

To whom it may concern,

I wish to make the following submission in relation to the Mental health act.

(a) While the availability of the service user to read their own notes is theoretically possible, in practice it remains difficult to achieve for the service user. This leads to a non-collaborative system where the mental health professional may espouse one idea to the service user and another in the writing of their notes. It maintains the concept of the expert fixing the service user for their own good and goes against the first principle of the [national framework of recovery](#), that of the “centrality of the persons lived experience”. The counter argument to this is usually two-fold. (1) that it is not in the best interest of the person or may be detrimental to their health. This has long been exploded and could only be valid in exceptional cases, not indiscriminately applied to all cases. In such a case the decision to restrict access should be made by the multidisciplinary team and not an individual mental health professional.

(2) There may be third party information in the notes that needs to be redacted. This is a valid argument required to maintain confidentiality. A separate appendix to notes where third party information is stored, and referenced to, could be created in the persons file, this can then be redacted at short notice.

The benefits to this action, of regular collaboration on notes, would be the inclusion of the persons own narrative in their care. The case for being heard and that their story has been listened to and recorded brings obvious benefits. Disagreements would occur, but in an upfront manner, where the service user is free to challenge the professionals opinion. Language would quickly change to be more recovery focused than medically dominated.

The act should make a recommendation that service users have quick access to their notes and are involved in reviewing them on a regular basis.

(b) ECT is still being prescribed despite widespread concerns around its [efficacy](#). It's baffling how this treatment persists when professionals, who state they are evidence based, declare they don't really know how the process works despite [guidance being provided](#) for professionals. The guidance linked to is purely a check box exercise. The fact that it continues in an involuntary capacity and that permanent damage can be caused may well be recorded with astonishment by future generations. Especially when the current evidence against it is so strong.

The Mental health act should empower the mental health commission to ensure that this “treatment” is fully explained, how it actually works, not how it may work, what it will do, along with all the concerns around it's efficacy and safety. Despite an abundance of policies, checks and procedures concerning ECT, this is still not the case.

(c) The evidence for the long-term use of psychiatric medications continues to be challenged and it's [efficacy questioned](#). This coupled with the [disastrous morbidity outcomes](#) would make any other branch of medicine pause and reflect. We see no reflection of this in our current care. Service users regularly don't know what medication they are taking, what it is purporting to do and if there is a plan to ever come off it. The now conclusive [evidence](#) of with-drawal symptoms is rarely explained and is being referred to as discontinuation syndrome, where mentioned at all.

The mental health act should empower the mental health commission to question, with the best efficacy of any favourable study of psychiatric medication lying at 50-60%, why then are 99.9% of service users medicated? Why is every service user medicated as a matter of course when we know from evidence it will have zero impact on 40% or more.

- (d) Diagnosis. A diagnosis may be welcomed by some service users or seen as a label to be despised by other service users. There is no quantitative evidence involved in psychiatric diagnosis hence an alternative formulation should be offered as well. The subjective opinion of the mental health professional should be placed alongside the subjective opinion of the service user. The benefits from this are, (1) the persons narrative changes from one of there is something wrong with me, to something happened to me. (2) The hierarchy of expert fixer and fixee is once again flattened and the service user is involved in [determining](#) their own care. (3) The [social and psychological determinants](#) of health are considered in determining the distress of the service user and allows them to make sense of why they feel distressed. An alternative to psychiatric diagnosis current exists in [the power threat meaning framework](#).

The mental health act, should make a recommendation, that alternative explanations for mental health distress exist, these explanations should be explored with the service users and given similar status to a psychiatric diagnosis.