



Psychosis

Psychological, Social and Integrative Approaches

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/rpsy20>

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To cite this article: Tom Todd (2021): “Epistemic injustice” in the administration of mental health legislation, *Psychosis*, DOI: [10.1080/17522439.2020.1853204](https://doi.org/10.1080/17522439.2020.1853204)

To link to this article: <https://doi.org/10.1080/17522439.2020.1853204>



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Published online: 15 Feb 2021.



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“Epistemic injustice” in the administration of mental health legislation

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ABSTRACT

The concept of “Epistemic Injustice” was used as a tool to interpret practices applied during the administration of Mental Health legislation by the Mental Health Tribunal Scotland. This highlighted instances of being wronged on several occasions in my capacity as a knower. Example contributory factors included the Tribunal structure and sub-optimal application of heuristics by panel members. Factors associated with an appeal process involving a “Designated Medical Practitioner” may offer some potential for improvement of routine application of administrative aspects of Mental Health legislation. Testimonial and hermeneutical issues should be considered.

ARTICLE HISTORY

Received 8 November 2020
Accepted 16 November 2020

KEYWORDS

Advance statement; tribunal; epistemic injustice; psychosis; legislation

I have been both helped and harmed by the mental health system. I have accepted and been grateful for medication when I have been unwell; however, my informed decision to decline “prophylactic” medication has, until recently, not been respected, to the detriment of my well-being. I regard this as a form of epistemic injustice.

Epistemic Injustice (EI), or knowledge injustice, occurs when “someone is wronged specifically in (their) capacity as a knower” (Fricker, 2007a).

I’m not the first to experience such a type of injustice, of course. Although first described in 2007 by Miranda Fricker (Fricker, 2007b), instances of it commonly occurred before then, and continue now.

A number of authors have written of EI in relation to practices in health care generally (Carel & Kidd, 2017), and some specifically in relation to mental health (Sanati & Kyratsous, 2015) (Scrutton, 2017). This article seeks to show its relevance to the interpretation of qualitative evidence, in the form of personal experiences, that have occurred when The Mental Health Act (Scottish Government, 2017) has been applied to me.

Fricker describes various concepts that underpin EI.

“Testimonial injustice” occurs when prejudice on the part of a hearer assigns to a speaker either a deficit or an excess of credibility.

“Hermeneutical injustice” occurs at a prior stage, where a range of factors (e.g., status as a psychiatric patient) bias agents in their interpretations of communications, and facilitate unequal participation in practices that generate social meanings.

“Agential power” is the capacity to exercise influence, as an individual, group or institution, over another agent.

“Identity power” requires there to be the presence of imaginative social coordination to arrive at a shared conception of social identity, and can be significant in testimonial exchanges. For example,

someone meeting me for the first time is likely to be influenced by whether I primarily identify as a science graduate or a psychiatric patient.

The core concept of EI, of the ways in which various agents go about managing and interpreting knowledge, makes use of the idea that knowledge is what good informants, or speakers, can be relied upon to share with hearers. In determining, either consciously or unconsciously, who can be relied upon, three attributes are routinely under consideration: whether the speaker is likely to be right about what they are saying, whether they are open and sincere, and whether they have "indicator properties" that enable you to assess the first two attributes accurately.

With respect to the third, heuristics are a means by which, as hearers, we make spontaneous assessments of credibility regarding knowledge exchange when we engage with a speaker; and particularly during a first, or single, meeting. This use of stereotype may be valid, or it may be misleading.

I will present examples to argue that on occasions when my word as a speaker has been rejected, by a variety of agents, during the time that the Mental Health Act has been operational, such instances have been not been justified by way of good reason, but have occurred as consequence of prejudice. Biases have been present, not corrected for, and acted on.

I have attended five Scottish Mental Health Tribunals. At each of them, I have been asked to respond to whether I consider that each of five "criteria to be met" for compulsory treatment is applicable to me. If panel members conclude from Tribunal proceedings that they are, then enforced treatment may be given.

The first is whether I do, in fact, have a mental disorder. There is a binary choice. If I don't recognise up front that I have recently experienced psychosis, my credibility as a speaker is immediately diminished, given that I have been in hospital, and treated effectively with medication. However, like an athlete who has broken his leg on more than one occasion, and doesn't consider himself to constantly, and primarily, fit into the category of "people who have a broken leg", most of the time I do not experience mental illness in my life, and I have long periods when I am well. How I identify with respect to my illness is more nuanced than the Tribunal structure allows me to represent; and so, I am obliged to identify as someone with a mental disorder, reinforcing the shared collective perception, both of my social type, and of the notion of a constant condition.

The second criterion addresses whether treatment is available for the disorder. A number of features apply here. There is a structural deficit, as the law makes no reference to a requirement for panel members to address perceived harms associated with any treatment. There is no formal consideration of testimony about adverse effects, and at Tribunals, I have attended, although members will listen politely when the subject is raised, it is not given serious consideration: reported benefits by the psychiatrist have invariably carried more weight. For example, one Tribunal report reframed my report of "horrendous" effects as "debilitating", and considered that more "benefit" would be obtained if I were to be forced to take the medication "that is likely to keep him well". These instances are consistent with panel members applying a credibility deficit to me, due to my identity as "someone with a mental disorder", and a credibility excess to the views of psychiatrists, due to their status as a doctor, with respect to what conditions might be considered to constitute a state of "wellness". The structural deficit, combined with applied biases, ensures that no meaningful challenges to the psychiatrists' views can occur.

Another of the criteria requires panel members to assess risk to me or others. I have relevant practical expertise in this area, having developed and implemented risk management procedures in medical device manufacture. At one tribunal I presented evidence about basic models of risk assessment that allow for consideration of the potential frequency of the perceived risk, and the potential severity of the risk. I suggested that the Mental Health Officer's refusal to work with me on the use of such a model (it was dismissed as "too academic") before the tribunal was a missed opportunity to allow the process of risk evaluation to be improved. There appeared to be little awareness of panel members of the existence of such models, and I was unable to participate to any useful extent in sharing knowledge that I had about a valid means of conducting an assessment.

Fricker describes such events as being a common feature of testimonial injustice; being barred from entry to the “community of informants”.

Further examples of testimonial injustice occurred in the failure of psychiatrists and Tribunal panel members to adequately consider my written advance statement, prepared when well, instead imposing unwanted treatment. My statement was in place prior to three of my Tribunals.

The report from the first acknowledges that “The Tribunal had before it ... an advance statement by the patient ...”, but there is no evidence that the statement was given any consideration in reaching a judgement.

The second report states “The patient has an advance statement which was lodged with the Tribunal and parties”. There is a further oblique reference stating that “After considering the written and oral evidence ...” but details of how it was considered and the influence on the decision are not provided.

The third report begins more promisingly by acknowledging details of information presented in my advance statement: “The patient had made an advance statement. In this he states that he would not wish to receive medication beyond four weeks after treatment of a relapse of his mental illness. Were the Compulsory Treatment Order to be extended, further medical treatment would be authorised in contradiction to the patient’s stated wishes. Fundamentally the patient objects to long term treatment with antipsychotic medication, which he feels has diminished his quality of life through unacceptable side effects. He acknowledges the benefit of, and is willing to accept, short term medical treatment when he experiences a relapse of his mental illness”. I had indicated, both prior to, and during, the Tribunal, the devastating effects of medication on my life. But the report goes on to accept a psychiatrist’s opinion about my quality of life over my own opinion. The psychiatrist’s stated reasons were accepted and there was inadequate interest in what was important to me.

“The (psychiatrist) had offered to reduce the dosage of (the) medication, in deference to the patient’s complaints about side effects. Initially the patient had refused this, much to the puzzlement of the doctor, but during the hearing today he appeared to agree to such a reduction. The (psychiatrist) acknowledged the patient’s side effects but was clear in his view that without regular medication there was significant risk to the patient which far outweighed the side effects in terms of potential loss of quality of life. His life chances and quality of life had already been severely adversely affected by his illness, his relapses and his hospital admissions. The Tribunal agreed with the doctor in this rounded view. It decided that the extension of the Compulsory Treatment Order and therefore medical treatment in the community held the best and least restrictive prospect for the patient’s continued stable mental health”.

Other instances of psychiatrists being afforded an excess of credibility at Tribunals occurred when, at one, false information that negatively misrepresented my out-patient appointment attendance record was presented and accepted; and at another, an interruption to refute my spoken evidence regarding the presence of dopamine receptors in areas of the body other than the brain, was accepted. Both Tribunal reports stated that “the Tribunal accepted the evidence of all the aforesaid professional witnesses as credible and reliable”. The Mental Health Act has no requirement for the Tribunal panel to record their view of the credibility and reliability of my evidence.

In summary, agential and identity power imbalances have operated, facilitated by the legal structure of the Mental Health Act, to control whose contributions were worthy of consideration. Hearer (panel member) identity prejudice has worked in advance of the Tribunal to adversely impact any hope of a fair testimonial exchange by undermining my credibility to an extent that even my views on what is important to my own quality of life were effectively not considered. Panel members have made unduly deflated judgements of my credibility, thus missing out on knowledge; and I have been wrongfully and unethically undermined in my capacity as a knower.

To conclude more positively, Fricker describes examples of exceptional testimonial justice being practised by individuals operating in poor hermeneutical environments. And I would like to record a further one here. A year after the last Tribunal, referred to above, authorised enforced treatment by

monthly injection, I was assessed by a psychiatrist in his role as Designated Medical Practitioner (Mental Welfare Commission, 2013). He wrote the following: "I concluded that you do have capacity to make decisions about your treatment. You were able to articulate your views clearly, and they were entirely in keeping with your advance statement. Therefore, I have not authorised any treatment to be administered without your consent. You are no longer required to accept the depot medication. Could I suggest you might arrange to meet with (your psychiatrist) for a discussion of which, if any, treatments you might wish to consent to, and under what circumstances". This letter has had a huge impact on my quality of life, for I have not been subject to any compulsory treatment since it was written at the end of 2018.

Such an act of individual exceptional judgement from both a moral and epistemic perspective is probably rare in relation to the numbers of Compulsory Treatment Orders authorised each year. But if the factors that allowed for its development and application can be more widely understood, protected and nurtured, it might yet help initiate improvements in some small part of the hermetical environment.

Acknowledgments

The author would like to acknowledge help in the form of suggestions and copy-editing from Jon Jureidini, Professor of Psychiatry and Paediatrics, Critical and Ethical Mental Health Research Institute, University of Adelaide, Australia.

Disclosure statement

No potential conflict of interest was reported by the author.

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References

- Carel, H., & Kidd, I. J. (2017). *Epistemic injustice in medicine and healthcare*. Routledge. The Routledge Handbook of Epistemic Injustice.
- Fricker, M. (2007a). *Epistemic injustice: Power & the ethics of knowing*. Oxford University Press.
- Fricker, M. (2007b). *Epistemic injustice: Power & the ethics of knowing*. Oxford University Press.
- Mental Welfare Commission. (2013). The role of the designated medical practitioner.
- Sanati, A., & Kyratsous, M. (2015). Epistemic injustice in assessment of delusions'. *Journal of Evaluation in Clinical Practice*, 21(3), 479–485. <https://doi.org/10.1111/jep.12347>
- Scottish Government. (2017). The mental health (care and treatment) (Scotland) act, 2003.
- Scrutton, A. P. (2017). *Epistemic injustice and mental illness*. Routledge. The Routledge Handbook of Epistemic Injustice.