individual refuses life-saving treatment and there are doubts as to their DMC, it may be that the evidentiary basis and the medical practitioner's certainty as to their DMC to make that decision should be commensurate with the consequences of refusal: see above n 18.

[57] *CC v KK* [2012] Court of Protection Law Reports 627, 647 [74] (Baker J) ('*CC*'). Cf Select Committee on the Mental Capacity Act 2005 (UK), *Mental Capacity Act 2005: Post-Legislative Scrutiny* (House of Lords Paper No 139, Session 2013–14), archived at <https://perma.cc/96H8-RZ3Q>, where the Select Committee, in examining the operation of the *Mental Capacity Act* (UK) (n 16), expressed concerns that the 'presumption of capacity … is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm' and the presumption 'has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult': at 51.

[58] *Royal Bank of Scotland plc v AB* [2020] (Employment Appeal Tribunal, Swift J, 27 February 2020), [23] ('*Royal Bank of Scotland Tribunal Appeal*'), affd *Royal Bank of Scotland plc v AB* [2021] EWCA Civ 345, [12] (Macur LJ, Stuart-Smith LJ agreeing at [21], Lewis LJ agreeing at [22]) and applied in *MM v Greenwich Royal London Borough Council* [2024] Public and Third Sector Reports 1452, 1469 [33] (Judge Stout). Although *Royal Bank of Scotland Tribunal Appeal* (n 58) concerned the capacity to litigate, there is no reason why a similar standard should not apply in the medical context: see Chloe Beale et al, 'Mental Capacity in Practice Part 1: How Do We Really Assess Capacity?' (2024) 30(1) *BJPsych Advances* 2, 3 ('Mental Capacity in Practice Part 1').

[59] *Royal Bank of Scotland Tribunal Appeal* (n 58) [26] (Swift J). See also *Z v Kent County Council* [2019] Court of Protection Law Reports 79, 87 [40] (Judge Lazarus) ('*Z*'). Determining an appropriate trigger for the assessment of capacity can be challenging: see Irene Tuttle, 'Limitations of Capacity Assessments' in Pēteris Dārziņš, William Molloy and David Strang (eds), *Who Can Decide?: The Six Step Capacity Assessment Process* (Memory Australia Press, 2000) 111, 113–17.

duty of care to the individual, often in the context of refusal of treatment where there is *legitimate doubt* as to their DMC to refuse.[60]

[60] Where there is legitimate doubt, issues around DMC should be 'resolved as soon as possible': *Re B* [2002] 2 All ER 449, 474 [100] (Butler-Sloss P). While the issue of DMC is being resolved, a medical practitioner may be able to provide treatment, despite refusal, in limited circumstances: see Kerri Eagle and Christopher Ryan, 'Mind the Gap: The Potentially Incapable Patient Who Objects To Assessment' (2012) 86(10) *Australian Law Journal* 685, 692–4. Detaining or restraining a person whilst determining their DMC may be required in some circumstances. However, without a legal power (from statute or the common law) or a valid defence to unlawful detention, detaining someone to determine DMC would generally not be permitted: see Michael Eburn, 'No Power To Detain a Patient Just Because It's Good for Them, *Australian Emergency Law* (Blog Post, 22 January 2023) <https://australianemergencylaw.com/2023/01/22/no-power-to-detain-a-patient-just-because-its-good-for-them/>, archived at <https://perma.cc/R5V4-6URL>; David Weber, 'Court Case Highlights Concerns over Patients Being Held Unlawfully in WA Hospitals', *ABC News* (online, 21 January 2023) <https://www.abc.net.au/news/2023-01-21/concerns-over-unlawful-detention-of-patients-in-perth-hospitals/101861020>, archived at <https://perma.cc/H4H7-MZZ8>; David Weber, 'Medical Law Expert Issues Warning to WA Hospital Staff over Patients Who Want To Leave', *ABC News* (online, 20 June 2023) <https://www.abc.net.au/news/2023-06-20/warning-for-wa-health-workers-over-unlawful-detention-hospitals/102497536>, archived at <https://perma.cc/79TU-ACQX>; Joint Standing Committee on the Corruption and Crime Commission, Parliament of Western Australia, *Unlawful Detention in Public Hospitals* (Report No 8, 30 March 2023) 9, archived at <https://perma.cc/2DUH-Y4UM>. Detaining or restraining a person whilst determining DMC may be defensible under the common law *doctrine of necessity* (or similar statutory defences), but this likely requires a real and 'immediate danger' to excuse what would otherwise be unlawful: *Re F* [1990] 2 AC 1, 75–8 (Lord Goff, Lord Jauncey agreeing at 83–4); Mark J Rankin, 'Abortion Law in New South Wales: The Problem with Necessity' (2018) 44(1) *Monash University Law Review* 32, 48–50, 50 n 142, 51–3; Anne-Maree Kelly et al, 'Detaining Patients against Their Will: Can Duty of Care Be Used To Justify Detention and Restraint in Emergency Departments?' (2023) 35(6) *Emergency Medicine Australasia* 896, 899; Michael Eburn, 'The Doctrine of Necessity: Explained', *Australian Emergency Law* (Blog Post, 31 January 2017) <https://australianemergencylaw.com/2017/01/31/4203/>, archived at <https://perma.cc/G9YG-JTUS>. A more challenging question is whether there can be a duty to detain or restrain a person whilst determining their DMC. In *Australian Capital Territory v JT* (2009) 4 ACTLR 68, Higgins CJ, in obiter, indicated that such a duty may exist: 'Even in the case of a competent adult refusing treatment, medical carers are not entitled to respect those wishes and may be under a duty not to if there is reason to suppose that the capacity of the patient to make a reasoned decision has been diminished by illness or medication, false assumptions, misinformation or undue influence. If so, the medical carers must apply such treatment as their clinical judgment deems to be in the best interests of the patient … *Thus the use of forcible restraint to achieve a therapeutic benefit or avert a therapeutic disaster would be the duty of medical carers to apply not an option they can simply chose to avoid out of distaste for it*.': at 73 [38] (citation omitted) (emphasis added). The medical practitioner's duty of care is not uncommonly invoked to justify treatment in the face of treatment refusal or incapacity: Scott Lamont, Cameron Stewart and Mary Chiarella, 'Capacity and Consent: Knowledge and Practice of Legal and Healthcare Standards' (2019) 26(1) *Nursing Ethics* 71, 80–1; Scott Lamont, Cameron Stewart and Mary Chiarella, 'Documentation of Capacity Assessment and Subsequent Consent in Patients Identified with Delirium' (2016) 13(4) *Journal*

2 *Functional Principle*

The DMC test is a functional test, meaning that its focus is on the functioning of the individual in arriving at a decision. As a functional test, it 'focuses upon the *personal ability* of the individual concerned to make a particular decision and the subjective processes followed' in arriving at a decision.[61] Because the focus is on the individual's ability, rather than whether they have actually carried out the process, a capacitous individual may choose not to undertake the decision-making process.[62] When an individual chooses not to engage with the DMC process, it can present significant challenges for the assessor. However, a complete lack of engagement may indicate an inability to understand.[63]

In settling on a functional test for DMC, during the consultation process for the *Mental Capacity Act* (UK), the UK Law Commission rejected the outcome-based approach and the status-based approach as they were thought to unduly undermine personal autonomy.[64] The outcome-based approach focuses on the

of Bioethical Inquiry 547, 553. However, this is a misunderstanding of the law. A medical practitioner's duty of care sets the standard of care expected of the medical practitioner in any given circumstance, it does not confer powers on the medical practitioner to undertake actions that would otherwise be unlawful. Without a power to detain or restrain, it is unlikely such a duty can be found: *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 224 [5] (French CJ); *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22, 78 [217] (Sheller JA) ('*Presland*'). Whilst the doctrine of necessity may provide a defence to detention or restraint whilst determining DMC, it is an open question whether the common law would impose a duty to detain or restrain (actions that are generally not considered as medical treatment) which is then contingent on the medical practitioner relying on the defence of the doctrine of necessity to legitimise their otherwise unlawful actions. A duty to exercise a statutory power to detain (such as those conferred by mental health legislation), whilst determining DMC, may be a more defensible ground for a duty to detain or restrain to arise. However, courts appear reticent to find a duty to exercise a statutory power to detain as it may give rise to inconsistent duties: *Hunter and New England Local Health District v McKenna* (2014) 253 CLR 270, 281–3 [29]–[33] (French CJ, Hayne, Bell, Gageler and Keane JJ); *Presland* (n 60) 117–18 [366]–[368], 123 [388] (Santow JA).

[61] Law Commission (UK), *Mentally Incapacitated Adults and Decision-Making: An Overview* (Consultation Paper No 119, 12 March 1991) 52 (emphasis added), archived at <https://perma.cc/7A49-CH4V> ('*Law Commission Paper No 119*'). See also *PBU* (n 1) 188–9 [153]–[155] (Bell J); *A Local Authority v JB* [2022] 1 AC 1322, 1338–9 [58]–[61] (Lord Stephens JSC, Lord Briggs, Lady Arden, Lord Burrows and Lady Rose JJSC agreeing) ('*JB*').

[62] See, eg, *QJ v A Local Authority* [2020] EWCOP 7, [24] (Hayden J) ('*QJ*'). See below nn 96–7 and accompanying text.

[63] *Re P* [2014] EWHC 119 (COP), [26] (Cobb J). But see *Z* (n 59) 92–3 [40] (Judge Lazarus); *QJ* (n 62) [24] (Hayden J); *Re DXI* [2016] NSWCATGD 4, [73]–[75] (Senior Members Tearle and McPhee and General Member Williams).

[64] Law Commission (UK), *Mental Incapacity* (Command Paper No 231, 28 February 1995) 32–4 [3.3]–[3.6], archived at <https://perma.cc/7W44-TB3H> ('*Law Commission Paper*

ultimate outcome the decision will have.[65] There were concerns that such a test 'would inevitably slide into an assessment of the "reasonableness" of a particular decision which could not be applied in an objective and non-discriminatory way'.[66] This approach risks overlooking 'the nature of decision-making that different people will make different decisions because they give greater weight to some relevant factors than to others'.[67]

The status-based approach focuses on attributes of the individual, such as a mental illness or neurocognitive disorder they may have, in determining their DMC.[68] Such an approach may be convenient but is unjustly discriminatory as it fails to show 'how membership of that category affects … competence as an individual'.[69]

Both the outcome of a decision[70] and the status of the individual, are not determinative of DMC under the functional approach.[71]

No 231'). See also *R v Cooper* [2009] 1 WLR 1786, 1789–90 [11]–[13] (Baroness Hale, Lord Hope agreeing at 1788 [3], Lord Rodger agreeing at 1788 [4], Lord Brown agreeing at 1796 [33], Lord Mance agreeing at 1796 [34]).

65 *Law Commission Paper No 231* (n 64) 33 [3.4]. The current guardianship law in WA arguably takes an outcome based approach to DMC as it requires the person to be able to make 'reasonable judgments': *Guardianship and Administration Act* (WA) (n 16) ss 4(3)(b), 4(3)(d), 43(1)(b)(ii), 64(1)(a), 110F. See also *LRCWA Guardianship and Administration Report* (n 16) 80 [6.32], 84 [6.56]–[6.57]. But see *C* [2024] WASAT 50, where the tribunal drew upon the common law and applied a functional approach in determining whether the person concerned could make 'reasonable judgments': at [39]–[45] (President Pritchard, Member Bunney and Sessional Member Caunt).

66 Law Commission, *Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction* (Consultation Paper No 128, 23 December 1992) 30 [3.30], archived at <https://perma.cc/7DE8-7BN3> ('*Law Commission Paper No 128*').

67 Ibid.

68 *Law Commission Paper No 119* (n 61) 51. A status based approach is taken to minors, who by their status as minors, are presumed not to have DMC until proven otherwise: see above n 14.

69 Ibid.

70 See, eg, *Mental Health Act* (ACT) (n 15) s 8(1)(e)(i); *Health Care Decision-Making Act* (NT) (n 15) s 8(8)(e); *Consent to Medical Treatment Act* (SA) (n 14) s 4(3)(d); *Mental Health Act* (SA) (n 15) s 5A(3)(d); *Guardianship and Administration Act* (Tas) (n 15) ss 12(1)(e)–(f); *Medical Treatment Planning Act* (Vic) (n 15) s 4(c)(i); *Mental Health and Wellbeing Act* (Vic) (n 15) s 87 (2)(d); *Mental Capacity Act* (UK) (n 16) s 1(4). See also *PBU* (n 1) 193 [168] (Bell J). But see Sam Boyle, 'Is the Wisdom of a Person's Decision Relevant to Their Capacity To Make That Decision?' (2020) 46(1) *Monash University Law Review* 39, 46–7; Neil Pickering, Giles Newton-Howes and Greg Young, 'Harmful Choices, The Case of C, and Decision-Making Competence' (2022) 22(10) *American Journal of Bioethics* 38, 39, 48; Shipsides, Keene and Martin (n 18) 17–18.

71 See, eg, *Guardianship and Administration Act* (Tas) (n 15) ss 12(1)(i)–(m); *Medical Treatment Planning Act* (Vic) (n 15) s 4(c)(ii); *Mental Health and Wellbeing Act* (Vic) (n 15) s 87(2)(c); *Mental Capacity Act* (UK) (n 16) s 2(3). See also *PBU* (n 1) 185–6 [144]–[146] (Bell J).

3 *Low Threshold Principle*

To maximise participation in decision-making, especially in those who may be vulnerable to having their DMC scrutinised, such as individuals with mental illnesses, the courts have set a low threshold for DMC. Justice Bell in *PBU*, endorsing the view of Hale LJ in *R (Wilkinson) v Broadmoor Hospital Authority*,[72] noted that

> the capacity threshold is a 'low one' because it would otherwise be over-inclusive … It is better that these persons be able to satisfy a low threshold of capacity and exercise their right to consent to or refuse medical treatment than to have a high threshold of capacity that they could not satisfy.[73]

By setting a low threshold for DMC, the law eschews the risk of depriving capacitous individuals of autonomy at the cost of finding DMC where there might be none.[74] It is important to consider this principle when interpreting and applying the DMC criteria. Where there is uncertainty in applying the DMC test, this principle may point to applying the test in a manner that would maximise autonomy.

In *Re T*, Lord Donaldson MR noted that in determining the DMC threshold

> [w]hat matters is that the doctors should consider whether at that time he had a *capacity which was commensurate with the gravity of the decision* which he purported to make. The more serious the decision, the greater the capacity required.[75]

There is some uncertainty as to whether the gravity of the decision refers to the complexity of the decision or the seriousness of the consequences of the decision.[76] There are circumstances where a simple decision, especially where

[72] [2002] 1 WLR 419, 446 [80].

[73] *PBU* (n 1) 195 [176]. See also *Tower Hamlets* (n 56) [30] (Hayden J); *R (B) v Dr SS* [2005] EWHC 86 (Admin), [91] (Silber J) ('*Dr SS*'); *Law Commission Paper No 119* (n 61) 109 [4.25]; *Law Commission Paper No 128* (n 66) 28 [3.23]; *Sheffield City Council v E* [2005] Fam 326, 365 [144]–[145] (Munby J).

[74] See *PBU* (n 1) 195 [176] (Bell J); *Consent to Medical Treatment* (SA) (n 14) s 4(3); *Mental Health Act* (SA) (n 15) s 5A(3). Although the role of assessing DMC is to determine whether the presumption of DMC has been rebutted, in practice it is often an exercise of determining whether the individual can meet the threshold of DMC, in essence reversing the onus: see above n 56. Setting a low threshold, to an extent, safeguards against this reversal of onus that arises during the assessment process. Those assessing DMC must be mindful of this in setting the threshold for DMC: see Malcolm Parker, 'Judging Capacity: Paternalism and the Risk-Related Standard' (2004) 11(4) *Journal of Law and Medicine* 482, 490.

[75] *Re T* (n 1) 113 (Lord Donaldson MR) (emphasis added). See also *Re MB* (n 26) 437 (Butler-Sloss LJ); *Law Commission Paper No 128* (n 66) 28 [3.23].

[76] See Parker (n 74) 486–7, 490.

treatment is refused, can have life-limiting consequences. This raises the question whether the threshold for DMC should be tied to the seriousness of the outcome of the decision, or to the complexity of the decision irrespective of outcome (or both).[77]

Similarly, in *Application of a Local Health District; Re a Patient Fay* ('*Re Fay*') Sackar J observed, without criticism, that it has been suggested that

> the capacity needed to refuse a particular treatment may well differ from that needed to consent to it. … [T]his may be particularly so where refusal involves a high risk and a low benefit but the risks of treatment are low with a high probability of benefit.[78]

With respect, in determining the threshold for DMC, this position should be doubted. First, to alter the DMC threshold based on an individual's decision is contrary to a functional approach to assessing DMC and would appear to adopt an outcome focused approach.[79] Second, to demand a higher threshold for DMC for refusal of treatment is a form of medical paternalism,[80] from which both the medical profession and the law continues to move away.[81] The preferred approach to interpreting Lord Donaldson MR's statement is likely 'as requiring greater scrutiny of capacity in cases where the decision is about life-

[77] See Benjamin Spencer and Matthew Hotopf, 'The Assessment of Mental Capacity', in Rebecca Jacob, Michael Gunn and Anthony Holland (eds), *Mental Capacity Legislation: Principles and Practice* (Cambridge University Press, 2nd ed, 2019) 13, 29–30.

[78] *Re Fay* (n 20) [38], citing Berna Collier, Chris Coyne and Karen Sullivan (eds), *Mental Capacity: Powers of Attorney and Advance Health Directives* (Federation Press, 2005) 74–5. But see *X v The Sydney Children's Hospitals Network* (n 2) 309 [66] (Basten JA, Beazley P agreeing at [1], Tobias AJA agreeing at [80]), quoting *Re W* [1993] Fam 64, 88 (Balcombe LJ): 'In logic there can be no difference between an ability to consent to treatment and an ability to refuse treatment.'

[79] See Collier, Coyne and Sullivan (n 78) 76. But see Allen E Buchanan and Dan W Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge University Press, 1990) 51–7. See also Parker (n 74) 483–5; Shipsides, Keene and Martin (n 18) 14–15.

[80] See, eg, *Heart of England* (n 1) 240 [27], where Jackson J cautioned in relation to proceeding with medical treatment when a patient changes their mind and consents (whereas their capacity was questioned when they initially refused treatment): 'There is a danger that in a difficult case like this the patient is regarded as capable of making a decision that follows medical advice but incapable of making one that does not.'

[81] See *Breen v Williams* (1996) 186 CLR 71, 114 (Gaudron and McHugh JJ); *Montgomery v Lanarkshire Health Board* [2015] AC 1430, 1461 [81] (Lords Kerr and Reed JJSC, Lord Neuberger PSC, Lords Clarke, Wilson and Hodge JJSC agreeing) ('*Montgomery*'); TT Arvind and Aisling M McMahon, 'Responsiveness and the Role of Rights in Medical Law: Lessons from *Montgomery*' (2020) 28(3) *Medical Law Review* 445, 449–51.

threatening conditions, before the patient is accepted as competent or not',[82] rather than a 'sliding scale of capacity … in proportion to the risk of refusal of treatment'.[83]

C *Decision-Making Capacity Criteria*

Before applying the DMC test, it is important to determine what the decision in question is, and the matters relevant to that decision.[84] Identification of these matters allows the assessor to set a *commensurate* DMC threshold, below which the individual is deemed to lack DMC.[85]

The *ability to understand the relevant information* criterion ('Understanding Criterion') and the *ability to use or weigh the relevant information* criterion ('Use/Weigh Criterion') of the DMC test are discussed in greater detail below as their proper application can be significantly distorted when insight intrudes into their assessment.

The *ability to retain the relevant information* criterion and the *ability to communicate a decision* criterion are, in most circumstances, easier to assess and there is less uncertainty about their interpretation and application.[86] These

[82] Cameron Stewart and Paul Biegler, 'A Primer on the Law of Competence To Refuse Medical Treatment' (2004) 78(5) *Australian Law Journal* 325, 333; Keene (ed) (n 4) 183–5. It is not uncommon to be faced with a situation where refusal of treatment confers significant risk and assent to treatment has significant benefit with little risk. Rather than altering the threshold for DMC based on refusal or assent, it may be that the medical practitioner's duty of care to their patient requires that they enquire into their patient's DMC to refuse treatment where the risk of refusal is high (in addition to their duty to provide the information to their patient to make the decision). When framed in this manner, the onus remains on the medical practitioner to disprove the presumption of the patient's DMC, and the threshold for capacity does not shift based on the consequences of acceptance or refusal of treatment: see Parker (n 74) 491. Shipsides, Keene and Martin term such an approach 'a *risk-investment sliding scale* in the assessment of capacity' where 'the higher the risk, the more investment (of time, resource, effort, etc) [would be] required in order to arrive at a conclusion that the person's decision is to be respected': Shipsides, Keene and Martin (n 18) 27 (emphasis in original). Shipsides, Keene and Martin also argue that that DMC test incorporates both consent and refusal in determining the threshold for capacity because the 'scope of a capacity assessment' includes 'the reasonably foreseeable consequences of deciding one way or another', so the 'relevant information' includes 'the reasonably foreseeable consequences of both consent and refusal': at 25. It should be noted that the threshold for DMC is a separate question to the evidentiary requirements to support a finding of incapacity: see above n 18.

[83] Parker (n 74) 487. See also Edmund Howe, 'Ethical Aspects of Evaluating a Patient's Mental Capacity' (2009) 6(7) *Psychiatry* 15, 16–18.

[84] See *JB* (n 61) 1339–40 [68]–[69], 1341 [73] (Lord Stephens JSC, Lord Briggs, Lady Arden, Lord Burrows and Lady Rose JJSC agreeing).

[85] Tracey Ryan-Morgan, *A Concise Guide to the Mental Capacity Act: Basic Principles in Practice* (Routledge, 2022) 10.

[86] See Beale et al, 'Mental Capacity in Practice Part 1' (n 58) 6.

criteria are not discussed further in this article as insight is not as relevant in their assessment.[87]

1 *Understanding Criterion*

This criterion requires the individual to be able to 'understand the information relevant to the decision'.[88] The definition of *understand* in this context is its ordinary denotation which includes '"perceive the meaning of", "grasp the idea of" or "comprehend"'.[89]

Consistent with the Low Threshold Principle, the degree of understanding required is of a general kind of the 'salient details'[90] that relates to the 'nature, purpose and effects of the treatment'[91] (or not having the treatment) as well as the consequences of the decision or of 'failing to make the decision'.[92] This would presumably include information such as the material risks of each of the treatment options (or not having the treatment).[93] The depth of the ability to

[87] But see Nuala B Kane et al, 'Applying Decision-Making Capacity Criteria in Practice: A Content Analysis of Court Judgments' (2021) 16(2) *PLOS ONE* e0246521:1–16, 6 ('Applying DMC Criteria').

[88] *Mental Capacity Act* (UK) (n 16) s 3(1)(a).

[89] *PBU* (n 1) 190 [160] (Bell J), quoting *Macquarie Dictionary* (7th ed, 2017) 'understand' (def 1).

[90] *LBL v RYJ* [2011] 1 FLR 1279, 1289 [58] (Macur J) ('*LBL*'). See also *CC* (n 57) 633 [22], 646 [69] (Baker J).

[91] *Re C* [1994] 1 WLR 290, 295 (Thorpe J). See also *PBU* (n 1) 190 [160], 195 [176], 196 [178] (Bell J); *Masterman-Lister* (n 27) 1534 [60] (Chadwick LJ), quoting *Re C* (n 91) 295 (Thorpe J).

[92] *Mental Capacity Act* (UK) (n 16) s 3(4).

[93] Consent is required prior to administering any treatment, without which any bodily interference with a person would constitute assault or battery: *Marion's Case* (n 1) 232, 233 (Mason CJ, Dawson, Toohey and Gaudron JJ), 309–10 (McHugh J); *PBU* (n 1) 184 [141] (Bell J); *White v Johnston* (2015) 87 NSWLR 779, 792–3 [53]–[59] (Leeming JA, Barrett JA agreeing at 782 [2]–[3]) ('*White*'). The person need only be 'advised in broad terms of the nature of the procedure to be performed' to provide valid consent and 'negative the offence of battery': *Rogers* (n 56) 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) (citation omitted). However, there may be other factors, such as fraud, that can vitiate consent: *White* (n 93) 793–6 [60]–[74] (Leeming JA, Barrett JA agreeing at 782 [2]–[3]); *Gawthrop v Bendigo Health* [2026] VSC 157, [489] (O'Meara J). In addition to obtaining consent, medical practitioners owe a duty to warn of material risks to their patients (ie in order for the consent to be 'informed'), these being risks that the patient would attach significance to in deciding whether to proceed with treatment: *Rogers* (n 56) 489–90 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 493–4 (Gaudron J); *Wallace v Kam* (2013) 250 CLR 375, 380 [8] (French CJ, Crennan, Kiefel, Gageler and Keane JJ); *Montgomery* (n 81) 1463 [87] (Lords Kerr and Reed JJSC, Lord Neuberger PSC, Lords Clarke, Wilson and Hodge JJSC agreeing). Failing to provide this information may give rise to a claim in negligence but does not generally affect the validity of the consent. This duty also requires medical practitioners to discuss reasonable alternative treatments (including not undergoing treatment): see *Rosenberg v Percival* (2001)

understand need only be in 'broad terms';[94] the individual need not be able to understand 'every last piece of information about [their] situation and [their] options'.[95]

In assessing this criterion, the 'question … is not whether the patient has understood the information, which a capacitous individual may choose to do or not do, but whether the person is capable of doing so'.[96] So there may be circumstances where an individual 'might be regarded as having capacity even if he does not *actually* understand' the information relevant to the decision as they may choose not to receive that information.[97] Such an approach is consistent with the Functional Principle.

205 CLR 434, 465 [101] (Kirby J); *Johnson v Biggs* [2000] NSWCA 338, [53] (Santow AJA); *McCulloch v Forth Valley Health Board* [2024] AC 925, 949 [57]–[58] (Lords Hamblen and Burrows JJSC, Lord Reed PSC, Lodge Hodge DPSC and Lord Kitchin JSC agreeing). The threshold of DMC needed should at the very least enable the medical practitioner to discharge their duty to warn. Otherwise, the medical practitioner may be faced with a situation where the patient is deemed to have DMC but is unable to understand the material risks of treatment, making it impossible for a medical practitioner to discharge their duty to warn. Such a situation would cause incoherence in the law: but see *PBU* (n 1) 209–10 [213]–[219]. Justice Bell noted that determining the information that an individual would need to be capable of understanding by reference to the informed consent provisions in the *Mental Health Act* (Vic) (n 15) s 69(2) 'would increase the threshold of capacity and not be consistent with the person's equal right to self-determination, to be free of non-consensual medical treatment and to personal inviolability': at 209 [213]. His Honour concluded that the '[d]etermination of capacity … is an anterior and independent question', and whilst the 'information bases may overlap', the 'relevant information for the purposes of [determining DMC] is not [to be] interpreted expansively to include' the information that needs to be supplied for informed consent under s 69 of the *Mental Health Act* (Vic): at 210–11 [220]. There is an inherent tension between the requirement of medical practitioners to provide sufficient information for an individual to make an informed decision and maintaining a low threshold for DMC to maximise autonomy; where more information is required for the duty to warn to be discharged, a greater cognitive capacity may be required.

94 *Law Commission Paper No 231* (n 64) 39 [3.18]; *PBU* (n 1) 195 [174] (Bell J).

95 *Heart of England* (n 1) 240 [25] (Peter Jackson J). See also at 242 [39].

96 *PBU* (n 1) 190 [159] (Bell J).

97 *Dr SS* (n 73) [87] (Silber J) (emphasis in original). Where a person has DMC, they can choose to waive their right to be *informed* of the material risks when consenting to treatment: *F v R* (1983) 33 SASR 189, 192–3 (King CJ); *Montgomery* (n 81) 1462 [85] (Lords Kerr and Reed JJSC, Lord Neuberger PSC, Lords Clarke, Wilson and Hodge JJSC agreeing). Where a person waives their right to information when refusing treatment, there remains some ambiguity as to whether that refusal can still be valid without the provision of adequate information: see Katrine Del Villar et al, 'Does a Refusal of Treatment Need To Be Informed?: Towards a Resolution of the Current Confusion in English, Canadian and Australian Common Law' (2024) 16(1) *McGill Journal of Law and Health* 61. Katrine Del Villar et al's conclusion that 'although information is highly desirable, a refusal should not need to be informed to be valid and effective … [as] a patient can choose not to receive it' would be consistent with the functional approach to determining DMC: at 122.

Despite this, there is often a reliance on *actual* understanding by medical practitioners assessing DMC. Christopher Ryan, Sascha Callaghan and Carmelle Peisah, in their article on assessing DMC, minimise the distinction between an *ability* to understand and *actual* understanding by concluding that

> for the purposes of clinical capacity assessment, the issue [of whether the person requires actual understanding] is somewhat moot, since it will normally only be possible to test the ability to understand information by reference to what the person actually understands.[98]

Whilst it may be clinically convenient to examine *actual* understanding, this does not reflect the law and there is a real danger of finding incapacity where there is none.[99] First, *actual* understanding depends on how the information has been provided to the individual. Where information has not been provided in a manner the individual can understand, focusing on *actual* understanding may lead to a false conclusion of incapacity. Second, requiring *actual* understanding imposes a burden on the individual to be receptive to information they may not want to receive. There are many in society who make use of non-conventional medical treatments,[100] and who may not want to receive information about conventional evidence-based treatments or believe their veracity, despite being capable of understanding it. In such situations, it can be tempting to falsely conclude that they do not have the *ability* to understand.[101] However, it is all the more imperative that the focus of the DMC assessment remains on their *ability* to understand rather than their *actual* understanding. Where they are not open to receiving or accepting the information, as challenging as it may be, an individual's *ability* to understand can still be ascertained by other

[98] Christopher Ryan, Sascha Callaghan and Carmelle Peisah, 'The Capacity To Refuse Psychiatric Treatment: A Guide to the Law for Clinicians and Tribunal Members' (2015) 49(4) *Australian & New Zealand Journal of Psychiatry* 324, 328.

[99] See *Starson v Swayze* [2003] 1 SCR 722, 733–4 [15] (McLachlin CJ).

[100] Amie Steel et al, 'Complementary Medicine Use in the Australian Population: Results of a Nationally-Representative Cross-Sectional Survey' (2018) 8 *Scientific Reports* 17325:1–7, 3; Mayuree Tangkiatkumjai, Helen Boardman and Dawn-Marie Walker, 'Potential Factors that Influence Usage of Complementary and Alternative Medicine Worldwide: A Systematic Review' (2020) 20 *BMC Complementary Medicine and Therapies* 363:1–15; *PBU* (n 1) 215–16 [242] (Bell J). Reliance on sources of health information other than medical practitioners has increased, which may also influence medical treatment decision-making: Edelman Trust Institute, *2025 Edelman Trust Barometer Special Report: Trust and Health* (Report, 2025) 15, 19, 22, archived at <https://perma.cc/ZQ89-F9LB>.

[101] See, eg, *TH* [2025] TASCAT 26, [51] (Presiding Member Ridley, Ordinary Members McArthur and Hale), where the Tribunal seems to conflate a lack of acceptance of the information with an inability to understand.

circumstantial evidence, such as whether they already understand concepts similar to the information in question.[102]

Actual understanding is one component of insight, and as will be discussed, the issues noted here in relation to *actual* understanding are amplified when insight is brought into the mix in assessing this criterion.

2 *Use/Weigh Criterion*

This criterion engages more cognitive processes than the Understanding Criterion as it requires the person to be able to utilise the information to arrive at a decision. Justice Bell in *PBU* noted that in this context,

> 'use' … means 'to employ for some purpose; to put into service; turn to account' and 'to avail oneself of; apply to one's own purposes' … [and the] verb 'weigh' relevantly means 'balance in the mind'.[103]

Although the legislative DMC test was framed as an alternative between 'use' or 'weigh',[104] Bell J held that depending on the decision, 'it may be necessary for the person to be capable of doing one or the other or both'.[105]

The standard to which the individual needs to be able to use/weigh information is low. The individual need only be able to use/weigh the 'salient details relevant to the decision to be made'.[106] Additionally, they are not required to be able to use/weigh the information to a careful standard,[107] nor are they required to arrive at a 'sensible, rational or well-considered decision'.[108]

Importantly, this is a subjective process, meaning that when weighing information, the individual will 'determine what weight to give it relative to other information'.[109] In the end, they may choose 'to attach no weight to that information in the decision-making process'.[110]

Assessing an individual's ability to use/weigh information can be challenging in practice when the subjective mental processes undertaken to arrive at

[102] See below n 247.

[103] *PBU* (n 1) 156 [53], quoting *Macquarie Dictionary* (n 89) 'use' (defs 1, 2), 'weigh' (def 3).

[104] *Mental Health Act* (Vic) (n 15) s 68(1)(c). See also *Mental Capacity Act* (UK) (n 16) s 3(1)(c).

[105] *PBU* (n 1) 156 [54].

[106] *LBL* (n 90) 1289 [58] (Macur J). See also *CC* (n 57) 646 [69] (Baker J).

[107] *PBU* (n 1) 156 [53], 214–15 [238] (Bell J). This was the error that the Tribunal fell into in relation to NJE: see above n 44 and accompanying text.

[108] *PBU* (n 1) 198 [182] (Bell J), citing *Re T* (n 1) 116 (Butler-Sloss LJ).

[109] *King's College Hospital NHS Foundation Trust v C* [2016] Court of Protection Law Reports 50, 61 [38] (MacDonald J) ('*King's College Hospital*').

[110] Ibid, quoted in *Tower Hamlets* (n 56) [14] (Hayden J).

the decision are not always apparent.[111] For example, where a person gives a particular fact zero weight, the assessor is required to delineate as to whether this was a conscious choice of a capacitous individual or the result of an impairment in their ability to use/weigh that has resulted in them giving no weight to that information.[112] Such a task is not easy. Nonetheless, as is required by the Functional Principle, the focus of the DMC assessment is their *ability* to use/weigh the information, not how they choose to use/weigh that information or the outcome of the process.[113]

There are likely various aspects to this criterion, including the ability to 'see the various parts of the argument and to relate the one to another'[114] and the ability to use that information in applying it to their circumstance.[115] Therefore, insight is often unsurprisingly linked with the assessment of this criterion.[116] However, as with the Understanding Criterion, insight can alter the manner in which this criterion is assessed, resulting in a higher threshold for DMC.[117]

III Insight and Decision-Making Capacity

A *Insight and Medical Treatment Decision-Making*

Insight in the medical context generally relates to the *actual* mental state of an individual: their actual understanding, acceptance and belief of the information given to them by a medical practitioner.[118] This 'differs from factual

111 See Beale et al, 'Mental Capacity in Practice Part 1' (n 58) 6–7.

112 See ibid. See also, eg, *King's College Hospital* (n 109) 73–4 [86]–[91] (MacDonald J). An 'inconsistency between … words and actions' may be evidence of an inability to use/weigh the information: *GWS* (n 24) [125] (Theis J).

113 But see Cressida Auckland, *Values and Disorder in Mental Capacity Law* (Cambridge University Press, 2024) ch 2. Examining the values and beliefs that underpin how a person chooses to weigh the relevant information may reveal 'that the decision reached is not one that the person would have made, but for the disorder' they may be suffering from: at 38.

114 *PCT v P* [2011] 1 FLR 287, 294 [35] (Hedley J).

115 See *Mental Health Act* (ACT) (n 15) s 7(e); Scott YH Kim et al, 'Broad Concepts and Messy Realities: Optimising the Application of Mental Capacity Criteria' (2022) 48(11) *Journal of Medical Ethics* 838, 839–40, 842. See also *St George's University Hospitals NHS Foundation Trust v LV* [2025] EWCOP 9, [9] (Morgan J).

116 See below Part IV. See, eg, *HKN v Mental Health Tribunal* [2019] VCAT 825, [76] (Senior Member Steele) ('*HKN*'): 'To weigh information is to assign it a level of importance relevant to other information or considerations. This is the process which may be interfered with by delusion, irrational fears or lack of acceptance or belief.'

117 See, eg, *CT* (n 23) [53]–[57] (Theis J).

118 See *Macquarie Dictionary* (n 89) 'insight' (def 3c) ('the capacity of a mental patient to know that they are suffering from mental disorder'). Although the definition refers to 'mental'

understanding in requiring that the individual consider the relevance [of the information] to [their] own situation'.[119] There are numerous other terms which are also commonly used that convey the same meaning as insight; these include 'appreciate' and 'believe'.[120] The word 'understand' can also convey notions of insight;[121] however, this is a different meaning to its use in the Understanding Criterion.[122]

Insight is a particularly prominent concept used in the assessment of those with mental illnesses, such as psychosis and schizophrenia.[123] For those with schizophrenia and psychosis, a lack of insight is correlated with the severity of illness as well as worse outcomes,[124] and treatment may improve the degree of

patient', the concept is often applied more generally in the clinical context: see Thomas Grisso and Paul S Appelbaum, *Assessing Competence To Consent to Treatment: A Guide for Physicians and Other Health Professionals* (Oxford University Press, 1998) 42–9. See also Lewis (n 9) 333: 'a correct attitude to a morbid change in oneself'. The concept of insight is also used in other contexts, for example in the disciplinary setting where it may denote 'an understanding of the nature of the conduct, an acceptance that the conduct was seriously wrong, an appreciation of why the practitioner engaged in that conduct, empathy with the consequences, and /or a willingness to take measures to identify risk factors and to avoid similar behaviour': *Medical Practitioners Board of Victoria v Grolaux [No 2]* [2009] VCAT 978, [8] (Deputy President Dwyer, Members Davis and Burge).

119 Michael Gunn, 'The Meaning of Incapacity' (1994) 2(1) *Medical Law Review* 8, 19, quoting Stephen J Anderer, 'A Model of Determining Competency in Guardianship Proceedings' (1990) 14(2) *Mental and Physical Disability Law Reporter* 107, 111.

120 *Macquarie Dictionary* (n 89) 'appreciate' (def 2) ('to be fully conscious of; be aware of; detect'), 'believe' (def 4b) ('to be persuaded of the truth or existence of').

121 Ibid 'understand' (def 8) ('to accept as a fact; believe').

122 Ibid 'understand' (def 1) ('to perceive the meaning of; grasp the idea of; comprehend'). See also above n 89 and accompanying text. If the word 'understand' is not properly construed within the context in which it is used, it can lead to an improper application of the DMC test: see Kane et al, 'Applying DMC Criteria' (n 87) 12.

123 'At the most fundamental level, poor insight in psychosis has been described as a seeming lack of awareness of the deficits, consequences of the disorder, and need for treatment': Xavier F Amador and Henry Kronengold, 'Understanding and Assessing Insight' in Xavier F Amador and Anthony S David (eds), *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* (Oxford University Press, 2nd ed, 2004) 3, 5. See also below n 210; Anthony S David, 'Insight and Psychosis' (1990) 156(6) *British Journal of Psychiatry* 798, 805–6; IS Marková and GE Berrios, 'The Meaning of Insight in Clinical Psychiatry' (1992) 160(6) *British Journal of Psychiatry* 850, 850; Russ Scott and Steve Prowacki, 'Insight and the Capacity To Refuse Treatment with Electroconvulsive Therapy' (2024) 31(2) *Journal of Law and Medicine* 273, 291–6. Insight is also used in the assessment of numerous other mental illnesses: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (American Psychiatric Publishing, 5th ed, 2013) 237–8, 242–4, 247–9.

124 Anthony David and Kevin Ariyo, 'Insight Is a Useful Construct in Clinical Assessments if Used Wisely' (2021) 47(3) *Journal of Medical Ethics* 185, 185. See also Tania M Lincoln, Eva Lüllmann, and Winfried Rief, 'Correlates and Long-Term Consequences of Poor Insight in

insight.[125] Therefore, insight can serve as an important clinical assessment tool into the disease state and response to treatment.[126]

Whilst insight is a familiar concept for medical practitioners, its definitional boundaries are 'fraught with ambiguities'.[127] Insight is not a binary state: a person may have insight in relation to some aspects of their medical state and not others, and the degree of insight may vary.[128] For example, a person may understand and accept that they have an illness but not accept the severity of their illness or the need for treatment; or, a person may accept that they have an illness, but not accept the specific diagnosis provided.[129]

For medical practitioners, insight is a convenient tool in assessing DMC.[130] Where an individual refuses treatment, assessing their insight can serve as a shorthand and starting point for determining their DMC as the DMC criteria are essentially subsumed into the assessment of their insight. Where the individual can demonstrate insight into the various aspects of their medical state and treatment decision, in most cases, they would easily surpass the DMC threshold.[131] This reliance on insight is reflected in courts, where medical evidence often refers to the insight of the individual concerned.[132] However, as will be discussed, there are dangers in relying on insight and it is important to examine what a medical practitioner means when referring to insight in any given context and disentangle its various components to truly appreciate an individual's state of mind.[133]

Patients with Schizophrenia: A Systematic Review' (2007) 33(6) *Schizophrenia Bulletin* 1324, 1330, 1338; Serge Sevy et al, 'The Relationship between Insight and Symptoms in Schizophrenia' (2004) 45(1) *Comprehensive Psychiatry* 16, 17–18.

125 Sean Phelan and Natasha Sigala, 'The Effect of Treatment on Insight in Psychotic Disorders: A Systematic Review and Meta-Analysis' (2022) 244 (June) *Schizophrenia Research* 126, 132.

126 See David and Ariyo (n 124) 185.

127 Laura Guidry-Grimes, 'Ethical Complexities in Assessing Patients' Insight' (2019) 45(3) *Journal of Medical Ethics* 178, 179. See also Kamens et al (n 9) 76, 83–8.

128 Scott and Prowacki (n 123) 291–6.

129 See, eg, *PBU* (n 1) 146–7 [10] (Bell J).

130 See Sándor Gurbai, Emily Fitton and Wayne Martin, 'Insight under Scrutiny in the Court of Protection: A Case Law Survey' (2020) 11 *Frontiers in Psychiatry* 560329:1–12, 2.

131 See Case (n 13) 375.

132 See below n 195; Kane et al, 'Applying DMC Criteria' (n 87) 6–7. See, eg, *ICV (Guardianship)* [2025] VCAT 463, [117], [133], [139], [151], [168] (Vice President Judge English).

133 See National Institute for Health and Care Excellence (UK), *Decision-Making and Mental Capacity* (NICE Guideline No NG108, 3 October 2018) 25 [1.4.24], archived at <https://perma.cc/66EX-F6HV> ('*NICE DMC Guideline*').

B *The Role of Insight in Assessing Decision-Making Capacity*

1 *Legislative Background*

Despite the clinical utility of insight, insight does not form a part of the legislative DMC test.[134] There was consideration by the UK Law Commission of including an 'appreciation' requirement during the consultation process for the *Mental Capacity Act* (UK), but this was ultimately felt to be unnecessary.[135] The Law Commission noted that there may be circumstances 'where the person concerned can understand information but where the effects of a mental disability prevent [them] from using that information in the decision-making process' and observed that they may be 'prevented by their disability from being able to believe' the information'.[136] There is some ambiguity as to whether the pathological non-belief results in the person not being able to use that information, or the inability to use that information (as a result of their disability) results in the pathological non-belief.[137] Regardless, it was felt that there was no need for an additional insight component in the DMC test separate to that of the Use/Weigh Criterion, as a lack of insight would be a possible consequence of an inability to use/weigh information.[138]

In Australia, the inclusion of an 'appreciation' criterion was considered as part of the DMC test in several states in their mental health legislation. During the consultation process for the review of the Australian Capital Territory mental health legislation, it was noted that 'an additional requirement for "appreciation" [would] … ensure that insight into the true nature of any mental illness or mental dysfunction is pre-requisite' for DMC.[139] Victoria also considered an 'appreciate' element in its mental health legislation, but there were concerns raised that it may impose a 'value judgment on the manner in which a person

[134] *Mental Capacity Act* (UK) (n 16) s 3; *PBU* (n 1) 199 [187] (Bell J).

[135] *Law Commission Paper No 231* (n 64) 38–9 [3.16]–[3.17].

[136] Ibid 38 [3.17].

[137] The latter approach would be more consistent with a DMC test that focuses on the functioning of the individual. The former approach has since been rejected: see below Part III(B)(3).

[138] Ibid 38–9 [3.17].

[139] ACT Government, *The Framework of Mental Health and Related Legislation in the ACT: An Options Paper* (Framework Paper, November 2009) 16. The proposed legislation was still framed as an ability to appreciate, rather than actual appreciation: at 24. Although, the intent of adding an 'appreciation' provision would seem to require the individual to demonstrate actual appreciation/insight, rather than an ability.

should weigh the information.'[140] Ultimately, no state has enacted an overt 'appreciation' requirement as part of any legislative DMC test.[141]

2 *Common Law:* Re C, Re MB *and* Re MM

Notions of insight in assessing DMC pre-date the legislative DMC test contained in the *Mental Capacity Act* (UK). In *Re C*, a seminal case on DMC decided before the *Mental Capacity Act* (UK) was enacted, C was a 68-year-old with a history of chronic paranoid schizophrenia who developed gangrene of his left foot.[142] An amputation was recommended, which he refused, and he was able to be stabilised without an amputation.[143] However, it was likely that the need for an amputation would arise again, so he sought an order from the Court preventing any future amputation of his foot without his express written consent.[144]

At the time of the hearing, C had ongoing grandiose delusions, including a belief that he had an 'international career in medicine'.[145] C also 'expressed complete confidence in his ability to survive his present trials aided by God, the good doctors and the good nurses'.[146] In determining his capacity to refuse, Thorpe J held that there were 'three stages to the decision (1) to take in and retain treatment information, (2) to *believe it* and (3) to weigh that information, balancing risks and needs'.[147] Notably, his Honour focused on whether C actually carried out the three stages, rather than an ability to do so.[148] Although C

[140] *PBU* (n 1) 199 [188] (Bell J).

[141] See above n 15. But see the *Mental Health Act* (Vic) (n 33) s 68(1), which has since been replaced by s 87(1) of the *Mental Health and Wellbeing Act* (n 15) (Vic), which seemingly required actual understanding for DMC, although this is not necessarily the same as insight: see ibid 190 [161] (Bell J). Under the *Mental Health Act* (ACT) (n 15) a component of DMC is that the person can 'understand how the consequences affect the person': at s 7(e). This is perhaps as close as any legislation has gone to overtly require an insight component for DMC. It is still framed as whether the 'person can', suggesting that it is still an ability to 'understand how the consequences affect the person', rather than actually demonstrating that: at s 7(e). As previously noted, a person's ability to 'understand how the consequences affect [them]' may be a component of their ability to use/weigh the relevant information: see above Part II(C)(2).

[142] *Re C* (n 91) 291 (Thorpe J).

[143] Ibid 291–2 (Thorpe J).

[144] Ibid 293, 295 (Thorpe J).

[145] Ibid 293 (Thorpe J).

[146] Ibid (Thorpe J).

[147] Ibid 292 (emphasis added).

[148] Ibid.

was 'impaired by schizophrenia', Thorpe J concluded that

> it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant treatment information, that *in his own way he believes it*, and that in the same fashion he has arrived at a clear choice.[149]

The later decision of *Re MB* aligned the common law DMC test with the then-proposed legislative DMC test of the *Mental Capacity Act* (UK).[150] However, the decision did not specifically address the belief requirement set out by Thorpe J, other than to note that if 'a compulsive disorder or phobia from which the patient suffers stifles belief in the information presented to her, then the decision may not be a true one'.[151]

In *Re MM*,[152] Munby J attempted to reconcile the belief component of the DMC test in *Re C* with what was said in *Re MB* and the legislative DMC test (which was to come into force shortly after the *Re MM* decision).[153] His Honour acknowledged that the belief requirement was 'seemingly missing both from the formulation of the test in *Re MB* and from s 3(1) of the [*Mental Capacity Act* (UK)]'.[154] However, his Honour went on to state:

> If one does not 'believe' a particular piece of information then one does not, in truth, 'comprehend' or 'understand' it, nor can it be said that one is able to 'use' or 'weigh' it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information.[155]

Although his Honour reframed the belief requirement for DMC, noted by Thorpe J in *Re C*, as an 'ability or capacity to "believe"',[156] the above passage would suggest that *actual* belief/insight is needed and is central to assessing the Understanding Criterion and the Use/Weigh Criterion.

[149] Ibid 295 (emphasis added).

[150] *Re MB* (n 26) 433–4, 437 (Butler-Sloss LJ for Saville and Ward LJJ).

[151] Ibid.

[152] [2009] 1 FLR 443.

[153] *University Hospitals Birmingham NHS Foundation Trust v Thirumalesh* [2025] Fam 25, 47–8 [53] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]) ('*Thirumalesh Appeal*').

[154] *Re MM* (n 152) 465 [81].

[155] Ibid. See also *R (B) v S* [2006] 1 WLR 810, 820 [34] (Lord Phillips CJ for the Court) ('*S*').

[156] *Re MM* (n 152) 465 [81].

3 *Legislative Decision-Making Capacity Test and Insight*

In interpreting and applying the DMC test, there has been uncertainty as to the relevance of insight in determining DMC. In Australia, Bell J, in *PBU*, held that insight was not a 'determinative normative criterion' in determining DMC, but rather a relevant fact to consider,[157] meaning that a 'person who lacks insight may, not must, be lacking in capacity'.[158] His Honour rationalised Thorpe J's decision in *Re C*, on the basis that Thorpe J had 'taken belief and insight … into account not as a criterion (a normative consideration) but as a factual consideration'.[159]

Justice Bell also quoted with approval Munby J's assertion that 'belief is subsumed in the more general requirements of understanding and of ability to use and weigh information'; his Honour did not quote the full passage (quoted above) in which that statement appears.[160] Justice Bell appears to have sidestepped the ostensible conflict between his Honour's conclusion that insight is a factual consideration and Munby J's assertion that belief is essentially a prerequisite for the Understanding Criterion and the Use/Weigh Criterion. Additionally, if insight is to be a factual consideration, it remains unclear what its proper use is in assessing the DMC criteria and how much weight should be afforded to it.

The decision in *Re MM* continued to carry weight in the UK until the 2024 England and Wales Court of Appeal ('Court of Appeal') decision in *University Hospitals Birmingham NHS Foundation Trust v Thirumalesh* ('*Thirumalesh Appeal*').[161] *Thirumalesh Appeal* was an appeal of the decision in *An NHS Trust v ST* ('*Thirumalesh Trial*').[162] This case involved Sudiksha Thirumalesh,[163] a 19-year-old (at the time of the trial decision) who suffered from a rare progressive mitochondrial illness.[164]

At trial, the dispute concerned Sudiksha's capacity to make future medical treatment decisions (as well as her capacity to litigate).[165] The medical consensus was that Sudiksha was approaching 'the final stage of her life' with an

[157] *PBU* (n 1) 203 [198].

[158] Ibid 201 [193].

[159] Ibid 200 [190].

[160] Ibid 201 [193].

[161] *Thirumalesh Appeal* (n 153).

[162] [2023] Medical Legal Reports 557 ('*Thirumalesh Trial*').

[163] Her identity was made public after the trial decision: *University Hospitals Birmingham NHS Foundation Trust v Thirumalesh* [2023] Medical Law Reports 599, 603 [39] (Peel J).

[164] *Thirumalesh Trial* (n 162) 558 [1] (Roberts J).

[165] Ibid 558 [2] (Roberts J). Her litigation capacity was contingent on her decision-making capacity in relation to medical treatment: at 570 [71] (Roberts J).

estimated prognosis of weeks to months and was unlikely to live long enough to undergo the experimental treatment she wanted to pursue.[166] Although Sudiksha 'was well aware' of the 'very poor prognosis' given by her doctors, she did 'not believe them'.[167] She was firmly of the view that she had 'the resilience and the strength to stay alive for long enough to undergo [experimental] treatment abroad',[168] and steadfastly refused palliative care.[169]

A central issue for the Court was whether Sudiksha's lack of acceptance of her poor prognosis, that is, her lack of insight into her prognosis, was sufficient to deprive her of her DMC for future medical treatment decisions, including the refusal of palliative care.[170] Unlike many of the other cases concerning insight and DMC, Sudiksha was not suffering from any discernible mental illness.[171]

Even though the expert evidence was not unanimous,[172] Roberts J found that Sudiksha was 'unable to make a decision for herself in relation to her future medical treatment, including the proposed move to palliative care, because she [did] not believe the information she [had] been given by her doctors'.[173] Her Honour based her decision on what was said by Munby J in *Re MM*, noting that 'a person's ability to understand, use and weigh information as part of the process of making a decision depends on him or her believing that the information provided for these purposes is reliable and true'.[174] This required her Honour to 'consider the extent to which the information provided to a person is capable of being established objectively as a "fact" or a "truth"' in determining the degree of belief required.[175] Because Sudiksha did not have the requisite belief of the information in relation to her condition, which her Honour found to be 'both reliable and true', she could not 'use or weigh that information' in the decision-making process.[176] This was contrasted with an unwise decision,

166 Ibid 558 [2]–[3], 563 [31] (Roberts J).

167 Ibid 559 [6] (Roberts J).

168 Ibid.

169 Ibid 559 [4] (Roberts J).

170 Ibid 574 [101], 574–5 [103] (Roberts J).

171 Ibid 565 [40], 573–4 [98] (Roberts J). Although her continued belief in her ability to survive was framed by one of the expert witnesses as a 'delusion which derives from a false reality in that she cannot contemplate her own death', there was insufficient evidence to support a finding that she suffered from any recognisable mental illness: at 563 [31] (Roberts J).

172 Ibid 559 [7].

173 Ibid 573 [93].

174 Ibid 571 [78], [80]–[81].

175 Ibid 571 [83].

176 Ibid 573 [93].

where the person is able to carry out the decision-making process but subjective factors may result in an objectively unwise decision.[177]

Her Honour concluded that Sudiksha's lack of insight stemmed from an 'impairment of, or a disturbance in the functioning of, her mind or brain', which was the result of:

- the 'cumulative effect of her circumstances over … a prolonged period';
- a 'profound inability to contemplate the reality of her prognosis'; and
- a 'fundamentally illogical or irrational refusal to contemplate an alternative'.[178]

The relevant circumstances included:

- 'the trauma of her initial admission to hospital';
- 'the length of her stay in the [intensive treatment unit]';
- being 'surrounded by patients dying around her on the unit' over months;
- enduring 'almost a year of intensive medical and surgical intervention which has been both painful and distressing'; and
- being 'frightened by the prospect of dying'.[179]

Ostensibly, Sudiksha's lived experience formed the basis of the conclusion that she lacked DMC.[180]

Sudiksha died shortly after the trial decision was handed down;[181] subsequently, her parents appealed against the declaration of incapacity.[182] In *Thirumalesh Appeal*, the Court of Appeal allowed the appeal on multiple grounds, including on the issue of insight, and provided much needed clarity on the importance of insight in applying the DMC test. Commenting on what was said about insight in *Re C*, *Re MB* and *Re MM*, King LJ noted:

[177] Ibid.

[178] Ibid 575 [103]. Cf *Re MB* (n 26) 436–7 (Butler-Sloss LJ for Saville and Ward JJ).

[179] *Thirumalesh Trial* (n 162) 575 [103].

[180] See ibid 575–6 (commentary). Life experiences may be a contributing factor in finding a lack of DMC: see, eg, *Nottingham University Hospitals NHS Trust v JM* [2023] EWCOP 38, [44] (Hayden J).

[181] *Thirumalesh Appeal* (n 153) 39 [1] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[182] Ibid 40 [7] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]). See also Letter from Professor Wayne Martin to Sir Andrew McFarlane, 8 October 2023 <https://autonomy.essex.ac.uk/wp-content/uploads/2024/04/Open-Letter-Belief-and-Capacity.pdf>, archived at <https://perma.cc/R2MA-787A>.

> With all the respect inevitably and properly given to Munby J (as he then was), the 'lack of correspondence' between Thorpe J's test as set out in [*Re C*] and that of Butler-Sloss LJ in [*Re MB*] is that, in [*Re C*], belief is stated to be a requirement, whereas, in [*Re MB*], although a lack of belief may undermine a decision, it is not an absolute requirement. For my part I am unable to see anything in Butler-Sloss LJ's judgment which could be taken to be saying, as Munby J suggested [in *Re MM*], that 'if one does not "believe" a particular piece of information then one does not, in truth, "comprehend" or "understand" it, nor can it be said that one is able to "use" or "weigh" it'.[183] …
>
> [T]here is no specific requirement of belief, whether subsumed into the general requirement of understanding or in the ability to use and weigh information or otherwise.[184]

Therefore, Roberts J was found to have made an error of law in her Honour's 'approach to the statutory test in saying that Sudiksha's refusal or inability to believe the "information" alone resulted in her failing the functional test'.[185]

The position of the Court of Appeal is in essence the same conclusion that was reached by Bell J in *PBU*, this being that 'an absence of belief *may* but not inevitably will … lead to a medical practitioner or a court to conclude' that the individual lacks DMC.[186] But unlike Bell J, the Court of Appeal did not attempt to rationalise what was said about belief in *Re C* and explicitly rejected the approach taken in *Re MM* with respect to insight.[187] Although Bell J was willing to accept that insight may be 'subsumed' into the Understanding Criterion and the Use/Weigh Criterion, as noted above, the conclusion drawn by his Honour that insight is not a prerequisite for DMC is at odds with the approach taken to insight by Munby J in *Re MM*.[188] To that end, the Court of Appeal's rejection of *Re MM* in *Thirumalesh Appeal* should be followed in Australia.

The decisions in *PBU* and *Thirumalesh Appeal*, whilst acknowledging that insight is not determinative of DMC, continue to insist that insight has relevance in determining DMC. However, it is argued in the following Part that references to insight confuse, rather than assist, courts in determining DMC.

[183] *Thirumalesh Appeal* (n 153) 48–9 [55] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[184] Ibid 62 [124].

[185] Ibid 63 [129] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[186] Ibid 62 [124] (emphasis in original) (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]). See *PBU* (n 1) 201 [193].

[187] See *Thirumalesh Appeal* (n 153) 46–9 [49]–[55], 63 [129] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[188] *PBU* (n 1) 201 [193], quoting *Re MM* (n 152) 465 [81] (Munby J).

This can result in an improper rise in the DMC threshold, especially for those with mental illnesses.

IV The Limits of Insight

In considering the role of insight in assessing DMC, it is trite to observe that the 'starting point for the ascertainment of the meaning of a statutory provision is the text of the statute whilst, at the same time, regard is had to its context and purpose'.[189] Insight does not appear as part of the DMC test, nor does the context of the development of the legislative test and its influence on the common law indicate that insight plays any significant role in the interpretation and application of the test.[190] This was acknowledged in *Thirumalesh Appeal* where the Court of Appeal agreed that the

> meaning of each of the words 'understand', 'use' and 'weigh' is … different from the meaning of the word 'believe'. The statutory language … [of the DMC test] is complete in meaning: there is no missing meaning, and no implicit or subsumed meaning that needs to be made explicit and no addition or embellishment is required.[191]

The Court of Appeal went on to note:

> All that is required is an application of the statutory words without any gloss. 'Does this person have the ability to understand?', 'Is this person able to use and weigh this information?' The danger is that the introduction of the word 'belief' is either the same as the statutory test, in which case it is otiose or, if that is not the case, there is the risk that by introducing a hard-edged requirement of 'belief' people will look for something different from the statutory test which is wrong in law. All that is required is the application of the words of the statute.[192]

However, as Butler-Sloss P observed in *Re B*, whilst the language of the DMC test may be 'clear and easily to be understood by lawyers', the 'application to individual cases in the context of a general practitioner's surgery, a hospital ward and especially in an intensive care unit is infinitely more difficult to achieve'.[193] Medical practitioners may also lack a detailed knowledge of the legal

[189] *SZTAL v Minister for Immigration and Border Protection* (2017) 262 CLR 362, 368 [14] (Kiefel CJ, Nettle and Gordon JJ).

[190] See above Part III(B).

[191] *Thirumalesh Appeal* (n 153) 50 [59] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[192] Ibid 62 [125] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[193] *Re B* (n 60) 455 [14]. See also Mooney et al (n 4) 817, 828–9, 832–7.

aspects of DMC test and its proper application.[194] It is therefore unsurprising that medical practitioners rely heavily on notions of insight in their DMC assessments;[195] it is a concept they are far more familiar with than the statutory DMC test.[196] Courts are then forced to grapple with determining how expert evidence that incorporates insight should be used in determining DMC.[197] It may be partly for this reason that both *PBU* and *Thirumalesh Appeal* continue to maintain that insight has relevance in determining DMC. These decisions have made clear that insight is not determinative of DMC; however, they have done little to ameliorate the confusion as to how insight should be used in determining DMC.

In a 2021 study, Kane and colleagues examined the rationales that UK courts considered in determining DMC.[198] They examined the capacity rationales in 131 judgments over a 10-year period and showed that 'appreciation' (ie insight)

[194] See Kimbali Wild et al, 'Reasons behind the Rise in Involuntary Psychiatric Treatment under Mental Health Act 2016, Queensland, Australia: Clinician Perspectives' (2025) 98 *International Journal of Law and Psychiatry* 102061:1–7, 5; Greg Young, Alison Douglass and Lorraine Davison, 'What Do Doctors Know about Assessing Decision-Making Capacity?' (2018) 131(1471) *New Zealand Medical Journal* 58, 61, 63–4; Elizabeth Jackson and James Warner, 'How Much Do Doctors Know about Consent and Capacity?' (2002) 95(12) *Journal of the Royal Society of Medicine* 601, 603.

[195] See, eg, *Surrey and Sussex Healthcare NHS Trust v AB* [2015] EWCOP 50, [37] (Keehan J); *PH v A Local Authority* [2011] Court of Protection Law Reports 128, 137 [33], 139–40 [38]–[45] (Baker J); *C v Guardianship and Administration Board* [2002] TASSC 29, [4]–[7] (Blow J). In the context of guardianship orders in NSW: *EKD* [2024] NSWCATGD 22, [55]–[56] (Senior Members Connor and Duffy, and General Member Watson); *DZT* [2022] NSWCATGD 7, [26]–[31] (Senior Members Booby and Landau, and General Member Newman); *KFT* [2022] NSWCATGD 19, [12]–[15] (Senior Members Barnes and Houlahan, and General Member Barnes); *EOK* [2017] NSWCATGD 27, [8], [11] (Senior Members Roushan and McPhee, and General Member Le Breton); *KGN* [2024] NSWCATGD 23, [41]–[47] (Senior Members Barnes and Banerjee, and General Member Pickering). Despite the assessment of capacity guidelines in NSW outlining the common law DMC test, there is greater focus on insight and little discussion of the capacity criteria in these guardianship decisions: *NSW Capacity Toolkit* (n 15) 85–7. This may be a consequence of not having a general legislative DMC test. The NSW Law Reform Commission recommended that a 'definition of decision-making ability that is consistent with similar provisions in the *Mental Capacity Act 2005* (UK)' be legislated, but this has not yet occurred: New South Wales Law Reform Commission, *Review of the Guardianship Act 1987* (Report No 145, May 2018) 56 [6.12], archived at <https://perma.cc/9JPP-WBC6>.

[196] See Mooney et al (n 4) 828–9.

[197] See *CT* (n 23) [60], where Theis J recommended that where insight is considered as part of the decision-making assessment, 'the assessor must clearly record what they mean by a lack of insight in this context and how they believe it affects, or does not affect, the person's ability to make the decision as defined by the statutory criteria, for example to use/weigh relevant information'.

[198] Kane et al, 'Applying DMC Criteria' (n 87) 3–4.

was the most-cited rationale in determining DMC.[199] Of the over 1,000 capacity rationales identified, 58 per cent had explicit links to the four DMC criteria.[200] Where the Understanding Criterion was cited, 'to appreciate' was linked in 42% of the rationales, and where the Use/Weigh Criterion was cited, 'to appreciate' was linked to 45 per cent of rationales.[201] Of the 42 per cent of rationales where there were no express links to the DMC criteria, 'to appreciate' remained the most common rationale at 43%.[202] This study shows that despite being 'purposely excluded from the wording of the [*Mental Capacity Act* (UK)] due to perceived complications',[203] insight is a pervasive concept in DMC determinations by courts.[204]

It is argued in this Part that insight, as clinically convenient as it may be, has the potential to distort the proper application of the DMC test. The end result is a DMC test that is more onerous than intended, risking finding incapacity where there is none. Those with mental illnesses or neurocognitive disorders are particularly vulnerable to the dangers that insight poses in threatening decision-making autonomy.[205]

A *Insight and Mental Illness*

Those with mental illnesses and other neurocognitive disorders, where issues around DMC commonly arise,[206] are particularly sensitive to the improper application and assessment of the DMC criteria. For example, those with anorexia are often found to lack DMC to refuse treatment by 'the combination of "status": the person is diagnosed with anorexia, and "outcome": the person refuses treatment'.[207] The decision to refuse treatment is used to find incapacity

199 Ibid 6.

200 Ibid.

201 Ibid 8.

202 Ibid.

203 Ibid 2.

204 Ibid 11. See also Gurbai, Fitton and Martin (n 130) 4, 7–8.

205 Guidry-Grimes (n 127) 181. But see Darold A Treffert, 'Dying with Their Rights On' (1973) 130(9) *American Journal of Psychiatry* 1041, 1041.

206 See Gareth S Owen et al, 'Mental Capacity To Make Decisions on Treatment in People Admitted to Psychiatric Hospitals: Cross Sectional Study' (2008) 337(7660) *BMJ* 40, 42; Ruth Cairns et al, 'Prevalence and Predictors of Mental Incapacity in Psychiatric In-Patients' (2005) 187(4) *British Journal of Psychiatry* 379, 379–80.

207 Sam Boyle, 'How Should the Law Determine Capacity To Refuse Treatment for Anorexia?' (2019) 64 *International Journal of Law and Psychiatry* 250, 254. See also Sam Boyle, Andrew McGee and Felicity Wood, 'How To Determine the Capacity of a Person with Depression Who

without necessarily considering the nexus between the patient's diagnosis and its symptomatology, and their ability to carry out the DMC criteria.

Where a lack of insight coincides with any form of mental illness or neurocognitive disorder and a refusal of treatment, there can be a similar temptation to improperly short-circuit the DMC assessment.[208] There can be a reflexive assumption that the lack of insight into their mental illness or need for treatment is caused by their mental illness. This lack of insight is then used to find incapacity without considering whether the mental illness is necessarily connected to their lack of insight and their inability to carry out the DMC criteria.[209]

It is evident that mental illness and other neurocognitive disorders can impact insight,[210] but as Bell J noted in *PBU*, there are a multitude of other factors that can equally influence insight:

> Insight is potentially affected in nature and degree by various non-capacity influences, including educational background, language proficiency, familiarity with medical issues and family and social relationships (negative and positive) and (often critically) the availability of appropriate support. …
>
> The way in which lack of belief or insight in respect of the illness and the need for treatment is considered when assessing capacity is a matter of importance to people with mental disability. This is because it is not uncommon, for various personal, social and medical reasons, for a person with mental disability to deny or diminish the illness and the need for treatment, or to choose non-advised treatment. Nor is it uncommon, for various personal, social and medical reasons, for persons not having mental disability to deny or diminish

Requests Voluntary Assisted Dying' (2024) 32(2) *Psychiatry, Psychology and Law* 276, 280–1. See, eg, *EF v Mental Health Tribunal* [2018] WASAT 22, [59], [71]–[80] (Members Leslie and Connor, and Senior Sessional Member Ng).

208 See, eg, *Heart of England* (n 1) 242 [40], where Peter Jackson J cautioned against readily finding a 'correlation between a lack of insight into schizophrenia and incapacity to' make a treatment decision unrelated to JB's mental illness, which in this case was an amputation. See also Office of the Chief Psychiatrist, Department of Health (Tas), *Mental Health Act 2013: Review of the Act's Operation* (Outcomes Report, June 2020) 34, archived at <https://perma.cc/RKH4-ZW69>.

209 See below Part V.

210 Anosognosia is a condition where the person is not aware of their deficits (ie lack insight) and can be seen in mental illnesses such as schizophrenia and neurocognitive disorders such as Alzheimer's disease: Benjamin Rose and Philip D Harvey, 'Anosognosia in Schizophrenia' (2025) 30(1) *CNS Spectrums* e24:1–8; Kevin D Morgan and Anthony S David, 'Neuropsychological Studies of Insight in Patients with Psychotic disorders' in Xavier F Amador and Anthony S David (eds), *Insight and Psychosis: Awareness of Illness in Schizophrenia and Related Disorders* (Oxford University Press, 2nd ed, 2004) 177; Dylan G Harwood et al, 'Frontal Lobe Hypometabolism and Impaired Insight in Alzheimer Disease' (2005) 13(11) *American Journal of Geriatric Psychiatry* 934.

> illness or the need for treatment, or to choose non-advised treatment. In neither case does this mean of itself that the person lacks capacity.[211]

In *Thirumalesh Trial*, Sudiksha's lack of insight may have been the product of various non-capacity influences noted by Bell J above, rather than a disturbance of the mind.[212] Relying on insight, especially in those with mental illnesses or neurocognitive disorders, without disentangling the factors contributing to insight, can lead a court to incorrectly finding incapacity.

B *Insight and the Understanding Criterion*

The linking of insight with the Understanding Criterion arguably distorts the true meaning of 'ability to understand'. The 2021 study by Kane and colleagues reveals that judges appear to use 'understanding' in 'two different senses: "understanding as grasping" and "understanding as appreciating"'.[213] The latter approach, which incorporates actual understanding and insight, as noted previously, is not consistent with the proper interpretation of this criterion.[214]

The Understanding Criterion is concerned with the *ability to understand*, not whether the person has *actually* understood or has insight. DMC does not require a demonstration of *actual* understanding.[215] Take for example the information relating to a diagnosis. Having the ability to understand the diagnosis is different to having insight into the diagnosis. The former depends only on the cognitive abilities of the person, and their actual understanding of the diagnosis will depend on how and what information is provided and their willingness to receive that information. Insight, on the other hand, requires the person to *actually* understand the information, *accept* the information and *apply* that information to their circumstance. The cognitive processes involved in demonstrating insight far exceed what is needed to have the *ability to understand*.

The effect of interpreting the Understanding Criterion as incorporating insight would raise the threshold for DMC in assessing this criterion.[216] This

[211] *PBU* (n 1) 201–2 [194]–[195]. See also Johnna Wellesley, Dominic Wilkinson and Bryanna Moore, 'Wish To Die Trying To Live: Unwise or Incapacitous?' (2024) 51(9) *Journal of Medical Ethics* 584, 585–6. See generally Polona Curk, Sándor Gurbai and Fabian Freyenhagen, 'Removing Compliance: Interpersonal and Social Factors Affecting Insight Assessments' (2020) 11 *Frontiers in Psychiatry* 560039:1–15.

[212] See *Thirumalesh Trial* (n 162) 575–6 (commentary).

[213] Kane et al, 'Applying DMC Criteria' (n 87) 12. See also above n 122.

[214] See above Part II(C)(1).

[215] See above nn 96–9 and accompanying text.

[216] Case (n 13) 375.

distorting effect can be seen in *Re ICO*.[217] The appellant in this case was a 37-year-old who suffered from treatment resistant chronic paranoid schizophrenia, for whom ECT was being considered.[218] She steadfastly refused ECT and appealed the decision of the Mental Health Tribunal to the Mental Health Court, which found she lacked DMC to refuse ECT.[219] The appeal was allowed on grounds not related to her DMC,[220] but in relation to DMC, the Court concluded that she had

> no insight into the complexity of her chronic relapsing mental illness and its effects on her mood, thoughts and behaviours. This *lack of insight* into her chronic mental illness or her need for treatment *affects her ability to understand* the nature and effect of a decision to give consent to the treatment of ECT.[221]

This conclusion was supported by expert evidence, which noted that the appellant was 'an intelligent woman and at an academic level [she] can understand the information provided to her'; however, she was 'not receptive to that information because she doesn't believe that ECT will be good for her because she doesn't believe she has a mental illness'.[222] Therefore, she had the *ability to understand* the information, but did not *accept* that information or *apply* that information to herself, thereby lacking insight.

Although the DMC test that *Re ICO* was concerned with was 'differently worded' to the DMC test Bell J considered in *PBU*,[223] it was 'broadly to the same effect'.[224] So, Wilson J, in arriving at her decision in relation to DMC, referred to *PBU*,[225] where Bell J quoted, with approval, an article by Ryan, Callaghan and Peisah which noted

[217] [2023] QMHC 1.

[218] Ibid [16], [33] (Wilson J).

[219] Ibid [1]–[2], [50], [153] (Wilson J).

[220] Ibid [154], [175]–[176] (Wilson J).

[221] Ibid [152] (Wilson J) (emphasis added). See also *CG v Mental Health Tribunal* [2021] WASAT 47, [33] (Deputy President Judge Glancy, Member Povey and Sessional Member Caunt); *GB v Mental Health Tribunal* [2021] WASAT 45, [28]–[29] (Deputy President Judge Glancy, Member Lavery and Sessional Member Caunt); *C v Guardianship and Administration Board* (n 195) [4]–[7] (Blow J).

[222] *Re ICO* (n 217) [151] (Wilson J).

[223] Ibid [95] (Wilson J).

[224] Ibid [97] (Wilson J).

[225] Ibid [103].

> [a] lack of insight may impact a person's ability to understand relevant information, but the presence or absence of insight is not a proxy for the presence or absence of decision-making capacity.[226]

With respect, this statement should not be accepted or followed to the extent that it supports a finding of an *inability to understand* on the basis of insight alone, which appears to have been the case in *Re ICO*. Ryan, Callaghan and Peisah, at least in part, seem to arrive at the conclusion that 'insight may impact a person's ability to understand' on the premise that 'under the common law test for capacity, there has been some debate as to whether a person is merely required to have the ability to understand the relevant information or whether it is necessary for the person to actually understand the information'.[227] This is no longer in doubt; there is no requirement of *actual* understanding in assessing the Understanding Criterion.[228]

There is a real danger that where insight is considered, despite having an *ability to understand*, like the appellant in *Re ICO*, the individual will be found to not satisfy this criterion.[229] It may be that the appellant in *Re ICO* did not have DMC to refuse ECT and may have had an inability to use/weigh the information, but by focusing on insight, the DMC assessment was prematurely curtailed at the Understanding Criterion and this represents an improper application of the DMC test.[230]

The notion that insight may directly impact a person's ability to understand should be rejected.[231] Focusing on insight in assessing the Understanding Criterion demands more than is required for this criterion, thereby significantly and unduly raising the threshold for DMC. The need for 'insight' to 'understand' is also contrary to the Low Threshold Principle and the Functional Principle.

C *Insight and the Use/Weigh Criterion*

Insight is most commonly linked with the Use/Weigh Criterion.[232] This is often on the basis that if an individual does not have insight into their condition or

[226] Ryan, Callaghan and Peisah (n 98) 328, quoted in *PBU* (n 1) 201 [194]. See also Cindy Tucker and Jimmy Zhang, 'Informed Consent in the Mental Health Context: When Can a Patient Say No?' (2023) 31(10) *Australian Health Law Bulletin* 170, 171.

[227] Ryan, Callaghan and Peisah (n 98) 328.

[228] See above n 96 and accompanying text.

[229] Cf *HKN* (n 116) [58] (Senior Member Steele).

[230] Cf *Re FYS* [2023] QHMC 3, [81], [84]–[85] (Ryan J).

[231] See Kim et al (n 115) 842.

[232] See Kane et al, 'Applying DMC Criteria' (n 87) 6, 8.

need for treatment, then they cannot use/weigh the relevant information to arrive at a decision.[233] Whilst this is ostensibly sound logic, linking insight to the Use/Weigh Criterion assumes a requirement that the person *actually* understands that information and *accepts* that information. However, it is argued that this is an incorrect interpretation of this criterion, and much like insight and the Understanding Criterion, insight here has a distorting impact on the interpretation and application of the Use/Weigh Criterion.

It is true that if an individual does not *actually* understand the information, they would not be in a position to *actually* be able to use/weigh that information. But this is not the situation that the DMC assessment is concerned with. A capacitous individual has a choice as to whether they want to understand or receive the information.[234] If they choose to not understand or receive that information, how can they then be expected to *actually* use/weigh that information? An individual's *ability to use/weigh* should not be contingent on whether they have an actual understanding.

Equally, a person is not required to accept information provided to them in order to demonstrate DMC. A capacitous person who chooses not to accept information will likely not be able to *actually* use/weigh that information, but that does not mean they lack the functional *ability to use/weigh* that information. This was the error made in *Thirumalesh Trial*, where the lack of acceptance of the prognosis formed the basis of the conclusion that Sudiksha lacked the 'ability to weigh any decisions she makes about active treatment versus palliative care'.[235] This was rightly overruled by the Court of Appeal.[236]

Finding that someone is unable to use/weigh information based on their lack of understanding or acceptance of information improperly short-circuits the DMC assessment. Such reasoning takes hold when considerations of insight heavily influence the DMC assessment, but is fundamentally flawed as it reveals nothing about the individual's functional ability to use/weigh information, which is the primary focus of the DMC assessment.[237] Requiring the individual to be in a position to *actually* use/weigh that information in effect reverses the onus onto the individual to demonstrate DMC. This undermines the Presumption Principle.

[233] See, eg, *R (B) v SS* [2005] Human Rights Law Reports 1377, 1406 [190] (Charles J), affd *S* (n 155) 820 [34] (Lord Phillips CJ for the Court).

[234] See above nn 96–9 and accompanying text.

[235] *Thirumalesh Trial* (n 162) 567 [51], 572–3 [92]–[93] (Roberts J).

[236] *Thirumalesh Appeal* (n 153) 66 [142]–[143], (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[237] *Law Commission Paper No 119* (n 61) 52 [2.44]. See also above Part II(B)(2).

In assessing the Use/Weigh Criterion, the question to be answered is: if the individual did understand the information and accept that information, would they then have the functional ability to use/weigh that information?[238] Framing the assessment in this manner focuses on their functioning and is not contingent on the individual actually carrying out any of the other DMC criteria or having insight. The *ability to understand*, and the *ability to use/weigh*, should be treated as separate enquiries examining the individual's functioning. One should not be treated as a prerequisite for the other, which appears to be the impact of using insight as a basis to find incapacity. If actual understanding and acceptance is required to use/weigh information, the freedom to choose whether to understand or accept the information afforded by the Understanding Criterion becomes illusory. By insisting on insight, there is a real danger of finding incapacity where there is none, especially in those whose beliefs do not align with the prevailing opinion on medical matters. Neil Allen's observation, commenting on Munby J's statement in relation to belief in *Re MM*,[239] is especially apposite:

> Are we able to use and weigh information relating to something we do not believe in? Can an atheist, for example, ever have the capacity to consent to a religious wedding if they do not believe in God? Can a Jehovah's witness ever capacitously decide to have a blood transfusion if they think other people's blood is evil? Surely it cannot be right; *otherwise we would not be able to understand anything that we did not believe in. It would make it impossible to disbelieve a doctor and retain capacity*.[240]

[238] If the decision is made on a false basis and there is no longer any opportunity to rectify this, the decision may not be valid in law, but that does not mean the individual lacks DMC. For example, where an individual has refused treatment on the basis of incomplete or incorrect information and are now unconscious such that further information cannot be supplied, then the scope of original decision may not cover the present circumstance and therefore may not be valid, irrespective of their DMC at the time of the decision: *Re T* (n 1) 114 (Lord Donaldson MR), 120 (Butler-Sloss LJ); *Hunter* (n 21) 94–5 [26]–[30] (McDougall J); Del Villar et al (n 97) 76–8. The question of DMC is separate to that of valid consent (or refusal): *Re T* (n 1) 117 (Butler-Sloss LJ); *Hunter* (n 21) 94 [26] (McDougall J). See also above n 93.

[239] See above n 155 and accompanying text.

[240] Allen (n 13) 169 (emphasis added). This flaw in reasoning can be seen in *NN* [2025] TASCAT 72, [58] (Presiding Member Morton, Ordinary Members Kavanagh and Fela) where the Tribunal noted that 'NN does not understand how the symptoms of his mental illness apply to him, and this impairs his ability to use or weigh information relevant to his treatment, such as the risks and benefits of treatment'. See also *TH* (n 101) [51] (Presiding Member Ridley, Ordinary Members McArthur and Hale): 'understanding the relevant information is a necessary foundation for using or weighing the information'; *LMM* [2025] TASCAT 104, [38]

In practice, it can be difficult to determine whether the individual is able to use/weigh information if they do not believe or accept that information (ie have *insight*). This is particularly difficult if they suffer from a mental illness or a neurocognitive disorder that might be directly affecting the functional processes needed for DMC. Such a task is not impossible, and the clinical convenience of insight should not abrogate the need to focus on the functioning of the individual in determining DMC.[241] The assessor must delineate whether the person truly lacks the ability to use/weigh information or whether they have the ability to use/weigh the information but have made a choice to not believe or accept that information. Where there is a false belief, consideration needs to be given as to whether this amounts to a pathological cognitive impairment, such as delusions, so as to deprive them of their ability to carry out the DMC criteria.

In *Thirumalesh Trial*, Sudiksha had insight into several 'aspects of her care and treatment'[242] and 'understood that her condition was progressive'.[243] She also expressed a strong desire to 'die trying to live' and to 'try everything',[244] a view which was shared by her family.[245] Her beliefs were not considered to be

(Presiding Member Ridley, Ordinary Members Morrissey and Jones); *BNI* [2025] TASCAT 42, [51] (Deputy President Mollross, Ordinary Members Bakas and Hale); *SK* [2025] TASCAT 53, [47] (Deputy President Mollross, Ordinary Members Walker and McShane); *DN* [2025] TASCAT 137, [45] (Presiding Member Ridley, Ordinary Members Kavanagh and Jordan); *DQL v Mental Health Tribunal* [2025] VCAT 121, [39] (Senior Member Powles).

241 There are numerous other means to ascertain whether an individual has DMC without adverting to insight. For example, the assessor can examine whether the person can understand concepts similar/parallel to the decision at hand; the assessor can examine whether the individual can use/weigh parallel concepts using hypothetical scenarios; and the assessor can undertake formal cognitive testing, providing objective evidence of their cognitive capacities. However, cognitive tests should be interpreted with caution and are generally not determinative of DMC on their own: Alex Ruck Keene and Annabel Price, 'Age-Related Dementia and the Law: The Challenges of Mental Capacity and Equality' in Sue Westwood and Nancy J Knauer, *Research Handbook on Law, Society and Ageing* (Edward Elgar, 2024) 437, 442; *XYZ* [2007] VCAT 1196, [68]–[69] (Deputy President Billings); *YA* [2024] WASAT 118, [19]–[20] (Member Bunney); Keene (ed) (n 4) 249–50. An example of using parallel concepts can be seen in *PBU* (n 1). Justice Bell noted that although PBU did not believe he had schizophrenia, he accepted he had other mental health problems for which 'he was willing to receive psychiatric and medical treatment' other than electroconvulsive therapy: *PBU* (n 1) 212 [229]. This, to his Honour, tended to 'suggest that he did have [the] ability' to make treatment decisions in relation to mental illnesses which may extend to ECT, which the Tribunal failed to take into consideration: at 213 [232]. There are numerous assessment tools that may aid in determining DMC: Catherine Pennington et al, 'Tools for Testing Decision-Making Capacity in Dementia' (2018) 47(6) *Age and Ageing* 778, 781.

242 *Thirumalesh Trial* (n 162) 567 [51] (Roberts J).

243 *Thirumalesh Appeal* (n 153) 51 [71] (King LJ).

244 Ibid.

245 Ibid 54 [91], 60 [115] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

the product of a delusion.[246] Such circumstantial factors may point to her having the functional ability to use/weigh the relevant information but choosing not to accept it.[247] *Thirumalesh Trial* provides a seminal example of the various non-capacity related factors that Bell J noted that affect one's lack of insight in relation to their medical issues, but that may not necessarily mean they lack DMC.[248] *Thirumalesh Trial* also demonstrates the threat to autonomy that considerations of insight poses in the DMC assessment.

V Rethinking Insight in Assessing Decision-Making Capacity

Finding that an individual does not have insight into their illness, or the need for treatment, on its own, does not delineate between whether the individual is incapable of understanding and using/weighing that information or has chosen not to accept or give weight to that information.[249] It simply denotes that they have not arrived at the subjective mental state that the medical practitioner wishes them to be at. As Dr Case notes,

> equating insight with capacity brings us perilously close to equating capacity with agreement. … [And] can mask a conclusion that [the individual] lacks capacity because he disagrees with the professional view as to what is in his best interests. As far as the law is concerned, consideration of what is in [the individual]'s best interests as part of the process of assessing capacity is taboo.[250]

246 *Thirumalesh Trial* (n 162) 574 [98] (Roberts J).

247 See *Thirumalesh Appeal* (n 153) 53–4 [89]–[91] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]); Dominic Wilkinson, Bryanna Moore and Johnna Wellesley, 'How a Court Ruled That Patients Have a Right To Disbelieve Doctors', *The Conversation* (online, 22 November 2024) <https://theconversation.com/how-a-court-ruled-that-patients-have-a-right-to-disbelieve-doctors-242090>, archived at <https://perma.cc/VA6Z-B9PP>.

248 See above n 211 and accompanying text.

249 Keene (ed) (n 4) 251 (citation omitted). See, eg, *Re RLB* [2017] SACAT 13, [47]–[48] (Executive Senior Member Rugless, Member Skinners and Box), where the expert evidence, in relation to DMC about ECT, noted that 'whilst RLB has some limited insight into the fact of his mental illness, he does not have an appropriate level of insight as to the severity of his depression and the serious effects of the illness on his thinking and functioning'. This statement would imply that the *level of insight* itself was a relevant factor in determining capacity but this evidence reveals nothing about the actual functioning of RLB with reference to the capacity criteria. Reference to lacking the *appropriate level of insight* risks introducing an extra-legislative criterion into the assessment of DMC.

250 Case (n 13) 370 (citations omitted). See also generally Magdalena Furgalska, '"Informed Consent Is a Bit of a Joke to Me": Lived Experiences of Insight, Coercion, and Capabilities in Mental Health Care Settings' (2023) 19(4) *International Journal of Law in Context* 456.

Despite the multitude of concerns with insight highlighted thus far, courts continue to insist that there is a role for insight in the assessment of DMC. But what does the proper use of insight in the DMC assessment look like, if at all possible? Whilst there is no doubt that insight has clinical utility,[251] it is argued that it is not an essential ingredient for the purposes of determining DMC, nor should it be the sole basis for finding incapacity.

In *PBU*, Bell J accepted that a 'lack of belief or insight in respect of a mental illness or need for treatment may be capable of supporting a finding of incapacity'.[252] In his Honour's finding that VCAT had erred, he noted that VCAT should have examined 'how non-acceptance of the diagnosis affected PBU's ability to function' in determining the DMC criteria.[253] At face value, VCAT's response may echo what Munby J stated in *Re MM*: 'If one does not "believe" a particular piece of information then one does not, in truth, "comprehend" or "understand" it, nor can it be said that one is able to "use" or "weigh" it.'[254] As has been argued, such a response is no longer acceptable, so how should this finding by Bell J be considered?

The preferred approach is to first assess the individual's DMC in relation to the treatment decision. Then, where there are doubts about DMC due to non-acceptance of, or a lack of insight into, relevant information, it may indicate the presence of pathological factors, such as 'delusional thinking and irrational fears' or cognitive deficits,[255] which help establish the underlying cause of the impairment in DMC. It is, however, important to delineate any non-pathological factors that may be impacting upon insight which would not ordinarily be sufficient to overcome the Presumption Principle.[256]

Those who lack DMC may be more likely to lack insight into their illness or need for treatment,[257] but the reverse cannot be concluded for any individual case without careful assessment. Where there is a lack of insight, the question should not be whether the lack of insight affects their DMC; rather, are the factors that are causing an impairment in their insight also affecting their

[251] See above nn 123–6, 210.

[252] *PBU* (n 1) 203 [198].

[253] Ibid 213 [232].

[254] *Re MM* (n 152) 465 [81].

[255] *PBU* (n 1) 202 [198] (Bell J).

[256] See above 211 and accompanying text. For example, where an individual appears to lack insight into their care needs, it 'may indicate a cognitive deficit causing a failure to appreciate a risk which is obvious to all others, or it might be a strategic attempt … to downplay aspects of a situation in order to maximise chances of the favoured outcome': Case (n 13) 370.

[257] See, eg, JHT Karlawish et al, 'The Ability of Persons with Alzheimer Disease (AD) to Make a Decision about Taking an AD Treatment' (2005) 64(9) *Neurology* 1514, 1517.

abilities in relation to the DMC criteria?[258] The lack of insight may be a symptom of their illness or impairment which may also be affecting their DMC.[259] When framed in this manner, insight plays a far less prominent role in determining DMC.

In *Thirumalesh Appeal*, the Court of Appeal pointed to *An NHS Trust v XB* ('*XB*')[260] as an example where 'lack of belief was critical to the determination of capacity'.[261] In that case, XB suffered a 'severe form of schizophrenia' and did 'not believe he had life threatening levels of hypertension, but rather believed that the essential medication necessary to control his blood pressure, was being used as a means to damage or control him'.[262] The following passage was quoted by King LJ from *XB* to support the notion that insight was 'critical' to determining DMC:

> Second, XB lacks the capacity to make the decision about the need to take the antihypertensive medication. XB understands what hypertension is and the serious consequences if left untreated. However, he continues to refuse treatment because he does not believe that he suffers from hypertension. He considers staff are lying to him about his diagnosis in order to damage or control him. As a result of his mental ill health he is unable to use or weigh up the information about the benefits and risks of taking or not taking the medication, as he does not believe he suffers from the condition being treated.[263]

XB clearly lacked insight into his condition, but this should not lead to the direct conclusion that he is unable to use/weigh treatment information. There are many in society who do not accept or believe that they have hypertension, or refuse treatment for idiosyncratic reasons who otherwise have DMC.[264] Rather,

[258] *PBU* (n 1) 215–16 [242] (Bell J).

[259] See above n 210. See also, eg, Sergio E Starkstein et al, 'Two Domains of Anosognosia in Alzheimer's Disease' (1996) 61(5) *Journal of Neurology, Neurosurgery, and Psychiatry* 485, 488; Emilia J Sitek et al, 'Unawareness of Deficits in Huntington's Disease' (2014) 3(2) *Journal of Huntington's Disease* 125, 133; Kenneth M Heilman, 'Possible Mechanisms of Anosognosia of Hemiplegia' (2014) 61 *Cortex* 30, 34; Ivana S Markova and German E Berrios, 'The Construction of Anosognosia: History and Implications' (2014) 61 *Cortex* 9, 15.

[260] [2021] Court of Protection Law Reports 505 ('*XB*').

[261] *Thirumalesh Appeal* (n 153) 49 [57] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[262] Ibid 49 [57] (King LJ, Singh LJ agreeing at 66 [144], Baker LJ agreeing at 66 [145]).

[263] *XB* (n 260) 516 [61] (Theis J), quoted in ibid 49 [57].

[264] See, eg, *RVL v Mental Health Tribunal* [2025] VCAT 114, [39] (emphasis added), where Senior Member Nihill found there was insufficient evidence to find a lack of DMC in relation to ECT, despite the applicant not believing the diagnosis of schizoaffective disorder:

it was XB's delusions relating to treatment that predominated his thinking, rendering him unable to use/weigh the information relevant to treatment. The lack of insight was a likely consequence of his 'delusional thinking caused by his treatment-resistant paranoid schizophrenia'.[265] But this lack of insight should not be the basis for finding an inability to use/weigh the information.[266] It was a consequence of his pathological delusions, which were a symptom of his schizophrenia. When the case is examined in this way, it is doubtful whether the lack of insight truly is *critical* to the determination of DMC.

Where there is a mental impairment/illness present, such as pathological delusions, the focus must be on whether there is a 'clear causative nexus' between the mental impairment/illness and the inability to undertake any of the DMC criteria.[267] It may be argued that a lack of insight is itself the delusion or pathology giving rise to incapacity, and it may just be semantics to avoid notions of 'insight'. But only by spelling out the factors impacting insight, such as the specific details of any delusions or beliefs and their pathological bases, can DMC be accurately assessed, and then properly scrutinised by a court.[268] In the

> RVL simply said that she did not want it, because she was concerned about the effect it might have on her memory and her personality, that it might take away her 'spark and originality'. … It is not, in my view, an uncommon response from some within the general community to associate ECT with possible memory loss, or possible effects on personality. This is not to say that these concerns are supported by scientifically validated evidence, simply that *these perspectives may sometimes be held by people who are not experiencing symptoms of psychotic illness or any other mental illness*. That RVL expressed these concerns did not demonstrate to me, to the required level of satisfaction, that she lacked capacity to give informed consent.

Cf *DSE v Mental Health Tribunal* [2025] VCAT 336, [51]–[57] (Senior Member Powles) ('*DSE*').

265 *XB* (n 260) 509 [20] (Theis J).

266 But see ibid 517 [71] (Theis J): 'Due to his mental ill health he is unable to accept the clear medical evidence that supports his diagnosis of hypertension and, as a consequence, is unable to understand the need to take the antihypertensive medication, or balance the serious consequences for his own health if he doesn't take it.'

267 *Re ZX* [2025] 1 WLR 1432, 1456 [67] (Baker LJ, Andrew LJ agreeing at 1458 [74], McFarlane P agreeing at 1458 [75]). See also *PBU* (n 1) 215–16 [242] (Bell J); *Re CS* [2017] 1 FLR 635, 640 [9] (Baker J). See, eg, *A NHS Trust v A* [2014] Fam 161, 174 [38], 175 [41]–[42] (Baker J); *NHS Trust v T* [2005] 1 All ER 387, 407 [61]–[62] (Charles J); *DSE* (n 264) [42]–[60] (Senior Member Powles).

268 *NICE DMC Guideline* (n 133) 25 [1.4.24]; Anthony S David, 'Insight, the Law and Psychiatry: Going Round in Circles or Playing Nice?' (2026) 105 *International Journal of Law and Psychiatry* 102194:1–6, 5. See also *Royal Borough of Greenwich v CDM* [2018] Court of Protection Law Reports 511, 519–21 [52] (Cohen J); *Re BV* [2025] EWCOP 41, [31] (Judge David Rees). The assessment of DMC is made more difficult where a mental illness relapses and remits such that the 'distinction between beliefs induced by illness and long-standing fundamental values becomes blurred': Elizabeth Fistein and Rebecca Jacob, 'Clinical Ambiguities in the

case of XB, irrespective of a history of schizophrenia, if he simply did not believe he had hypertension regardless of the delusions, it is reasonable to conclude that he lacked insight. But without the delusions linked to his schizophrenia, that disbelief may not be sufficient grounds to find an inability to use/weigh the relevant information.

There may also be pathological factors other than those arising from mental illnesses affecting DMC, like in *Norfolk and Norwich Healthcare (NHS) Trust v W*, where W presented in labour but denied she was pregnant.[269] In determining that she lacked DMC, Johnson J noted 'she was incapable of weighing up the considerations that were involved' because she 'was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour'.[270]

If the DMC criteria are properly assessed, there is likely limited value in independently considering insight as part of the DMC assessment. Rather, where there is a lack of insight, it may be a clinical clue that alerts the medical practitioner to consider further evaluating the individual's mental state. This may provide pertinent information that may be impacting upon their DMC. In this regard, when determining DMC, finding a lack of insight is a starting point, rather than a destination.

Whilst medical practitioners may continue to rely on insight for a multitude of clinical reasons, courts should be cautious in using insight in making their DMC determination. Without a close examination of the assessments undertaken in determining DMC, deference to insight may unjustly threaten the decisional autonomy of individuals and may also lead to less transparent decision-making by courts.

VI Conclusion

DMC is an important concept that serves to maintain autonomy whilst also protecting the vulnerable.[271] These competing goals are achieved through the

Assessment of Capacity' in Rebecaa Jacob, Michael Gunn and Anthony Holland (eds), *Mental Capacity Legislation: Principles and Practice* (Cambridge University Press, 2nd ed, 2019) 102, 109. The question arises as to whether they have 'been so ill for so long that [their] illness would remain part of who [they are], even if [they] had capacity': at 109, quoting *A Local Authority v E* [2012] Court of Protection Law Reports 441, 457 [78] (Peter Jackson J).

269 [1996] 2 FLR 613, 614 (Johnson J).

270 Ibid 616.

271 On the complex nature of the concept of DMC: Auckland (n 113) 21–30; Paula Case, 'Negotiating the Domain of Mental Capacity: Clinical Judgement or Judicial Diagnosis?' (2016) 16(3–4) *Medical Law International* 174, 175 n 2; Pēteris Dārziņš, William Molloy and David

DMC test and its underpinning principles. The proper interpretation and application of the DMC test is an especially important safeguard in promoting autonomy in medical treatment decision-making for those whose DMC is often questioned. The determination of DMC can be a complex process and often challenging;[272] the use of insight risks disturbing the balance that the DMC test and its principles seek to achieve.

The DMC test, as it is currently formulated, is not without fault,[273] and reasonable minds may differ on where the line should be drawn to meet the threshold for DMC for a particular decision.[274] Courts often rely heavily on medical opinion in determining DMC,[275] and when insight intrudes into this assessment, it has the potential to alter the application of the DMC test by courts. It does this especially in relation to the Understanding Criterion and the Use/Weigh Criterion by demanding more of the individual than is required by the proper application of the DMC test. Those with mental illnesses and other neurocognitive disorders are particularly susceptible to these distorting effects of insight on the DMC assessment. The consequence of this is that a court may find incapacity where there should not be.

Insight also morphs the DMC test such that it undermines important principles that underpin the DMC assessment. First, demanding insight of the individual requires them to *actually* understand and use/weigh the relevant information. This is contrary to the Functional Principle. Second, by requiring that the person *actually* be in a position to undertake the decision-making

Strang, 'What is Capacity?' in Pēteris Dārziņš, William Molloy and David Strang (eds), *Who Can Decide? The Six Step Capacity Assessment Process* (Memory Australia Press, 2000) 1, 1–3; Tuttle (n 59) 111–13.

272 See, eg, *Calderdale Metropolitan Borough Council v LS* [2025] EWCOP 10, [2] (Cobb J). The assessment of DMC is usually carried out by speaking with the individual and/or undertaking cognitive assessment tasks. However, some forms of mental incapacity are only evident by examining how a person functions on a daily basis. For example, those with executive dysfunction may be able to answer questions appropriately and perform well on cognitive testing, seemingly demonstrating DMC. However, there is a complete disconnect between what they say and what they do in actuality, meaning that 'it is unlikely to be possible to conclude that the person lacks capacity as a result of their impairment on the basis of one single assessment': *Draft Code of Practice* (n 20) 54 [4.38].

273 See Genevra Richardson, 'Mental Capacity at the Margin: The Interface between Two Acts' (2010) 18(1) *Medical Law Review* 56, 64; Marshall B Kapp and Douglas Mossman, 'Measuring Decisional Capacity: Cautions on the Construction of a "Capacimeter"' (1996) 2(1) *Psychology, Public Policy, and Law* 73, 78–9; Auckland (n 113) ch 2; Lisa Eckstein and Scott YH Kim, 'Criteria for Decision-Making Capacity: Between Understanding and Evidencing a Choice' (2017) 24(3) *Journal of Law and Medicine* 678, 680–4. See generally Binesh Hass, 'Reasonableness in Capacity Law' (2023) 86(6) *Modern Law Review* 1447; Binesh Hass, 'The Values and Rules of Capacity Assessments' (2022) 48(1) *Journal of Medical Ethics* 816.

274 See Tuttle (n 59) 127–30.

275 See Boyle, 'Medical Evidence of Capacity' (n 16) 574.

process (ie have actual understanding to be able to use/weigh that information), the effect of insight is to reverse the burden of demonstrating DMC onto the individual; this negates the Presumption Principle. Third, a consequence of the more demanding DMC test that arises as a result of considerations of insight is that it weakens the protections afforded by the Low Threshold Principle.

Whilst insight may have numerous clinical uses, it is not formally a part of the DMC test. Insight may coincide with incapacity, especially in those with mental illnesses and other neurocognitive disorders, but without disentangling the factors contributing to insight, seldom should it be grounds to find incapacity; such grounds, when examined closely, are shaky at best. The focus of the DMC assessment should be on the individual's cognitive ability to carry out the DMC process with reference to the four criteria rather than simply adverting to notions of insight.

In many respects, Australia is at a nascent stage of its DMC jurisprudence. There remains a lack of uniformity in the legislative frameworks governing DMC around Australia and there has been limited judicial consideration of the DMC test in higher courts. However, Australia is in a privileged position to learn from the legal developments which have taken place in the UK over the past two decades during which the *Mental Capacity Act* (UK) has been in force, and avoid the pitfalls that the use of insight can create.