

The Scottish Mental Health Law Review is due to report in September, having consulted widely on aspects of the law including incapacity, advance statements and independent advocacy.

Tom Todd has an advance statement in place, having experienced several psychiatric admissions to hospital over the last fifteen years. He has been diagnosed with a bipolar condition and has attended tribunal hearings, where use of enforced medication has been considered by a panel.

Here, he writes about his experiences, and how his preferences regarding the use of psychiatric drugs haven't always been heard...



Challenging the power dynamic in mental health services

A mental health tribunal is supposed to be where the various opinions about how best to implement an agreed treatment plan are heard. Appropriate interventions are explored and there is the opportunity for the person whose health is being considered to contribute.

The main issue for me at all the tribunals I have attended in recent years has been the enforced use of medication for prophylactic (or preventative) purposes. I have used antipsychotic medication intermittently over a period of years and have found it to be effective in addressing acute episodes of illness. I have also experienced horrendous side effects.

I prepared an advance statement a number of years ago that expressed a preference to use medication to resolve acute instances of relapse, with an option to consider whether or not to continue with it after no longer than one month of use. I wrote a supporting document explaining the rationale for this, with references to articles from, among others, other people with lived experience of using medications, and academic psychiatrists.

At the tribunals I have attended little attention has been paid to the rationale that I prepared and I have, unfortunately, been subject to Compulsory Treatment Orders that have caused me substantial, and ongoing, distress.

The reason why I feel so strongly about enforced medication is that I have experienced numerous effects

that I perceive as being associated with the drugs, including thoughts of suicide, uncontrollable foot, lip and tongue movements, tremor, breathing irregularities, akathisia, sexual dysfunction, optical nystagmus, lethargy, skin lesions and drooling.

Unfortunately, Section 64 of the Mental Health Act does not reference the potential adverse effects of any treatments that a Responsible Medical Officer (psychiatrist) is seeking to impose.

Moreover, although ostensibly I have had fair opportunity to have my views represented at tribunals, looking at what unfolded through the lens of the 'Epistemic Injustice' concept highlights some serious, problematic and systemic issues.

Epistemic Injustice is a term coined by philosopher Miranda Fricker to describe what happens when someone is 'wronged specifically in (their) capacity as a knower'.

This can happen because of who they are – for example, someone with the identity of 'psychiatric patient' is likely to be seen as less able to know what interventions may be optimal for them, simply because of their identity status. As a result, their statements may be dismissed without due consideration. This can be described as a particular kind of epistemic injustice, called 'testimonial injustice'.

They may also have less access to essential knowledge, and be less confident in the first place, because they are part of a marginalised group, and this is consistent with what Fricker refers to as 'hermeneutical injustice'. This is where a person's social experience is obscured from collective understanding.

People often make mental shortcuts and arrive at spontaneous assessments when they engage with a speaker, particularly during a first, or single, meeting. When this assessment is subject to unintentional bias, it can contribute to instances of Epistemic Injustice, and I believe this has been a factor in each of the tribunals that I have attended.

The structure of Section 64 is also relevant. At all tribunals, I have been asked to respond to whether I consider that each of five 'criteria to be met' for compulsory treatment are applicable to me. If panel members conclude from proceedings that they are, then enforced treatment may be given.

Criteria that are especially relevant are as follows:

► **Whether I do, in fact, have a mental disorder:** 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. Nuanced positions, such as the fact that characteristics of my illness are present only intermittently, are not considered.

► **Whether treatment is available for the disorder:** There is no requirement for panel members to address perceived harms associated with any treatment. Although members

have listened politely when the subject is raised, it hasn't been given serious consideration. Reported benefits by the psychiatrist have invariably carried more weight.

► **Assessment of the risk to me or to others:** I have relevant practical expertise in this area from my work in Quality Systems implementation. At one tribunal I presented evidence showing how basic models of risk assessment hadn't been utilised in assessments of me. I suggested that this was a missed opportunity to improve the process of risk evaluation. There appeared to be little awareness among panel members of the existence of such models.

Agential and identity power imbalances have operated during tribunals I have been present at, controlling whose contributions were worthy of consideration. My credibility has been undermined by 'hearer identity prejudice' on the part of panel members, adversely impacting any hope of fair consideration.

The experience of not having my preferences adequately considered has been devastating. There have been serious consequences for both my physical and emotional wellbeing. I am constantly having to self-appraise my views to defend against coercive health care practices, and have developed a personal identity that is overly, but necessarily, defensive.

More positively, I have experienced the support of a number of professionals along the way.

One psychiatrist, in his role as designated medical practitioner, enabled me to have compulsory treatments substantially stopped from the end of 2018 until the beginning of this year.

And when another psychiatrist was influential in bringing about a more recent request for compulsory treatment at the beginning of this year, I was grateful for the representation of the mental health officer at the resulting tribunal. The officer sided with me with respect to my ability to consider treatment preferences, stating that in their view I did not have significantly impaired decision-making ability (SIDMA), another of the criteria in Section 64. This ensured that no compulsory treatment was authorised.

I am presently working voluntarily with health care professionals to optimise my treatment plan.

My hope going forward is that the Scottish Mental Health Law Review, with its recognition of the potential advantages from taking a human rights-based approach to recommendations it makes, will take appropriate account of the many valid testimonies from individuals like me relating to the seriousness of widespread, and continuing, harms from enforced treatments.

The present situation of constant vulnerability to scientifically, and morally, inadequate judgements about appropriate use of medications cannot be allowed to continue. Reasoned changes to the Mental Health Act can make an important contribution to respect for, and the enhancement of, all of our rights as individuals to enjoy the highest attainable standard of physical and mental health.

Tom Todd works as a volunteer at CAPS Advocacy in Edinburgh, involved in promoting collective advocacy and peer work, and as a blog editor at the Critical and Ethical Mental Health research group at Adelaide University



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