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# Epistemic Injustice in Cases of Compulsory Psychiatric Treatment

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# Abstract

There is a growing body of philosophical research into epistemic injustice in the psychiatric context; this thesis examines the impact of this distinct form of injustice on people in compulsory psychiatric treatment specifically, that is, on people receiving treatment without their consent. Epistemic injustice poses an intrinsic harm to those who experience it, but it can result in secondary practical consequences. In the case of compulsory psychiatric treatment, these consequences can be severe, including the infringement of peoples' rights to liberty and autonomy.

I begin with a focus on testimonial injustice, as described by Miranda Fricker. I will show that compulsory treatment cases provide fertile ground for this form of injustice, and explore the idea that testimonial injustice functions at an institutional level in this context. To demonstrate this I use a case study, the Victorian *Mental Health Act 2014,* focusing particularly on the role of capacity assessments, which I will argue constitute a formal credibility judgment. Fricker's proposed remedy for testimonial injustice is the cultivation of the virtue of testimonial justice, however, I argue that on its own, this will not be sufficient for combatting institutional testimonial injustice. Examining solutions to this problem, I argue for structural solutions in the form of proposals for legislative and policy changes.

This will require the incorporation of epistemic resources that challenge the dominant clinical perspective, which I hold can and have been developed and disseminated through liberation movements. To that end, I examine the history of Mad Pride and some of the barriers and objections to its aims. Mad activism promotes the view that experiences commonly taken to be illness or disorder under the socially dominant set of epistemic resources are, in fact, grounds for culture and identity, and ought not to be pathologised. I seek to demonstrate not only that the alternative epistemic resources presented by Mad positive activists are valid, but that while it fails to take seriously alternative epistemic resources developed by consumers, survivors, and ex-patients, psychiatry as a discipline cannot properly engage in the democratic discussion required for objective inquiry. I ultimately contend that this will not be possible while compulsory treatment remains a reality, providing an epistemic argument for its elimination.

# Declaration

This thesis comprises only my original work towards the Master of Arts (Advance Seminar & Shorter Thesis) in Philosophy. To the best of my knowledge, due acknowledgement has been made in the text to all research material used. This thesis is fewer than the maximum word limit in length, exclusive of tables, maps, bibliographies, and appendices.

# Acknowledgements

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Finally, love and thanks go to my mum Julie, dad James, and sister Nicola. I can't put into words the appreciation I have for your faith in me. Writing a thesis is difficult, writing a thesis during a pandemic proved nearly impossible – and would have been entirely, if not for you.

This thesis is dedicated to consumers, survivors, and ex-patients of the Victorian mental health system, especially those who have experienced compulsory treatment, those who are no longer with us, and those who tirelessly campaign for change. Your courage gives me hope for a better future. *Nothing about us without us.*

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# Introduction

This thesis explores the impact of epistemic injustice on people who live with the experience of psychiatric diagnoses, including those imposed or presumed. Epistemic injustice refers to a harm done to a person in their capacity as a 'knower', or epistemic agent. Miranda Fricker identifies two kinds of epistemic injustice, testimonial and hermeneutical. In her words, "testimonial injustice occurs when prejudice cause a hearer to give a deflated level of credibility to a speaker's word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker, 2007, p. 1). I examine each in turn.

While there is growing recognition in philosophy concerning epistemic injustice in psychiatry, research into the application of the concept within this context has so far lacked specific emphasis on cases of compulsory psychiatric treatment, that is, treatment given without consent. My aim is to address this gap. On Fricker's view, epistemic injustice poses an intrinsic harm to knowers, and can lead to secondary practical harms. It is these secondary consequences that concern me primarily. I will demonstrate that epistemic injustice has an impact on the use of compulsory psychiatric treatment, which can result in the serious infringement of human rights to liberty and autonomy, and will ultimately provide an epistemic justification for considering its elimination.

Throughout this thesis, it will be necessary to refer to what is most commonly termed 'mental illness', which, as I will show, is a contested concept. The definition given in Section 3 of the *Mental Health Act 2014* (Vic), which will form the basis of a case study herein, is "a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory." However, some who are diagnosed or labelled as having 'mental illness' prefer to use different language to refer to those experiences, for example, they may reject their medicalisation, and identify as Mad, or as neurodivergent.[1] I will use 'Madness/mental illness' (hereafter M/MI) to denote experiences of this kind, although I acknowledge that this will not reflect everyone's preferred terminology.

I will also need to refer collectively to people who are marginalised on the basis of a diagnosis, or presumption of, M/MI. For brevity and consistency, I will use the term 'experients' to denote people who experience M/MI, in the hope that this captures people who both identify with diagnostic labels, and those who do not but who nevertheless are likely to experience epistemic injustice on the basis of their presumed mental health. I will use 'consumer' when discussing people who are engaged with or have engaged in the past with mental health services in the Victorian context. This is the term most often employed by mental health services in Australia, including organisations run by and for experients. Epstein (2013) describes the introduction of this term in Australian mental health discourse: "[t]he logic for the language was a reaction to some of the elitism, lack

[1] The neurodiversity paradigm is not the subject of this thesis, however a definition of this concept can be found in Bertilsdotter Rosqvist, Stenning, and Chown (2020).

of accountability and communication disasters experienced by patients. Patients started to fight back … The logic was: *Because you provide me with a service for which I duly pay I expect good service, good communication, and active decision-making opportunities.* We want a say" (p. 5).

I will begin in Part I by providing an overview of Fricker's concept of testimonial injustice, going on to show how people who experience M/MI meet the central case – that they constitute a marginalised group about which 'identity-prejudicial' stereotypes exist, and are subject to credibility deficits on this basis. Having done so, I then turn to an exploration of the impacts of testimonial injustice on a narrower subset of the aforementioned group, namely, people subject to or undergoing assessment for compulsory psychiatric treatment. I will show that compulsory treatment provides fertile ground for this form of injustice, and explore the idea that testimonial injustice functions at an institutional level in compulsory treatment cases. To demonstrate this I use a case study, the *Mental Health Act 2014* (Vic)*,* focusing particularly on the role of capacity assessments, which I will argue function as a *formal* credibility judgment. Lessons derived from this core example will likely be applicable elsewhere, as comparative research indicates that, at least in the case of Ireland, Scotland, England and Wales, Ontario (Canada) and Victoria, "largely similar procedures for admission, detention and treatment of involuntary patients are employed" (Cronin, Gouda, McDonald, & Hallahan, 2017, p. 268). I will show that while we have good reasons to support Fricker's proposed remedy for testimonial injustice, which involves the cultivation of the virtue of testimonial justice, in the case of compulsory treatment it will not, on its own, be sufficient. I will therefore propose several structural solutions to address institutional testimonial injustice. Though developed in the Victorian context, these proposals are generalisable, and could be implemented across jurisdictions whose mental health legislation involves the assessment of experients' capacity as a condition of treating people without their consent.

In Part II, I turn to an examination of Fricker's concept of hermeneutical injustice, and the ways in which hermeneutical injustices function in relation to epistemic resources regarding M/MI. I further provide an overview of the concepts willful hermeneutical ignorance and contributory injustice, and show how experients' use of alternative epistemic resources to make sense of their experiences renders them liable to the same. Having elaborated on these further forms of epistemic injustice in the mental health setting, I turn to approaches for overcoming them. I look at the potential for liberation movements to generate and disseminate new epistemic resources, focusing on the history of Mad Pride, and exploring some of the tensions within the community of experients that may be hindering its aims. Mad activism promotes the view that experiences commonly taken to be illness or disorder under the socially dominant set of epistemic resources (medical psychiatry) are, in fact, grounds for culture and identity and should not be pathologised. This presents a concern for experients who find that psychiatry offers them the best options for support. I argue that a pluralist framework, which adds to, rather than replaces, epistemic resources, is both plausible and important for psychiatry's development as a discipline. In fact, I will show that while it fails to take seriously alternative epistemic resources developed by consumers, survivors, and ex-patients, psychiatry cannot properly engage in the democratic discussion required for objective

inquiry. Further, I argue that this kind of engagement cannot take place while the possibility of compulsory treatment allows dominant knowers to wield power over experients. Ultimately, I will provide a distinctly *epistemic* reason for promoting the reduction and elimination of compulsory treatment. While not the only reason put forth in debates on this topic, it is an argument which as yet has not received sufficient recognition.

This thesis will explore competing hermeneutical resources used by knowers, both dominant and marginalised, to explain and articulate experiences that are currently predominantly taken to be indicative of mental illness or disorder. While I aim to fairly represent the tensions therein, I do not intend to make a claim here about the ontological nature of these experiences. That is, I make no claim about how these experiences ought to be definitively described, and will not defend either a conception of these experiences as illness, or as grounds for identity here.

My analysis concentrates on resources developed by communities primarily residing in the Global North, including the discipline of psychiatry and its development as a branch of evidence-based medicine, and Mad activism, largely as it occurs in countries such as Canada, the UK, Australia, and in Western Europe. The scope of this thesis prevents fuller exploration of conceptions of M/MI in other parts of the world, but it is clear that cultural background plays a significant role in the way in which people understand their experiences of the same (Luhrmann, Padmavati, Tharoor, & Osei, 2015). We know that that prejudice in relation to race (McKenzie & Bhui, 2007), gender (Tone & Koziol, 2018), and sexuality (Rees, Crowe, & Harris, 2020) have already been shown to affect experients' treatment within mental health services. Other forms of identity prejudice are likely to intersect with the experience of epistemic injustice on the basis of perceived mental health in psychiatric settings, however, in order to elucidate the distinct nature of epistemic injustice in compulsory treatment cases, I will concentrate here on M/MI.

Finally, a note on the methodological commitments of this thesis: I am interested in epistemic injustice in psychiatry and against experients not as an academic exercise in interpretation, but because of a belief that it is harmful, intrinsically and practically, and because I desire to do something to help address it. To that end, I make this disclosure – while I have mental health diagnoses, and an experience of treatment, I have no firsthand experience of compulsory psychiatric treatment.[2] As this thesis largely concerns compulsory treatment, wherever possible, I commit throughout to an attempt to amplify the voices of those who have. We cannot overcome epistemic injustice against experients without acknowledging their lived experience and expertise, and without affording credibility on this subject where it is due – to those who have been subject to injustice themselves.[3] That is the spirit in which I undertake writing this thesis and which I hope will be apparent.

[2] I work closely with consumers in compulsory psychiatric treatment as an independent mental health advocate, an experience that partially inspired this thesis.

[3] For an exploration, and criticism, of the ways in which philosophy as a discipline can alienate people with lived experience by creating a false dichotomy between researchers and the researched, see Russo and Beresford (2015).

# Part I: Testimonial Injustice

## i. Testimonial Injustice and Mental Health

I now turn to a more detailed examination of testimonial injustice. For Fricker (2007), the central case of testimonial injustice is characterised as an "identity-prejudicial credibility deficit" (p. 38). Importantly, the central case is systematic; testimonial injustices are "connected, via a common prejudice, with other types of injustice" (Fricker, 2007, p. 27). Systematic testimonial injustices are caused by 'tracker' prejudices, those that follow the subject through various social domains (e.g. economic, educational, professional, legal, political etc.), rendering the subject liable to injustices within them. The foremost type of prejudice that can track people in this way is prejudice relating to social identity. Thus, a speaker sustains a testimonial injustice if they experience diminished credibility as a result of identity prejudice on the part of the hearer, that is, prejudice against the speaker *qua* member of a social group.

On Fricker's account, the primary way in which prejudice inserts itself into testimonial exchange, thereby affecting hearers' judgments of credibility, is via stereotypes. Specifically, through negative identity-prejudicial stereotypes, which are defined as "a widely held disparaging association between a social group and one or more attributes, where this association embodies a generalisation that displays some (typically, epistemically culpable) resistance to counter-evidence owing to an ethically bad affective investment" (Fricker, 2007, p. 35). Negative identity-prejudicial stereotypes are not merely over-generalised beliefs about a particular social category; they are damaging because, unlike stereotypes more generally, which can be reliable or unreliable, negative identity-prejudicial stereotypes rely on false associations. They constitute an unreliable empirical generalisation. Further to this, they are not the result of 'bad epistemic luck,' such as a lack of evidence; they remain in spite of counter-evidence, due to some kind of ethically flawed motivation.

When we engage in a testimonial exchange, we may need to make a credibility judgment about a speaker. We want to know whether it is rational to trust what that person says, or to gauge their "competence and sincerity" (Fricker, 2007, p. 32). To assess a person's 'epistemic trustworthiness', we might use stereotypes as heuristics. When we rely on negative identity-prejudicial stereotypes as a shorthand way of doing so, our perception of the speaker is distorted, and we leave them vulnerable to epistemic injustices.

Can we say, then, that epistemic injustice affects experients of M/MI? To demonstrate this, it is necessary to show how this example meets the conditions of Fricker's central case of testimonial injustice. Does the social group in question also experience this kind of systematic identity prejudice resulting from stereotypes about the group as a whole? The answer to this question must surely be a resounding 'yes.' Analyses of implicit bias towards experients reveal that three of the most common stereotypes surrounding 'mental illness' are negative; they include the beliefs that 'people with mental illness' are

dangerous, incompetent, and responsible for the onset and offset of their condition (Robb & Stone, 2016). Further proof is the research into the stigmatisation of mental illness itself, and the effects of stigma on the social outcomes of experients. Stereotypes and stigma are closely related phenomena. Anderson (2010), for example, suggests that group stigma arises from "the attribution of negative stereotypes to dishonourable internal traits, which rationalize antipathy towards the group. The tendency to attribute negative stereotypes dispositionally yields stigmatization of disadvantaged groups" (p. 46). Mental health charity SANE released their *National Stigma Report Card* in 2020, which surveyed participants with complex mental health issues to understand their experiences of stigma across 14 domains. Highlighting the domain of mental health treatment, it was found that "a total of 71.8% of all 1,912 participants indicated that they had experienced some level of stigma and discrimination in the preceding 12 months when seeking mental healthcare" (Groot et al., 2020, p. 166).

The stigmatisation of experients is clear, and can result in difficulties and access issues for this group of people across a great many social dimensions, such as in housing, education, employment, and the legal system. Stigma is unfortunately also present and still prevalent in medical settings, which is the subject of this thesis. One review of the literature pertaining to the stigmatisation of experients by nursing staff in particular suggests:

> …nurses in general medical settings often held negative attitudes of fear, blame and hostility towards patients with psychiatric illness, having a detrimental impact on their client care… Nurses who choose to work in psychiatry were themselves found to have negative attitudes and discriminatory behaviour … and to be more pessimistic about positive outcomes of psychiatric illnesses than were general nurses and the lay public. (Ross & Goldner, 2009, p. 565)

Given the existence of stigma and negative stereotypes around M/MI, it is almost certain that experients face identity prejudice, and thus that they are affected by testimonial injustice. Of course, on Fricker's view, a speaker sustains a testimonial injustice only if a negative credibility judgment made against them is the result of identity prejudice, and not some other factor (such as empirical evidence that the speaker is not telling the truth). In the following section, I consider the view that, in some cases, affording credibility deficits to experients may be justified. For now, I take it that, just as with any group subject to identity prejudice, individual people within the group may be more or less reliable on given topics.

In general, however, we may say that experients are subject to epistemic injustices, and this is not a revelatory claim; in the last several years, philosophers and clinicians alike have begun to turn their attention to the question of epistemic injustices against experients, particularly those injustices perpetrated by health workers. There is a growing body of academic literature on epistemic injustice and mental health and illness (Kurs & Grinshpoon, 2018; Kyratsous & Sanati, 2017; Scrutton, 2017), disability (Dohmen, 2016), in psychiatric and mental health treatment settings (Crichton, Carel,

& Kidd., 2017; Lakeman, 2010; Sanati & Kyratsous, 2015), and indeed in medicine more broadly (Carel & Kidd, 2014, 2017; Kidd & Carel, 2016).[4] Crichton et al. (2017), for example, argue that 'people with mental disorder' are vulnerable to experience epistemic injustices in treatment contexts, outlining contributory conditions for this: pervasive negative stereotyping of experients, stigmatisation resulting from problems associated with 'mental disorder' itself (e.g. lack of access to education, adequate employment opportunities, or financial security, social isolation, and substance use) which are often assumed to be the experient's fault, and from the value placed by health professionals on 'hard' or 'objective' evidence over experients' reporting about their own lives.

In the introduction, I specified a methodological commitment to amplify the voices of experients in conversations about their lives and oppression. While there is growing recognition in the philosophical literature of the ways in which experients' credibility is questioned by health workers, reports from people who have used mental health services also seem to indicate that the concept of epistemic injustice provides a useful framework for understanding the frustration they often encounter in this context. Louise Pembroke (1992) says this about her experience:

> I am a survivor of psychiatric treatment. My life was reduced to numerous lists of symptoms and treated accordingly ... My worldview and experience of living were unimportant. My distress was only acknowledged within a medical framework which is not my explanatory framework. My differences in perception are dismissed as hallucinations. The spiritual activity in my life is written off as delusional. My need to physically self-harm is reduced to attention seeking. My difficulties around eating are pronounced a disorder ... Whatever way I expressed my distress or dissent it was declared invalid, stupid or sick. (p. 23)

Epistemic injustice is not a new phenomenon – Pembroke's memoir in *Eating Distress* was published 15 years prior to *Epistemic Injustice,* and while she does not explicitly acknowledge the frameworks she uses to interpret her experiences – either of distress or of mistreatment by health services –it has always struck me as illuminating, for it seems to exemplify the two kinds of epistemic injustice that Fricker outlines. Pembroke's testimony is not given credibility, it is declared invalid because she is perceived as ill, and to explain her experience she draws on hermeneutical resources her doctors appear not to share, or perhaps, do not want to share – a point I will return to in Part II.

### ii. The Harms of Testimonial Injustice: Compulsory Psychiatric Treatment and Human Rights

For now, let us continue the analysis of testimonial injustice as it affects experients, and turn to the case of compulsory psychiatric treatment. Crichton et al. (2017) claim that a

[4] For a comprehensive bibliography of epistemic injustice, healthcare, and illness, see: https://ianjameskidd.weebly.com/epistemic-injustice-healthcare-and-illness-a-bibliography.html

consequence of epistemic injustice in treatment contexts is "that patient testimonies and interpretations are not acknowledged as credible, and patients are thus undermined in their capacity as knowers and contributors to the epistemic effort to reach a correct diagnosis and treatment" (p. 65). I intend to add to this analysis by demonstrating that the secondary consequence of epistemic injustice raised here (impoverished diagnostic efforts) is not the only by-product of epistemic injustice in psychiatry, but that, as I will show below, it can result in significant violations of experients' human rights.

Compulsory psychiatric treatment, alternatively known as involuntary or forced treatment, refers to the practice of providing psychiatric treatment to a person without their consent. A 'compulsory psychiatric patient' is one who is compelled to receive treatment by law. 'Treatment' is defined in Section 3 of the *Mental Health Act 2014* (Vic) as "things done in the course of professional skill to remedy mental illness or to alleviate the symptoms and reduce the ill effects of mental illness. It includes electroconvulsive treatment and neurosurgery for mental illness." The practice of compulsory treatment can also frequently involve a person's detention, namely in a psychiatric inpatient unit or facility.

Intuitively, many people feel that compulsory treatment exists ostensibly to prevent harm. The general idea is that when a person is 'acutely unwell', 'mad', or 'not in their right mind', such that they cannot comprehend risks associated with their behaviour, interventions are required to prevent harm to themselves or others. Modern mental health legislation in the Anglophone world has its origin in two common law doctrines. The first of these is *parens patriae*, which dates back to the reign of Edward I in 13th century England. It allowed the sovereign to intervene in situations where a person was deemed of 'unsound mind' and therefore unable to look after their own interests. The second of these doctrines concerns the 'police powers' of the state, introduced by the *Vagrancy Act 1744*. These laws justified intervention to protect the property of others from the interference of 'mad' people. Together, these two doctrines continue to inform modern mental health legislation in many jurisdictions, wherein detention and involuntary treatment is permitted on the general basis of preventing risk to self or others (Gooding, 2017, p. 23).

A case could be made that doctrine of *parens patriae* and the *Vagrancy Act* initially came about as a way to protect not human life, health, or wellbeing, but to secure property and financial interests. Some have argued in regard to *parens patriae* that "the court's treatment of the insane seems to have been largely motivated by humanitarian rather than financial concerns" (Custer, 1978, p. 196). However, it remains the case that "… partially as protection for the idiot and partially as compensation for the king's services, all transfers of property by the idiot were voided, and the profits of his land went to the crown. The king retained control of the land during the idiot's lifetime…" (Custer, 1978, p. 196). In the 18th and 19th centuries, the focus of mental health legislation in the UK began to shift more towards the role of the state in medical treatment. Custer (1978) claims that doctors of this period were primarily concerned with the providing treatment quickly and easily, and with protection from the risks associated with certifying someone as a 'lunatic', while lawyers gave greater weight to the person's liberty. It would appear

that the 'medical men' he describes won out, in a sense, for in the 20th century, the law began to endorse greater clinical discretion, granting psychiatrists, rather than magistrates alone, the ability to impose detention and involuntary treatment (Gooding, 2017). This continues today in the UK and other jurisdictions, including all Australian states and territories.

What role does mental health law see itself fulfilling today? Our example, the *Mental Health Act 2014* (Vic), which allows for the detention and involuntary treatment of persons taken to be 'mentally ill', lists one of its objectives in Section 10 as "to provide for persons to receive assessment and treatment in the least restrictive way possible with the least possible restrictions on human rights and human dignity …" There is an attempt herein to promote and safeguard human rights, however, the idea that compulsory treatment is designed with the benefit of experients in mind has long been disputed by legal scholars, philosophers, human rights activists, and of course, by people who have experienced it (noting that people who have experienced compulsory treatment may also be activists, lawyers, and academics). In *Madness and Civilization*, Foucault puts forward the claim that the 'confinement' of the Mad was historically a mechanism for the control and segregation of 'undesirables', a socially constructed category, and that their confinement made such people available as objects of study for doctors, leading to the pathologisation of Madness and the rise of modern psychiatric institutions. Despite a nominally greater focus on compassionate care in these institutions, he held that they maintain their original purpose, remaining as restrictive and controlling as their earlier counterparts (Foucault, 1988).

Foucault published this genealogy during the Civil Rights era, and it is from these struggles for justice that the psychiatric survivor movement drew inspiration and grew. Chamberlin (1978) produced key work in the intellectual development of this movement, bringing themes of self-determination, autonomy, and the protection of human rights to the forefront of user-led discussions about psychiatric treatment. Mad activism continues, and this work has been far-reaching in some distinct ways – these themes are evident in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD; 2008), which has strengthened calls for the elimination of involuntary psychiatric treatment. The UNCRPD Committee (2014), states:

> The denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem. This practice constitutes arbitrary deprivation of liberty and violates articles 12 and 14 of the Convention…As has been stated by the Committee in several concluding observations, forced treatment by psychiatric and other health and medical professionals is a violation of the right to equal recognition before the law and an infringement of the rights to personal integrity (art. 17); freedom from torture (art. 15); and freedom from violence, exploitation and abuse (art. 16). (pp. 10)

On this basis, arguments have been made that legislation such as the *Mental Health Act 2014* (Vic), which permit this, are incompatible with Australia's obligations under international human rights law. Australia ratified the UNCRPD but declared reservations which, despite the above profession by the UNCRPD Committee, state in part: "Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards" (United Nations, 2008).

Just as I do not have space to do justice here to the legal history and defence of involuntary psychiatric intervention, I am unable to give a full account of the history of its detractors and their associated movements and, for the time being, will leave aside the question of whether compulsory treatment is legally or ethically justifiable. Rather, I take it for now that compulsory treatment will continue to be used in psychiatric medicine, and my aim is therefore to take a closer look at the way in which epistemic injustice might be affecting clinicians' judgements when electing to place someone in compulsory treatment, and how it affects the testimony of people who subsequently receive it.

Australia has some of the highest rates of compulsory treatment globally, and as at 2010-11 Victoria had the highest rates of Community Treatment Orders in Australia (Light, Kerridge, Ryan, & Robertson, 2012). The peak body in Victoria representing people who use the mental health system, the Victorian Mental Illness Awareness Council (VMIAC), have criticised this approach, stating in their policy position paper on compulsory treatment that "[t]here is no place for compulsory mental health treatment, unless it is specifically requested by a person.[5] Compulsory mental health treatment is an inappropriate and ineffective response to mental and emotional distress. It violates our human rights and discriminates against us by treating us differently based on a diagnosis of mental illness" (VMIAC, n.d.). While views in Victoria on the permissibility of compulsory treatment differ, the Victorian government, through the passing of the *Mental Health Act 2014* (Vic) 'Mental Health Principles', have nonetheless made a formal commitment to reducing its use, outlining in Section 11 that "persons receiving mental health services should be provided assessment and treatment in the least restrictive way possible with voluntary assessment and treatment preferred…"

Despite this, Victorian reports show that over half the adults who underwent a psychiatric inpatient admission in 2018-19 did so involuntarily. Of Adult admissions (ages 25-65 years) 54.3% were involuntary, as were 21.9% of Child and Adolescent admissions, and 46.7% of Aged admissions (65 years and over). The average duration of a period of compulsory treatment in 2018-19 was 75.6 days. 12.9% of people in compulsory treatment were on an Order for more than 12 months. In terms of compulsory treatment in the community, 14.4% of Adults, 5.3% of Aged, and 1.1% of Child and Adolescent consumers accessing the public mental health system were on an Order in that time period (Department of Health and Human Services, 2019). On the rate of CTOs, VMIAC states "[t]hese rates are high because of the laziness of psychiatrists … It's much easier for them

[5] For example, in an advanced directive specifying their treatment preferences.

to put someone on a community treatment order and to force them on medication than it is to negotiate and spend time with somebody, **listening to them**" [emphasis mine] (Stark, 2013).

I take the question of whether experients are listened to very seriously, and in what follows I will argue that it is possible that epistemic injustices may be playing a role in the use, or overuse, of compulsory treatment. If we can address this, I believe we will likely see a reduction. I raise the issue of compulsory treatment as this setting seems a particularly fertile ground for epistemic injustices. For example, testimonial injustice is simply more likely to occur in the compulsory treatment case because this kind of treatment constitutes formal, state-sanctioned recognition of a person's membership of the social group 'experients'.

People in compulsory treatment are particularly vulnerable to testimonial injustice because it occurs in a context in which that person's status as a member of a group subject to identity prejudice is already made salient. For people in compulsory treatment, there is no possibility of avoiding association with the social group subject to identity prejudice. 'Compulsory patients', to use the language of the *Mental Health Act 2014* (Vic)*,* are automatically labelled as 'mentally ill' by virtue of an Order being made, as inherent in the criteria is the judgment that 'the person has a mental illness'. While this could perhaps be said of anyone accessing mental health treatment, the compulsory case leaves very little room for interpretation or doubt. Unlike 'private' patients in Victoria (people who access mental health treatment voluntarily through a provider of their choice, rather than via the public health system), people on Orders are not just taken to be 'mentally ill' due to contact with a health service. They are explicitly legally designated as such, and, at least in Victoria, this information is registered on a state-wide database that can be accessed by staff in any public health service in the state (Department of Health and Human Services, 2017).

Perhaps unlike race or gender, which have also been subject to extensive discussion in regard to epistemic injustice, a person's mental states can fluctuate and are not always visible or immediately ascertainable to others. Consequently, some experients may not feel the effects of testimonial injustice in some contexts. If they are not taken to be members of the social group by their interlocutor, then identity prejudice may not be at work. In short, if somebody does not know that you have a mental health diagnosis, then they are less likely to apply identity-prejudicial stereotypes about 'mentally ill' people to you when assessing your credibility. A study by the Mental Health Council of Australia (2011) showed that 44.7% of respondents felt that medical professionals "had changed their behaviour toward them once finding out about their mental illness" (p. 16). In the case of compulsory treatment, there is little, if any, possibility of 'passing' – that is, being regarded as a member of a different identity group.

Further, the effects of testimonial injustice are also apt to be more severe for those undergoing compulsory treatment than in general cases of testimonial injustice against experients. As noted earlier, Crichton et al. (2017) argue that epistemic injustice can undermine experients' ability to participate in efforts to establish a correct diagnosis and

treatment. I think we can add to this, and that it is worth differentiating a stronger harm. In compulsory treatment cases, the downgrading of an experients' credibility can result in significant rights violations in addition to diagnostic mistakes or poor treatment provision. I think people will intuitively agree that the harms resulting from testimonial injustice are stronger in compulsory cases. If I opt to see a psychiatrist whom I discover does not believe me about my experiences and as a result is not providing treatment I find helpful, then I have wasted my time and money but am ultimately still free to pursue other options.[6] In contrast, however, if I am apprehended by police or visited by emergency mental health clinicians and made to submit to psychiatric assessment, and the psychiatrist does not believe me about my experiences and consequently makes a diagnosis of 'mental illness', I could be detained and treated without my consent. This could occur regardless of the supports I find helpful, or even whether I identify as needing that support. The issue is not merely that a person could be undermined in the epistemic effort to find a correct diagnosis and treatment – it could be that the person *has no need of* treatment but is not believed about this, and made to submit to it anyway.

While not the focus of their paper, Crichton et al. have already demonstrated how testimonial injustice against experients, or people taken to be experients, can result in involuntary detention and treatment. In one case, a former nun was detained under the Mental Health Act due to concerns over her use of incense for religious rituals, but it was later determined by a Tribunal that "there was no evidence of a psychotic illness, as had been claimed by the psychiatrist and one of the psychiatric nurses, and that section 2 should therefore be rescinded" (Crichton et al., 2017, p. 66).

It might be objected that, given that the woman in question did not turn out to have a psychiatric disorder, this is not an example of testimonial injustice against a member of the social group I discuss, i.e. she is not an experient of M/MI. To this I would say that she was taken to be a member of the social group by more than one person (the police, the psychiatrist, and the nurse) and that therefore she would have been subject to the identity-prejudicial stereotypes relevant to the social group in question. She experienced testimonial injustice on this basis. As we know, mental states are harder to determine than some other features of identity such as skin colour or gender presentation, and "[i]n psychiatry, there is virtually no hard evidence and diagnoses have to be made mainly on the basis of what patients say and how they behave" (Crichton et al., 2017, p. 67). It stands to reason then that negative identity-prejudicial stereotypes could be misapplied to people whom others take to be acting in ways consistent with those attributed to the social group.

My view is that the above woman's unjustified psychiatric detention is a more egregious harm than a failure to correctly diagnose her. Further, while testimonial injustice indeed diminishes diagnostic efforts, it is especially important to recognise this in cases where a person's human rights to liberty and autonomy are at stake. This is why in exploring

[6] Seeking and finding adequate mental health treatment is difficult for many reasons, including stigma and the incurrence of financial burdens, and poor provision of treatment or the provision of inadequate treatment due to testimonial injustice is still a serious issue, though not my focus here.

epistemic injustice in psychiatry, we must consider compulsory treatment cases in particular.

## iii. Addressing Testimonial Injustice: An Institutional Problem?

At this point, it seems reasonable to address the most common objection to the claims that 'compulsory patients' are at significant risk of testimonial injustice, and that this results in the practical harm of unjustified rights violations, which is usually something like: downgrading a person's credibility is only a testimonial injustice if it is the result of identity-prejudicial stereotyping, and not if the person *is actually* unreliable and lacking in credibility.

It is fair to say that some people who are involuntary hospitalised or treated can give testimony that is not credible to others for reasons other than identity-prejudicial stereotyping. A person whose mental or emotional distress or overwhelm is very severe may say or do things that indicate a limited or altered understanding of their situation relative to others. For example, they may hear or see things that are not able to be independently witnessed or confirmed. Downgrading a person's credibility in an instance like this would not constitute a testimonial injustice. If I am convinced there is a person standing in the corner of the room, and none of my interlocutors can see or hear this person, they would not be doing me an injustice in failing to believe my testimony that there is another person there. This is because they would have stronger counter-evidence not to believe it if more than one person has attempted to independently verify my statement and come up empty. It is, however, important that due diligence is done – in another real-world case, Crichton et al. (2017) describe an instance wherein a consumer testifies to being a relative of the then Soviet leader. This was not initially thought worth checking, and it was assumed the consumer was experiencing grandiose delusions. However, it later turned out to be true, which as the authors have identified, *is* an example of testimonial injustice.

It remains the case however that, occasionally, some statements made by experients will simply not be credible to others for good reasons, and that these reasons will sometimes relate specifically to the person's mental state. Since people in compulsory treatment also tend to be the kind of experients whose mental and emotional distress is more visible to others, and since overt mental and emotional distress is stereotypically assumed to negatively impact reliability and capability, there exists a "widely held assumption that people who meet the criteria for civil commitment under mental health law generally lack mental capacity" (Gooding, 2017, p. 80), i.e. that they do not have the ability to make decisions for themselves (such as the decision to voluntarily pursue treatment).

To judge someone's capacity for self-determination is, I think, a kind of credibility judgment. It might not be immediately obvious that assessments of mental capacity involve credibility judgments and so are ripe for testimonial injustice. However, when we look at how these assessments are conducted, it becomes apparent that testimony plays a large role in them. In Victorian mental health legislation, capacity to provide informed

consent to treatment is deemed present when a person is able to demonstrate a) that they understand information about the proposed treatment, b) that they can retain it, c) that they can use and weigh the information, and d) that they can communicate a decision (*Mental Health Act 2014* (Vic) s. 68). When clinicians are making a judgment about whether someone has mental capacity of this kind, they are relying on a person's testimony about their understanding. If the person is assumed to be mistaken or not telling the truth about their experiences, if they cannot articulate their experience due to a lack of hermeneutical resources, or if they are using different resources to medical practitioners to make sense of their situation, then their credibility may be downgraded, leading to a judgment that they do not possess decision-making capacity. To experience testimonial injustice in the context of a capacity assessment is especially worrying as, if a judgment is made that a person lacks capacity when they in fact are able to make decisions regarding their treatment, then, like the former nun in the previous case study, they are likely to experience further injustices in the form of denial of their right to liberty and autonomy.

I propose that the assumption that people who meet the criteria for compulsory treatment lack mental capacity rests on negative identity-prejudicial stereotypes – the same kinds of stereotype at work in testimonial injustices. As we know, stereotypes are not inherently harmful or negative. They are a cognitive tool that people use to make judgments quicky, which is sometimes necessary. The idea that experients who meet legal criteria for compulsory treatment lack the capacity to for example consent to or to refuse treatment may hold true in some individual cases – but mental capacity or the ability to self-determine should not be judged via stereotypes. Capacity in mental health law is highly context-dependent – having the capacity to give informed consent to treatment is time and decision specific, such that 'having capacity' is not a blanket state of being, but rather only relevant to a particular choice a person is making at a given time. When decisions about capacity are made on the basis of uninterrogated assumptions about a person's membership of a particular social group, we open ourselves up to committing testimonial injustice because stereotypes are, by definition, a blanket approach: a fixed, overgeneralised belief about the group.

There is evidence to suggest that clinicians making capacity judgments are sometimes doing so on the basis of negative-identity prejudicial stereotypes, rather than genuine engagement with experients. We already know that 'compulsory patients' are in general more liable to experience testimonial injustice in treatment settings, a context in which capacity assessments are frequently used. Further, people tend not to have similar assumptions about capacity to consent to treatment in general medical settings, despite the fact that one of the most comprehensive studies into mental capacity comparing people with mental health diagnoses and people without, the MacArthur Treatment Competence (MAC) Study, showed that the majority of research participants hospitalised on the basis of mental health diagnoses did not lack capacity to consent to treatment, and that more than half were found to have similar levels of capacity to research subjects hospitalised for physical healthcare. The authors claim that "…the justification for a blanket denial of the right to consent to or refuse treatment for persons hospitalized because of mental

illness cannot be based on the assumption that they uniformly lack decision-making capacity" (Appelbaum & Grisso, 1995, p. 171).

The MAC Study also found significant differences in decision-making abilities between people diagnosed with schizophrenia and participants with physical health conditions, noting that "[f]or any given measure, approximately 25% of the schizophrenic group scored in the "impaired" range, compared with 5%-7% of angina patients…" (Appelbaum & Grisso, 1995, p. 171), but regardless, it is clear that not everyone who is involuntarily hospitalised on the basis of this diagnosis lacks mental capacity. Testimonial injustice comes into play in these settings when clinicians assume this is true of everyone with this diagnosis, and make credibility judgments on that basis. Psychiatrists Sanati and Kyratsous discuss this phenomenon in their work on epistemic injustice and delusions. They present case studies from clinical practice of people subject to epistemic injustice "on the basis of having an illness that is so often associated with attributions of *irrationality, bizarreness* and *incomprehensibility*" (Sanati & Kyratsous, 2015, p. 483). While they do not explore capacity assessments in particular, they argue that testimonial injustices can occur *even when* a person is assessed as having current delusions, due to the complex nature of delusions and the inability of practitioners to understand delusions holistically.

Assuming, then, that someone *generally* lacks credibility on the basis of a mental health diagnosis, compulsory order, or even on the basis of active 'psychotic symptoms', can result in testimonial injustice. This is counterintuitive for many people, who view psychosis in particular as rendering experients almost completely unreliable in their testimony, not just in regard to a particular 'delusion.' While not every instance of a treatment order being made will involve testimonial injustice, once a person is in compulsory treatment, testimonial injustice can lead to people who are capable of making decisions about their treatment having their views and preferences overruled, because their credibility may be downgraded when others are making judgments about their mental capacity.

What options do we have for addressing testimonial injustice in compulsory treatment cases? In her book, Fricker focuses on the practical cultivation of virtues as a remedy to epistemic injustice. She argues that Aristotelean virtue ethics has an epistemological counterpart; just as one can possess moral virtues, one can possess epistemic ones (in fact, part of being morally virtuous is being epistemically virtuous.) Hearers perceive speakers in epistemically loaded ways, in much the same way as a moral agent perceives the world in a morally charged way. Aristotle's moral agent needs a moral perceptual capacity; similarly, Fricker's hearer needs what she calls a "testimonial sensibility" (Fricker, 2007, p. 71), a rational sensitivity that is trained by repeated experiences of testimonial exchange. This training should instil in us good epistemic habits, such that our credibility judgments are reliable. However, testimonial sensibility can fail – even if we are personally committed to being free from prejudice as hearers, we still live in a world where there are residual prejudices that could influence our credibility judgments, and cannot always escape its clutches. Where testimonial sensibility fails, testimonial injustice can occur.

To remedy epistemic injustice, Fricker (2007) presents one particular testimonial virtue, that of testimonial justice. The virtuous hearer is one who reliably succeeds in correcting for the influence of prejudice in her credibility judgments. Testimonial justice is the virtue that hearers must hold in order to be able to overcome the influence of identity prejudice when judging a speaker's credibility – the virtue that helps detect and correct for identity prejudice. Testimonial justice is a disposition to prevent one's prejudices from interfering with judgments of others' testimony, and is achieved by means of *reflexive critical openness* to the word of others. A virtuous hearer is one who has a critical awareness that allows them to "be alert to the impact not only of the speaker's social identity but also the impact of their *own* social identity on their credibility judgment" (Fricker, 2007, p. 91).

Research on epistemic injustice in psychiatry has proposed that training programs for psychiatrists encouraging the cultivation of virtues will help to alleviate epistemic injustice in the mental health sector generally. Philosophers and clinicians alike have emphasised the need for mental health workers to adopt testimonially virtuous attitudes when interacting with experients. For example, Scrutton (2017) says "[in] order for these injustices to be overcome and epistemic justice practiced, mental health professionals need to be cognizant of the ways in which experients are epistemically privileged – for example, in having unique knowledge of what their experiences are like and, in some cases, of what might be best for them" (p. 353). Crichton et al. (2017) suggest that "by listening carefully to what patients tell them, doctors can make a conscious effort to imagine how things seem from the patient's perspective. In this way the relationship can become a genuinely collaborative one, rather than one in which the doctor decides what is in the patient's best interests" (p. 69).

In *Epistemic Injustice,* Fricker's discussion of testimonial injustice concentrates largely on individual testimonial exchanges – one person, the speaker, gives testimony to a hearer who doesn't afford them due credibility. In instances such as these, the avoidance of testimonial injustice will be aided if the hearer has an awareness of this phenomenon and a commitment to mitigating their prejudices. However, if we think about instances in which experients are likely to be giving testimony to clinicians in compulsory treatment cases, we can see that they are often highly formalised, and governed by complex institutional structures that affect hearers' ability to practise testimonial justice. What happens when a mental health professional who wants to cultivate the virtue of testimonial justice is prevented from doing so by the institutions to which they belong and may be beholden? What happens when professionals are *not* concerned with epistemic injustice, and there is no institutional push to rectify this?

Carel and Kidd (2017) gesture at what they call 'structural epistemic injustice' or, "forms of injustice generated by systems, institutions, and practices" (p. 344), suggesting we might need a deeper understanding of this concept if we are to address epistemic injustice entirely. There are probably several forms that structural epistemic injustice could take. I will concentrate here on the way in which it plays out in medico-legal institutions, which are integral to the functioning of compulsory psychiatric treatment, and hold that in some cases their structures both fail to promote the virtue of testimonial justice amongst their

members, or actively prevent the cultivation of this virtue and encourage testimonial injustice.

Being able to work with clinicians who listen to them and take them seriously would obviously be beneficial to experients engaging with health services and likely reduce testimonial injustice. However, my interest in this thesis is in compulsory treatment specifically, which I argue is a special case that will take more than an emphasis on individuals cultivating the virtue of testimonial justice to address. I suggest that testimonial injustice is operating at an *institutional* level in the compulsory treatment case. I argue that epistemic injustices in the case of compulsory psychiatric treatment are perpetrated in no small part because provision for them is literally written into law, and that this concern is unlikely to resolved by focusing on individual virtuousness alone.

My suggestion is that the legal system as regards compulsory treatment is itself testimonially unjust. I draw here on Fricker (2010) and Anderson (2012), who have both argued that institutions can be testimonially just, or unjust. For institutions to be just, their members (either as individuals or collectives within the institution, for example, a complaints committee) must jointly commit to neutralising prejudice in its judgments of speakers' credibility. Fricker and Anderson agree that a fundamental criterion of good design when it comes to these institutions are underlying structures that ideally should encourage the virtue of testimonial justice, and discourage testimonial *in*justice. It would take a group of especially testimonially virtuous people for an institution to be testimonially just where it lacks structures that allow for it, such as giving hearers enough time to make unbiased assessments, or having clear and transparent procedures for making complaints, contesting unequal treatment, and ensuring checks and balances.

The ways in which legal structures can embed testimonial injustice are shown clearly in the *Mental Health Act 2014* (Vic). Interestingly this legislation, which was introduced in part in response to the UNCRPD in an attempt to promote consumers' involvement in their treatment, contains an example of a virtue-encouraging structure. The law requires a 'presumption of capacity', and states in Section 70, Subsection 1 that "[b]efore treatment or medical treatment is administered to a person in accordance with this Act, the informed consent of the person must be sought" and in Subsection 2 that "[t]he person seeking the informed consent of another person to a treatment or medical treatment must presume that the other person has the capacity to give informed consent". Although not explicitly designed for this purpose, on the face of it, Section 70 essentially provides a default rule for epistemic agents that, in theory, could work to support them to correct biases in credibility judgments. It encourages clinicians away from the negative-identity prejudicial stereotype in question: that people in compulsory treatment lack the capacity to make treatment decisions.

Unfortunately for our purposes, Section 70 contains a third subsection, which states "despite subsection (2), a person does not have to seek the informed consent of another person to treatment or medical treatment if the person forms the opinion that the other person does not have the capacity to give informed consent at the time that the informed consent would otherwise be sought" *(Mental Health Act 2014*, (Vic)). So, clinicians are

supposed to at least act as if they believe that an experient has the capacity to consent, unless they have some reason – have formed the opinion – that the experient cannot. The law does not specify how the person who would otherwise seek consent ought to form that opinion. We might expect that they do so on the basis of a formal and documented capacity assessment that adheres to the definition of informed consent provided in the *Act* – but what if they do not? What if, in forming an opinion about a person's capacity, clinicians are instead relying on stereotypes, and downgrading credibility without good reason?

Evidence suggests that this has been true in this jurisdiction in the past, despite the existence of the default rule. In 2018, the Victorian Supreme Court delivered a judgment in relation to compulsory ECT given to two consumers of Victorian mental health services, PBU and NJE. The consumers were seeking to appeal compulsory orders made by the Victorian Civil and Administrative Tribunal (VCAT). VCAT had upheld orders originally made by the Mental Health Tribunal (MHT). Justice Bell found that VCAT had misapplied the law in relation to whether these consumers had the capacity to decide if they wanted ECT, and in so doing had breached their human rights. The clinicians treating PBU and NJE, the MHT that heard their treating team's application for ECT, and the VCAT panellists all apparently believed that the consumers did not have the capacity to consent to treatment. Their justifications for this were later found by Justice Bell to be erroneous in law, and discriminatory towards people with 'mental disabilities'. He found that standards were applied to PBU and NJE that would not have been applied to 'ordinary patients' (*PBU & NJE v Mental Health Tribunal*, 2018). While we cannot know all the thought processes behind the decisions made by PBU and NJE's treating team and panellists, it is possible that (mis)perceptions about the capabilities of people who are subject to compulsory treatment, compared with 'ordinary patients', played a role in determining their view of these consumers' credibility and thus decision-making capacity.

The inclusion of the presumption of capacity in the *Mental Health Act* (Vic) did not spare PBU and NJE from testimonial injustice, and capacity tests were not carried out to the standard required by law.[7] Does this mean that default rules designed to promote testimonial justice will always be ineffective? I suggest, rather, that there is a problem with the application conditions of this particular rule. Because this rule has an exemption clause – that it is permissible to avoid consent seeking in certain circumstances – but people *may not be capable of fairly assessing whether the exemption applies*, then the default rule can become rather useless in practice. What this shows us is that not only do we need structural mechanisms in place to promote testimonial injustice, but that they must be carefully calibrated. Although mental health legislation varies across jurisdictions, in the Anglophone world at least, all mental health legislation allows for the assessment, detention, and treatment of people with 'mental illness' without their consent

[7] Further research in this area indicates that the Victorian MHT seldom considers decision-making capacity. Consumers who are taken to lack decision-making capacity by their treating professionals on the basis of testimonial injustice may therefore have no recourse at hearings designed to provide an independent opportunity for review of compulsory treatment. See Maylea and Ryan (2018).

in certain circumstances, and as such it is worth paying closer attention to consent-seeking and capacity assessment processes across them all.

When it comes to seeking consent and assessing capacity in compulsory treatment cases, we are struggling to get it right, not just because individuals who make up the mental healthcare system might be lacking the virtue of testimonial justice, but because the institutions that comprise this system are not testimonially just. They often do not consistently require that their members jointly commit to neutralising prejudice in credibility judgments – our example, the *Mental Health Act 2014* (Vic), gives people who are disinclined to practise the virtue of testimonial justice an 'out' by not providing the right institutional protections for our default rule. We need robust structures in place that are designed specifically to correct for cognitive biases and implemented correctly. Doing so will mean that even if we cannot eradicate stereotypes completely – even if individuals cannot be testimonially virtuous all the time, are still working on it, or don't intend to be at all – then we can at least mitigate their effects.

### iv. Proposals for Changing Institutional Structure

In the previous section, I discussed the potential application of Fricker's virtue-based approach to the problem of testimonial injustice in compulsory psychiatric treatment. I have argued, in line with Anderson (2012), that while we have good reasons to support this approach, it will not on its own be sufficient. While I agree that mental health professionals ought to cultivate the virtue of testimonial justice, this kind of personal development will be difficult to achieve without structural change. As the example of the *Mental Health Act 2014* (Vic) shows, legislation governing compulsory treatment does not always provide the structural support necessary for individuals to achieve this virtue, and in some cases can actively work against the endeavour.

I will now consider possibilities for structural change that are designed to both promote the virtue of testimonial justice and discourage testimonial injustice. In this section, I draw on a combination of philosophical work and empirical research to develop practical legislative and policy proposals specific to the context of compulsory psychiatric treatment, which could be used to address testimonial injustice in clinical practice. These proposals would be maximally effective if they were incorporated into mental health legislation. My reasons for claiming this are twofold; a) there is evidence to suggest that the establishment or amendment of laws influences moral-epistemic attitudes, and b) structures or principles designed to promote testimonial justice, were they enshrined in law, could potentially be assessed for compliance in ways that individual healthcare service policies might not, allowing greater opportunity for checks and balances.

There are of course ethical questions about legislating for beliefs or attitudes, even aside from empirical facts about whether this is possible. In the previous section, we saw that although the current *Mental Health Act 2014* (Vic) requires that clinicians 'presume capacity', their own judgment, whether based on clinical expertise or inaccurate assumptions, will usually win out. Despite this, Australia has in the past attempted to

use legislation to affect social attitudes with regard to people with 'mental illness'; the introduction of the *Mental Hygiene Act 1938* (Qld) saw a change from outdated terminology in the *Insanity Act 1884* (Qld), such as 'insane', 'lunatic', and 'unsound mind,' to the scientific language of health, referring instead to the 'mentally sick' on the basis that this would place mental illness "on the same plane in the minds of the people as physical illness, in order to make them realise that a mental illness may be treated successfully if attended to properly, like other forms of bodily illness" (Wilson, 2003, p. 75). Research conducted by the Australian Government's federal Department of Health (1997) into young Australians' knowledge, attitudes, and experience relating to mental health issues and services revealed that 87% of respondents agreed that 'mental illness can happen to anybody' and 74% disagreed that 'mental illness is a sign of weakness in a person'. Potentially indicating a belief that mental illness can be successfully treated, 67% disagreed that 'once you have a mental illness you have it for life'.

This certainly does not conclusively prove that mental health legislation changes are responsible for shifts in social attitudes towards experients. However, classically, the goal of legal regulation has been to change behaviours, and there are historical examples of the law achieving this aim both directly, through fear of sanctions or prospect of reward, and indirectly, by changing attitudes about the regulated behaviours. Here we might think of anti-smoking laws, which directly influence behaviour by preventing people from engaging in it in certain contexts. Such laws also indirectly influence behaviour via the formation of new social attitudes with regard to smoking. Laws banning smoking indoors require that smokers may have to wait to smoke, to leave social gatherings, or to go outside into bad weather, contributing to the attitude that smoking is burdensome or antisocial. Additionally, legal requirements around warnings on cigarette packaging informing people of the ways in which it harms them, and others around them, encourage people to think of smoking as dangerous and morally problematic, for example (Bilz & Nadler, 2014).

If we agree that testimonial injustice in the mental health sector is a problem, then we will want our institutions to mitigate its effects by preventing the operation of identity-prejudicial credibility assessments, and by promoting the virtue of testimonial justice. It is at least possible that further changes to mental health legislation could indirectly help to address our identity-prejudicial stereotypes about experients, and therefore mitigate the effects of testimonial injustice. While it is not practically possible to legislate that staff in the mental health system simply become more epistemically virtuous, if required by law to carry out actions such as consent-seeking and capacity testing, clinicians may come to view this as important to their work, or at the very least, be prevented from behaving in unjust ways lest they suffer reproach or sanctions.

With this in mind, I now turn to three proposals: a) that decisions to place a person in compulsory treatment be made by more than one person, with appropriate expertise, *at the outset,* b) that all people placed in compulsory treatment be assigned an independent advocate and lawyer, on an opt-out basis, and c) that there be provision for legally binding 'advance directives' in mental health legislation.

As we have seen, there are two main points at which testimonial injustice in compulsory treatment is most likely to occur: when a clinician or MHT (or similar body) is deliberating about whether to place someone in compulsory treatment, as in the case of the former nun, and when the person is already on an Order of some kind and deliberations are being made about whether or not to provide treatments/procedures without consent, as in the case of PBU and NJE. For our purposes, these are the two moments at which it is crucial that people be afforded due credibility, for they are the moments at which liberty and autonomy hang in the balance.

The distinction between these points can blur – a person's medical or psychiatric history, including past instances of compulosry treatment, is, as we have seen, formally recorded – in medical records and legal reports like those provided to the Tribunal. This history follows a person for life and can continue to be used as evidence against a person's reliability or credibility in further deliberations about compulsory treatment. According to Scrutton (2017):

> Mental health diagnoses are particularly 'sticky': a past diagnosis can result in a confirmation bias that leads to ongoing testimonial and other forms of epistemic injustice. Richard Bentall reports the case of Andrew, whose past diagnosis made Andrew's upset behaviour at his grandmother's funeral immediately pathologizable. Bentall reports that, in the absence of any irrational behaviour or a report by Andrew of pathological experiences, his detainment in a psychiatric ward was justified on account of his being 'excessively polite', and his decision to wear a suit interpreted as evidence that he was 'grandiose'. (p. 349)

Relatedly, testimonial injustice in the compulsory treatment case can be self-validating. An initial testimonial injustice, resulting in someone being placed in compulsory treatment, will reinforce itself. For example, once a person is in compulsory treatment on an inpatient psychiatric unit, the testimony they give, which might otherwise have cast doubt on the need for compulsory treatment, can be downgraded or potentially ignored. Complaints, repudiations, or concerns about the treatment or detention on the part of the person experiencing it are taken to be symptoms of their 'disorder', and therefore further proof that they require compulsory treatment for a 'mental illness' into which they have no 'insight' (broadly, recognition of one's illness). A person who loudly protests that they have done nothing wrong, that they have no illness, that they shouldn't be locked up, who attempts to 'abscond', or who defends themselves physically from forced treatment they do not need (even if this is *true*, as with Andrew and the former nun) will not be seen by staff as responding reasonably to being held and drugged against their will, but as 'aggressive' or 'heightened'. In the words of one self-identified psychiatric survivor, "… it's alright if you're not mentally ill and you're angry and express anger. But if you've had a psych disability or whatever, if you become angry and express it, then that's seen in a totally different context." (Wadsworth, 1997, p. 2)

The problems of 'sticky' diagnoses and self-validation are not easily overcome. Clinicians of all specialities are trained to examine medical histories, often for good reason, to

identify future risk factors, but because psychiatric histories are so heavily reliant on soft diagnosis (observation and experient reports, rather than 'hard' evidence like biopsies and blood tests), this can go awry where testimonial injustice is present. To account for this, it is worth considering proposals that better support group moral deliberation from the initial stages of compulsory treatment. If only one person makes an assessment on compulsory treatment there is potential for testimonial injustice to occur, and, if a person is detained or treated as a result of an undue credibility deficit, for them to experience secondary injustices such as the violation of their rights to liberty and autonomy for a significant period of time.

To return to our case legislation – as it currently stands in Victoria, a person can be detained based on a minimum of two assessments, each conducted by one person only, for possibly as long as 32 days. An Assessment Order (AO; 24-72 hours) can be made by any medical/mental health practitioner and allows for a consultant psychiatrist to 'examine' the person to determine whether they require further compulsory treatment in the form of a Temporary Treatment Order (TTO; up to 28 days). If the consultant feels the person requires treatment beyond this, they can apply to the MHT for a Treatment Order (TO), which can last anywhere up to six months in the inpatient setting, and a year in the community. While this varies in practice, it is still legally permissible that, for up to a month, a person can be involuntarily treated or detained without the automatic ability to state their case to an independent body consisting of more than one decision maker.

The exception to this is if a person directly contacts the MHT to request a hearing to contest their order, or formally requests a second opinion, but research indicates that people are not always aware of these options, despite provision for them in the *Act.* The Victorian Mental Health Complaints Commissioner, the independent body set up under the *Mental Health Act 2014* (Vic) to safeguard rights and resolve complaints about public mental health services, found that 32% of in-scope complaints made in 2018-19 were around communication, more specifically, "a statement of rights or information about the Mental Health Tribunal appeal process not being provided..." (Mental Health Complaints Commissioner, 2019, p. 20)

Further to this, treating teams are required to submit a report to the MHT outlining their evidence for recommending further compulsory treatment, which of course relies on their assessment, but could prove problematic if it replicates inaccurate information as a result of an initial testimonial injustice. Tribunal members are bound by the rules of Procedural Fairness, which means that they must make decisions impartially and free from actual or apprehended bias. Despite this, Tribunal members are human, and not infallible when it comes to testimonial injustice. The MHT most often grants in favour of treating teams. Their Annual Report 2017-18 reveals that since 2016, only 6% of TTOs brought before the members each year have been revoked at 28 day hearings (Mental Health Tribunal, 2018). The majority of people who attend these hearings remain in compulsory treatment following them, meaning the treating psychiatrist's decision is being upheld 94% of the time, which does not bode well for people who were placed on TTOs as a result of epistemic injustice in the first instance.

The bias test used by the Victorian MHT, as in most Australian administrative law, asks "would a fair-minded lay observer reasonably apprehend (in the sense that there is a real and not remote possibility) that a member might not bring an impartial mind to the hearing?" (Mental Health Tribunal, n.d, p.3). As we have seen, identity-prejudicial stereotypes regarding mental health and illness are pernicious and deeply entrenched, and 'impartial' doesn't necessarily translate to the average (however fair-minded) layperson as 'committed to neutralising prejudice in credibility judgments' or possession of 'reflexive critical openness'. In theory, to be truly impartial might rightly equate to the same thing, but in practice, it usually relates to whether the Tribunal member has a pre-existing relationship with the experient, or to some aspect of their conduct (for example, if they have openly made disparaging remarks about the experient). Ruling out these instances still would not preclude the possibility of testimonial injustice.

What could a better system look like? Recent work by Tollefsen and Lucibella (2019) suggests that groups sometimes possess better expertise to make moral judgments than individuals, "because of a group's ability to take up and adjudicate between multiple diverse viewpoints" (p. 448). They ask us to consider the case of medical ethics committees, which provide guidance and often, determinations, to clinicians facing moral dilemmas. This, they suggest, is a clear case of a group offering moral testimony, and that, while it would be possible for one person to fill this role, a group, provided it allows for open dialogue and exchange, is better placed to do so. The authors draw on Longino's work on scientific inquiry to show that objective practices rely on the possibility of criticism from different points of view. The more differing points of view there are in an epistemic community, the more likely it is that their epistemic practice will be objective. While Longino's work concerns scientific inquiry, the authors hold that this is applicable to group moral testimony as well (Tollefsen & Lucibella, 2019).

Compulsory psychiatric treatment is a serious ethical matter, and testimonial injustice is just one way in which decisions around its use may be affected. However, greater objectivity will help to correct for testimonial injustice in credibility judgements and to reach unbiased decisions, thereby limiting occasions wherein people are involuntarily treated as a result of identity-prejudicial stereotyping. In a departure from the current constitution of, for example, the Victorian MHT, it will be important that the panel or committee making these decisions be made up of people with diverse viewpoints on mental health care. In Part II, I expand on the variation between hermeneutical resources employed by clinicians compared to those used by experients, but for the time being will suggest that this panel should include people with non-clinical perspectives, including people who have experienced psychiatric treatment themselves, especially compulsory treatment, as well as people with a demonstrated understanding of mental health law and international human rights law.

I further propose that the MHT determination be introduced earlier than 28 days, such that the consultant psychiatrist would need to apply for a TTO, rather than make this order themselves. This could of course prove logistically burdensome, particularly when compared with the current system in Victoria. I cannot do justice to every consideration here, but acknowledge that finding the staff and resources to implement a Tribunal

system with faster 'turnaround' will not be simple. When the new *Mental Health Act* (Vic) was proposed in 2014, it was heralded as a 'human rights standout', and it was remarked upon that 28 days is the shortest statutory period in the country (Cannold, 2014). Nevertheless, a commitment to mitigating testimonial injustice and its harmful effects, such as unwarranted detention, would require that the decision to treat someone compulsorily be made by an appropriately constituted group of people, and occur at an earlier stage than current MHT hearings, to avoid the problem of self-validation.

A second proposal for structural reform designed to encourage testimonial justice in cases of compulsory treatment is the provision of advocacy services and legal representation for experients in compulsory treatment. In Victoria, people in compulsory treatment have a legal right to access advocacy and to have representation at Tribunal hearings, but information about how to access this is not always provided to those who could stand to benefit from it, nor are services readily available due to funding constraints. If there were provision in law for every consumer to have an advocate, the Department of Health would be required to fund programs like the Independent Mental Health Advocacy (IMHA) service to meet demand.

People are more likely to report favourable outcomes at tribunal hearings if they have legal representation, (Victoria Legal Aid, 2016) and an independent evaluation of Victoria's IMHA service conducted by RMIT University in 2018 reported that "[a]ll participant groups who had encountered and interacted with IMHA gave overwhelmingly positive feedback to the evaluation team. Consumers gave the most praise of IMHA, with more than one person telling the evaluation team that 'IMHA saved my life'" (Maylea et al., 2019, p. 15). Just as having legal representation at Tribunal hearings results in preferred outcomes for consumers, the IMHA evaluation found that having an advocate helped to ensure that consumers were involved in decisions around their treatment, and supported consumers to feel *listened to.* The evaluation consistently identified that mental health services in Victoria are not operating in compliance with the *Act*, and IMHA has proven to be "extremely effective at assisting them to do so" (Maylea et al., 2019, p. 38).

Analysing these results within an epistemic injustice framework, it seems that lawyers and independent advocates are not always subject to the same identity-prejudicial stereotypes that would result in credibility deficits (although they could face other barriers to communication e.g. lack of access to 'medical jargon'). A further study conducted by Newbigging and Ridley (2018) revealed that "[t]he presence of an advocate served to legitimise the participant's voice and their presence altered the communicative exchange so that health professionals were more respectful and listened more keenly, increasing the likelihood that service users' views, preferences, and choices would be heard" (p. 44).

Finally, given the prevalence of the identity-prejudicial stereotypes regarding the capacity of people in compulsory treatment to make decisions about said treatment, we might consider structural changes that allow for people to document their treatment preferences in advance of an Order being made. The Victorian *Act* allows for this in a limited sense –

there is a provision for consumers to make an 'Advance Statement'. If someone is in compulsory treatment, the treating psychiatrist must, under the *Act,* have regard to a person's Advance Statement, but can ultimately overrule the person's preferences if they believe they are not clinically appropriate. An Advance Statement in Victorian law is not legally binding, as per Section 73 of the *Mental Health Act 2014* (Vic).

In contrast, the Australian Capital Territory's *Mental Health Act 2015* allows consumers to produce and 'Advance Consent Direction', stipulating their treatment preferences and what they consent or do not consent to. The person must be assessed as having decision-making capacity to do this and must have spoken with their treatment team about their options, which is different to Victoria, where a person need only 'understand what an advance statement is and the consequences of making an advance statement'. Perhaps because of this difference, Advance Consent Directions have greater legal force than Advance Statements, and do not allow treatment preferences to be overridden except in very limited circumstances, and then only with the approval of ACAT, the equivalent of VCAT in Victoria (*Mental Health Act 2015* (ACT), s. 27-31).

While it is more onerous to produce an Advance Consent Direction than an Advance Statement, it offers far greater protection to the consumer that their treatment preferences will be followed, even when they are determined to lack capacity at the time the treatment is administered. Legally binding advance directives, made when someone has capacity, ought to be considered as a strategy as they could reduce the possibility that identity-prejudicial stereotypes are at work. Even if a clinician cannot engage with the consumer in a testimonially just exchange at the point in time at which treatment decisions are being made, the secondary effects of testimonial injustice, a violation of the person's autonomy, will be avoided if the clinician is bound to honour their choices regardless of their personal views. Obviously, this structural approach does not address the epistemic harm done to the person if they are deemed to lack capacity when they in fact do not, but it could protect them from the resulting practical harm of being treated against their will.

I have here argued that testimonial injustice exists against people who experience or are taken to experience M/MI, and that this injustice is particularly rife in cases of compulsory treatment. One way we might address this is to encourage clinicians who enforce compulsory mental health treatment to cultivate the virtue of testimonial justice. However, this may prove difficult as the medico-legal institutions to which clinicians belong are not always designed to promote this. This issue will require structural solutions, in the form of changes to mental health legislation. Enacting change of this kind can be difficult to achieve if people are not already invested in combatting testimonial or epistemic injustice more broadly. I now turn to a discussion of hermeneutical injustice, in order to explore further possibilities for the creation of new moral-epistemic frameworks that might allow us to consider the impacts of mental health legislation, and indeed 'mental illness' itself, in a different light.

# Part II: Hermeneutical Injustice

## i. Hermeneutical Injustice and Mental Health

In the previous section, we looked at testimonial injustice against people who experience M/MI, noting that experients can struggle to have their testimony taken seriously, even when they truthfully report their concerns and needs. In this section, we will explore further the reasons whereby experients are often presumed to lack credibility or appear irrational to treatment providers; namely they may be using a different set of hermeneutical resources to communicate their experiences.

On Fricker's definition, a hermeneutical injustice takes place when a person has some significant aspect of their social experience obscured, due to flaws in shared resources for social interpretation. The example she gives is of a woman called Carmita Wood, who left her employment at a US university in the 1970s due to sexual harassment from a senior male colleague. However, this occurred prior to the existence of the term 'sexual harassment', and certainly prior to its inclusion in law and workplace policies designed to protect victims. Because Wood could not identify the exact reason for leaving her job on a claim form, she was denied unemployment benefits. Society lacked the concept of sexual harassment, and so Wood had no recourse to render her experience – of discomfort, fear, and embarrassment – intelligible to others. Wood was unable to make sense of her experience, and therefore suffered an epistemic harm, which led to the secondary harm posed by her inability to access support payments. The hermeneutical 'lacuna', or gap, resulted in an asymmetrical disadvantage for Wood, compared with her male employer, who did not suffer the same epistemic harms, or resulting practical harms, that she did. Hermeneutical injustice occurs in climates of hermeneutical marginalisation – wherein certain kinds of people are excluded from the process of developing shared social meanings (Fricker, 2007). In the workplace in 1970s America, women were hermeneutically marginalised in this sense – relatively new to the workforce, outnumbered, and without representation in key areas like law and industrial relations, they did not play an equal role in the development of social meanings with respect to appropriate workplace behaviour, for example.

As a result of unequal relations in society, the shared meanings we rely on to understand experiences often tend to reflect the lives of dominantly situated knowers – those who hold material, social, or 'identity power'. Members of social groups who are most affected by gaps in understanding may be unable to participate equally in the project of developing social meanings. According to Fricker (2007):

> This sort of marginalization can mean that our collective forms of understanding are rendered structurally prejudicial in respect of content and/or style: the social experiences of members of hermeneutically marginalised groups are left inadequately conceptualized and so ill-understood, perhaps even by the subjects themselves; and/or attempts at communication made by such groups, where they do not have an adequate grip

> on the content of what they aim to convey, are not heard as rational owing to their expressive style being inadequately understood. (pp. 6–7)

Some experients struggle greatly as a result of these hermeneutical gaps. A relevant example drawn from Fricker (2007) concerns the diagnosis of postnatal depression. Prior to that concept's existence, women who experienced it were taken to be 'bad mothers' – to be experiencing personal failure. Postnatal depression was collectively misunderstood, and as a result, marginalised people – women – were at a disadvantage. She tells the story of Wendy Sandford, who, attending a workshop on women's medical and sexual issues in the late 1960s, had the following thoughts:

> In that one forty-five-minute period I realized that what I'd been blaming myself for, and what my husband had blamed me for, wasn't my personal deficiency. It was a combination of physiological things and a real societal thing, isolation. That realization was one of those moments that makes you a feminist forever. (p. 149)

Fricker describes Sandford's revelation as a "moment in which some kind of epistemic injustice is overcome," (Fricker, 2007, p. 149) in that Sandford could now understand and communicate a significant aspect of her social experience. Some experients may lack the ability to make sense of their circumstances, particularly if access to dominant hermeneutical resources, such as medical knowledge, are unavailable to them. It would be a mistake to suggest that the epistemic tools of dominantly situated knowers are never useful for rendering some experiences intelligible to experients and to those around them, like Wendy Sandford. For some, medical diagnoses are very helpful to 'recovery' (broadly, a sense of hope, healing, or empowerment). As one person states, "[w]e make the future, but it's like you can't see beyond it. You can't see to tomorrow. It's horrible for someone with depression. I didn't know I was depressed. I never understood it. Now I can see it, I can actually recognise it" (Wayland, Smith-Merry, Kokany, & Hancock, 2017, p. 4).

In their discussion of sanism and psychocentrism, LeBlanc and Kinsella (2016) argue that it is not just the experience of M/MI itself that can be difficult to convey, but indeed the experience of the injustices to which experients are subject: "… [f]or Mad persons there may well be an extant hermeneutical lacuna hindering the articulation of the experience of sanist aggressions, both systemic and in the form of microaggressions" (p. 70). Experients have, for many years, been voicing their experiences of injustice and oppression. However, the concept of *sanism* as an issue of social justice, that is, prejudice directed toward people with psychiatric diagnosis, is still gaining ground, especially relative to public awareness of racism or sexism, for example. Consequently, "the large majority of Mad persons still lack adequate hermeneutic resources for describing the prejudice and discrimination against them" (LeBlanc & Kinsella, 2016, p. 70).

Thus, unequal hermeneutical participation – the inability to contribute to shared meanings – can leave some marginalised knowers unable to convey their experiences and further, unable to convey the impact that has. However, experients are not always given the opportunity to share their perspective even when they are able to comprehend their

own experience or to recognise that the existing, dominant epistemic resources do not reflect it. Hermeneutical injustice, on Fricker's account, is not carried out by individual actors; there is no 'perpetrator'. In Wendy Sandford's case, for example, there was no one person preventing her from making sense of her experiences – rather, the injustice she suffered was a result of a gap in collective hermeneutical resources. Postpartum depression was "previously ill-understood by the subject herself, because collectively ill-understood" (Fricker, 2007, p. 149). Philosophers building on Fricker's work have posited further forms of hermeneutical injustice that are not purely structural, that is, instances in which hermeneutical injustice is perpetrated where it is clear that an individual or individuals are culpable in some way.

Gaile Pohlhaus Jr., for example, has claimed that, while it is often in the best interests of marginally situated knowers to familiarise themselves with and use the dominant set of epistemic resources, so as to best make themselves understood, "it is of no immediate use to those in dominant positions to acquire and use epistemic resources that make sense of experiences that are salient to those marginally situated" (Pohlhaus, 2012, p. 719). Mental health professionals are not usually expected to use the epistemic resources developed by experients, in fact, they are usually expected *not* to. This is detrimental, as other approaches may provide a fuller interpretation and be more therapeutic for the experient. As Scrutton (2017) has pointed out, experients may be epistemically privileged, and have unique insight into what will be helpful for them. They may also take positive value from certain phenomena, such as voice hearing, but this will often be overlooked by professionals whose reliance on a certain set of epistemic resources lead them to interpret 'hearing voices' as inherently negative, a sign of a 'disordered' mind, or a problem to be resolved.

So far, we have looked at epistemic resources that take the form of concepts. There are of course different philosophical views on the ontological status of concepts, but they are generally thought to be, in a sense, the building blocks of thoughts. Socially shared concepts are an example of a hermeneutical resource – they allow people to render their experiences intelligible and articulate them to others. Carmita Wood, for example, was able to do this once feminist consciousness-raising resulted in the development of the concept of 'sexual harassment', the shared meaning of which we now take to be something like 'unwanted sexual advances or unwelcome sexual behaviour.' Concepts are not the only kind of hermeneutical resource, however. Camp (2019), for example, has outlined what she terms 'characterizations'. Characterizations are "a set of intuitive beliefs about an individual or a kind, which need not be extension-determining, or constitutive of conceptual competence, or even reflectively endorsed, but which are easily evoked…" (p. 19). In contrast to concepts, characterizations are "informationally, experientially, and affectively rich" (Camp, 2019, p. 20). A characterization is a kind of frame, which applies a collection of properties to some subject. Characterizations are also unlike stereotypes, in that they aren't always communally shared – in Camp's words, "my characterization of a romantic afternoon excursion may not match yours (or sadly, anyone else's), and I may have a characterization of something the rest of the community simply doesn't notice, such as my route to work" (Camp, 2015, p. 604). Further, characterizations do not merely consist of a collection of attributed features, but "*structure* those properties in a complex

pattern with powerful cognitive effects" (Camp, 2015, p. 605). Some features of the characterization will be more prominent than others, and some will be more central, that is, explain more of the characterization's other features.

While classic examples of hermeneutical injustice, like Carmita Wood's, are addressed by filling a hermeneutical lacuna with a new concept, hermeneutical injustice can involve more than just the absence of a concept. A hermeneutical injustice can also be constituted by impoverished characterizations – that is, characterizations that do not account for marginalised knowers' framing of a given subject or make salient the features most relevant to them. We can see this more clearly by returning to the point about experients who find value in voice hearing. A study into the experience of voice hearing revealed that

> [m]ost participants felt that their voice-hearing experiences were meaningful and therefore sought alternative understandings (often spiritual) to an illness-based medical view. Those who had received a diagnosis of mental illness tended to view their voices as more than just 'a bunch of symptoms that need fixing' … This often conflicted with the medical approach they were offered." (Jackson, Hayward, & Cooke, 2011, p. 491)

What is happening here is not a conceptual deficit. We interpret our world using not just concepts, but also frames and associative links. The concept of voice hearing is shared by both experients and their clinicians, and it picks out the same phenomenon (roughly 'hearing voices that others can't hear') but its associations and features are not shared. Experients are employing a different characterization of voice hearing to the clinicians diagnosing them, one that frames voice hearing differently and associates it with, for example, spiritual flourishing and meaning, rather than illness, disorder, abnormality, or risk. Hermeneutical justice for the experients in this instance would be achieved by *reframing the concept of voice hearing*, thereby changing its associations, rather than inventing a new concept to replace it or filling an existing hermeneutical gap.

To reframe in this way would involve a willingness to understand the associations employed by experients in their characterizations. The reluctance on the part of dominant knowers to use marginalised epistemic resources is what Pohlhaus Jr. refers to as *willful hermeneutical ignorance*. She argues that a dominantly situated knower's "continued engagement in the world while refusing to learn to use epistemic resources developed from marginalised suitedness" (Pohlhaus, 2012, p. 722) also constitutes a kind of injustice, and that individuals can be held to account on this score. As Crichton et al. (2017) and Scrutton (2017) have highlighted, in the Global North in the 21st century, the practice of psychiatry rests largely on a medical framework, which leaves little room for differing perspectives. The dominant set of epistemic resources concerning our understanding of M/MI are medical, and the ability to interpret experiences correctly in this context is assumed to lie with clinical experts such as psychiatrists, not with experients themselves. As Scrutton (2017) states, "medical diagnosis effectively constitutes a monopoly on the way the experience is interpreted" (p. 349). This epistemic framework is not always the one on which experients rely or with which they are comfortable. During the Royal Commission into Victoria's Mental Health System, Victoria Legal Aid developed a report

entitled *Your Story, Your Say,* to assist people who use the mental health system to share their perspectives. One participant described their experience of attempting to defend their own, non-medical framework:

> Now that I'm off the medication, I'm more in tune with my reality. I've had to fight for my own reality though, because services and medication tried to take it away from me. Being closer to my reality, I can make the right choices about what I want to do and who I want to be around. The doctors and psychiatrists never understood me in there. They only know one thing: antipsychotics. They can only see and understand what their university told them. They don't know what it's like to have been on drugs or been on the streets. Instead of listening to me, they just say I'm paranoid. They aren't interested in listening to me, to what the voices are saying, or what I care about. (Victoria Legal Aid, 2020, p. 29)

Another participant talked about their experience of being forced to adapt to the needs of their health service provider: "[m]ental health services have never been helpful to me. They never ask me what I want or need. I am bent out of shape to fit what they need. Sometimes they're so focused on what they want and need, it's like the train is so busy trying to be on schedule that it's leaving all of the passengers behind" (Victoria Legal Aid, p. 19). As with testimonial injustice, the experience of hermeneutical injustice can lead to secondary, practical harms. These experients identify as being left without adequate support, because their understanding of their experiences does not correspond to those of mental health services, made up of dominantly situated knowers. We can easily imagine cases wherein people who protest they do not have a 'mental illness', because it is not the way in which they characterise their experience, are compulsorily treated with medication to which they do not consent, even where they identify other supports that would be more helpful to them.

The pathologisation of mental and emotional distress, or the use of a medical framework to interpret changes in mood, perception, memory, or thought patterns, is now almost ubiquitous in Australia, the Anglophone world, and many jurisdictions in the Global North with mental health legislation. Although to be 'mentally ill' still carries significant stigma, it is the primary lens through which experiences like Wendy Sandford's and Louise Pembroke's are now conceived, whether they appreciate it as Sandford did, or find it harmful, as did Pembroke and the *Your Story* participants above.

The use of a medical paradigm has been criticised, perhaps most often by experients who identify as survivors of psychiatric abuse or compulsory treatment, but also quite vocally by clinicians aligned with various 'anti-psychiatry' movements, probably most notably by Szasz (1974), who argued that what psychiatry refers to as mental illnesses are in fact "problems in living" (p. 25). While alternative understandings of these experiences exist, psychiatry as a discipline and society more broadly for the most part do not seem to have adopted the epistemic tools developed and used by marginalised knowers. Further, dominantly situated knowers who uphold a medical framework often wilfully fail to employ the epistemic resources developed by marginalised knowers and can actively work

against the inclusion of those resources to shared social meanings, excluding consumers from the process of developing epistemic resources.

Dotson (2012), building on the work of both Fricker and Pohlhaus Jr., refers to this as *contributory injustice,* "the circumstance where an epistemic agent's willful hermeneutical ignorance in maintaining and utilizing structurally prejudiced hermeneutical resources thwarts a knower's ability to contribute to shared epistemic resources within a given epistemic community by compromising her epistemic agency" (p. 32). Miller Tate (2019) has discussed the phenomenon of contributory injustice in psychiatry in relation to voice-hearing specifically, contrasting the clinical approach to voice-hearing (or 'auditory hallucinations') with that of the Hearing Voices Network (HVN). Compared to clinical psychiatry, HVN has a user-led stance in which "voice hearers are considered to be experts by experience, attendance is informal and not time-limited, and in which all perspectives are respected as valid and there is no expectation to conform with any particular explanatory framework (e.g., psychological, biomedical, spiritual, paranormal)" (Longden, Read, & Dillon, 2018, p. 184). Within HVN support groups, cessation of voices is not the end goal, rather, HVN provides a space for those who hear voices to accept and share their experience, and develop constructive relationships with their voices. Miller Tate demonstrates that there are alternative hermeneutical resources for conceptualising what is known as psychosis under the medical framework, and that clinicians who dismiss these perspectives are committing contributory injustice.

Miller Tate contends that "the requirements of contributory justice in Psychiatry are that clinicians are *familiar with* and *take seriously* the many different interpretive frameworks through which service users make sense of their experiences" (Miller Tate, 2019, p. 99). While I agree wholeheartedly, as with the cultivation of the virtue of testimonial justice, there are structural impediments to creating this kind of openness among clinicians. Mental health services have a heavily vested interest in the promotion of the medical framework. It is widely encompassing, and underpins law, research funding, and employment opportunities in the field. The medical framework is so deeply entrenched that there is existing terminology, developed by dominant knowers, to describe people who exhibit behaviours consistent with the medical framework but who reject its explanatory power. Experients who are taken to have mental illness but who resist the labels offered by this framework are deemed to lack 'insight'. In clinical psychiatry, insight generally refers to a person's ability to recognise that they have a mental disorder. David has proposed that in the context of psychosis, "insight has at least three dimensions: (a) awareness of illness, (b) the capacity to relabel psychotic experiences as abnormal, and (c) treatment compliance" (David, 1990, p. 805).

Australian consumer organisation, Our Consumer Place*,* have their own definition of insight. In 2013, they developed the *MadQuarry Dictionary* (a play on 'Macquarie' – the definitive dictionary of Australian English). The *MadQuarry Dictionary* is an epistemic resource, designed by consumers of mental health services to facilitate education for clinicians about the consumer perspective and to assist consumers navigating mental health services in a humorous way. How to demonstrate insight, according to service users? "**Insight** *noun* **1.** Agreeing with your doctor. **2.** What we know we have to

demonstrate in prescribed ways to get out [of hospital]" (Our Consumer Place, 2013, p. 14).

As things stand, many mental health professionals are "almost certainly ignorant of the alternative frameworks available (or their value)" (Miller Tate, 2019, p. 98), but they also have no strong motivations for learning. Epistemic injustice is a well-known concept among philosophers, and there is growing recognition among clinicians, but there is also relatively little impetus for health services to address these forms of injustice. Despite the inherent and secondary harms of epistemic injustice, clinicians, as dominantly situated knowers, do not face the same repercussions as experients, its victims. They do not experience the same violence or trauma that can result from coerced or forced treatments, for example, and it is not they who suffer the consequences if only inadequate or inappropriate supports can be provided by the system ostensibly designed to help.[8] Experients often find themselves in the position of having to 'agree with the doctor', and the doctor simply will not have as much on the line.

In Victoria, whose mental health legislation I explored in the previous section, a Royal Commission into the Mental Health System occurred recently. Four commissioners were appointed, with backgrounds in law, psychiatry, public policy, and economics, however no 'lived experience' or 'consumer' commissioner was named. The state government's press release claimed "[w]e don't have all the answers when it comes to mental health. That's why we're drawing on the experts who know the sector best and the Victorians who have lived experiences to help us find them," (Premier of Victoria, 2019) setting up an interesting dichotomy between 'experts' and people with lived experience, and failing to acknowledge that consumers of mental health services could in fact count as having expert knowledge. While consumers and their representational bodies were invited to give evidence, the CEO of VMIAC, the peak body for mental health consumers in Victoria commented: "It's really disappointing that we don't have a consumer commissioner…[t]he people who've survived the mental health system have the most important expertise for this royal commission, but they're not there" (Carey, 2019). In spite of a major bid to reform Victoria's mental health system, consumer leadership and participation has not been a priority; experients continue to be shut out.

### ii. Mad Pride: Liberation Movements as a Means of Overcoming Epistemic Injustices

Having identified these further kinds of epistemic injustice present in the mental health setting, let us turn to approaches we might take to address them. In the first instance, I explore how it is that marginalised communities can come to develop resources for understanding their experiences – how they fill the hermeneutical lacunae resulting from their unequal participation in the project of developing shared social meanings. Further, I seek to understand the mechanism of willful hermeneutical ignorance in this context,

[8] For an exploration of some of the harms faced by mental health and community workers employed within inadequate and unjust systems, see Reynolds (2011).

and ask how, for example, we get to a point where an intensive, state-wide investigation into the failings of the mental health system does more than pay lip service to the existence of such resources.

To that end, in this section I explore the history and aims of the Mad Pride movement, a civil and human rights movement advocating for the full social inclusion of Mad people, including their right to self-define their experiences. According to Rashed (2019), "[c]entral to Mad Pride discourse is a reversal of the customary understanding of madness as illness in favor of the view that madness can be grounds for identity and culture" (p. 19). Mad Pride can thus be characterised as a liberation movement – a collective struggle for independence. Woomer (2018) contends that liberation movements can serve as "a means for generating and disseminating moral knowledge, and for cultivating agents who are receptive to this knowledge" (p. 454). She holds that liberation movements affect the epistemological frameworks of those within them because they provide an epistemic community that can be used not only to develop new tools, but to develop the moral imagination – to challenge people to think of what currently seems impossible.

This is what the Mad Pride movement aims to do for people living with diagnoses of, and the stigma of, 'mental illness'. Much mental health activism, Mad Pride and Mad positive activism in particular, seek to counteract discrimination by rejecting the language of 'mental illness', 'disease', and 'disorder' – a radical departure from the way things currently stand. Mad Pride views Madness as an identity, and argues that society should recognise the validity and worth of that identity. Mad activists picture a world in which options for support other than psychiatric treatment are widely available, and the dominant understanding of Madness as 'illness' or 'disorder' ceases to take precedence.

The concept of 'pride' in relation to mental health diagnoses officially came into use in the early 1990s in Toronto, Canada, where a protest was organised in response to local community prejudices towards people with a psychiatric history living in boarding houses in the suburb of Parkdale (Reaume, 2008). Called the Psychiatric Survivor Pride day, it was an event organised as part pride parade, part protest, but there were precursors. As we saw earlier, the modern consumer/survivor/ex-patient (hereafter c/s/x) movement is generally considered to have begun in the 1970s in the wake of other civil rights movements that emerged at that time, sometimes encompassing ideas developed by 'antipsychiatry' intellectuals in the 1960s.

C/s/x movements have helped to bring about significant breakthroughs for people living with mental health diagnoses and using mental health services, and played a large role in reforms made to psychiatric practice in the past half-century: the introduction of safeguarding legislation for people who are involuntarily detained or treated, consciousness raising and the modelling of alternatives to psychiatry, the idea of recovery-oriented care designed to centre consumers' needs, the inclusion of consumer and carer advisory groups in mental health services, and peer support networks and peer or other mental health advocacy, for example.

There are therefore good reasons to believe that Woomer's hypothesis is correct. C/s/x movements like Mad Pride, and the preceding activism out of which it grew, have helped experients of M/MI to form new epistemic resources to describe their experiences, to decide for themselves how to best understand them, what strategies to use to cope or navigate during these experiences, whether or not to embrace these experiences as part of their identity, and how other people ought to relate to them should they choose to do so. To quote one Mad Pride activist:

> Madness is an aspect of my identity – who I am and how I experience the world – not an "illness" that is separate from me or a collection of "symptoms" I want cured … Canadian health care institutions are currently pushing for the public to think about Mad people as individuals with "illness" (have you noticed all the mental health awareness campaigns?) This fails to recognise us an equity-seeking group. We are a people who form communities and create cultures based on our unique ways of thinking, knowing, relating, organising, and living. We promote alternatives to medical ideas about madness. (Rashed, 2019, p. 20)

Clearly, then, the Mad Pride movement and its precursors have been helpful for generating alternative hermeneutical resources, for example, characterizations of phenomena like 'voice hearing' that are non-medicalised. However, Woomer contends also that liberation movements can help us not just to develop, but to disseminate moral-epistemic knowledge. It is this dissemination that I am most concerned with here, because, despite the aforementioned advances, marginalised alternative understandings of M/MI have not received much uptake – at least, not enough to shake the foundations of medical psychiatry, and we must ask why this is.

One possible reason for the lack of uptake of marginalised knowers' hermeneutical resources is that, as we know, the community of experients is not homogenous. There is disagreement about how to characterise these phenomena not just in broader society, but within the group itself. Mad activism represents a subset of the community of experients, and c/s/x movements are broader than Mad activism. Mental health activism more broadly has focused on areas like involuntary or coercive treatment, lack of access to supports, paternalism and lack of involvement in treatment planning, and stigma, but not all who fight for better conditions for experients agree that their experiences define them in the same way Mad activists do.

C/s/x communities navigate this 'internal' dissent in various different ways. Almost certainly, there are some Mad activists who are steadfast in the view that people who choose to pathologise their experiences are simply mistaken, having been led astray by the pharmaceutical industry or browbeaten by practitioners of psychiatric medicine. Merinda Epstein describes some of these tensions in her memoir, where she recounts her years campaigning to embed lived experience and consumer expertise into the mental health workforce in Victoria: "[t]here are consumers today who strongly believe we have sold out to the forces that enslave us" (Epstein, 2013, p. 13).

One worry that experients who do not identify with Madness may have is that if the dominant hermeneutical resources for understanding phenomena currently described as mental disorder were to be replaced by alternative ones, people who benefit from medical interventions and identify with this framework will be left without the means to conceptualise and address these experiences in the way they currently find most helpful. Wendy Sanders' coming to understand her situation as postnatal depression, a medical issue that could be treated and presumably resolved in some way, rather than a personal failure as a mother, was no doubt very important to her. Some experients find that diagnostic labels resonate with them as the best way to characterise their experience. Some do not view their experiences as a facet of their identity, or as something in which to take pride, like author Clare Allan (2006), who has lived experience and opposes the central aim of the Mad Pride movement:

> Mad Pride clearly has its roots in Gay Pride, Black Pride, Women's Lib and other civil rights movements. But with one crucial difference, at least for me: mental illness is not an identity. Nor is it something I wish to celebrate … Mental illness is ruthless, indiscriminate and destructive. It is also an illness. It is certainly not a weakness, but nor is it a sign of a special "artistic" sensitivity … Mental illness is an illness, just as cancer is an illness; and people die from both.

In response to these concerns: I make no suggestion that the dominant hermeneutical resources be *replaced,* at least, not in their entirety. What I suggest, which in some ways is quite a modest proposal, is that the people who have these experiences be free to *determine for themselves* the most useful way of understanding them. This would not mean ruling out pharmacological or other medical interventions, just as it shouldn't rule out other options for support that are currently extremely difficult to access due to the supremacy of the medical framework. In Sidley's (2019) words, "[e]ach individual who is struggling with emotional pain and overwhelm is uniquely positioned to try to make sense of their difficulties and convey them to others in language that best captures the experience" (p. 124).

Mad activists reject the idea that their experiences constitute an illness or disorder, and the idea that others should have the right to pathologise or medicalise them. At the very heart of the Mad Pride movement is the idea of self-determination – their goal is for people who experience what they term Madness to be fully accepted, in order to be able to thrive as they are, with the supports they choose. Mad Pride does not advocate for the eradication of supports, but for their expansion, to include non-medical options for enhancing wellbeing. Such options, for example peer led crisis and respite services, Soteria houses, or Hearing Voices Networks, are often unavailable in mainstream mental health systems due to the dominance of more 'clinical' approaches.

Experients who identify with medical language or understandings of their life experiences may not feel that Mad Pride is relevant to them, and their stance ought to be respected. For these experients, Mad Pride simply offers new ways of thinking about one's experiences and new possibilities for working through them – it is not a threatening fist,

but an outstretched hand. While Mad activists are by and large more critical of psychiatric medications, procedures, and 'treatments' than the average person, and may advocate for more comprehensive pharmaceutical testing, research, or controls, there is little evidence to suggest that activists and allies aligned with the aims of Mad Pride want to eliminate access to options for support, or to pressure people into forgoing things they find helpful in coping with problems in living, mental distress, or emotional overwhelm. Mad activists may be more likely to suggest that people who currently use psychiatric medications might benefit from alternatives, but they should, in line with their aims, respect the autonomy of those who choose to use them. In fact, interviews with Mad activists from organisations such as MindFreedom International and the Icarus Project demonstrate they are not "anti-medication" (Robinson & Rodrigues, 2009) and in some cases use psychiatric medication themselves (Glaser, 2008).

The Mindful Occupation Collective (2019) describe a pluralist vision, in which experients have access to a broader range of hermeneutical resources for making sense of their experiences, as well as practical options for navigating them:

> **Radical mental health is about options**. Some may assume that radical mental health is simply "anti-psychiatry." However, most of us take far more complicated, diverse, and nuanced viewpoints. Radical mental health may mean accepting some of the things that mainstream, medicalized models suggest for our well-being, while discarding some of the things we may not find useful, helpful, or positive. In practice, this means supporting people's self-determination for personal, ongoing decision-making, including whether or not to take psychiatric drugs, and whether or not to use diagnostic categories. Importantly, this support is done with an acknowledgement that the pressure to make more medicalized choices is significant in our society, and as such that these carry considerably more influence then, and often shout over, alternatives. (p. 142)

Disagreement between experients, then, may not be the stumbling block it first appears on the path to hermeneutical justice. While marginalised knowers like Mad activists and other self-identified consumers, service users, and psychiatric survivors may hold what seem to be fairly radical views in contrast to the dominant framework, they are in general concerned with adding to, rather than ousting, existing epistemic resources.

### iii. A Pluralist Approach: An Epistemic Argument for the Elimination of Compulsory Psychiatric Treatment

Aside from the concerns of experients who identify with dominant hermeneutical resources provided by the psychiatric system, there are various objections to the aims of the Mad Pride movement. Some of these objections consider the practical feasibility of the

de-medicalisation and/or de-pathologisation[9] of M/MI, noting that a system of classification is necessary for identifying options for treatment or support, for example. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), widely recognised as one of the most popular psychiatric diagnostic guides, "[r]eliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates" (American Psychiatric Association, 2013, p. 5).

Classification, in the form of diagnostic labelling, is used not just to identify treatments and guide research, but to gain access to services that are otherwise gatekept. Many experients will be aware of the difficulties involved in accessing supports that alleviate their problems in living, like classroom or workplace accommodations, without a diagnosis, as these tend also to rely on the submission of medical documentation to the organisation in question. In this thesis, I am concerned primarily with the feasibility of disseminating marginalised knower's hermeneutical resources, and do not have the space to do justice to a full enquiry into the practical logistics of the de-medicalisation and/or de-pathologisation projects supported by the Mad Pride movement. However, to demonstrate the possibility of a pluralist system, Mad and other c/s/x activists and advocates point to isolated communities and services taking a more radical approach to M/MI, such as the Italian city of Trieste, revolutionised in the 1970s by the psychiatrist Franco Basaglia (Mezzina, 2014), the Leeds Survivor-Led Crisis Service (Venner, 2009), Soteria houses (Mosher, 1999), and the town of Geel in Belgium, the oldest 'community psychiatric service' in the world (van Bilsen, 2016). While not all of these alternatives to inpatient psychiatric care were developed by c/s/x thinkers, and while not all are involved with Mad Pride or the de-pathologisation project, they certainly represent a radical departure from the kinds of mental health treatment provided in mainstream systems dominated by medical psychiatry, choosing, for example, not to employ restrictive interventions such as compulsory detention, non-consensual medication, seclusion, or restraint.

Instead, what I intend to explore here is the objection to the expansion of the set of hermeneutical resources to include marginalised understandings of M/MI on the grounds that these resources are simply *wrong,* whereby wrong I mean something like, unsupported by the evidence, or empirically unfounded. Dominant knowers who oppose alternative, marginalised understandings sometimes claim that they do so specifically for *epistemic* reasons. The claim is generally along the lines that non-medical approaches to (what are taken to be) psychiatric problems are, for example, not well-researched, not scientific, not objective, or not 'evidence-based'. This is in contrast to medical psychiatry, which they argue is, and therefore should form the basis of collective understanding.

An assumption being made here is that marginalised understandings of M/MI purport to *represent how things are.* If this is the case, and they conflict with dominant

[9] Noting that medicalisation and pathologisation are connected, yet distinct, concepts. For more on this, see Sholl (2017).

understandings, then only one set of epistemic resources can be 'correct' in the sense of supporting inquiry that is (more) truth-conducive. This raises a problem for the pluralist view, which ought to be seriously considered. What if the way psychiatry understands these experiences is simply the most accurate way to do so? As we have seen, epistemic resources are used to acquire and transmit knowledge, and to be denied participation in developing shared resources for knowledge on the basis of identity prejudice is an inherent wrong. However, further harms can arise from this; Carmita Wood was harmed when she couldn't 'name' sexual harassment, not just epistemically, but because it meant she couldn't claim unemployment benefits and was left without a source of income on which to survive. Sometimes, knowledge acquisition and transmission are important not only so that we can understand the truth of things, but insofar as they are *useful* for material ends. I would suggest that frameworks, characterizations, or concepts that help people to pursue particular ends – for example, mental or emotional wellbeing – can be correct in the sense of 'useful', and that by this definition, more than one framework can be 'correct', whereby we mean something like: 'helps experients to understand and articulate their experiences, and find support to cope with them'. It is conceivable that someone might reject a diagnostic label but find that a 'psychiatric' medication is useful in controlling or managing some mental or emotional states for which they want support, or that someone might embrace a diagnosis but prefer not to use 'medical' interventions to treat it. An expansion of the set of epistemic resources relating to M/MI therefore need not necessarily conflict, but provide options for understanding and support not yet considered by dominant knowers.

In fact, it appears there is relatively little published psychiatric research that engages in good faith with alternative understandings of phenomena currently taken to be the result of 'mental illness'. One notable exception is Rashed's work in philosophy of psychiatry. Rashed (2019), both a psychiatrist and philosopher, provides a detailed and nuanced discussion of Mad activism and 'the demand for recognition', exploring key objections to Mad activism's aims, and attempting to reconcile skeptics and supporters. While research into consumer experiences is growing (often undertaken in allied health disciplines and co-produced with consumers), as is consumer research itself, psychiatry as a discipline rarely goes to the effort of defending the use of the overarching medical paradigm. Where psychiatry does engage with criticism, it is usually with the movement known as critical psychiatry. Critical psychiatry, like the anti-psychiatry movement before it, built around the ideas of Foucault, Laing, Szsasz, and other thinkers of their day, is a movement predominantly supported by clinicians, rather than consumers, and can be distinguished in that respect from grassroots c/s/x movements like Mad Pride (Moncrieff & Steingard, 2019).[10]

One potential reason for this is perhaps the assumption on the part of the psychiatric discipline that some of these criticisms are not worth engaging with. In a recent op-ed

[10] Of course, some clinicians are also experients, but generally speaking, have different situatedness. Working in the system, their views tend to reflect the dominant paradigm, not the standpoint of marginalised knowers oppressed by that system. For more on how mental health professionals view their own lived experience, including the 'us and them' divide, see King, Brophy, Fortune, and Byrne (2020).

about critical psychiatry, Stea, Black, and Pierre (2020) allow that psychiatry must be open to scientific critique, and to confronting its 'tarnished past', but want to rule out critiques made by experients:

> But beyond scientific critique, psychiatry has long been a target of criticism that has been moralistic and ideological as well … More recently, however, the anti-psychiatry movement has lost its way. It has transformed from a predominantly academic and political movement to one of consumer groups, akin to the anti-vaccine saga. In its current form, anti-psychiatry exists as a disorganized entity outside of mainstream medicine, largely propagated on social media and in non-peer-reviewed sources like newspaper opinion articles, books, and blogs that evade scientific dialogue and critique.

The authors of this piece, all clinicians, seem to imply that they do not view criticisms of psychiatry that are ideological or moral in nature, or that are made by experients, who are assumed not to be academics, as important to the development of the discipline. This seems a highly uncharitable view of c/s/x critiques of psychiatry. While the discipline of Mad Studies is perhaps still in its infancy compared with psychiatry, and while consumer-led research is typically less common than other kinds of psychiatric research, it is not necessarily because this research lacks rigour, or because the views of experients are commensurate with those of 'anti-vaxxers'. C/s/x thinkers may engage in research that does not follow the same norms as medical psychiatry, for example they may preference narrative inquiry or analysis or qualitative methods "because of the focus on peoples' stories" (Faulkner, 2017, p. 506). While this differs from some clinical approaches to research, it does not necessarily mean it is less valuable. Philosophical research is not conducted in the same way as research in the biomedical sciences; this does not make it wrong or less likely to get at the truth of some matters.

It is also the case that c/s/x research does not garner the same funding opportunities as other psychiatric research, possibly due in part to the predominance of the medical framework and the challenge that it presents to that authority. Thus it can appear that c/s/x inquiry is being conducted 'on the fringes', rather than within the academy, as opportunities to undertake research that challenges the status quo are rare.[11] Power in this instance functions to reassert itself; Geekie (2013), drawing on Foucault, claims in a discussion of alternative conceptions of 'schizophrenia' that "those with power act in such a way as to legitimize their own knowledge … while simultaneously discrediting other knowledges that may challenge their dominant knowledge" (p. 182). Faulkner (2017) provides an example of how dominant knowers cement their epistemic resources at the cost of marginalised understandings:

> Researchers seeking large-scale funding grants from the National Institute for Health Research have to 'play the game' and construct clinical trials with conventional medical outcome measures, even if they wish to explore such things as recovery and peer support, which are not clinical interventions. As a

[11] See, for example, the discussion of barriers in Russo (2012).

> result, the mental health discourse tends to be dominated by discussion and research on clinical treatments at the expense of social and psychological factors, strategies for living with mental distress and creative or spiritual issues of identity (p. 504).

These misperceptions about the nature of what might be termed moral or ideological critiques of psychiatry likely stem themselves from epistemic injustice. Because c/s/x researchers, by definition, must disclose lived experience of M/MI, they, unlike others undertaking research into psychiatry, then become subject to the identity-prejudicial stereotypes that engender epistemic injustice. They may face testimonial or contributory injustice, and their research may not receive the uptake it deserves due to wilful hermeneutical ignorance. As Wallcraft (2019) notes, "[m]ental health service users have traditionally been excluded from creating the knowledge that is used to treat us, and many of us have suffered from the misunderstanding of our needs by people who have been taught to see us as by definition incapable of rational thought" (p. 133). Stea et al. (2020), too, recognise a distinctly epistemic problem, although they take a different view:

> Like many debates today, seemingly irreconcilable differences in perspective about psychiatric treatment often boil down to disputes over epistemology and the evidential basis of knowledge or facts; in other words, differences in belief about how we come to acquire knowledge. While human beings tend to see subjective, lived experience as an irrefutable reality as well as a source of great meaning, psychiatrists -- perhaps more than anyone -- know that subjective perceptions are biased and often wrong. The scientific method is an antidote to that bias, with truth being determined by repeated, objective, and controlled observations and experiments…

The claim that the scientific method provides an antidote to bias and the implication that experients' explanatory frameworks are biased in ways that psychiatry is not are interesting, and I think, open for debate. Objectivity is a contested concept in philosophy of science. According to Longino (1990), objectivity is based on democratic discussion. On this view, the production of knowledge is a communal practice, which takes place through interactions of inquirers, both critical and cooperative. Longino argues that a scientific community of inquirers will be objective to the degree that they satisfy four criteria: "(1) there must be recognized avenues for the criticism of evidence, of methods, and of assumptions and reasoning; (2) there must exist shared standards that critics can invoke; (3) the community as a whole must be responsive to such criticism; (4) intellectual authority must be shared equally among qualified practitioners" (p. 76).

On this account, the discipline of psychiatry could be said to lack elements of objectivity. Namely, as we saw above, psychiatry lacks public venues for the criticism of knowledge claims, as c/s/x research has fewer options for funding and publication, and, in particular, psychiatry as whole does not always extend intellectual authority to these researchers. Worse still, they are often not taken to be members of the community of inquiry at all. Of course, on Longino's view, a given community of inquiry need only extend to people who have something to contribute and are qualified to do so. Do c/s/x researchers have a claim

to intellectual authority in this inquiry? Stea et al. (2020) suggest not, however they move from suggesting that lived experience should not be taken as the arbiter of inquiry to implying that it has no relevance, which does not follow. The relatively weak empiricist claim that experience is a pathway to knowledge would indicate that, minimally, people with a lived experience of M/MI and of using the psychiatric system possess intellectual authority within the community of inquiry into its development.

Tekin (2020) identifies first person reports of one of "three pillars of knowledge on mental disorders" (p. 89), the others being scientific and clinical work, and further that "[s]imply stated, their inclusion is necessary if we want to obtain a complete understanding of mental disorders" (p. 90). Taking things a step further, I hold that we cannot have the kind of democratic discussion advanced by Longino, or produce objective knowledge, without engagement with marginalised knowers' hermeneutical resources, and that, while compulsory treatment remains a reality, democratic discussion cannot be properly achieved. Cooperative interactions between inquirers are prevented when one party possesses power over the others. While marginalised knowers cannot be made to accept dominant epistemic resources as accurate, they face heavy penalties for not conforming to their use. Marginalised knowers can be, and are, forced to accept interventions that are supported by the dominant framework, not just by means of social sanctions, but by law. As we saw, when people using the mental health system (by choice or otherwise) object to 'illness' labels given to them, this is sometimes taken as further proof that they need treatment, which can then be given to them against their will.

To achieve hermeneutical justice for experients of M/MI, we need to allow for the development and dissemination of alternative hermeneutical resources through which people can understand and render their experiences knowable. The current dominant set of epistemic resources through which these experiences are understood is medical psychiatry, which is in many parts of the world, literally enforced by law – dominant knowers in this context possess institutional power that is difficult to confront, as the consequences of doing so can be severe. The use of compulsory treatment is a driving factor in the closing off of possibilities, including those that would promote justice, and can be criticised on that basis.

# Conclusion

The practice of compulsory psychiatric treatment rests on frameworks that pose significant risk of hermeneutical injustice towards experients. The pursuit of hermeneutical justice would be greatly served by its elimination. This will help prevent the obfuscation and marginalisation of experients' epistemic resources by allowing for their genuine engagement in the development of shared social meanings. For some, this will be quite a radical claim. For example, former Chief Psychiatrist for Victoria, Ruth Vine, since appointed Victoria's Deputy Chief Medical Officer for Mental Health, gave evidence at the Royal Commission to the effect that there will always be a need for compulsory psychiatric treatment, particularly for 'psychosis', stating "as the person considers the cause of their experience to be external, they will not seek, or will evade, treatment" (Vine, 2020).

Despite this, concerns about the efficacy of compulsory treatment (Kisely & Campbell, 2015), as well as the ability to adequately measure it success (Light, 2014), particularly in the community setting, have been raised by empirical research. Further, there are legal arguments for the elimination of compulsory treatment to be found in human rights theory (Maylea & Hirsch, 2017). I have proposed here that we also have a strong *epistemological* reason for so doing. Broadening the scope and availability of epistemic resources for understanding M/MI will benefit both experients, who may find alternative supports more useful than mainstream treatment, and the discipline of psychiatry, which will gain new insights by listening to the people it purports to serve. This will be difficult to achieve while practitioners, as dominant knowers, are able to enforce their preferred framework by legal means.

Compulsory treatment is perhaps one of the most complex ethical issues in medicine, certainly within psychiatry. This thesis does not present a full investigation into the ethical, legal, or empirical defences or criticism of compulsory treatment. Rather, I provide an argument that has so far not received the same consideration – that compulsory treatment hinders the pursuit of epistemic justice for experients of M/MI. The argument for elimination of compulsory treatment on the grounds of epistemic injustice is but one approach to the issue, and perhaps will be shown to be outweighed by competing factors. However, it is one which may help us gain a deeper understanding of the ethical considerations surrounding knowledge acquisition and transmission in formal legal and medical settings, and the structural approaches needed to address them.

I have argued in Part I that testimonial injustice affects experients of M/MI, in particular, those who are subject to compulsory treatment or at risk of it, in part due to the likelihood that their decision-making capacity will be assessed during this process in what is essentially a formal 'credibility judgment'. Because the clinicians who make these judgments are required to act in line with mental health legislation, which does not promote the virtue of testimonial justice, structural solutions will be necessary to help correct for identity prejudice clinicians may possess. The proposals I have made involve

changes to the current medico-legal framework, and may prove challenging to implement given current power imbalances.

Consequently, in Part II I explored some of the differences in hermeneutical resources used by experients, as marginalised knowers, and dominant knowers who hold material and social power over them. I investigated the ways in which hermeneutical injustices arise in the psychiatric context, and one proposal for addressing them in the form of a liberation movement that can both generate and disseminate new moral-epistemic resources. A key barrier to the success of c/s/x activism is the prevailing view amongst dominant knowers that the alternative epistemic resources these communities employ are, in contrast to medical psychiatry, scientifically invalid. I sought to demonstrate not only that these alternative epistemic resources are valid, but that psychiatry as a discipline will struggle to claim objectivity without engaging with them. I have tried to show that a pluralist vision, which allows for the retention of some dominant epistemic resources while also promoting alternatives, offers experients the best chance of epistemic justice and support for the challenges that M/MI can present. Finally, I have argued that this vision will remain out of reach while compulsory treatment remains a reality, because it provides a formal avenue through which dominant knowers can compel marginalised knowers to conform to interventions based on epistemic resources that do not fully capture their experience.

If the arguments put forward here are compelling, then then they ought to inform our future ethical thinking about compulsory treatment and the legal frameworks surrounding it. The Final Report of the Royal Commission was released on 4th March 2021. While it sets no goals for the elimination of compulsory treatment, it recommends that the government act immediately to ensure it is used only as a last resort (State of Victoria, 2021), an endeavour that is to be supported by the repeal of the current *Mental Health Act 2014* and enacting of a new 'Mental Health and Wellbeing Act'. In theory, this would provide at least one jurisdiction with the opportunity to seriously consider the impacts of epistemic injustice on experients' testimony and to engage with experients' epistemic resources. To do so would be a further step on the journey toward a pluralist vision encompassing epistemic justice for experients. Just as epistemic injustice results in secondary harms, epistemic justice will result in in secondary goods, in the form of a wider array of options for support for experients.

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