Not glossing over insight: insight and capacity assessments

ARTICLE

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SUMMARY

Capacity assessments under the Mental Capacity Act 2005 (MCA) are a routine part of daily clinical practice in England and Wales. One element of these is the role of insight within the MCA's capacity criteria. This article focuses on the issue of insight and capacity in a recent Court of Protection judgment, discussing how to assess insight in clinical practice and elucidating key issues regarding the role and assessment of insight within capacity assessments. The article includes a 10-point checklist for capacity assessments that was presented in the judgment, and a discussion of insight assessments that can guide documentation and be implemented in clinical practice.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the complexities of capacity and insight assessments in the context of a recent Court of Protection case
- demonstrate a greater understanding of the role of insight in capacity assessments
- outline dimensions for the assessment of insight in clinical practice.

KEYWORDS

Consent and capacity; psychiatry and law; Mental Capacity Act 2005; insight; Court of Protection.

Insight and capacity assessments are foundational components of psychiatric practice, but their interchangeable use in a legal context has been subject to criticism (David 2020). This article reviews a Court of Protection judgment – *CT v London Borough of Lambeth & Anor* [2025] – in which the assessment of insight is considered within Mental Capacity Act 2005 (MCA) capacity assessments. It also considers the important role of the assessment of insight in such assessments. The MCA is specific to England and Wales, but the concepts it relies on are more universal.

The concepts of insight and capacity

In 1934, Aubrey Lewis defined insight as 'a correct attitude towards a morbid change in oneself' (Lewis 1934). Considering how fundamental a component insight is in everyday psychiatric practice, the dearth of literature providing guidance to clinicians on its assessment is surprising. The concepts of insight and capacity are integral to the mental state examination. The two concepts inevitably overlap and it has been highlighted that there is an empirical and common sense connection between insight and decision-making capacity (David 2020). However, there is a clear and relevant legal and clinical distinction between the two – insight is a clinical concept, whereas decision-making capacity is a legal concept. A 2023 Court of Protection judgment (*Warrington Borough Council v Y & Ors* [2023]: para. 45) observed that insight is also not to be viewed 'as equating to or synonymous with capacity' and to merge these two would be to detract 'from personal autonomy'. It also commented that 'every adult from time-to-time lacks insight into an issue or indeed into themselves'. To demonstrate that insight is compromising decision-making capacity, consideration needs to be given to the factors influencing this compromise, and there is increasing scrutiny of how the two are being linked. In a similar way, the relationship between insight and involuntary treatment is also increasingly being subject to more intense scrutiny (David 2020). The phrase 'lack of insight' is often used as a proxy for lack of capacity, but without corresponding justification it is subject to criticism and may serve to undermine an individual's testimony (David 2020).

Assessment of insight

Insight can be formally assessed using various scales and instruments – an example is the Scale to Assess Unawareness of Mental Disorder (SUMD), which is considered the most widely used clinician-rated insight/awareness scale (Trevisi 2012). The SUMD is a 20-item semi-structured interview of questions evaluating global insight, insight into illness and insight into symptoms (Cuesta 2000). It has proven reliability and validity for assessing insight in schizophrenia (Paillot 2010). However, in everyday clinical practice the assessment of insight is done more informally.

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Consideration needs to be given to cultural influences on insight, as current insight definitions largely rely on Western notions of health and illness and hence it is difficult to have a universal measure for insight, (Jacob 2010). In reviewing assessment of insight across cultures Jacob (2010) argued that its assessment should be against 'the local cultural standards rather than universal yardsticks'.

There is recognition that insight is not an 'all or nothing concept' (Reddy 2015), but that there are varying degrees (David 1990). Various descriptions of levels of insight are often used, including 'limited', 'full' and 'partial'. However, as far back as 1999 this has been criticised as something that should be a 'thing of the past', and that instead a comment is required as to which aspects of the clinician's formulation are accepted by the patient (Surguladze 1999). More descriptive detail is thus required as justification; merely pronouncing insight to be lacking is insufficient (David 2020).

David (1990) described there being at least three dimensions to consider as part of insight:

- the recognition that one has a mental illness (awareness);
- the ability to relabel unusual mental events (delusions and hallucinations) as pathological (attribution);
- the recognition of the need for treatment (action).

Amador & David (2004) expanded the concept of insight, with five dimensions for insight in schizophrenia (which could easily be applied to other disorders):

- awareness of having a mental illness;
- awareness of the consequences of mental illness;
- awareness of symptoms of mental disorder;
- attribution of symptoms to a mental disorder;
- awareness of the effects of medication.

The case of *CT*

CT v London Borough of Lambeth & Anor [2025] was an appeal to the Court of Protection of a previous judgment (5 September 2024), by the Official Solicitor as the litigation friend, for a person known in court as CT. The previous judgment had concluded that CT lacked capacity to (a) conduct court proceedings, (b) make decisions about residence and (c) make decisions about his care needs. The appeal was heard on 4 February 2025. The core issue was whether CT should remain in or leave hospital – if he left hospital, he would be street homeless as no placement was identified.

Background

CT was in his 50s. Aged 12 he developed epilepsy following a head injury. As an adult he started misusing alcohol and illicit drugs following the death of a close family member. He subsequently lost his business and home and had long periods being street homeless. He had regular hospital admissions over many years for physical and mental health problems. In addition to epilepsy, CT's 'significant' physical health issues included chronic obstructive pulmonary disease, gastric ulcer, pneumothorax, chronic back pain, arthritis, osteoporosis and femoral head avascular necrosis. His 'complex psychiatric history' included several 'mental impairments' including:

- post-traumatic stress disorder;
- suspected antisocial personality disorder;
- dysexecutive syndrome – secondary to brain injury as a child;
- polysubstance use/dependency – for which he had intermittently been prescribed methadone;
- an undescribed cognitive impairment – shown by cognitive assessments including the Addenbrooke's Cognitive Examination, the Frontal Assessment Battery and the Montreal Cognitive Assessment.

The judgment noted that these 'impairments lead to specific care needs and affect [CT's] decision-making in relation to physical care needs and residence' (*CT*: para. 22).

CT was admitted to an acute hospital in 2023 with shortness of breath. In May 2024, he was medically fit for discharge and subject to a standard Deprivation of Liberty Safeguards (DoLS) order, which was about to expire. He wanted to leave hospital and return to being street homeless. CT had previous experience of supported accommodation and care homes and had also been street homeless for a considerable period prior to this admission. He was assessed and provided with unspecified 'mental health support' by liaison psychiatry from a mental health trust owing to suicidality and a wish to self-discharge against medical advice.

Owing to a disagreement between clinicians and the local authority social workers regarding his capacity to make decisions about his residence and care at discharge, the acute hospital trust made an application to the Court of Protection. The DoL assessor found that CT had capacity to make decisions for these matters. The trust disagreed and sought from the court a 'safe discharge' and in the interim to have ongoing authority to deprive him of his liberty. An initial court order made interim declarations under section 48 of the MCA authorising his deprivation of liberty in hospital.

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In July 2024, the court made an order for CT's discharge into a care home. The day after discharge he started a fire necessitating evacuation of residents and staff. He was returned to the acute hospital, where he was detained under s. 2 of the Mental Health Act 1983. On 25 July 2024, he was assessed as having capacity to stay as an informal patient and discharged from s.2 following a Mental Health Review Tribunal hearing. It was concluded that 'he had capacity to make decisions relating to residence and care' (*CT*: para. 12). He was soon placed under an urgent DoLS order and a further standard authorisation sought from the local authority on 5 August 2024. The DoL assessor assessed CT as 'having capacity and therefore a standard authorisation was not granted' (*CT*: para. 13). The urgent authorisation expired on 18 August 2024 and he remained as an informal patient.

A continued dispute between the acute hospital trust and local authority ensued regarding CT's capacity, and a court hearing was arranged for 19–20 August 2024. The Court of Protection chronologically considered ten pieces of written evidence from 23 November 2023 until the time of the court hearing – six concluded that CT lacked capacity and four that he had capacity – from various sources, including consultant psychiatrists, a consultant in respiratory medicine and social workers (including a joint assessment between a social worker and consultant liaison psychiatrist). Further oral evidence was considered in court from two social workers and a consultant psychiatrist. The position of the local authority and the Official Solicitor was that CT had capacity to make decisions regarding residence and care. The contrasting position of the mental health trust providing CT with mental health support while in the acute hospital was that he lacked such capacity.

Final judgment

The final judgment was issued on 5 September 2024. The salient issues and reasoning from it are outlined in Box 1. The judge concluded that CT lacked capacity to make decisions about his residence and care and that it was in his best interests to be deprived of his liberty while the local authority searched for suitable supported living. CT was moved to a placement in December 2024, where he was residing at the time of the appeal in February 2025.

The legal framework

The judgment reviewed previous case law pertinent to this case. This reiterated key principles when assessing capacity in a summary from *A Local Authority v H* [2023]. The following were considered pertinent (*CT*: para. 27).

- 'The determination of the question of capacity is always decision specific. All decisions, whatever their nature, fall to be evaluated within the straightforward and clear structure of ss 1 to 3 of the [MCA], which requires the court to have regard to "a matter" requiring "a decision". There is neither need nor justification for the plain words of the state to be embellished'.
- 'The outcome of the decision made is not relevant to the question of whether the person taking the decision has capacity for the purposes of the Mental Capacity Act 2005', i.e. people can make unwise decisions when they are assessed as having capacity.
- 'For a person to be found to lack capacity there must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in s.3(1) of

BOX 1 Salient issues and reasoning from the appealed judgment in the case of *CT*

- The judge reiterated that his assessment of capacity 'was based on awareness of mental impairment being relevant information', i.e. CT needed to have insight into having a mental impairment.
- The judge explained that he had given weight to the assessments that concluded CT did have capacity.
- It was noted that CT had recently been better able to engage with and express himself to social workers.
- The judge concluded that CT could not use or weigh:
  - 'the fact that he has mental impairments and that these lead to specific care needs and impact on his wider decision-making ability';
  - 'his own impulsivity, lack of planning ability and lack of foresight when he is making decisions about his care needs';
  - 'the knowledge of his mental impairments';
  - 'the impact of [his] mental impairment';
- and that:
  - CT was unaware that the impact of his mental impairment 'leads to a lack of foresight when weighing the consequences of refusing treatment' and 'his impulsivity means he is unable to weigh that impulsivity when making decisions';
  - CT's inability to weigh the likely outcome of the refusal of care and the influence that his mental impairment has on his acceptance of care 'explains the history of admission to and self-discharge from previous placements'.

(After *CT v London Borough of Lambeth & Anor* [2025]: paras 23–25)

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the Act' [the functional test of the MCA] and the "impairment of, or a disturbance in the functioning of, the mind or brain" required by s 2(1) of the Act' [the diagnostic test].
- 'With respect to the functional test, the question is not whether the person's ability to take the decision is impaired by the impairment of, or disturbance in the functioning of, the mind or brain but rather whether the person is rendered unable to make the decision by reason thereof'.

The judgment noted that the Supreme Court (*A Local Authority v JB* [2021]) had affirmed that assessment of capacity requires the court to address two questions:

> '(1) First, whether the person is unable to make a decision in relation to a particular matter [the functional test]; and only if so
>
> (2) Second, whether that inability is caused by an impairment of or disturbance in the functioning of P's mind/brain [the diagnostic test]' (*CT*: para. 28).

The judgment reiterated the MCA Code of Practice (Department for Constitutional Affairs 2007: para. 4.16) in addressing understanding of information about the decision to be made, which states: 'It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way that is most appropriate to help the person to understand. Quick or inadequate explanations are not acceptable unless the situation is urgent'. It advises that relevant information includes: 'the nature of the decision, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all'.

An important Court of Appeal case (*Thirumalesh Chellamal Hemachandran and another v Sudiksha Thirumalesh and another* [2024]) was cited when considering whether an individual could understand or use and weigh information that he or she did not believe. That judgment held that:

> 'the Judge made an error of law in regarding the absence of belief as determinative of the functional test [...] where there is an objectively verifiable medical consensus as to the consequences of having or not having medical treatment, if the patient does not believe or accept that information to be true, it may be that they are unable to understand and or use and weigh the information in question' (*CT*: para. 31).

The grounds of the appeal were threefold (Egan 2025).

- *The relevant information ground* – the judge set too high a bar in considering the relevant information that CT needed to consider when making decisions about residence and care needs. The judge 'erred' in stating that CT's mental impairments were relevant information that he needed to understand and use and weigh.
- *The correct order ground* – the judge appeared to start with CT's mental impairments, deciding that they led to his inability to take decisions, rather than starting with whether he could understand/retain/use or weigh the relevant information and communicate his decision and then, only if he was unable to do so, considering whether that inability was because of his mental impairment(s). This was contrary to the Supreme Court guidance in *A Local Authority v JB* [2021], which emphasises that the functional test is first and the diagnostic test second.
- *The changed facts ground* – as capacity assessments are time and decision specific, the judge 'erred in not fully acknowledging the change in the factual matrix at the time of the hearing'.

Insight and capacity assessments

The judgment contained discussion of the issue of insight when assessing capacity. On the relevant information ground, the Official Solicitor's legal team observed that 'the way the Judge took into account CT's mental impairment as affecting his decision making creates a circular approach and results in those who have a mental impairment to inevitably be found to lack capacity', i.e. by 'the inclusion of insight into his/her mental impairment on the list of relevant information'. It was further suggested that the 'logical conclusion' of this circular approach was that CT could not 'weigh the impact of his mental impairment because of his mental impairment' (*CT*: para. 36). It was submitted that the judge therefore 'erred when he added the requirement for CT to have insight into the effect of his mental impairment to the list of relevant information' (para. 38).

Submissions from Mind, the mental health charity, considered insight within capacity assessments (*CT*: para. 44). These considered the risks 'in requiring those whose capacity is being assessed to be aware of and accept their mental impairment(s), or to use and weigh such knowledge and the impact of them, or to weight the lack of "*foresight*" as it will turn the statutory test on its head'.[a] It was clear that 'the first focus should be on the person's functional ability to make the decision and then determining whether such inability is because of a mental impairment, as required by ss2-3 MCA 2005 and *JB*' and that 'An insight requirement risks unduly influencing the statutory criteria'.

a. Quotations show the original emphasis (italics) unless otherwise indicated.

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The submissions further observed (*CT*: para. 46) that 'Insight must not be conflated with decision-making capacity. A person may lack insight but retain capacity to make various decisions', referring to *Heart of England NHS Foundation Trust v JB* [2014], a case involving an individual with schizophrenia who was assessed as needing surgical amputation of her leg. The submissions sagely noted: 'as illustrated by [*JB*], a necessary correlation would have to be established between a lack of insight and the person's inability to decide the matter. And, as advised by the NICE guidelines, those assessing and determining capacity must clearly record what they mean by lack of insight and how they believe it affects or does not affect the person's ability to make the decision as defined by the statutory criteria' – the National Institute for Health and Care Excellence guidelines referred to here (NICE 2018) do not directly define insight.

In addressing the second ground of appeal (*CT*: para. 47), Mind recognised that 'a lack of insight *may* be relevant to, but not determinative of, whether the person has a mental impairment for the purposes of s2 MCA 2005'. It noted 'Equally, [. . .] someone might lack insight for reasons other than mental impairment. For example, it could be caused by P's educational background, language proficiency, lack of familiarity with medical issues and the lack of appropriate support'. It was contended that:

- including the person's insight into their mental impairment as relevant information undermined the importance of proving that the person's inability to decide is because of that mental impairment ('the causative nexus');
- it conflated the functional and mental impairment tests and watered down the evidential burden on capacity assessors and judges to demonstrate how and why the inability to decide is because of the mental impairment;
- in this case, the judge ultimately concluded that CT lacked capacity because he was unable to weigh the impact of his mental impairments, which was entirely circular reasoning;
- the key issue should have been whether CT was unable to decide the matter *because* of the mental impairment(s).

The court decision

This was 'a difficult and complex case' (*CT*: para. 48). The capacity assessments and conclusions of the professionals were divided, some being 'finely balanced'. For issues relating to capacity, it was 'important to keep the structure of any decision making firmly anchored in the statutory framework' – which was emphasised in *Hemachandran*, in that '*All that is required is an application of the statutory words without any gloss*'.

The judgment accepted that all three grounds of the appeal were established. On the first ground (*CT*: para. 55), it was accepted that the judge had erred by setting the bar too high in considering the relevant information for CT, and especially that CT's mental impairments (including insight) were relevant information that he needed to understand and use and weigh. The course taken by the judge had conflated the two-stage test (from *JB*) and created a circular approach that risked leading to the inevitable conclusion that those who have mental impairment lack capacity, which undermined the MCA principles and safeguards. What was required was 'a careful delineation of the relevant information, relevant to the particular case in question, and then an assessment, in accordance with the [MCA] framework, whether the individual can understand, retain, use/weigh that relevant information and communicate the decision'. It was only if that process concluded that the individual 'is unable to make a decision within that statutory framework that the court then has to consider whether the inability is "*because of, an impairment of, or a disturbance in the functioning of, the mind or brain*"'. This vital delineation was 'not present or clear'.

In relation to the second ground (*CT*: para. 57), it was noted the 'two stage test in *JB* is clear' – including insight as part of his mental impairment had 'the effect that the Judge did not conduct the functional test in accordance with the requirements of the MCA 2005' and 'conflated and risked blurring the two distinct tests'. The judge had not taken a structured approach of properly going through the list of identified relevant information from both written and oral evidence. The effect was that 'the Judge's conclusion on the first stage was determined by CT's mental impairment and not by resolving the key evidential dispute in respect of the functional test'.

On the third ground (*CT*: paras 58–59) it was noted that social worker assessments had concluded that CT had capacity to make decisions about his residence and care, but that the judge had not explained why later social worker assessments were not preferable or capable of being relied on. A 'striking feature' was the 'evidential divide on capacity' between clinicians and social workers. It was observed that the form used by the local authority and social workers in their capacity assessments enabled a structured approach to assessments in accordance with the statutory framework. The form:

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- identified the decision;
- set out the relevant information that the person must understand, retain, use or weigh in regard to the decision;
- included what had been done to enhance the capacity of the person to maximise their ability to make the decision for themselves;
- checked the person's ability to communicate;
- requested a summary of the options that had been discussed with the person;
- structured each stage of the requirements in s.3 MCA (understand, retain, use, weigh, communicate).

The judge praised the high standard of the reports of two social workers who had used this form and demonstrated relevant detail at each stage, with clear reasoning underpinning their conclusions. This was compared with some of the clinicians' assessments, which were less structured in format. Because capacity assessments are time and decision specific, the judgment advised that the dates when the individual was assessed 'should always be clearly set out and borne in mind' (*CT*: para. 59).

The parties agreed that in the event of the appeal being allowed, the matter should be returned to the previous judge to 'consider what, if any, further directions need to be made to determine the issue of capacity' (*CT*: para. 61).

The involved parties had provided the court with checklists to assist those assessing capacity. The judge 'whilst not wanting to add to the growing industry of checklists', recognised their usefulness and presented them as a 10-point checklist (Box 2).

Discussion

CT v London Borough of Lambeth & Anor [2025] appears to be the first court case to meaningfully shine a light on the issue of insight within capacity assessments. In doing so it shows the nuances and intricacies of insight assessments in themselves but also in the context of capacity assessments. The key learning point for clinical practice is that 'insight' is a clinical concept and is separate from the legal assessment of capacity, i.e. the two should not be conflated. Although this judgment opined that insight should not be used as part of the MCA capacity criteria, insight will of course be of importance in an overall clinical assessment that feeds into an MCA capacity assessment. So, although it is not part of the statutory MCA criteria, insight nevertheless is an intrinsic part of any mental health assessment and as such cannot be ignored or glossed over.

The relevance (or otherwise) of insight and information

A commentary on the *CT* case did not consider that the judgment 'should be taken as a general finding that a person's insight into any mental disorder is *irrelevant* to whether a person has decision-making

BOX 2 Checklist for assessing capacity, from the case of *CT*

'(1) The first three statutory principles in s.1 MCA 2005 must be *applied in a non-discriminatory manner* to ensure those with mental impairments are not deprived of their equal right to make decisions where they can be supported to do so.
(2) In respect of the third principle regarding unwise decisions, particular care must be taken to *avoid the protection imperative* and the risk of pathologising disagreements.
(3) As set out in *A Local Authority v JB* [2021], *whether the person is able to make the decisions must first be addressed*. Only if it is proven that one or more of the statutory criteria are not satisfied should the assessor them proceed to consider whether such inability is because of a mental impairment.
(4) Those assessing capacity must vigilantly ensure that the assessment is *evidence-based, person-centred, criteria-focussed and non-judgmental*, and not made to depend, implicitly or explicitly, upon the identification of a so-called unwise outcome.
(5) Insight is a clinical concept, whereas *decision making capacity is a legal concept*. Capacity assessors must be aware of the conceptual distinction and that, depending on the evidence, a person may be able to make a particular decision even if they are described as lacking insight into their general condition.
(6) In some cases, a *lack of insight may be relevant to, but not determinative of*, whether the person has a mental impairment for the purposes of s.2 MCA 2005.
(7) When assessing and determining the legal test for mental capacity, all that is required is the *application of the statutory words in ss.2-3 MCA 2005 without any gloss*; having 'insight' into mental impairment is not part of that test.
(8) *Relevant information will be different in each case* but will include the nature of the decisions, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.
(9) The relevant information is to be shared with the individual and the *individual should be supported* to understand the relevant information. *The individual is not required to identify relevant information him/herself.*
(10) If a lack of insight is considered to be relevant to the assessment of capacity, *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.'

(Reproduced from *CT v London Borough of Lambeth & Anor* [2025]: para. 60. Italics added.)

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capacity' (Ruck Keene 2025). It noted 'While insight and capacity are distinct concepts, a person's ability or inability to recognise the impact of a mental impairment or illness may be relevant to their ability to keep themselves safe in a living situation, or problem-solve during times of difficulty'. Another salient point related to what information is and is not relevant for a specific decision, where it was noted that this will depend on the nature of the decision to be taken and that 'a person's insight is not necessarily in a separate "silo" to the relevant information to make a particular decision'.

Focus on the MCA criteria

For optimised application of mental capacity criteria, it has been advised that capacity evaluators should explicitly justify their capacity determination for a given decision by referencing each specific MCA criterion (Kim 2022). Lack of insight is often used as a rationale to justify a lack of decision-making capacity, more commonly the criterion for understanding the information, or using and weighing information. Where insight is felt to be compromising a person's decision-making capacity, guidance advises the use of using and weighing (Owen 2023), although in practice legal judgments often incorporate multiple MCA criteria and there continues to be a considerable overlap in the use of these criteria (Kim 2022).

Professional differences in capacity decisions

Ten pieces of written evidence regarding capacity were considered by the court, which reached varying conclusions as to CT's capacity. The discrepancy in the evaluation of capacity between professions – in this case, social workers and psychiatrists – with the former almost invariably reaching a conclusion in favour of capacity and the latter finding a lack of capacity, was notable, with 'distinct traces' of professional cultural differences involved regarding capacity decisions (Ruck Keene 2025). Differing professional opinions have also been reported in cases in the liaison psychiatry setting (Kane 2022).

The starting point for any capacity assessment is the presumption of capacity – whether there is a difference in threshold for the questioning of that capacity by different professional groups is harder to establish. Each individual professional is likely to have its own threshold at which capacity is brought into question on a particular decision and case. Capacity in the context of homelessness and in the context of discharge from hospital have been noted as frequent 'flashpoints' and notoriously difficult to assess owing to conflation of the issues at hand and the inadvertent influence of limited resources, which at times are a practical restraint on options (Ruck Keene 2025).

The five dimensions of insight

In addition to the 10-point capacity assessment checklist devised by the court in *CT* (Box 2), other valuable learning points for assessing insight are described in Box 3, including the use of insight dimensions described by Amador & David (2004) above. Although the latter were suggested over 20 years ago, and despite academic interest in the concept of insight in psychosis having increased markedly over the same period (David 2020), they retain their relevance to insight assessments today. In the absence of more modern alternatives, we

BOX 3 Assessment of insight: learning points

- A lack of insight should not be used as a shortcut to conclude that someone lacks capacity to make a decision.
- Insight is not all-or-nothing – there are various dimensions to insight, and a more substantial comment as to insight should be part of a capacity assessment, particularly where it has relevance to the likelihood of adherence to medication or clinical response.
- Cultural considerations may be required, given the largely Western influence of current perceptions of insight, i.e. assessment of insight should be made against local cultural standards rather than uniform, universal criteria, to ensure accuracy and cultural competence in clinical practice (Jacob 2010).
- Instruments such as the Scale to Assess Unawareness of Mental Disorder (SUMD) provide a more structured tool for the assessment of insight.
- Dimensions to consider when assessing insight include (Amador 2004):
  - awareness of having a mental illness
  - awareness of the consequences of mental illness
  - awareness of symptoms of mental disorder
  - attribution of symptoms to a mental disorder
  - awareness of the effects of medication.
- If a professional decides that lack of insight is impairing someone's decision-making capacity, they should explain the rationale for their decision, rather than using the 'blanket term' without proper scrutiny.
- Decision-making capacity and insight assessment can be particularly complex in the context of homelessness or discharge from hospital. The judgment in *CT v London Borough of Lambeth & Anor* [2025] demonstrates that the bar can sometimes be set 'too high' in these contexts.

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MCQ answers
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advocate for their use in clinical practice as a framework for insight assessment, affording a more consistent approach to assessments than is often current practice. Such dimensions can also be easily applied to different diagnoses (even though devised for schizophrenia). In applying these dimensions, clinicians need to be cognisant of cultural factors and how local cultural standards may influence insight assessments (and mental state examinations in general). We believe that development of further practical guidance for clinicians on this topic, particularly regarding its cross-cultural assessment and application, would be of merit.

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Author contributions

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Declaration of interest

None.

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MCQs

Select the single best option for each question stem

1 How many stages are there in the assessment of capacity as affirmed by the Supreme Court?
a One
b Two
c Three
d Four
e Five.

2 Which of the following is *not* true of capacity assessments?
a They should start from a presumption that the patient is lacking capacity
b They are time specific
c They are decision specific
d There must be a causal connection between being unable to make a decision by reason of one or more of the functional elements set out in section 3(1) of the MCA 2005
e Every effort must be made to provide information in a way that is most appropriate to help the person to understand.

3 Which of these would *not* be considered relevant in assessing decision-making capacity according to the judge's checklist in *CT*?
a The nature of the decisions
b The reason why the decision is needed
c The individual's ability to identify relevant information him/herself
d Likely effects of deciding one way or another
e Likely effects of making no decision at all.

4 Which of the following is *not* one of Amador & David's five dimensions of insight in schizophrenia?
a Awareness of having a mental illness
b Awareness of the consequences of mental illness
c Awareness of symptoms of mental disorder
d Attribution of symptoms to an external factor
e Awareness of the effects of medication.

5 Which of the following is the most appropriate descriptor for insight?
a Full
b Partial
c None
d Lacking
e A comment as to which aspects of the clinician's formulation are accepted by the patient.

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