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Reforming the Mental Health Act: summary

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This publication is available at https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act-summary

We (the UK government) want to let you know about the changes we are proposing to improve care for people who are detained under the Mental Health Act (MHA). This document:

- summarises the main changes proposed, which are available in the full White Paper[footnote 1]
- tells you where you can find out more information
- explains how you can tell us what you think about the changes.
- explains how the proposals relate to Wales

What has happened so far

The Mental Health Act (the act) sets out when someone can be detained in hospital and treated for a mental health disorder, at times against their wishes. This is sometimes called being 'sectioned'.

The act sets out the process for assessment, treatment and protection of people's rights.

In October 2017 the UK government announced an independent review of the Mental Health Act. The review was asked to look at how the act is used and how practice can be improved. The review looked at why:

- rising numbers of people are being detained under the act
- disproportionate numbers of people from black, Asian and minority ethnic (BAME) groups are being detained.

The review made 154 recommendations on how the Mental Health Act should be improved. (https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review)

What we're doing now

We have considered the review's recommendations and are proposing changes to improve mental health services and people's experiences under the Mental Health Act. This is called a 'White Paper'.

The changes aim to make sure that:

- people are detained for shorter periods of time, and only detained when absolutely necessary
- when someone is detained the care and treatment they get is focused on making them well
- people have more choice and autonomy about their treatment
- everyone is treated equally and fairly and disparities experienced by people from black and minority ethnic backgrounds are tackled
- people with a learning disability and autistic people are treated better in law and reduce the reliance on specialist inpatient services for this group of people

The White Paper is split into 3 main parts. These are:

- Part 1: legislative reforms – the changes we are proposing to the Mental Health Act itself
- Part 2: reforming policy and practice to improve patient experience – the government's plans to bring about an overall culture change within mental health services, so that people have a far better experience of care under the act
- Part 3: the UK government's response to the Independent Review of the Mental Health Act – the government's response to each of the review's recommendations (this is not covered in this document)

We would like to hear your views on the proposals, so that we can take these into consideration before any changes are made.

The main changes we are proposing in the Mental Health Act white paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act) are summarised in this document.

How do the proposals relate to Wales?

The current Mental Health Act applies in both England and Wales. Although health policy is devolved to Wales, justice matters remain reserved to the UK government. There is also a separate devolved system for tribunals in Wales. [footnote 2]

The White Paper represents the position of the UK government, which commissioned the Independent Review of the Mental Health Act. The review's proposals were largely focused on how the law and mental health system operates in England, although it did make some consideration of policy and practice in Wales.

Devolved matters

The majority of the White Paper concerns health policy which is devolved to Wales. Improving mental health outcomes is a cross-cutting priority in Wales and the Welsh government has a policy commitment to deliver excellent mental health services. Given that the act has application in both England and Wales, the findings of the review and the proposals set out in this White Paper also need to be carefully considered in the context of how the act currently operates alongside specific legislation, mental health services and systems in Wales. In particular, the Mental Health (Wales) Measure 2010 has already put some similar proposals, such as care plans for people subject to detention, on a statutory footing in Wales.

The Welsh government will continue to engage with the UK government on the proposals set out in the White Paper as it considers appropriate next steps for Wales and develops its own response to the review.

Reserved matters

Reserved matters where the UK government could apply changes in both England and Wales are highlighted below and in the White Paper (in particular in relation to the criminal justice system). However, even in reserved areas, the UK and Welsh governments are working closely to understand any distinct impacts and issues for Wales, and there may be cases where it is appropriate for Wales to take a different approach to reform from that being proposed in England.

It is not uncommon that Welsh patients are cared for in England and English patients cared for in Wales. Both governments are therefore committed to ensuring a joined up, person-centred mental health system that works for all patients and staff in these circumstances.

Responding to this consultation in Wales

We want to ensure that voices from Wales are heard during the consultation period. We will be working with the Welsh government to ensure that this consultation will also help inform policy decisions in Wales. While consultation responses to the White Paper will be received directly by the UK government, if you are responding to this consultation in Wales, your feedback will also be shared with the Welsh government.

On reserved matters, all responses from England and Wales will be fully considered by the UK government. On devolved matters, both governments will read all responses, however, feedback from Wales will not be counted or addressed separately as part of the UK government's consultation response.

Part 1: legislative reforms

Chapter 1: new guiding principles

There are 4 new guiding principles that people working to provide care will need to consider while carrying out their duties. These principles are central to our plans to modernise and improve the Mental Health Act. They are:

- choice and autonomy – making sure people's views and choices are respected
- least restriction – making sure the act's powers are used in the least restrictive way
- therapeutic benefit – making sure patients are supported to get better, so they can be discharged from the act as quickly as possible
- the person as an individual – making sure patients are viewed and treated as rounded individuals

We want these principles to be included up front in the act, as well as in the Code of Practice, which provides practical guidance for staff on how to follow the law. We hope that this change will help ensure that the principles are applied in all aspects of the care and treatment of people under the act.

You can answer the consultation question about applying the guiding principles:

Question

We propose embedding the principles in the MHA and the MHA code of practice. Where else would you like to see the principles applied to ensure that they have an impact and are embedded in everyday practice?

Your answer can be up to 500 words.

Chapter 2: clearer, stronger detention criteria

The detention criteria are the conditions in law that decision makers must demonstrate that a person is meeting before they are detained under the Mental Health Act. There are 2 main criteria. The first is that the person is suffering from a mental illness severe enough to justify detention. The second is that the person needs to be detained for their health and safety, or to protect other people.

A detention of a person can be for medical assessment (section 2 of the act) or for treatment (section 3 of the act).

We want to strengthen and clarify the criteria for detention under sections 2 and 3 of the act, so that patients are only detained when it is absolutely appropriate. These changes are driven by the following guiding principles:

- therapeutic benefit – more consideration must be given to how care and treatment provided under the act will promote recovery and facilitate patients to get better
- least restriction – ensuring a person is only detained where it is absolutely necessary, and where not detaining poses a substantial risk of significant harm being caused to themselves or others

The reasons why a person meets the detention criteria will need to be documented by their responsible clinician, including the specific risk that justifies detention and, where applicable, how detention will deliver therapeutic benefit.

The reasons for detention should be shared with the patient and reviewed by other decision makers, including by the Mental Health Tribunal when it considers appeals. We hope that this will increase transparency and accountability.

See chapter 2: clearer, stronger detention criteria in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for more information and you can also answer the consultation questions about changes to the detention criteria:

Question

We want to change the detention criteria so that detention must provide a therapeutic benefit to the individual. Do you agree or disagree with this proposal?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

We also want to change the detention criteria so that an individual is only detained if there is a substantial likelihood of significant harm to the health, safety or welfare of the person, or the safety of any other person. Do you agree or disagree with this change?

- strongly agree
- agree
- disagree

- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Chapter 3: giving patients more rights to challenge detention

We want to ensure that a patient's case for discharge from hospital is reviewed more regularly and that patients have more opportunities to appeal for discharge so they are not detained for longer than is necessary.

We will do this by making the changes set out below.

More frequent review of a patient's case for detention

We want to make sure that the responsible clinician and other decision makers are required to review the patient's case for discharge more regularly. We also intend to increase people's access to the First Tier Tribunal (Mental Health) (Tribunal), which provides vital independent scrutiny of detention.

These changes are supported by the following proposals:

- for patients under section 3 of the act, they should have 3 formal opportunities to appeal their detention at the tribunal, rather than only 2 within their first year of detention
- patients detained under section 2 should be able to apply for discharge during the first 21 days, as opposed to the current 14 day cut off
- independent mental health advocates should be able to apply to the Mental Health Tribunal on the patient's behalf, so that no one slips through the net
- the frequency of automatic referrals to the tribunal are increased to ensure people detained under the Mental Health Act have their case heard
- the tribunal takes into account the patient's statutory care and treatment plan when they consider an application for discharge. This should clearly set out the responsible clinician's justification for the patient's continued detention

See chapter 3: giving patients more rights to challenge detention in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for more information on our plans for giving patients more rights to challenge their detention. You can answer the consultation questions on the proposed time intervals for referring a patient to the tribunal.

Question

Do you agree or disagree with the proposed timetable for automatic referrals to the Mental Health Tribunal (see table 1 for details)?

1) Patients on a section 3

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

2) Patients on a community treatment order (CTO)

- strongly agree
- agree
- disagree

- strongly disagree
- not sure

3) Patients subject to part 3

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

4) Patients on a conditional discharge

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Table 1: frequency of automatic referrals

Type of patient	Current provisions	Proposed provisions
Patients subject to section 3	Referral 6 months after the detention started, if the patient had not made an appeal.	Referral 4 months after detention starts, if the patient had not already made an appeal.
	Thereafter referral takes place if more than 3 years have elapsed since the case was last considered by the tribunal.	Thereafter, referral would take place 12 months after the detention started, if the Tribunal has not considered the case in the intervening months.
	For patients under the age of 18, cases are referred to the Tribunal annually.	After the first 12 months of detention, referral would take place annually.
Patients on a CTO	During the CTO, referral takes place 6 months after detention begins, if the tribunal has not considered the case in the first 6 months.	Referral would take place 6 months after the patient was put on the CTO, if the tribunal has not considered the case in the first 6 months.
	Thereafter, referral takes place if more than 3 years (or 1 year in the case of a patient under 18) have elapsed since the case was last considered by the tribunal.	Thereafter, referral would take place 12 months after the patient was put on the CTO, if the Tribunal has not considered the case in the intervening month and continue to take place annually.
	If the CTO is revoked, referral to the Tribunal takes place as soon as possible.	

Type of patient	Current provisions	Proposed provisions
Patients subject to Part 3	Referral takes place if the tribunal has not considered the patient's case in the last 3 years.	Every 12 months.
Patients on a Conditional Discharge (restricted, part 3 patients)	These patients have no right to an automatic referral.	Referral would take place 24 months following receipt of the conditional discharge by the patient. Thereafter, referral would take place every 4 years.

Changes to the tribunal's responsibilities

Where the continuation of a patient's detention is justified, we want to give the tribunal the power to grant leave or direct the transfer of patients to other, less restrictive settings, to help facilitate the patient's recovery. We also propose to give the tribunal the power to direct services in the community, where this is a barrier to discharge. We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal.

Other changes to procedures around a patient's detention

We propose removal of existing parts of the detention review process, which the review concluded were ineffective or are compensated for by the above reforms, which will ensure that a patient's case for discharge is more frequently reviewed:

- removal of the automatic referral to a tribunal when a patient's community treatment order (CTO) is ended and they return to hospital. A CTO is an order made by the responsible clinician to give the patient supervised treatment in the community, instead of staying in hospital
- removal of the role of associate hospital managers (AHMs) (also known as a hospital managers' panel) in reviewing a patient's case for discharge from detention or a CTO

More information on these changes can be read at chapter 3: giving patients more rights to challenge detention in part 1 the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act). You can also answer the following consultation questions:

Question

We want to remove the automatic referral to a tribunal received by service users when their community treatment order is revoked. Do you agree or disagree with this proposal?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

We want to give the Mental Health Tribunal more power to grant leave, transfers and community services.

We propose that health and local authorities should be given 5 weeks to deliver on directions made by the Mental Health Tribunal. Do you agree or disagree that this is an appropriate amount of time?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you agree or disagree with the proposal to remove the role of the managers' panel in reviewing a patient's case for discharge from detention or a community treatment order?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Chapter 4: strengthening the patient's right to choose and refuse treatment

We plan to update the Mental Health Act so that patients:

- have greater influence over decisions about their care and treatment
- can expect their wishes and preferences to be respected and followed
- have the opportunity to challenge their care and treatment if their wishes are not followed

We will do this by making the changes set out below.

Introducing advance choice documents

In an advance choice document, people will be able to set out in advance the care and treatment they would prefer and/or treatments they wish to refuse should they later become too unwell to make these decisions themselves. The document can also set out other important information like details of the patient's nominated person, crisis planning arrangements and early signs of relapse.

Our reforms will require that advance choice documents must be taken into account if the patient later lacks the relevant mental capacity to express their wishes.

We propose that advance choice documents will, in most cases be treated as equivalent to the wishes and preferences expressed by someone with the relevant capacity so long as, at the time of writing, the individual had the relevant mental capacity.

You can read more about what can be included in an advance choice document, and how they will work in practice in chapter 4: strengthening the patient's right to choose and refuse treatment in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act). You can also answer consultation questions about what should be included in a patient's advance choice document and how the validity of an advance choice document should be determined:

Question

Do you have any other suggestions for what should be included in a person's advance choice document?

Your answer can be up to 500 words.

Question

Do you agree or disagree that the validity of an advance choice document should depend on whether the statements made in the document were made with capacity and apply to the treatment in question, as is the case under the Mental Capacity Act?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Making care and treatment plans statutory

We propose that all patients must have a detailed care and treatment plan in place by day 7 of detention and that this is signed off by the medical or clinical director by day 14. The care and treatment plan should include information such as:

- the care and treatment provided and how it can be delivered in the least restrictive way
- how the patient's wishes and preferences are taken into consideration, including the content of any advance choice document
- the responsible clinician's reasoning when the patient's wishes and preferences are not followed, however they have been expressed
- how the recommendations from Care (Education) and Treatment Reviews have been taken on board in the case of patients with a learning disability or autistic patients, including any reasons why these have not been followed.
- planning for discharge, including aftercare arrangements
- acknowledgement of any protected characteristics, for example known cultural needs, and how the plan will take account of these

You can read more about what we propose should be included in a care and treatment plan and how they will work in practice in chapter 4: strengthening the patient’s right to choose and refuse treatment in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act). You can also answer the consultation question on what else should be contained in the statutory care and treatment plan:

Question

Do you have any other suggestions for what should be included in a person's care and treatment plans?

Your answer can be up to 500 words.

Introducing a new framework for patient consent and refusal of medical treatment

We want to give patients greater control over their care and treatment and the right to refuse specific medical treatments at a much earlier point in detention. To achieve this, we propose reforms to part 4 of the act, which regulates decisions about a patient's care and treatment, including what happens when a patient gives consent to treatment being administered to them, and what happens when they don't.

These reforms will improve existing safeguards and introduce new ones for patients who are not consenting to treatment. A key change we wish to make is to bring forward the point at which the second opinion appointed doctor (SOAD) reviews a patient's treatment. The SOAD is independent of their responsible clinician and reviews whether the treatment is right from a clinical perspective and if the patient's views and rights have been sufficiently considered. Currently, the SOAD must certify a patient's treatment 3 months after the treatment began, where they are not consenting. We propose to give the patient access to the SOAD at day 14 of detention and, where the patient lacks the relevant capacity to consent to treatment, we will require that the SOAD certifies their treatment at month 2, as opposed to month 3.

Another important reform we propose to make is the ability for patients to appeal treatment decisions at the tribunal, before a single judge, where there is evidence to suggest their wishes and preferences were inappropriately overruled by the responsible clinician.

Chapter 4 sets out more details on the changes we want to make around:

- the rights of patients to be involved in decisions around medical treatment, and to refuse specific treatments, with different rules depending on whether someone refuses with or without capacity and on the nature of the treatment
- the procedures that must be followed by health professionals to ensure that they take account of a patient's wishes and preferences around medical treatment
- the rights of patients to appeal decisions made by the responsible clinician around their treatment and how these differ for patients with and without the relevant mental capacity and those with an advance choice document
- changes to the criteria for administering treatment in urgent circumstances that protect the right of the patient to refuse treatment, if they have relevant capacity to do so

You can also answer the consultation questions on these changes:

Question

Do you agree or disagree that patients with capacity who are refusing treatment should have the right to have their wishes respected even if the treatment is considered immediately necessary to alleviate serious suffering?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you agree or disagree that in addition to the power to require the responsible clinician to reconsider treatment decisions, the Mental Health Tribunal judge (sitting alone) should also be able to order that a specific treatment is not given?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Chapter 5: improving support for people who are detained

Nominated person

One of the overarching aims of our planned reforms is to give people more choice and autonomy when subject to the act.

This section discusses our plans to replace the current nearest relative role, which we think is out of date and does not give the patient enough say in who is involved in their care, with a new statutory role, known as the 'nominated person'. Individuals will be able to choose their nominated person, if they want one, at the point of detention under the act or in their advance choice document.

If a patient is too unwell to make this decision, an approved mental health professional (AMHP) will appoint one for them. AMHPs are mental health professionals who have been approved by a local authority to carry out certain duties under the act. They are responsible for coordinating a person's assessment and admission to hospital if they are sectioned under the act.

The nominated person will have all the powers of the nearest relative, plus some new powers and rights, including:

- the right to be consulted on statutory care and treatment plans to ensure the patient's best interests are protected
- the right to be consulted on transfers between hospitals, as well as about renewals and extensions of detentions and CTOs
- the ability to appeal clinical treatment decisions, on behalf of the patient where they are too unwell to do so themselves
- the power to object to the use of a CTO on behalf of the patient
- the power to apply for discharge to the tribunal on behalf of the patient

We will change the process around overruling decisions made by the nearest relative, so that the nominated person will not forfeit their role in the patient's care if they object to the patient's detention.

You can read more about the powers of the nominated person, which patients will have access to them and the circumstances and procedures by which their powers can be overruled and where this responsibility lies in chapter 5: improving the support for people who are detained in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act). You can also answer the consultation questions about the new powers of the nominated person:

Question

Do you agree or disagree with the proposed additional powers of the nominated person?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

We want to see that more patients have the right to a nominated person. We intend to extend this right to patients in the criminal justice system, who are subject to part 3 of the act (also called forensic patients), however, the nominated person's powers will be more limited.

For children and young people, those aged 16 and 17 will have the same right to choose a nominated person as an adult. For children under 16, we think that if they are ‘Gillick competent’, where they have sufficient understanding, maturity and intelligence to fully understand, we think that they should be able to choose a nominated person too.

You can find more information on this area in chapter 5: improving the support for people who are detained in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) and you can also answer the consultation question on the ability of children and young people to choose a nominated person:

Question

Do you agree or disagree that someone under the age of 16 should be able to choose a nominated person (including someone who does not have parental responsibility for them), where they have the ability to understand the decision (known as 'Gillick competence')?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Advocacy

Independent mental health advocates (IMHAs) provide important safeguards to people detained under the MHA. We want to expand the role of IMHAs so that they can also:

- support patients to take part in care planning
- support individuals to prepare advance choice documents
- challenge treatment decisions where they have reason to believe they are not in the patient's best interests
- appeal to the tribunal when patients are too unwell to do so themselves

High quality advocacy is critical to make sure people get the support they need when detained. We are considering how we can improve the role and we welcome your views on whether this can be achieved by professionalising the service.

A priority in the delivery of higher quality services is the development of culturally appropriate advocacy for people of all ethnic backgrounds and communities. We will be conducting culturally-sensitive advocacy pilots to learn how to better respond to the diverse needs of individuals from minority ethnic communities.

You can answer the consultation questions on the expanded powers of IMHAs and how we can ensure that high quality advocacy services are delivered across the board:

Question

Do you agree with the proposed additional powers of independent mental health advocates?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you agree or disagree that advocacy services could be improved by:

1) enhanced standards

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

2) regulation

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

3) enhanced accreditation

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

4) none of the above, but by other means

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Chapter 6: community treatment orders (CTOs)

The purpose of CTOs is to enable some inpatients, who might otherwise remain detained under the act, to be discharged into the community with conditions intended to maintain ongoing contact with services, in order to provide support and prevent relapse.

We will reform CTOs so that they are only used where there is strong justification for doing so and where the CTO is considered to deliver a genuine therapeutic benefit to the patient.

To achieve this, we will:

- strengthen the criteria to make a CTO in the first place, so it reflects the new criteria for detaining someone under section 3 of the act
- increase the evidence requirements needed to make a CTO and the conditions around it
- change the process for recalling a person subject to a CTO back to hospital, so it is less disruptive to the individual
- require that more professionals have to sign off on a CTO, to ensure greater scrutiny
- give the tribunal powers to order that the responsible clinician reconsiders the conditions of a patient's CTO where they are overly restrictive
- give the nominated person the right to object to a CTO, on behalf of the patient
- introduce an expectation that a CTO should last no longer than 24 months

We hope that these reforms lead to fewer people being placed on CTOs and, where they are used, that patients benefit from the structure they provide to support continued engagement with mental health services.

We will monitor the effects of these reforms over an initial 5-year period. We will further review and update Government policy on the use of CTOs in line with the emerging evidence.

You can read information on the proposed reforms to CTOs in chapter 6: community treatment orders (CTOs) in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act).

Chapter 7: the interface between the Mental Health Act and the Mental Capacity Act

When a person needs to be admitted to hospital because of their mental disorder, the clinician may need to decide whether the person should be admitted under the Mental Health Act or the Mental Capacity Act's Deprivation of Liberty Safeguards (DoLS), which will soon be replaced by Liberty Protection Safeguards (LPS).

This choice between which framework is most appropriate arises if the patient:

- is suffering from a mental illness that puts their own safety at risk and requires hospital admission for medical treatment
- lacks the relevant mental capacity to consent to detention and treatment
- is not objecting to detention or treatment

In these circumstances, it is currently unclear which legal framework should be used. There are also opposing views on which legal safeguards are better for patients.

We are exploring the review's idea of introducing a simpler 'dividing line' between the Mental Health Act and the Mental Capacity Act to make it clear which framework a clinician should use to detain a patient in these circumstances.

This proposal would mean that the choice would be removed, and decision makers would use the DoLS or LPS and not the Mental Health Act, if a patient:

- lacks the relevant mental capacity to consent to detention and treatment
- and is not objecting to detention or treatment

You can read more on this issue at chapter 7: the interface between the Mental Health Act and the Mental Capacity Act in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) and also answer the consultation question on how we should make clearer the dividing line between the Mental Capacity Act and the Mental Health Act:

Question

How should the legal framework define the dividing line between the Mental Health Act and the Mental Capacity Act so that patients may be made subject to the powers which most appropriately meet their circumstances?

Your answer can be up to 500 words.

Prior consent to be admitted as an informal patient

We also discuss whether we should make a provision in the MHA clearly setting out the right of individuals to consent in advance to admission to hospital for treatment for a mental illness. This would mean that, if an individual had given prior consent and they later become unwell and lose the relevant capacity, then they would be admitted as informal or voluntary patients, as opposed to being detained under the MHA or subject to the DoLs or LPS.

You can read more about what this would mean for patients in chapter 7: the interface between the Mental Health Act and the Mental Capacity Act in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) and you can answer the consultation question on whether we should change the legislation to make clear the option of prior consent to admission as an informal patient.

Question

Do you agree or disagree that the right to give advance consent to informal admission to a mental health hospital should be set out in the Mental Health Act (MHA) and the MHA code of practice to make clear the availability of this right to individuals?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

If you agree, please provide reasons for your answer (up to 500 words).

Are there any safeguards that should be put in place to ensure that an individual's advance consent to admission is appropriately followed?

Your answer can be up to 500 words.

Emergency powers in the Mental Health and Mental Capacity Acts

We want to improve the powers available to health professionals in accident and emergency departments so that individuals in need of urgent mental health care, stay on site, pending a clinical assessment. This aims to avoid the use of the police to hold individuals who are in crisis and are attempting to leave A&E, potentially leading to further distress to the individual.

We discuss the merits of relying on section 4B of the Mental Capacity Act to achieve this objective versus extension of section 5 of the Mental Health Act, both of which would provide health professionals in A&E with powers to temporarily hold people in specific circumstances.

See chapter 7: the interface between the Mental Health Act and the Mental Capacity Act in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for further details of this change and you can also answer the consultation question:

Question

We want to ensure that health professionals are able to temporarily hold individuals in A&E when they are in crisis and need a mental health assessment, but are trying to leave A&E.

Do you think that the amendments to section 4B of the Mental Capacity Act achieve this objective, or should we also extend section 5 of the Mental Health Act (MHA)?

- rely on section 4B of the Mental Capacity Act only
- extend section 5 of the MHA so that it also applies A&E, accepting that section 4B is still available and can be used where appropriate

Please give reasons for your answer (up to 500 words).

Chapter 8: Caring for patients in the Criminal Justice System

Some people in contact with the criminal justice system may have a mental illness severe enough to require treatment in hospital. This could be identified after arrest by the police, recognised by a court, or a person may later become unwell in custody.

We want to ensure that people in these circumstances have access to the right care, at the right time, while fulfilling our duty to protect the public.

Part 3 of the act sets out the framework for the care of these patients. Many of our reforms to improve patient care will apply to patients under this part of the act, however, there are some exceptions:

- the new criteria for detention will not apply to part 3 patients
- the nominated person for a part 3 patient will have limited powers
- tribunal powers and automatic referrals to the tribunal will differ for these patients compared to civil patients
- changes to the detention criteria for individuals with learning disability and/ or autism will not apply to part 3 patients

The criminal justice system covers both England and Wales. We particularly welcome responses from people both in England and Wales to the consultation questions in chapter 8: caring for patients in the Criminal Justice System in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act).

Court powers: aligning Magistrate and Crown Courts

The MHA gives magistrates' courts power to divert a person in mental health crisis away from the criminal justice system and into hospital for assessment and/or treatment. However, there can currently be delays in ensuring people get the care and treatment they need.

To speed up the process, the review recommended that the magistrates' courts' powers should be increased to bring them in line with the Crown Court. As we are currently considering other reforms to the magistrates' courts, made by the Law Commission, we wish to give this further consideration before we make our decision on the review's recommendation.

Read chapter 8: caring for patients in the Criminal Justice System in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for a full discussion of this proposal.

Secure transfers: transferring people between prison or immigration and removal centres and hospital

We want to ensure that people who need care and treatment under the MHA are not being held in prisons or immigration and removal centres (IRCs) inappropriately.

To speed up transfers of patients from prison or IRCs to mental health inpatient settings, we will introduce a 28-day statutory time limit in England once new guidance, being prepared by NHS England and Improvement (NHSEI), is properly embedded.

You can answer the consultation question on what else should be in place before we can safely bring in the statutory time limit for transferring patients.

Question

To speed up the transfer from prison or immigration removal centres (IRCs) to mental health inpatient settings, we want to introduce a 28-day time limit.

Do any further safeguards need to be in place before we can implement a statutory time limit for secure transfers?

- Yes
- No
- Not sure

Please give reasons for your answer (up to 500 words).

We also want to introduce a new independent, statutory role for managing the process of transferring people from prison to hospital so that barriers are more quickly overcome, and the patient's needs are put first. We are also considering giving people who are waiting to be transferred the right to have an IMHA.

You can answer the consultation question on how we should introduce the new statutory role:

Question

We want to establish a new designated role for a person to manage the process of transferring people from prison or an immigration removal centre (IRC) to hospital when they require inpatient treatment for their mental health.

Which of the following options do you think is the most effective approach to achieving this?

- expanding the existing approved mental health professional (AMHP) role in the community so that they are also responsible for managing prison or IRC transfers
- creating a new role within NHS England and Improvement (NHSEI) or across NHSEI and Her Majesty's Prison and Probation Service to manage the prison or IRC transfer process
- an alternative approach (please specify)

Please give reasons for your answer (up to 500 words).

When there is no hospital bed available and a defendant (meaning a person against whom a criminal or civil action is brought) requires mental health care and treatment, courts may be forced to put them in prison as a 'place of safety'. We wish to make sure that alternative locations are in place to end the use of prison as a place of safety.

Restricted patients

Restricted patients are patients detained in hospital under part 3 of the act who are subject to special controls by the Secretary of State for Justice, due to safety concerns.

For restricted patients, the responsible clinician must seek the consent of the Secretary of State for Justice to allow the patient leave, or to transfer the patient to another hospital, or to discharge the patient. The review raised its concerns about inefficiencies in this system which resulted in delays in securing this consent. We have since worked to address this and we are already seeing positive progress.

You can read chapter 8: caring for patients in the Criminal Justice System in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for a discussion on our approach to reducing delays in the system and progress that has been made so far.

Conditionally discharged patients

Some restricted patients who no longer meet the statutory test for detention in hospital must be discharged. This can be an absolute discharge, with no conditions. Or, if deemed appropriate by the tribunal or the Justice Secretary, a conditional discharge.

A conditional discharge allows patients to move into the community. But they must follow certain conditions, and there is a power which means they may be recalled to hospital if it is necessary to protect the public from harm. There were 2,821 conditionally discharged patients in the community in 2019.

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor. Social supervision is an important role, balancing public protection with the care and support of conditionally discharged patients. It has traditionally been a local authority social worker, although other professionals can also take on this role. There is currently some confusion about which professionals should play this role and a lack of national guidance about how it should operate.

Question

Conditionally discharged patients are generally supervised in the community by a psychiatrist and a social supervisor.

How do you think that the role of social supervisor could be strengthened?

Your answer can be up to 500 words.

Release of transferred prisoners by the Parole Board

For part 3 patients who are being treated in a mental health hospital and who are serving an indeterminate or life sentence, decisions around the person's discharge from hospital and release from prison can be complicated.

Currently, the tribunal and then the Parole Board are separately required to consider decisions on discharge and release respectively, resulting in delays.

We are doing work to streamline processes and to identify procedural changes to reduce delays.

Giving the tribunal the power to discharge someone with conditions which restrict freedom in the community

For a small number of restricted patients, the risk they pose to others may still remain significant at the point they are no longer therapeutically benefittingfrom detention in hospital. We want to make sure that the risk these patients pose is managed in the most appropriate and least restrictive way, while progressing the individual along their care pathway.

To achieve this, we want to give the tribunal the power to discharge restricted patients into the community, under supervision and with conditions that restrict their freedom.

The criteria for doing this and the safeguards the patient would have access to are set out in chapter 8: caring for patients in the Criminal Justice System in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act).

You can also answer the consultation question on whether we should make this new discharge power possible and what it should involve.

Question

For restricted patients who are no longer therapeutically benefiting from detention in hospital, but whose risk could only be managed safely in the community with continuous supervision, we think it should be possible to discharge these patients into the community with conditions that amount to a deprivation of liberty.

Do you agree or disagree that this is the best way of enabling these patients to move from hospital into the community?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

If you agree, please give reasons for your answer (up to 500 words).

We propose that a 'supervised discharge' order for this group of patients would be subject to annual tribunal review. Do you agree or disagree with the proposed safeguard?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Question

Beyond this, what further safeguards do you think are required?

Your answer can be up to 500 words.

Victims of unrestricted patients

We want to improve the level of information provided to victims of offenders who become subject to the act who have no restriction order, and how it is shared.

See chapter 8: caring for patients in the Criminal Justice System in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for more details on the work we are doing to make sure that victims receive the information to which they are entitled.

Chapter 9: people with a learning disability and autistic people

We are committed to reducing the reliance on specialist inpatient services for people with a learning disability and autistic people and to developing community alternatives. As part of this, we want to limit the ability to detain people with a learning disability or autistic people under the act.

Both a learning disability and autism are lifelong conditions, which cannot be removed through treatment. We recognise that some people with a learning disability and autistic people may require treatment for a mental illness and we want to ensure that people receive high quality and safe care that is the most appropriate for them.

We propose changing the act to be clearer that autism or a learning disability are not considered to be mental disorders for the purposes of most powers under the act.

Our proposal is to allow for the detention of people with a learning disability and autistic people for assessment, under section 2 of the act, when their behaviour is so distressed that there is a substantial risk of significant harm to the person or to other people (as for all detentions) and a probable mental health cause to that behaviour that warrants assessment in hospital.

Where the driver of this behaviour is not considered to be a mental health condition, for example it is due to an unmet support need, an unmet social or emotional need, or an unmet physical health need (including untreated pain), grounds for a detention under the MHA would no longer be justified and the detention should cease.

You can read chapter 9: people with a learning disability and autistic people in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) to out more about the rationale behind this proposal and you can answer the consultation questions:

Question

Do you agree or disagree with the proposed reforms to the way the Mental Health Act applies to people with a learning disability and autistic people?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you agree or disagree that the proposed reforms provide adequate safeguards for people with a learning disability and autistic people when they do not have a co-occurring mental health condition?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you expect that there would be unintended consequences (negative or positive) of the proposals to reform the way the Mental Health Act applies to people with a learning disability and autistic people?

- Yes
- No
- Not sure

Please give reasons for your answer (up to 500 words).

Question

We think that the proposal to change the way that the Mental Health Act applies to people with a learning disability and autistic people should only affect civil patients and not those in the criminal justice system. Do you agree or disagree?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

Do you expect that there would be unintended consequences (negative or positive) on the criminal justice system as a result of our proposals to reform the way the Mental Health Act applies to people with a learning disability and to autistic people?

Your answer can be up to 500 words.

For people with a learning disability and autistic people, we want to make it a statutory requirement for the responsible clinician to consider the findings and recommendations made as part of care and treatment reviews in the patient's care and treatment plan. We know that care and treatment reviews (or care education and treatment reviews in the case of children) are effective in reducing hospital admissions when they are undertaken correctly and acted upon, this is why we want to give them statutory force.

Question

Do you agree or disagree that the proposal that recommendations of a care and treatment review (CTR) for a detained adult or of a care, education and treatment review (CETR) for a detained child should be formally incorporated into a care and treatment plan and responsible clinicians required to explain if recommendations aren't taken forward, will achieve the intended increase compliance with recommendations of a CETR?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 200 words).

Ensuring an adequate supply of community services for people with a learning disability and autistic people

We are also developing a duty on health and social care commissioners to collaborate to ensure provision of community-based support and treatment for this group. This will be set out in the Mental Health Act.

You can answer the consultation questions on this issue:

Question

We propose to create a new duty on local commissioners (NHS and local government) to ensure adequacy of supply of community services for people with a learning disability and autistic people. Do you agree or disagree with this?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

We propose to supplement this with a further duty on commissioners that every local area should understand and monitor the risk of crisis at an individual-level for people with a learning disability and autistic people in the local population through the creation of a local ‘at risk’ or ‘support’ register. Do you agree or disagree with this?

- strongly agree
- agree
- disagree
- strongly disagree
- not sure

Please give reasons for your answer (up to 500 words).

Question

What can be done to overcome any challenges around the use of pooled budgets and reporting on spend on services for people with a learning disability and autistic people?

Your answer can be up to 500 words.

Chapter 10: children and young people

We want to strengthen the rights and support children and young people receive when subject to the act.

In addition to legislative changes, all of which will be available to children and young people, we will ensure that care and treatment plans are provided to all children and young people receiving inpatient mental health care, irrespective of whether they are detained under the act.

See chapter 10: children and young people in part 1 of the White Paper (https://www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act#part-1-proposals-for-reform-of-the-mental-health-act) for a discussion of the review's recommendations around assessing the 'competence' of children and young people to consent to their own medical treatment and make decisions about their care and treatment without parental permission or knowledge.

We wish to fully consider these recommendations as part of our review of the code of practice.

Chapter 11: the experiences of ethnic minority communities

Profound inequalities exist across mental health services and under the act for people from BAME communities, in particular for black African and Caribbean people. We are making a series of reforms to tackle these inequalities:

- the introduction of a new Patient and Carer Race Equality Framework (PCREF) to embed structural and cultural change in healthcare delivery to improve how patients from diverse ethnic backgrounds access and experience mental health care
- the development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for black African and Caribbean people
- research that aims to support the improvement in mental health outcomes for people from ethnic minority communities

These reforms are supported by work being led by NHSEI to improve the diversity of the mental health workforce and by the wider reforms discussed in the White Paper.

Part 2: reforming policy and practice around the new act to improve patient experience

This section of the White Paper describes the current and future work the government and the NHS is undertaking to bring about changes so people have better experiences of care.

Transforming mental health services

The NHS Long Term Plan outlines the ambition for a radical transformation of mental health services, so that patients have better experiences of inpatient care and better mental health outcomes.

This transformation of mental health services is backed by additional investment rising to £2.3 billion each year by 2023 to 2024 and includes a renewed focus on services for people with severe mental illness and on improving the provision of community care. Ambitions include:

- increasing staff on acute inpatient wards – such as peer support workers, psychologists and occupational therapists to minimise time spent in hospital and improve outcomes
- reducing the lengths of stay in adult acute inpatient mental health settings
- establishing a culture of learning across the NHS so that, when things go wrong, commissioners and providers ensure that issues are circumvented in future
- ensuring that everyone has mental health crisis care support available at all times via NHS 111 by 2023 to 2024
- expanding community services to support 370,000 adults with severe mental illness to provide more support to people in the community before they need crisis or inpatient care, including under the MHA

Supporting people in the community

In addition to the Long Term Plan's ambitions to expand and improve community mental health care to address current gaps and prevent avoidable admissions we wish to make sure that all service users in contact with community mental health teams, inpatient care and/or social services have a high-quality care plan, personalised around their needs.

The current process around the provision of aftercare in the community for patients who have been discharged from the Mental Health Act can be confusing and there are inconsistencies in the way it is carried out. We want to produce national guidance on how budgets and responsibilities should be shared to pay for aftercare.

Improving ward culture for patients and staff

In addition to improving mental health services, we will take steps to create the best ward cultures to improve patient experience. A key part of this is the development of a quality improvement programme focused on implementing the Mental Health Act reforms. This will be led by NHSEI and will aim to address issues around quality, patient experience, leadership and culture.

Inpatient safety and risk

The safety of patients in mental health services will always be a crucial concern. The NHS Long Term Plan committed to a new Mental Health Safety Improvement Programme (MHSIP) which aims to tackle priority mental health safety issues:

- sexual safety for inpatients
- reducing restrictive practice
- reducing suicide and deliberate self-harm

You can read part 2 of the White Paper to find out more about the work that is underway in these priority areas.

We will work to ensure that new patient safety measures do not come at the expense of developing and maintaining truly therapeutic environments that support people to recover.

Improving the physical ward environment

Inpatient settings should offer rehabilitative environments that enable the delivery of therapeutic care and that support the recovery of patients.

We will improve the physical environment of mental health services, making them far better places for patients and for staff. As part of this, we will bring an end to dormitory accommodation, allowing patients the privacy of their own room and en-suite bathroom. The government has committed over £400 million for this purpose and has identified 1,200 beds that will receive this upgrade over the next 4 years. This is an important step towards improving sexual safety in mental health services and towards ending breaches of single-sex accommodation.

We are also investing in the building of new mental health hospitals as part of the government's hospital building programme.

The role of the Care Quality Commission (CQC)

The CQC has consistently reported that many people continue to experience care that is not person-centred and does not fully protect their rights.

Driven by these findings and the ambitions of the Long Term Plan, the CQC will review how it assesses factors that inform the quality of inpatient care, such as the physical layout of wards, the safety fixtures and fittings and the provision of same-sex accommodation.

In addition, the CQC will be working with people who use services, families, providers, frontline staff and other stakeholders to improve the way that they regulate services, with a particular focus on improving ward culture, given the critical role this can play in a patient's recovery.

Read part 2 of the White Paper to learn more about the other work the CQC is taking forward to help improve the experience of patients in mental health services. You can also answer the consultation question on how the CQC's monitoring role could be extended.

Question

How could the Care Quality Commission support the quality (including safety) of care by extending its monitoring powers?

Your answer can be up to 500 words.

Removing police cells as 'places of safety'

A 'place of safety' is a designated safe place where people who are experiencing a mental health crisis can be taken and where a mental health assessment can be carried out.

Currently, people can be taken to police cells for a mental health assessment. We want to put an end to this and ensure that, in future, all people in mental health crisis are taken to a clinical environment, where they can receive the care and support they urgently need. We have committed to reform the MHA to stop the use of police cells as places of safety by 2023 to 2024.

Enabling better handovers from police to health services

Currently, more people experiencing a mental health crisis are taken to hospital by the police than by ambulance.

The NHS Long Term Plan commits to investment to improve the capacity and capability of ambulance services to meet mental health demand, helping to avoid the use of the police to convey patients.

The mental health workforce

Expanding and developing the mental health workforce is vital to fulfilling our commitment to modernise the Mental Health Act. The government will be working with NHSEI, Health Education England and other stakeholders to look at further national support requirements, including training staff on the changes to the act, meaningful co-production and the development of expert-by-experience leadership roles within providers and local systems.

These reforms are, to an extent, supported by broader work to expand and develop the mental health workforce as part of the NHS Long Term Plan. However, we anticipate that the reforms will require further expansion of the workforce to meet additional demands.

We are working to increase the diversity of the mental health workforce to ensure that it better meets the needs of the community it serves. This involves work to recruit more people from the black African and Caribbean communities into mental health professions and supporting them to rise to senior levels.

We know that improving staff morale is important to delivering high quality patient care. NHSEI is working to improve the experience of staff and therefore the experience of patients through its Improving Health and Wellbeing programme.

Read part 2 of the White Paper for more information on our plans to expand and develop the mental health workforce.

Data and digital

The government is committed to working with all the organisations involved in the operation of the act to bring about improvements to data collection and to new digital approaches to service delivery. This is a critical part of building a modern mental health service that can more efficiently respond to patients' needs.

This ambition has been accelerated during the pandemic period in 2020, which has served to highlight the benefits that digital can bring.

Impact assessment

Alongside the White Paper we have produced an impact assessment (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/946264/mha-review-impact-assessment.pdf) in which we have estimated likely costs and benefits of implementing the proposed changes to the act.

Please provide information (up to 500 words). You can also upload files when you respond to the consultation (https://consultations.dhsc.gov.uk/5fd10ed02513901f29167e1d).

Question

In the impact assessment (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/946264/mha-review-impact-assessment.pdf) we have estimated likely costs and benefits of implementing the proposed changes to the act. We would be grateful for any further data or evidence that you think would assist the departments in improving the methods used and the resulting estimates.

We are interested in receiving numerical data, national and local analysis, case studies or qualitative accounts, etc that might inform what effect the proposals would have on the following:

- different professional groups, in particular:
  - how the proposals may affect the current workloads for clinical and non-clinical staff, independent mental health advocates, approved mental health professionals, Mental Health Tribunals, SOADs etc
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
- service users, their families and friends, in particular:
  - how the proposal may affect health outcomes
  - ability to return to work or effects on any other daily activity
  - whether the proposals are likely to have any other effects on specific interested groups that have not currently been considered
  - any other impacts on the health and social care system and the justice system more broadly

Please provide information (up to 500 words). You can also upload files when you respond to the consultation.

Responding to the consultation

There are a lot of questions and you may not wish to answer all of them. We have created a survey (https://consultations.dhsc.gov.uk/5fd10ed02513901f29167e1d) so you can answer as many or a few questions as you would like.

The questions have been divided up into sections and themes. The consultation will be open until 21 April 2021. This consultation is our formal consultation with the public.

Respond to the consultation. (https://consultations.dhsc.gov.uk/5fd10ed02513901f29167e1d)

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1. A white paper is a document produced by the government that sets out proposals for future legislation.
2. The functions, which in England are performed by the Mental Health jurisdiction of the First-tier Tribunal (usually referred to as the Mental Health Tribunal or MHT), are dealt with by a separate tribunal in Wales, the Mental Health Review Tribunal for Wales, or MHRTW. This is a devolved Welsh Tribunal under the President of Welsh Tribunals and is administered by the Welsh government. It's important to note that the response to the recommendations in this White Paper only refer to the MHT in England and not the MHRTW.

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- Department of Health & Social Care (https://www.gov.uk/government/organisations/department-of-health-and-social-care)

Open consultation

Diwygio'r Ddeddf Iechyd Meddwl

Published 13 January 2021

This publication is available at https://www.gov.uk/government/consultations/reforming-the-mental-health-act/diwygior-ddeddf-iechyd-meddwl

Rydym ni (Llywodraeth y DU) eisiau rhoi gwybod i chi am y newidiadau rydym yn eu cynnig i wella'r gofal i bobl sy'n cael eu cadw dan y Ddeddf Iechyd Meddwl. Mae'r ddogfen hon:

- yn crynhoi'r prif newidiadau arfaethedig, sydd ar gael yn y Papur Gwyn llawn[footnote 1]
- yn dweud wrthych ble i gael rhagor o wybodaeth
- yn egluro sut y gallwch ddweud wrthym beth yw eich barn am y newidiadau
- yn egluro sut mae'r cynigion yn berthnasol i Gymru

Beth sydd wedi digwydd hyd yma

Mae'r Ddeddf Iechyd Meddwl (y Ddeddf) yn nodi pryd y gellir cadw rhywun mewn ysbyty a'i drin am anhwylder iechyd meddwl, ar adegau yn groes i'w ddymuniadau. Yn Saesneg, mae hyn weithiau yn cael ei alw yn 'sectioned'.

Mae'r Ddeddf yn nodi'r broses ar gyfer asesu a thrin pobl a diogelu eu hawliau.

Ym mis Hydref 2017, cyhoeddodd Llywodraeth y DU adolygiad annibynnol o'r Ddeddf Iechyd Meddwl. Gofynnwyd i'r Adolygiad edrych ar sut y defnyddir y Ddeddf a sut y gellir gwella ymarfer. Edrychodd yr Adolygiad ar pam:

- mae mwy a mwy o bobl yn cael eu cadw o dan y Ddeddf
- mae nifer anghymesur o bobl o grwpiau Du a lleiafrifoedd ethnig yn cael eu cadw

Gwnaeth yr Adolygiad 154 o argymhellion ar sut y dylid gwella'r Ddeddf Iechyd Meddwl.

Beth rydyn ni'n ei wneud nawr

Rydym wedi ystyried argymhellion yr Adolygiad ac rydym yn cynnig newidiadau i wella gwasanaethau iechyd meddwl a phrofiadau pobl o dan y Ddeddf Iechyd Meddwl. 'Papur Gwyn' yw'r enw ar hyn.

Nod y newidiadau yw sicrhau:

- bod pobl yn cael eu cadw am gyfnodau byrrach, a dim ond pan fydd hynny'n gwbl angenrheidiol y cânt eu cadw
- pan fydd rhywun yn cael ei gadw, bod y gofal a'r driniaeth y mae'n eu cael yn canolbwyntio ar ei wneud yn iach
- bod pobl yn cael mwy o ddewis ac ymreolaeth ynghylch eu triniaeth
- bod pawb yn cael ei drin yn gyfartal ac yn deg, a mynd i'r afael â'r gwahaniaethau a brofir gan bobl o gefndiroedd Du a Lleiafrifoedd Ethnig
- bod pobl ag anabledd dysgu a phobl awtistig yn cael eu trin yn well o dan y gyfraith a lleihau'r ddibyniaeth ar wasanaethau arbenigol i gleifion mewnol ar gyfer y grŵp hwn o bobl
- bod pawb yn cael ei drin yn gyfartal ac yn deg ac yr eir i'r afael â'r gwahaniaethau yn y cyfraddau cadw sy'n bodoli rhwng rhai grwpiau ethnig

Mae'r Papur Gwyn wedi'i rannu'n dair prif ran. Dyma nhw:

- Rhan 1: Diwygiadau deddfwriaethol – y newidiadau rydym yn eu cynnig i'r Ddeddf Iechyd Meddwl ei hun
- Rhan 2: Diwygio polisi ac ymarfer i wella profiad cleifion – cynlluniau'r Llywodraeth i sicrhau newid diwylliant cyffredinol o fewn gwasanaethau iechyd meddwl, er mwyn i bobl gael profiad llawer gwell o ofal o dan y Ddeddf
- Rhan 3: Ymateb Llywodraeth y DU i'r Adolygiad Annibynnol o'r Ddeddf Iechyd Meddwl – ymateb y Llywodraeth i bob un o argymhellion yr Adolygiad (nid ymdrinnir â hyn yn y ddogfen hon)

Hoffem glywed eich barn am y cynigion, er mwyn i ni allu ystyried hynny cyn gwneud unrhyw newidiadau.

Mae'r prif newidiadau rydyn ni'n eu cynnig ym mhapur gwyn y Ddeddf Iechyd Meddwl yn cael eu crynhoi yn y ddogfen hon.

Sut mae'r cynigion yn berthnasol i Gymru?

Mae'r Ddeddf Iechyd Meddwl bresennol yn gymwys yng Nghymru a Lloegr. Er bod polisi iechyd wedi'i ddatganoli i Gymru, mae materion cyfiawnder yn dal heb eu datganoli gan Lywodraeth y DU. Mae system ddatganoledig ar wahân hefyd o ran tribiwnlysoedd yng Nghymru.[footnote 2]

Mae'r Papur Gwyn yn cynrychioli safbwynt Llywodraeth y DU, a gomisiynodd yr Adolygiad Annibynnol o'r Ddeddf Iechyd Meddwl. Roedd cynigion yr Adolygiad yn canolbwyntio i raddau helaeth ar sut y mae'r gyfraith a'r system iechyd meddwl yn gweithredu yn Lloegr, er ei fod wedi rhoi rhywfaint o ystyriaeth i bolisi ac ymarfer yng Nghymru.

Materion datganoledig

Mae'r rhan fwyaf o'r Papur Gwyn yn ymwneud â pholisi iechyd sydd wedi'i ddatganoli i Gymru. Mae gwella canlyniadau iechyd meddwl yn flaenoriaeth drawsbynciol yng Nghymru ac mae gan Lywodraeth Cymru ymrwymiad polisi i ddarparu gwasanaethau iechyd meddwl rhagorol. Gan fod y Ddeddf yn gymwys yng Nghymru a Lloegr, mae angen ystyried canfyddiadau'r Adolygiad a'r cynigion a nodir yn y Papur Gwyn hwn yn ofalus hefyd yng nghyd-destun y ffordd y mae'r Ddeddf yn gweithredu ar hyn o bryd ochr yn ochr â deddfwriaeth, gwasanaethau a systemau iechyd meddwl penodol yng Nghymru. Yn arbennig, mae Mesur Iechyd Meddwl (Cymru) 2010 eisoes wedi rhoi rhai cynigion tebyg, megis cynlluniau gofal ar gyfer pobl sy'n cael eu cadw, ar sail statudol yng Nghymru.

Bydd Llywodraeth Cymru yn parhau i ymgysylltu â Llywodraeth y DU ar y cynigion a nodir yn y Papur Gwyn wrth iddi ystyried camau nesaf priodol ar gyfer Cymru ac wrth iddi ddatblygu ei hymateb ei hun i'r Adolygiad.

Materion a gedwir yn ôl

Tynnir sylw isod ac yn y Papur Gwyn at faterion a gedwir yn ôl lle gallai Llywodraeth y DU wneud newidiadau yng Nghymru a Lloegr (yn enwedig mewn perthynas â'r system cyfiawnder troseddol). Fodd bynnag, hyd yn oed mewn meysydd a gedwir yn ôl, mae Llywodraethau Cymru a'r DU yn gweithio'n agos i ddeall unrhyw effeithiau a materion penodol i Gymru, ac efallai y bydd achosion lle mae'n briodol i Gymru fabwysiadu dull diwygio gwahanol i'r hyn sy'n cael ei gynnig yn Lloegr.

Nid yw'n anghyffredin i gleifion o Gymru gael gofal yn Lloegr ac i gleifion o Loegr gael gofal yng Nghymru. Mae'r ddwy Lywodraeth felly wedi ymrwymo i sicrhau system iechyd meddwl gydgysylltiedig sy'n canolbwyntio ar yr unigolyn ac sy'n gweithio i'r holl gleifion a'r staff yn yr amgylchiadau hyn.

Ymateb i'r ymgynghoriad hwn yng Nghymru

Mae arnom eisiau sicrhau bod lleisiau o Gymru yn cael eu clywed yn ystod y cyfnod ymgynghori. Byddwn yn gweithio gyda Llywodraeth Cymru i sicrhau y bydd yr ymgynghoriad hwn hefyd yn helpu i lywio penderfyniadau polisi yng Nghymru. Er y bydd ymatebion i'r ymgynghoriad ar y Papur Gwyn yn mynd yn uniongyrchol i law Llywodraeth y DU, os ydych chi'n ymateb i'r ymgynghoriad hwn yng Nghymru, bydd eich adborth hefyd yn cael ei rannu â Llywodraeth Cymru. O ran materion a gedwir yn ôl, bydd yr holl ymatebion o Gymru a Lloegr yn cael eu hystyried yn llawn gan Lywodraeth y DU. O ran materion datganoledig, bydd y ddwy Lywodraeth yn darllen pob ymateb, fodd bynnag, ni fydd adborth o Gymru yn cael ei gyfrif na'i drafod ar wahân fel rhan o ymateb Llywodraeth y DU i'r ymgynghoriad.

Rhan 1: Diwygiadau deddfwriaethol

Pennod 1: Egwyddorion arweiniol newydd

Mae pedair egwyddor arweiniol newydd y bydd angen i bobl sy'n gweithio i ddarparu gofal eu hystyried wrth gyflawni eu dyletswyddau. Mae'r egwyddorion hyn yn ganolog i'n cynlluniau i foderneiddio a gwella'r Ddeddf Iechyd Meddwl. Sef:

- dewis ac ymreolaeth – sicrhau bod barn a dewisiadau pobl yn cael eu parchu
- cyfyngiad lleiaf – sicrhau bod pwerau'r Ddeddf yn cael eu defnyddio yn y ffordd leiaf cyfyngol
- budd therapiwtig – sicrhau bod cleifion yn cael eu cefnogi i wella, fel y gellir eu rhyddhau o'r Ddeddf cyn gynted ag y bo modd
- y person fel unigolyn – gwneud yn siŵr bod cleifion yn cael eu gweld a'u trin fel unigolion cyflawn.

Rydym am i'r egwyddorion hyn gael eu cynnwys yn amlwg yn y Ddeddf, yn ogystal ag yn y Cod Ymarfer, sy'n rhoi arweiniad ymarferol i staff ar sut i ddilyn y gyfraith. Rydym yn gobeithio y bydd y newid hwn yn helpu i sicrhau bod yr egwyddorion yn cael eu rhoi ar waith ym mhob agwedd ar ofal a thriniaeth pobl o dan y Ddeddf.

Gallwch ateb y cwestiwn ymgynghori am gymhwyso'r egwyddorion arweiniol:

> Cwestiwn ymgynghori 1: Rydym yn cynnig ymgorffori'r egwyddorion yn y Ddeddf Iechyd Meddwl ac yng Nghod Ymarfer y Ddeddf Iechyd Meddwl. Ble arall hoffech chi weld yr Egwyddorion yn cael eu rhoi ar waith i sicrhau eu bod yn cael effaith ac yn cael eu gwreiddio mewn arferion bob dydd?

[Testun rhydd – 500 gair]

Pennod 2: Meini prawf cadw cliriach a chadarnach

Y meini prawf cadw yw'r amodau yn y gyfraith y mae'n rhaid i lunwyr penderfyniadau ddangos bod person yn eu cyflawni cyn iddo gael ei gadw o dan y Ddeddf Iechyd Meddwl. Mae dau brif faen prawf. Y cyntaf yw bod y person yn dioddef o salwch meddwl digon difrifol i gyfiawnhau ei gadw. Yr ail yw bod angen cadw'r person er mwyn ei iechyd a'i ddiogelwch, neu er mwyn amddiffyn pobl eraill.

Gall person gael ei gadw ar gyfer asesiad meddygol (adran 2) neu ar gyfer triniaeth (adran 3).

Rydym am gryfhau ac egluro'r meini prawf ar gyfer cadw o dan adrannau 2 a 3 y Ddeddf, fel mai dim ond pan fydd hynny'n gwbl briodol y caiff cleifion eu cadw. Mae'r newidiadau hyn yn seiliedig ar yr egwyddorion arweiniol canlynol:

- budd therapiwtig – rhaid rhoi mwy o ystyriaeth i sut y bydd y gofal a'r driniaeth a ddarperir o dan y Ddeddf yn hybu adferiad ac yn hwyluso cleifion i wella
- cyfyngiad lleiaf – sicrhau mai dim ond os yw'n gwbl angenrheidiol y caiff person ei gadw, a lle mae peidio â'i gadw yn peri risg sylweddol o niwed sylweddol iddo ef ei hun neu i eraill

Bydd angen i'r rheswm pam fod unigolyn yn bodloni'r meini prawf cadw gael ei gofnodi gan ei Glinigydd Cyfrifol, gan gynnwys y risg benodol sy'n cyfiawnhau ei gadw a, lle bo'n berthnasol, sut y bydd ei gadw yn sicrhau budd therapiwtig.

Dylid rhannu'r rhesymau dros ei gadw gyda'r claf a dylent gael eu hadolygu gan lunwyr penderfyniadau eraill, yn cynnwys gan y Tribiwnlys Iechyd Meddwl pan fydd yn ystyried apeliadau. Gobeithiwn y bydd hyn yn arwain at fwy o dryloywder ac atebolrwydd.

Gweler Pennod 2 y Papur Gwyn am ragor o wybodaeth a gallwch hefyd ateb cwestiynau'r ymgynghoriad am newidiadau i'r meini prawf cadw:

Cwestiwn ymgynghori 2: Rydym eisiau newid y meini prawf cadw fel bod rhaid i gadw ddarparu budd therapiwtig i'r unigolyn. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn Ymgynghori 2a: Rhowch resymau dros eich ateb – [Testun rhydd – 200 gair]

Cwestiwn ymgynghori 3: Rydym hefyd am newid y meini prawf cadw fel mai dim ond os oes tebygolrwydd sylweddol o niwed sylweddol i iechyd, diogelwch neu les y person, neu i ddiogelwch unrhyw berson arall, y caiff unigolyn ei gadw i. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn Ymgynghori 3a: Rhowch resymau dros eich ateb

[Testun rhydd – 200 gair]

Pennod 3: Rhoi mwy o hawliau i gleifion herio cadw

Rydym am sicrhau bod yr achos dros ryddhau claf o'r ysbyty yn cael ei adolygu'n fwy rheolaidd a bod cleifion yn cael mwy o gyfleoedd i apelio i gael eu rhyddhau er mwyn sicrhau nad ydynt yn cael eu cadw'n hirach nag sy'n angenrheidiol.

Byddwn yn gwneud hyn drwy wneud y newidiadau a nodir isod.

Adolygiad mwy cyson o'r achos dros gadw claf

Rydym am wneud yn siŵr bod gofyn i'r Clinigydd Cyfrifol a phobl eraill sy'n gwneud penderfyniadau adolygu'r achos dros ryddhau claf yn fwy rheolaidd. Rydym hefyd yn bwriadu cynyddu mynediad pobl at y Tribiwnlys Haen Gyntaf (Iechyd Meddwl) (Tribiwnlys), sy'n craffu'n annibynnol ar gadw.

Mae'r cynigion canlynol yn cefnogi'r newidiadau hyn:

- Ar gyfer cleifion o dan adran 3 y Ddeddf, dylent gael tri chyfle ffurfiol i apelio yn erbyn eu cadw yn y Tribiwnlys, yn hytrach na dim ond dau o fewn eu blwyddyn gyntaf o gael eu cadw.
- Dylai cleifion sy'n cael eu cadw o dan adran 2 allu gwneud cais am gael eu rhyddhau yn ystod y 21 diwrnod cyntaf, yn hytrach na'r cyfnod terfyn o 14 diwrnod ar hyn o bryd.
- Dylai Eiriolwyr Iechyd Meddwl Annibynnol allu gwneud cais i'r Tribiwnlys Iechyd Meddwl ar ran y claf, fel nad oes neb yn llithro drwy'r rhwyd.
- Bod amlder atgyfeiriadau awtomatig i'r Tribiwnlys yn cynyddu er mwyn sicrhau bod achos pobl sy'n cael eu cadw o dan y Ddeddf Iechyd Meddwl yn cael ei glywed.
- Bod y Tribiwnlys yn ystyried Cynllun Gofal a Thriniaeth statudol y claf pan fydd yn ystyried cais am ryddhau. Dylai hyn nodi'n glir beth yw cyfiawnhad y clinigydd cyfrifol dros barhau i gadw'r claf.

Gweler pennod 3 y Papur Gwyn am ragor o wybodaeth am ein cynlluniau i roi mwy o hawliau i gleifion herio eu cadw. Gallwch ateb cwestiynau'r ymgynghoriad am y cyfnodau arfaethedig ar gyfer atgyfeirio claf i'r Tribiwnlys.

Cwestiwn ymgynghori 4: Ydych chi'n cytuno neu'n anghytuno â'r amserlen arfaethedig ar gyfer atgyfeiriadau awtomatig i'r Tribiwnlys Iechyd Meddwl (gweler tabl 1, isod, am fanylion)?

a) Cleifion o dan adran 3

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

b) Cleifion ar Orchymyn Triniaeth Gymunedol (GTG)

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

c) Cleifion sy'n ddarostyngedig i Ran III

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

d) Cleifion ar Ryddhad Amodol

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn 4a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Tabl 1: amlder atgyfeiriadau awtomatig

Math o glaf	Ar hyn o bryd	Cynnig
Cleifion sy'n ddarostyngedig i adran 3	Atgyfeiriad 6 mis ar ôl dechrau'r cyfnod cadw, os nad oedd y claf wedi gwneud apêl. Wedi hynny, byddir yn atgyfeirio os oes mwy na 3 blynedd wedi mynd heibio ers i'r Tribiwnlys ystyried yr achos ddiwethaf. I gleifion o dan 18 oed, caiff achosion eu hatgyfeirio i'r Tribiwnlys yn flynyddol.	Atgyfeiriad 4 mis ar ôl dechrau'r cyfnod cadw, os nad oedd y claf wedi gwneud apêl. Wedi hynny, byddid yn atgyfeirio 12 mis ar ôl i'r cyfnod cadw ddechrau, os nad yw'r Tribiwnlys wedi ystyried yr achos yn y cyfamser. Ar ôl y 12 mis cyntaf o gadw, byddai'r achos yn cael ei atgyfeirio'n flynyddol.

Math o glaf	Ar hyn o bryd	Cynnig
Cleifion ar GTG	Yn ystod y GTG, byddir yn atgyfeirio 6 mis ar ôl dechrau'r cyfnod cadw, os nad yw'r Tribiwnlys wedi ystyried yr achos yn y 6 mis cyntaf. Wedi hynny, byddir yn atgyfeirio os oes mwy na 3 blynedd (neu 1 flwyddyn yn achos claf o dan 18) wedi mynd heibio ers i'r Tribiwnlys ystyried yr achos ddiwethaf. Os bydd y GTG yn cael ei ddirymu, byddir yn atgyfeirio i'r Tribiwnlys cyn gynted ag y bo modd.	Byddid yn atgyfeirio 6 mis ar ôl i'r claf gael ei roi ar GTG, os nad yw'r Tribiwnlys wedi ystyried yr achos yn y 6 mis cyntaf. Wedi hynny, byddid yn atgyfeirio 12 mis ar ôl i'r claf gael ei roi ar GTG, os nad yw'r Tribiwnlys wedi ystyried yr achos yn y cyfamser, a bydd yn parhau i gael ei atgyfeirio'n flynyddol.
Cleifion sy'n ddarostyngedig i Ran III	Mae'r achos yn cael ei atgyfeirio os nad yw'r Tribiwnlys wedi ystyried achos y claf yn y 3 blynedd diwethaf.	Bob 12 mis
Cleifion ar Ryddhad Amodol (cyfyngedig, cleifion rhan III)	Nid oes gan y cleifion hyn hawl i gael eu hatgyfeirio'n awtomatig.	Byddid yn atgyfeirio 24 mis ar ôl i'r claf gael ei ryddhau'n amodol. Wedi hynny, byddid yn atgyfeirio bob 4 blynedd.

Newidiadau i gyfrifoldebau'r Tribiwnlys

Os oes cyfiawnhad dros barhau i gadw claf, rydym am roi'r pŵer i'r Tribiwnlys i roi caniatâd neu gyfarwyddo trosglwyddo cleifion i sefydliadau eraill, llai cyfyngol, i helpu i hwyluso adferiad y claf. Rydym hefyd yn cynnig rhoi'r pŵer i'r Tribiwnlys i gyfarwyddo gwasanaethau yn y gymuned, lle mae hyn yn rhwystr rhag ryddhau. Rydym yn cynnig y dylid rhoi 5 wythnos i awdurdodau iechyd ac awdurdodau lleol i gyflawni cyfarwyddiadau a wneir gan y Tribiwnlys Iechyd Meddwl.

Newidiadau eraill i weithdrefnau sy'n ymwneud â chadw claf

Rydym yn cynnig dileu rhannau presennol o'r broses adolygu cadw, y daeth yr Adolygiad i'r casgliad eu bod yn aneffeithiol neu y gwneir iawn amdanynt gan y diwygiadau uchod, a fydd yn sicrhau bod yr achos dros ryddhau claf yn cael ei adolygu'n amlach:

- Cael gwared â'r atgyfeiriad awtomatig i Dribiwnlys pan fydd Gorchymyn Triniaeth Gymunedol (GTG) claf yn dod i ben a'i fod yn dychwelyd i'r ysbyty. Gorchymyn yw GTG a wneir gan y Clinigydd Cyfrifol i roi triniaeth dan oruchwyliaeth i'r claf yn y gymuned, yn hytrach nag aros yn yr ysbyty.
- Dileu rôl Rheolwyr Ysbyty Cysylltiol (a elwir hefyd yn banel Rheolwyr Ysbyty) wrth adolygu'r achos dros ryddhau claf o gyfnod cadw neu GTG.

Mae rhagor o wybodaeth am y newidiadau hyn ar gael ym Mhennod 3 y Papur Gwyn. Gallwch hefyd ateb y cwestiynau ymgynghori canlynol:

Cwestiwn ymgynghori 5: Rydym am ddileu'r atgyfeiriad awtomatig i Dribiwnlys a gaiff defnyddwyr gwasanaeth pan fydd eu Gorchymyn Triniaeth Gymunedol yn cael ei ddirymu. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn Ymgynghori 5a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Cwestiwn ymgynghori 6: Rydym eisiau rhoi mwy o bŵer i'r Tribiwnlys Iechyd Meddwl allu caniatáu gadael, trosglwyddiadau a gwasanaethau cymunedol. Rydym yn cynnig y dylid rhoi 5 wythnos i awdurdodau iechyd ac awdurdodau lleol i gyflawni cyfarwyddiadau a wneir gan y Tribiwnlys Iechyd Meddwl. Ydych chi'n cytuno neu'n

anghytuno bod hyn yn gyfnod priodol o amser?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 6a: Rhowch resymau dros eich ateb.

[Testun rhydd – 200 gair]

Cwestiwn ymgynghori 7: Ydych chi'n cytuno neu'n anghytuno â'r cynnig i ddileu rôl panel y rheolwr wrth adolygu'r achos dros ryddhau claf o gyfnod cadw neu GTG?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 7a: Rhowch resymau dros eich ateb.

[Testun rhydd – 200 gair]

Pennod 4: Cryfhau hawl y claf i ddewis a gwrthod triniaeth

Rydym yn bwriadu diweddaru'r Ddeddf Iechyd Meddwl er mwyn i gleifion:

- Cael mwy o ddylanwad dros benderfyniadau am eu gofal a'u triniaeth
- Gallu disgwyl i'w dymuniadau a'u dewisiadau gael eu parchu a'u dilyn
- Cael cyfle i herio eu gofal a'u triniaeth os nad yw eu dymuniadau'n cael eu dilyn

Byddwn yn gwneud hyn drwy wneud y newidiadau a nodir isod.

Cyflwyno Dogfennau Dewisiadau Ymlaen Llaw

Mewn Dogfen Dewisiadau Ymlaen Llaw, bydd pobl yn gallu nodi ymlaen llaw pa ofal a thriniaeth fyddai orau ganddynt a/neu driniaethau y byddent yn dymuno eu gwrthod os byddant yn mynd yn rhy sâl i wneud y penderfyniadau hyn eu hunain. Gall y ddogfen hefyd nodi gwybodaeth bwysig arall megis manylion Person Enwebedig y claf, trefniadau cynllunio ar gyfer argyfwng ac arwyddion cynnar o lithro'n ôl.

Bydd ein diwygiadau'n mynnu bod Dogfennau Dewisiadau Ymlaen Llaw yn cael eu hystyried os na fydd gan y claf y galluedd meddyliol perthnasol yn ddiweddarach i fynegi ei ddymuniadau.

Rydym yn cynnig y bydd Dogfennau Dewisiadau Ymlaen Llaw, yn y rhan fwyaf o achosion, yn cael eu trin fel pe baent yn cyfateb i'r dymuniadau a'r dewisiadau a fynegir gan rywun sydd â'r galluedd perthnasol ar yr amod bod gan yr unigolyn, adeg ysgrifennu'r ddogfen, y galluedd meddyliol perthnasol.

Gallwch ddarllen mwy am yr hyn y gellir ei gynnwys mewn Dogfen Dewisiadau Ymlaen Llaw, a sut y bydd yn gweithio'n ymarferol, ym Mhennod 4.1 y Papur Gwyn. Gallwch hefyd ateb cwestiynau'r ymgynghoriad am yr hyn y dylid ei gynnwys yn Nogfen Dewisiadau Ymlaen Llaw y claf a sut y dylid penderfynu ar ddilysrwydd Dogfen Dewisiadau Ymlaen Llaw:

Cwestiwn ymgynghori 8: Oes gennych chi unrhyw awgrymiadau eraill ar gyfer yr hyn y dylid ei gynnwys yn Nogfen Dewisiadau Ymlaen Llaw yr unigolyn?

[Testun rhydd – 500 gair]

Cwestiwn ymgynghori 9: Ydych chi'n cytuno neu'n anghytuno y dylai dilysrwydd Dogfen Dewisiadau Ymlaen Llaw ddibynnu ar pa un a gafodd y datganiadau yn y ddogfen eu gwneud gyda galluedd a'u bod yn gymwys i'r driniaeth dan sylw, fel sy'n wir o dan y Ddeddf Galluedd Meddyliol?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 9a: Rhowch resymau dros eich ateb. [Testun rhydd – 500 gair]

Gwneud Cynlluniau Gofal a Thriniaeth yn rhai statudol

Rydym yn cynnig bod yn rhaid i bob claf gael Cynllun Gofal a Thriniaeth manwl erbyn diwrnod 7 y cyfnod cadw a bod y Cyfarwyddwr Meddygol neu'r Cyfarwyddwr Clinigol yn cymeradwyo'r cynllun erbyn diwrnod 14. Dylai'r Cynllun Gofal a Thriniaeth gynnwys gwybodaeth megis:

- y gofal a'r driniaeth a ddarperir a sut y gellir eu cyflwyno yn y modd lleiaf cyfyngol
- sut mae dymuniadau a dewisiadau'r claf yn cael eu hystyried, gan gynnwys unrhyw Ddogfen Dewisiadau Ymlaen Llaw
- rhesymeg y Clinigydd Cyfrifol pan nad yw dymuniadau a dewisiadau'r claf yn cael eu dilyn, sut bynnag y maent wedi cael eu mynegi
- sut mae argymhellion yr Adolygiadau Gofal (Addysg) a Thriniaeth wedi cael eu hystyried yn achos cleifion sydd ag anabledd dysgu neu gleifion awtistig, gan gynnwys unrhyw resymau pam na ddilynwyd y rhain.
- Cynllunio ar gyfer rhyddhau, gan gynnwys trefniadau ôl-ofal
- Cydnabod unrhyw nodweddion gwarchodedig, e.e. anghenion diwylliannol hysbys, a sut bydd y cynllun yn ystyried y rhain

Gallwch ddarllen mwy am ein cynigion o ran yr hyn y dylid ei gynnwys mewn Cynllun Gofal a Thriniaeth, a sut y bydd yn gweithio'n ymarferol, ym Mhennod 4.2 y Papur Gwyn. Gallwch hefyd ateb cwestiwn yr ymgynghoriad ar beth arall y dylid ei gynnwys yn y Cynllun Gofal a Thriniaeth statudol:

Cwestiwn ymgynghori 10: Oes gennych chi unrhyw awgrymiadau eraill ar gyfer yr hyn y dylid ei gynnwys yng Nghynllun Gofal a Thriniaeth yr unigolyn?

[Testun rhydd – 500 gair]

Cyflwyno fframwaith newydd ar gyfer cydsyniad claf a gwrthod triniaeth feddygol

Rydym am roi mwy o reolaeth i gleifion dros eu gofal a'u triniaeth a'r hawl i wrthod triniaethau meddygol penodol yn gynharach o lawer yn eu cyfnod cadw. I gyflawni hyn, rydym yn cynnig diwygiadau i Ran IV y Ddeddf, sy'n rheoleiddio penderfyniadau am ofal a thriniaeth claf, gan gynnwys beth sy'n digwydd pan fydd claf yn cydsynio i driniaeth gael ei rhoi iddo, a beth sy'n digwydd pan nad yw'n gwneud hynny.

Bydd y diwygiadau hyn yn gwella'r mesurau diogelu presennol ac yn cyflwyno rhai newydd ar gyfer cleifion nad ydynt yn cydsynio i driniaeth. Un newid allweddol yr ydym am ei wneud yw bod y pwynt pan fydd y meddyg a benodir i roi ail farn (SOAD) yn adolygu triniaeth claf yn digwydd yn gynharach. Mae'r meddyg SOAD yn annibynnol ar y clinigwr cyfrifol ac yn adolygu a yw'r driniaeth yn iawn o safbwynt clinigol ac a yw barn a hawliau'r claf wedi cael eu hystyried yn ddigonol. Ar hyn o bryd, rhaid i'r meddyg SOAD ardystio triniaeth claf 3 mis ar ôl i'r driniaeth ddechrau, lle nad yw'n cydsynio. Rydym yn cynnig rhoi mynediad i'r claf at y meddyg SOAD ar ddiwrnod 14 y cyfnod cadw ac, os nad oes gan y claf y galluedd perthnasol i gydsynio i driniaeth, byddwn yn mynnu bod y meddyg SOAD yn ardystio ei driniaeth ym mis 2, yn hytrach na mis 3.

Un diwygiad pwysig arall sy'n cael ei gynnig yw'r gallu i gleifion apelio yn erbyn penderfyniadau am driniaeth yn y Tribiwnlys, gerbron un barnwr, lle mae tystiolaeth i awgrymu bod eu dymuniadau a'u dewisiadau wedi cael eu diystyru'n amhriodol gan y clinigydd cyfrifol.

Mae Pennod 4.3 a 4.4 yn rhoi rhagor o fanylion am y newidiadau rydym am eu gwneud o ran:

- Hawliau cleifion i fod yn rhan o benderfyniadau ynghylch triniaeth feddygol, ac i wrthod triniaethau penodol, gyda rheolau gwahanol yn dibynnu ar pa un a yw rhywun yn gwrthod gyda neu heb alluedd ac ar natur y driniaeth.
- Y gweithdrefnau y mae'n rhaid i weithwyr iechyd proffesiynol eu dilyn i sicrhau eu bod yn ystyried dymuniadau a dewisiadau'r claf yng nghyswllt triniaeth feddygol.

- Hawliau cleifion i apelio yn erbyn penderfyniadau a wnaed gan y clinigydd cyfrifol ynghylch eu triniaeth a sut mae'r rhain yn wahanol i gleifion sydd â'r galluedd meddyliol perthnasol neu sydd heb y gallu meddyliol perthynasol, a'r rheini sydd â Dogfen Dewisiadau Ymlaen Llaw.
- Newidiadau i'r meini prawf ar gyfer rhoi triniaeth mewn amgylchiadau brys sy'n amddiffyn hawl y claf i wrthod triniaeth, os oes ganddo alluedd perthnasol i wneud hynny.

Gallwch hefyd ateb cwestiynau'r ymgynghoriad ar y newidiadau hyn:

Cwestiwn ymgynghori 11: Ydych chi'n cytuno neu'n anghytuno y dylai cleifion sydd â galluedd ac sy'n gwrthod triniaeth fod â'r hawl i'w dymuniadau gael eu parchu hyd yn oed os ystyrir bod y driniaeth yn angenrheidiol ar unwaith i liniaru dioddefaint difrifol?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 11a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Cwestiwn ymgynghori 12: Ydych chi'n cytuno neu'n anghytuno, yn ogystal â'r pŵer i fynnu bod y Clinigydd Cyfrifol yn ailystyried penderfyniadau ynghylch triniaeth, y dylai barnwr y Tribiwnlys Iechyd Meddwl (yn eistedd ar ei ben ei hun) hefyd allu gorchymyn na roddir triniaeth benodol?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 12a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Pennod 5: Gwella'r gefnogaeth i bobl sy'n cael eu cadw

Person Enwebedig

Un o nodau cyffredinol ein diwygiadau arfaethedig yw rhoi mwy o ddewis ac ymreolaeth i bobl pan fyddant yn dod o dan y Ddeddf.

Mae'r adran hon yn trafod ein cynlluniau i ddisodli'r rôl Perthynas Agosaf bresennol sydd, yn ein barn ni, yn hen ffasiwn ac nad yw'n rhoi digon o lais i'r claf o ran pwy sy'n ymwneud â'i ofal, gyda rôl statudol newydd, a elwir yn 'Berson Enwebedig'. Bydd unigolion yn gallu dewis eu Person Enwebedig, os ydynt am gael un, ar adeg eu cadw o dan y Ddeddf neu yn eu Dogfen Dewisiadau Ymlaen Llaw.

Os bydd claf yn rhy sâl i wneud y penderfyniad hwn, bydd Gweithiwr Iechyd Meddwl Proffesiynol Cymeradwy yn penodi un ar ei gyfer. Gweithwyr iechyd meddwl proffesiynol yw Gweithwyr Iechyd Meddwl Proffesiynol Cymeradwy sydd wedi cael eu cymeradwyo gan awdurdod lleol i gyflawni dyletswyddau penodol o dan y Ddeddf. Maent yn gyfrifol am gydlynu asesiad person a'i dderbyn i'r ysbyty os yw'n cael ei gadw dan orfod o dan y Ddeddf.

Bydd gan y Person Enwebedig holl bwerau'r Perthynas Agosaf, ynghyd â rhai pwerau a hawliau newydd, gan gynnwys:

- Yr hawl i gael cyfle i fynegi barn ar Gynlluniau Gofal a Thriniaeth statudol i sicrhau bod buddiannau gorau'r claf yn cael eu gwarchod
- Yr hawl i gael cyfle i fynegi barn ar drosglwyddiadau rhwng ysbytai, yn ogystal ag ar adnewyddu ac ymestyn cyfnodau cadw a Gorchmynion Triniaeth Gymunedol
- Y gallu i apelio yn erbyn penderfyniadau am driniaeth glinigol, ar ran y claf lle mae'n rhy sâl i wneud hynny ei hun
- Y pŵer i wrthwynebu defnyddio GTG ar ran y claf
- Y pŵer i wneud cais i'r Tribiwnlys ar ran y claf am iddo gael ei ryddhau.

Byddwn yn newid y broses yn ymwneud â diystyru penderfyniadau a wneir gan y Perthynas Agosaf, fel na fydd y Person Enwebedig yn fforffedu ei rôl yng ngofal y claf os yw'n gwrthwynebu iddo gael ei gadw.

Gallwch ddarllen mwy am bwerau'r Person Enwebedig, pa gleifion fydd yn cael mynediad atynt a'r amgylchiadau a'r gweithdrefnau ar gyfer diystyru eu pwerau a ble mae'r cyfrifoldeb hwn yn gorffwys ym Mhennod 5 y Papur Gwyn. Gallwch hefyd ateb cwestiynau'r ymgynghoriad am bwerau newydd y Person Enwebedig:

Cwestiwn ymgynghori 13: Ydych chi'n cytuno neu'n anghytuno â phwerau ychwanegol arfaethedig y Person Enwebedig?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 13a: Rhowch resymau dros eich ateb.

[Testun rhydd – 200 gair]

Rydym am weld bod gan fwy o gleifion yr hawl i Berson Enwebedig. Bwriadwn ymestyn yr hawl hon i gleifion yn y system cyfiawnder troseddol, sy'n ddarostyngedig i Ran III y Ddeddf (a elwir hefyd yn gleifion fforensig), fodd bynnag, bydd pwerau'r Person Enwebedig yn fwy cyfyngedig.

Ar gyfer plant a phobl ifanc, bydd gan y rhai 16 ac 17 oed yr un hawl i ddewis Person Enwebedig ag oedolyn. Ar gyfer plant dan 16 oed, os ydynt yn "gymwys yn ôl Gillick", lle mae ganddynt ddealltwriaeth, aeddfedrwydd a deallusrwydd digonol i ddeall yn llawn, credwn y dylent allu dewis Person Enwebedig hefyd.

Mae rhagor o wybodaeth am y maes hwn ar gael ym Mhennod 5 a gallwch hefyd ateb cwestiwn yr ymgynghoriad ar allu plant a phobl ifanc i ddewis Person Enwebedig:

Cwestiwn ymgynghori 14: Ydych chi'n cytuno neu'n anghytuno y dylai rhywun dan 16 oed allu dewis Person Enwebedig gan gynnwys rhywun nad oes ganddo gyfrifoldeb rhiant drosto, lle mae ganddo'r gallu i ddeall y penderfyniad (a elwir yn "gymhwysedd Gillick")?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 14a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Eiriolaeth

Mae Eiriolwyr Iechyd Meddwl Annibynnol yn darparu mesurau diogelu pwysig i bobl sy'n cael eu cadw o dan y Ddeddf Iechyd Meddwl. Rydyn ni eisiau ehangu rôl Eiriolwyr Iechyd Meddwl Annibynnol fel eu bod hefyd yn gallu:

- Cefnogi cleifion i gymryd rhan mewn cynllunio gofal
- Cefnogi unigolion i baratoi Dogfennau Dewisiadau Ymlaen Llaw
- Herio penderfyniadau ynghylch triniaeth lle mae ganddynt reswm i gredu nad ydynt er lles gorau'r claf;
- Apelio i'r Tribiwnlys pan fydd cleifion yn rhy sâl i wneud hynny eu hunain

Mae eiriolaeth o ansawdd uchel yn hanfodol i sicrhau bod pobl yn cael y gefnogaeth sydd ei hangen arnynt pan fyddant yn cael eu cadw. Rydym yn ystyried sut y gallwn wella'r rôl ac rydym yn croesawu eich barn ynghylch a ellir cyflawni hyn drwy broffesiynoli'r gwasanaeth.

Un o'r blaenoriaethau wrth ddarparu gwasanaethau o ansawdd uwch yw datblygu eiriolaeth sy'n briodol yn ddiwylliannol ar gyfer pobl o bob cefndir ethnig a phob cymuned. Byddwn yn cynnal cynlluniau peilot eiriolaeth sy'n sensitif i ddiwylliannau er mwyn dysgu sut i ymateb yn well i anghenion amrywiol unigolion o gymunedau lleiafrifoedd ethnig.

Gallwch ateb cwestiynau'r ymgynghoriad ar bwerau helaethach Eiriolwyr Iechyd Meddwl Annibynnol a sut y gallwn sicrhau bod gwasanaethau eiriolaeth o ansawdd uchel yn cael eu darparu'n gyffredinol:

Cwestiwn ymgynghori 15: Ydych chi'n cytuno â'r pwerau ychwanegol arfaethedig ar gyfer Eiriolwyr Iechyd Meddwl Annibynnol?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 15a: Rhowch resymau dros eich ateb.

[Testun rhydd – 200 gair]

Cwestiwn ymgynghori 16: Ydych chi'n cytuno neu'n anghytuno y gellid gwella gwasanaethau eiriolaeth drwy:

- Safonau Gwell [Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]
- Rheoleiddio [Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]
- Achredu gwell [Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]
- Dim un o'r uchod, ond drwy modd arall [Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 16a: Rhowch resymau dros eich ateb

[Testun rhydd – 500 gair]

Pennod 6: Gorchmynion Triniaeth Gymunedol (GTGion)

Pwrpas GTGion yw galluogi rhai cleifion mewnol, a fyddai fel arall efallai yn parhau i gael eu cadw o dan y Ddeddf, i gael eu rhyddhau i'r gymuned ar amodau sydd wedi'u bwriadu i gynnal cysylltiad parhaus â gwasanaethau, er mwyn darparu cefnogaeth ac atal llithro'n ôl.

Byddwn yn diwygio GTGion fel mai dim ond pan fydd cyfiawnhad cryf dros wneud hynny a phan ystyrir bod y Gorchymyn yn rhoi budd therapiwtig gwirioneddol i'r claf y cânt eu defnyddio.

I gyflawni hyn, byddwn yn:

- Cryfhau'r meini prawf ar gyfer gwneud GTG yn y lle cyntaf, fel ei fod yn adlewyrchu'r meini prawf newydd ar gyfer cadw rhywun dan Adran 3;
- Cynyddu'r gofynion tystiolaeth sydd eu hangen i wneud GTG a'r amodau o'i amgylch;
- Newid y broses ar gyfer galw person sy'n destun GTG yn ôl i'r ysbyty, fel ei fod yn amharu llai ar yr unigolyn;
- Mynnu bod mwy o weithwyr proffesiynol yn gorfod cymeradwyo GTG, i sicrhau mwy o graffu
- Rhoi pwerau i'r Tribiwnlys i orchymyn bod y clinigydd cyfrifol yn ailystyried amodau GTG claf os ydynt yn rhy gaeth;
- Rhoi'r hawl i'r Person Enwebedig wrthwynebu GTG, ar ran y claf;
- Cyflwyno disgwyliad na ddylai GTG bara mwy na 24 mis.

Rydym yn gobeithio y bydd y diwygiadau hyn yn arwain at roi llai o bobl ar GTGion a, phan fyddant yn cael eu defnyddio, bod cleifion yn elwa o'r strwythur y maent yn ei ddarparu i gefnogi ymgysylltiad parhaus â gwasanaethau iechyd meddwl.

Byddwn yn monitro effeithiau'r diwygiadau hyn dros gyfnod cychwynnol o bum mlynedd. Byddwn yn adolygu ac yn diweddaru polisi'r Llywodraeth ar ddefnyddio GTGion yn unol â'r dystiolaeth sy'n dod i'r amlwg.

Gallwch ddarllen gwybodaeth am y diwygiadau arfaethedig i GTGion ym Mhennod 6 y Papur Gwyn.

Pennod 7: Y rhyngwyneb rhwng y Ddeddf Iechyd Meddwl a'r Ddeddf Galluedd Meddyliol

Pan fydd angen i berson gael ei dderbyn i'r ysbyty oherwydd ei anhwylder meddwl, efallai y bydd angen i'r clinigydd benderfynu a ddylai'r person gael ei dderbyn o dan y Ddeddf Iechyd Meddwl ynteu o dan Drefniadau Diogelu wrth Amddifadu o Ryddid y Ddeddf Galluedd Meddyliol, a fydd yn cael eu disodli cyn bo hir gan Fesurau Diogelu Amddiffyn Rhyddid.

Mae'r dewis hwn rhwng pa fframwaith sydd fwyaf priodol yn codi os yw'r claf:

- yn dioddef o salwch meddwl sy'n peryglu ei ddiogelwch ei hun, neu ddiogelwch pobl eraill, ac sy'n ei gwneud yn ofynnol iddo gael ei dderbyn i'r ysbyty am driniaeth feddygol;
- s nad oes ganddo'r galluedd meddyliol perthnasol i gydsynio i gael ei gadw a'i drin; ac,
- nad yw'n gwrthwynebu cael ei gadw neu ei drin.

Yn yr amgylchiadau hyn, nid yw'n glir ar hyn o bryd pa fframwaith cyfreithiol y dylid ei ddefnyddio. Ceir hefyd safbwyntiau croes ynghylch pa fesurau diogelu cyfreithiol sy'n well ar gyfer cleifion.

Rydym yn edrych ar syniad yr Adolygiad o gyflwyno 'ffin' symlach rhwng y Ddeddf Iechyd Meddwl a'r Ddeddf Galluedd Meddyliol i'w gwneud yn glir pa fframwaith y dylai clinigydd ei ddefnyddio i gadw claf o dan yr amgylchiadau hyn.

Byddai'r cynnig hwn yn golygu y byddai'r dewis yn cael ei ddileu, a byddai'r rhai sy'n gwneud y penderfyniadau yn defnyddio'r Trefniadau Diogelu wrth Amddifadu o Ryddid/Mesurau Diogelu Amddiffyn Rhyddid ac nid y Ddeddf Iechyd Meddwl, pe bai claf:

- heb y galluedd meddyliol perthnasol i gydsynio i gael ei gadw a'i drin;
- ac nad yw'n gwrthwynebu cael ei gadw neu ei drin.

Gallwch ddarllen mwy am y mater hwn ym Mhennod 7 y Papur Gwyn a hefyd ateb cwestiwn yr ymgynghoriad ar sut y dylem wneud y ffin rhwng y Ddeddf Galluedd Meddyliol a'r Ddeddf Iechyd Meddwl yn gliriach:

Cwestiwn ymgynghori 17: Sut y dylai'r fframwaith cyfreithiol ddiffinio'r ffin rhwng y Ddeddf Iechyd Meddwl a'r Ddeddf Galluedd Meddyliol fel y gellir gwneud cleifion yn ddarostyngedig i'r pwerau sydd fwyaf priodol i fodloni eu hamgylchiadau?

[Testun rhydd 500 gair]

Caniatâd ymlaen llaw i gael ei dderbyn fel claf anffurfiol

Rydym hefyd yn trafod a ddylem wneud darpariaeth yn y Ddeddf Iechyd Meddwl sy'n nodi'n glir hawl unigolion i gydsynio ymlaen llaw i gael eu derbyn i'r ysbyty am driniaeth am salwch meddwl. Byddai hyn yn golygu, pe bai unigolyn wedi rhoi caniatâd ymlaen llaw a'i fod yn mynd yn sâl yn ddiweddarach ac yn colli'r galluedd perthnasol, y byddai'n cael ei dderbyn fel claf anffurfiol neu wirfoddol, yn hytrach na chael ei gadw o dan y Ddeddf Iechyd Meddwl neu'n ddarostyngedig i'r Trefniadau Diogelu wrth Amddifadu o Ryddid/Mesurau Diogelu Amddiffyn Rhyddid.

Gallwch ddarllen mwy am yr hyn y byddai hyn yn ei olygu i gleifion ym Mhennod 7 y Papur Gwyn a gallwch ateb cwestiwn yr ymgynghoriad ynghylch a ddylem newid y ddeddfwriaeth i egluro'r dewis o gydsynio ymlaen llaw i glaf gael ei dderbyn fel claf anffurfiol.

[Testun rhydd – 500 gair]

Cwestiwn ymgynghori 18: Ydych chi'n cytuno neu'n anghytuno y dylai'r hawl i roi caniatâd ymlaen llaw i dderbyn cleifion i ysbyty iechyd meddwl yn anffurfiol gael ei nodi yn y Ddeddf Iechyd Meddwl a Chod Ymarfer y Ddeddf i'w gwneud yn glir bod yr hawl hon ar gael i unigolion?

[Cytuno/Anghytuno]

Cwestiwn ymgynghori 18a: Rhowch resymau dros eich ateb

[Testun rhydd – 500 gair]

Os ydych yn cytuno:

Cwestiwn ymgynghori 18b: A oes unrhyw fesurau diogelu y dylid eu rhoi ar waith i sicrhau bod cydsyniad unigolyn ymlaen llaw i gael ei dderbyn yn cael ei ddilyn yn briodol?

[Testun rhydd – 500 gair]

Pwerau Brys yn y Ddeddf Iechyd Meddwl a'r Ddeddf Galluedd Meddyliol

Rydym am wella'r pwerau sydd ar gael i weithwyr iechyd proffesiynol mewn adrannau damweiniau ac achosion brys fel bod unigolion y mae angen gofal iechyd meddwl brys arnynt yn aros ar y safle, hyd nes y ceir asesiad clinigol. Nod hyn yw osgoi defnyddio'r heddlu i ddal unigolion sydd mewn argyfwng ac sy'n ceisio gadael Adrannau Damweiniau ac Achosion Brys, a allai arwain at fwy o drallod i'r unigolyn.

Rydym yn trafod manteision dibynnu ar adran 4B y Ddeddf Galluedd Meddyliol i gyflawni'r amcan hwn o'i gymharu ag ymestyn adran 5 y Ddeddf Iechyd Meddwl, a byddai'r naill a'r llall yn rhoi pwerau i weithwyr iechyd proffesiynol mewn Adrannau Damweiniau ac Achosion Brys i gadw pobl dros dro o dan amgylchiadau penodol.

Gweler Pennod 7 y Papur Gwyn am ragor o fanylion am y newid hwn a gallwch hefyd ateb cwestiwn yr ymgynghoriad:

Cwestiwn ymgynghori 19: Rydym am sicrhau bod gweithwyr iechyd proffesiynol yn gallu dal unigolion dros dro mewn Adrannau Damweiniau ac Achosion Brys pan fyddant mewn argyfwng a bod angen asesiad iechyd meddwl arnynt, ond eu bod yn ceisio gadael Adrannau Damweiniau ac Achosion Brys. Ydych chi'n meddwl bod y diwygiadau i adran 4B y Ddeddf Galluedd Meddyliol yn cyflawni'r amcan hwn, neu a ddylem ni hefyd ymestyn adran 5 y Ddeddf Iechyd Meddwl?

- A) Dibynnu ar adran 4B y Ddeddf Galluedd Meddyliol yn unig
- B) Ymestyn adran 5 y Ddeddf Iechyd Meddwl fel ei bod hefyd yn berthnasol i Adrannau Damweiniau ac Achosion Brys, gan dderbyn bod adran 4B yn dal ar gael ac y gellir ei defnyddio lle bo'n briodol

Cwestiwn ymgynghori 19c: Rhowch resymau dros eich ateb

[Testun rhydd – 500 gair]

Pennod 8: Gofalu am gleifion yn y System Cyfiawnder Troseddol

Efallai y bydd gan rai pobl sy'n dod i gysylltiad â'r system cyfiawnder troseddol salwch meddwl digon difrifol i fod ag angen triniaeth yn yr ysbyty. Gallai hyn gael ei ganfod ar ôl i'r unigolyn gael ei arestio gan yr heddlu, cael ei gydnabod gan lys, neu gall person fynd yn sâl yn ddiweddarach yn y ddalfa.

Rydym am sicrhau bod pobl yn yr amgylchiadau hyn yn cael mynediad at y gofal iawn, ar yr adeg iawn, tra'n cyflawni ein dyletswydd i amddiffyn y cyhoedd.

Mae Rhan III y Ddeddf yn nodi'r fframwaith ar gyfer gofalu am y cleifion hyn. Bydd llawer o'n diwygiadau i wella gofal cleifion yn berthnasol i gleifion o dan y rhan hon o'r Ddeddf, fodd bynnag, ceir rhai eithriadau:

- Ni fydd y meini prawf newydd ar gyfer cadw cleifion yn berthnasol i gleifion Rhan III
- Pwerau cyfyngedig fydd gan y Person Enwebedig ar gyfer claf Rhan III
- Bydd pwerau'r Tribiwnlys ac atgyfeiriadau awtomatig i'r Tribiwnlys yn wahanol i'r cleifion hyn o'u cymharu â chleifion sifil
- Ni fydd newidiadau i'r meini prawf cadw ar gyfer unigolion ag anabledd dysgu a/neu awtistiaeth yn berthnasol i gleifion Rhan III

Mae'r system cyfiawnder troseddol yn cwmpasu Cymru a Lloegr. Rydym yn croesawu'n arbennig ymatebion gan bobl yng Nghymru a Lloegr i gwestiynau'r ymgynghoriad yn y bennod hon o'r Papur Gwyn.

Pwerau Llysoedd – cysoni Llysoedd Ynadon a Llys y Goron

Mae'r Ddeddf Iechyd Meddwl yn rhoi pŵer i lysoedd ynadon ddargyfeirio person sydd mewn argyfwng iechyd meddwl o'r system cyfiawnder troseddol ac i'r ysbyty ar gyfer asesiad a/neu driniaeth. Fodd bynnag, gall fod oedi ar hyn o bryd o ran sicrhau bod pobl yn cael y gofal a'r driniaeth y mae arnynt eu hangen.

Er mwyn cyflymu'r broses, argymhellodd yr Adolygiad y dylid cynyddu pwerau'r llysoedd ynadon i sicrhau eu bod yn cyd-fynd â Llys y Goron. Gan ein bod ar hyn o bryd yn ystyried diwygiadau eraill i'r llysoedd ynadon, a wnaed gan Gomisiwn y Gyfraith, rydym yn dymuno rhoi ystyriaeth bellach i hyn cyn i ni wneud ein penderfyniad ar argymhelliad yr

Adolygiad.

Darllenwch Bennod 8 y Papur Gwyn i gael trafodaeth lawn ar y cynnig hwn.

Trosglwyddiadau Diogel - trosglwyddo pobl rhwng y Carchar neu Ganolfannau Mewnfudo a Symud a'r ysbyty

Rydym am sicrhau nad yw pobl y mae angen gofal a thriniaeth arnynt o dan y Ddeddf Iechyd Meddwl yn cael eu cadw mewn carchardai neu Ganolfannau Mewnfudo a Symud mewn modd amhriodol.

Er mwyn cyflymu'r broses o drosglwyddo cleifion o'r carchar neu Ganolfannau Mewnfudo a Symud i sefydliadau iechyd meddwl ar gyfer cleifion mewnol, byddwn yn cyflwyno terfyn amser statudol o 28 diwrnod yn Lloegr pan fydd canllawiau newydd, sy'n cael eu paratoi gan NHS England and Improvement (NHSEI), wedi'u gwreiddio'n briodol.

Gallwch ateb cwestiwn yr ymgynghoriad ynghylch beth arall ddylai fod yn ei le cyn y gallwn gyflwyno'r terfyn amser statudol ar gyfer trosglwyddo cleifion yn ddiogel.

Cwestiwn ymgynghori 20: Er mwyn cyflymu'r broses o drosglwyddo o garchar neu ganolfan symud mewnfudwyr (IRC), rydym eisiau cyflwyno terfyn amser o 28 diwrnod. A oes angen rhoi rhagor o fesurau diogelu ar waith cyn y gallwn weithredu terfyn amser statudol ar gyfer trosglwyddiadau diogel?

Oes/Nac oes/Ddim yn siŵr

Cwestiwn ymgynghori 20a: Rhowch resymau dros eich ateb.

[Testun rhydd – 500 gair]

Rydym hefyd am gyflwyno rôl statudol, annibynnol newydd i reoli'r broses o drosglwyddo pobl o'r carchar i'r ysbyty fel bod rhwystrau'n cael eu goresgyn yn gynt, a bod anghenion y claf yn cael eu rhoi gyntaf. Rydym hefyd yn ystyried rhoi'r hawl i bobl sy'n aros i gael eu trosglwyddo i gael Eiriolwr Iechyd Meddwl Annibynnol.

Gallwch ateb cwestiwn yr ymgynghoriad ar sut y dylem gyflwyno'r rôl statudol newydd:

Cwestiwn ymgynghori 21: Rydym am sefydlu rôl ddynodedig newydd ar gyfer unigolyn i reoli'r broses o drosglwyddo pobl o'r carchar neu o Ganolfan Mewnfudo a Symud i'r ysbyty pan fydd angen triniaeth fel claf mewnol arnynt ar gyfer eu hiechyd meddwl. Pa un o'r dewisiadau canlynol ydych chi'n meddwl yw'r dull mwyaf effeithiol o gyflawni hyn?

- Ehangu rôl bresennol Gweithiwr Iechyd Meddwl Proffesiynol Cymeradwy yn y gymuned fel ei fod hefyd yn gyfrifol am reoli trosglwyddiadau carchar/canolfan mewnfudo a symud
- Creu rôl newydd o fewn NHSEI neu ar draws NHSEI a Gwasanaeth Carchardai a Phrawf Ei Mawrhydi i reoli proses drosglwyddo'r carchardai/canolfannau mewnfudo a symud
- Dull arall posibl (rhowch fanylion)

[Testun rhydd – 100 gair]

- Cwestiwn ymgynghori 21a: Rhowch resymau dros eich ateb

[Testun rhydd – 200 gair]

Pan nad oes gwely ysbyty ar gael a bod ar ddiffynnydd (h.y. person y mae achos troseddol neu sifil yn cael ei ddwyn yn ei erbyn) angen gofal a thriniaeth iechyd meddwl, gall llysoedd gael eu gorfodi i'w roi yn y carchar fel "lle diogel". Rydym am wneud yn siŵr bod lleoliadau eraill ar gael i roi diwedd ar ddefnyddio carchar fel lle diogel.

Cleifion dan Gyfyngiadau

Cleifion dan gyfyngiadau yw cleifion sy'n cael eu cadw mewn ysbyty o dan Ran III o'r Ddeddf ac sy'n ddarostyngedig i fesurau rheoli arbennig gan yr Ysgrifennydd Gwladol dros Gyfiawnder, oherwydd pryderon diogelwch.

I gleifion dan gyfyngiadau, rhaid i'r Clinigydd Cyfrifol ofyn am ganiatâd yr Ysgrifennydd Gwladol dros Gyfiawnder i roi caniatâd i'r claf adael, neu i drosglwyddo'r claf i ysbyty arall, neu i ryddhau'r claf. Cododd yr Adolygiad ei bryderon ynghylch aneffeithlonrwydd yn y system hon a oedd yn arwain at oedi rhag sicrhau'r caniatâd hwn. Ers hynny, rydym wedi gweithio i fynd i'r afael â hyn ac rydym eisoes yn gweld cynnydd cadarnhaol.

Gallwch ddarllen Pennod 8 y Papur Gwyn am drafodaeth ar ein dull o leihau oedi yn y system a'r cynnydd sydd wedi'i wneud hyd yma.

Cleifion a ryddheir yn amodol

Rhaid rhyddhau rhai cleifion dan gyfyngiadau nad ydynt bellach yn bodloni'r prawf statudol ar gyfer eu cadw mewn ysbyty. Gall hyn fod yn rhyddhad diamod. Neu, os yw'r Tribiwnlys neu'r Ysgrifennydd Cyfiawnder o'r farn bod hynny'n briodol, yn rhyddhad amodol.

Mae rhyddhad amodol yn caniatáu i gleifion symud i'r gymuned. Ond rhaid iddynt ddilyn amodau penodol, ac mae pŵer sy'n golygu y gellir eu galw'n ôl i'r ysbyty os yw'n angenrheidiol i amddiffyn y cyhoedd rhag niwed. Roedd 2,821 o gleifion a ryddhawyd yn amodol yn y gymuned yn 2019.

Mae cleifion a ryddheir yn amodol yn cael eu goruchwylio'n gyffredinol yn y gymuned gan seiciatrydd a goruchwyliwr cymdeithasol. Mae Goruchwyliaeth Gymdeithasol yn rôl bwysig, yn cydbwyso diogelwch y cyhoedd â gofal a chefnogaeth i gleifion a ryddheir yn amodol. Yn draddodiadol, gweithiwr cymdeithasol awdurdod lleol fu'n cyflawni'r rôl, er y gall gweithwyr proffesiynol eraill ymgymryd â hi hefyd. Ar hyn o bryd mae rhywfaint o ddryswch ynghylch pa weithwyr proffesiynol ddylai gyflawni'r rôl hon a diffyg arweiniad cenedlaethol ynghylch sut y dylai weithredu.

Cwestiwn ymgynghori 22: Mae cleifion a ryddheir yn amodol fel arfer yn cael eu goruchwylio yn y gymuned gan seiciatrydd neu oruchwyliwr cymdeithasol. Sut ydych chi'n meddwl y gellid cryfhau rôl y Goruchwylydd Cymdeithasol?

[Testun rhydd – 500 gair]

Rhyddhau carcharorion sydd wedi'u trosglwyddo gan y Bwrdd Parôl

Yn achos cleifion Rhan III sy'n cael eu trin mewn ysbyty iechyd meddwl ac sy'n bwrw dedfryd amhenodol neu ddedfryd oes, gall penderfyniadau ynghylch rhyddhau'r person o'r ysbyty a'i ryddhau o'r carchar fod yn gymhleth.

Ar hyn o bryd, mae'n rhaid i'r Tribiwnlys ac yna'r Bwrdd Parôl ystyried penderfyniadau ynghylch rhyddhau o'r ysbyty a rhyddhau o'r carchar ar wahân, gan arwain at oedi.

Rydym yn gwneud gwaith i symleiddio prosesau ac i ganfod newidiadau gweithdrefnol i leihau oedi.

Rhoi'r pŵer i'r Tribiwnlys ryddhau rhywun ar amodau sy'n cyfyngu ar ryddid yn y gymuned

I nifer fach o gleifion dan gyfyngiadau, gall y risg y maent yn ei hachosi i eraill barhau i fod yn sylweddol pan nad ydynt mwyach yn elwa'n therapiwtigo gael eu cadw yn yr ysbyty. Rydym am wneud yn siŵr bod y risg y mae'r cleifion hyn yn ei hachosi yn cael ei rheoli yn y ffordd fwyaf priodol a lleiaf cyfyngol, gan symud yr unigolyn yn ei flaen ar hyd ei lwybr gofal.

I gyflawni hyn, rydym eisiau rhoi'r pŵer i'r Tribiwnlys i ryddhau cleifion dan gyfyngiadau i'r gymuned, o dan oruchwyliaeth a chydag amodau sy'n cyfyngu ar eu rhyddid.

Mae'r meini prawf ar gyfer gwneud hyn a'r mesurau diogelu y byddai'r claf yn gallu cael mynediad atynt wedi'u nodi ym Mhennod 8 y Papur Gwyn.

Gallwch hefyd ateb cwestiwn yr ymgynghoriad ynghylch a ddylem wneud y pŵer rhyddhau newydd hwn yn bosibl a beth ddylai ei olygu.

Cwestiwn ymgynghori 23: I gleifion dan gyfyngiadau nad ydynt bellach yn elwa'n therapiwtig o gael eu cadw yn yr ysbyty, ond na ellid ond rheoli eu risg yn ddiogel yn y gymuned gyda goruchwyliaeth barhaus, credwn y dylai fod yn bosibl rhyddhau'r cleifion hyn i'r gymuned ar amodau sy'n cyfateb i amddifadu o ryddid. Ydych chi'n cytuno neu'n anghytuno mai dyma'r ffordd orau o alluogi'r cleifion hyn i symud o'r ysbyty i'r gymuned?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 23a: Rhowch resymau dros eich ateb. [Testun rhydd – 500 gair]

Os ydych yn cytuno:

Cwestiwn ymgynghori 24: Rydym yn cynnig y byddai gorchymyn 'rhyddhau dan oruchwyliaeth' ar gyfer y grŵp hwn o gleifion yn destun adolygiad Tribiwnlys blynyddol. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 25: Y tu hwnt i hyn, pa fesurau diogelu pellach sydd eu hangen yn eich barn chi?

[Testun rhydd – 500 gair]

Dioddefwyr cleifion nad ydynt dan gyfyngiadau

Rydym am wella lefel y wybodaeth a ddarperir i ddioddefwyr troseddwyr sy'n dod o dan y Ddeddf, nad oes ganddynt orchymyn cyfyngu, a sut mae'n cael ei rhannu.

Gweler Pennod 8 am fwy o fanylion am y gwaith yr ydym yn ei wneud i sicrhau bod dioddefwyr yn derbyn y wybodaeth y mae ganddynt hawl iddi.

Pennod 9: Pobl ag Anabledd Dysgu a Phobl Awtistig

Rydym wedi ymrwymo i leihau'r ddibyniaeth ar wasanaethau cleifion mewnol arbenigol ar gyfer pobl ag anabledd dysgu a phobl awtistig ac i ddatblygu dewisiadau amgen yn y gymuned. Fel rhan o hyn, rydym am gyfyngu ar y gallu i gadw pobl ag anabledd dysgu neu bobl awtistig o dan y Ddeddf.

Mae anabledd dysgu ac awtistiaeth yn gyflyrau gydol oes, na ellir eu dileu drwy driniaeth. Rydym yn cydnabod y gall fod ar rai pobl ag anabledd dysgu a phobl awtistig angen triniaeth ar gyfer salwch meddwl ac rydym eisiau sicrhau bod pobl yn cael gofal diogel o ansawdd uchel sydd fwyaf priodol iddynt hwy.

Rydym yn cynnig newid y Ddeddf i fod yn gliriach nad yw awtistiaeth nac anabledd dysgu yn cael eu hystyried yn anhwylderau meddyliol at ddibenion y rhan fwyaf o bwerau o dan y Ddeddf. Ein cynnig yw caniatáu i bobl ag anabledd dysgu a phobl awtistig gael eu cadw i'w hasesu, o dan adran 2 y Ddeddf, pan fydd eu hymddygiad yn dangos cymaint o gynnwrf fel bod risg sylweddol o niwed sylweddol i'r person neu i bobl eraill (fel sy'n wir am bob cyfnod cadw) a bod achos iechyd meddwl tebygol i'r ymddygiad hwnnw sy'n teilyngu asesiad yn yr ysbyty.

Os nad yw sbardun yr ymddygiad hwn yn cael ei ystyried yn gyflwr iechyd meddwl, er enghraifft ei fod i'w briodoli i angen am gymorth sydd heb ei ddiwallu, angen cymdeithasol neu emosiynol sydd heb ei ddiwallu, neu angen iechyd corfforol sydd heb ei ddiwallu (gan gynnwys poen heb ei drin), ni fyddai cyfiawnhad mwyach dros ei gadw'n gaeth o dan y Ddeddf Iechyd Meddwl a dylid rhoi'r gorau i'w gadw'n gaeth.

Gallwch ddarllen Pennod 9 y Papur Gwyn i gael rhagor o wybodaeth am y rhesymeg wrth wraidd y cynnig hwn a gallwch ateb cwestiynau'r ymgynghoriad:

Cwestiwn ymgynghori 26: Ydych chi'n cytuno neu'n anghytuno â'r diwygiadau arfaethedig i'r ffordd y mae'r Ddeddf Iechyd Meddwl yn gymwys i bobl ag anabledd dysgu a phobl awtistig:

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 26a: Rhowch resymau dros eich ateb

[500 gair]

Cwestiwn ymgynghori 27: Ydych chi'n cytuno neu'n anghytuno bod y diwygiadau arfaethedig yn darparu mesurau diogelu digonol ar gyfer pobl ag anabledd dysgu a phobl awtistig pan nad oes ganddynt gyflwr iechyd meddwl sy'n cyd-ddigwydd?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 27a: Rhowch resymau dros eich ateb

– [500 gair]

Cwestiwn ymgynghori 28: Ydych chi'n credu y byddai canlyniadau anfwriadol (negyddol neu gadarnhaol) i'r cynigion i ddiwygio'r ffordd y mae'r Ddeddf Iechyd Meddwl yn gymwys i bobl ag anabledd dysgu a phobl awtistig?

[Byddai/Na fyddai/Ddim yn siŵr]

Cwestiwn ymgynghori 28a: Rhowch rhesymau dros eich ateb.

[Testun rhydd: 500 gair]

Cwestiwn ymgynghori 29: Rydym yn meddwl dylai'r cynnig i newid y ffordd y mae'r Tribiwnlys Iechyd Meddwl yn berthnasol i bobl gydag anawsterau dysgu a phobl awtistig ond effeithio ar gleifion sifil ac nid y sawl sydd yn y system cyfiawnder troseddol. Ydych chi'n cytuno neu'n anghytuno?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 29a: Rhowch resymau dros eich ateb

[500 gair]

Cwestiwn ymgynghori 30:

Ydych chi'n disgwyl y byddai goblygiadau anfwriadol (rhai cadarnhaol neu rai negyddol) ar y system cyfiawnder troseddol o ganlyniad i'n cynigion i ddiwygio'r ffordd mae'r Ddeddf Iechyd Meddwl yn berthnasol i bobl ag anawsterau dysgu a phobl awtistig?

[Testun rhydd 500 gair]

Ar gyfer pobl ag anabledd dysgu a phobl awtistig, rydym am ei gwneud yn ofyniad statudol i'r Clinigydd Cyfrifol ystyried y canfyddiadau a'r argymhellion a wnaed fel rhan o Adolygiadau Gofal a Thriniaeth yng Nghynllun Gofal a Thriniaeth y claf. Gwyddom fod Adolygiadau Gofal a Thriniaeth (neu Adolygiadau Gofal, Addysg a Thriniaeth yn achos plant) yn effeithiol o ran lleihau derbyniadau i ysbytai pan gânt eu cynnal yn gywir a phan weithredir arnynt. Dyna pam yr ydym am roi grym statudol iddynt.

Cwestiwn ymgynghori 31: Ydych chi'n cytuno neu'n anghytuno y bydd y cynnig y dylai argymhellion Adolygiad Gofal a Thriniaeth ar gyfer oedolyn sy'n cael ei gadw neu Adolygiad Gofal, Addysg a Thriniaeth (CETR) ar gyfer plentyn sy'n cael ei gadw gael eu hymgorffori'n ffurfiol mewn Cynllun Gofal a Thriniaeth ac y bydd gofyn i glinigwyr cyfrifol egluro os nad yw argymhellion yn cael eu rhoi ar waith, yn cyflawni'r bwriad i gynyddu cydymffurfiad ag argymhellion Adolygiad Gofal, Addysg a Thriniaeth?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 31a: Rhowch resymau dros eich ateb.** [Testun rhydd 200 gair]

Sicrhau cyflenwad digonol o wasanaethau cymunedol ar gyfer pobl ag anabledd dysgu a phobl awtistig

Rydym hefyd yn datblygu dyletswydd ar gomisiynwyr iechyd a gofal cymdeithasol i gydweithio i sicrhau bod cymorth a thriniaeth yn y gymuned yn cael eu darparu ar gyfer y grŵp hwn. Bydd hyn yn cael ei nodi yn y Ddeddf Iechyd Meddwl.

Gallwch ateb cwestiynau'r ymgynghoriad ar y mater hwn:

Cwestiwn ymgynghori 32: Rydym yn cynnig creu dyletswydd newydd ar gomisiynwyr lleol (GIG a Llywodraeth Leol) i sicrhau bod y cyflenwad o wasanaethau cymunedol yn ddigonol ar gyfer pobl ag anabledd dysgu a phobl awtistig. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 32a: Rhowch resymau dros eich ateb. [500 gair]

Cwestiwn ymgynghori 33: Rydym yn cynnig ategu hyn â dyletswydd bellach ar gomisiynwyr y dylai pob ardal leol ddeall a monitro'r risg o argyfwng ar lefel unigol i bobl ag anabledd dysgu a phobl awtistig yn y boblogaeth leol drwy greu cofrestr "mewn perygl" neu "gefnogi" leol. Ydych chi'n cytuno neu'n anghytuno â'r cynnig hwn?

[Cytuno'n gryf/ Cytuno/ Anghytuno/ Anghytuno'n gryf/ Ddim yn siŵr]

Cwestiwn ymgynghori 33a: Rhowch resymau dros eich ateb.

[500 gair]

Cwestiwn ymgynghori 34: Beth y gellir ei wneud i oresgyn unrhyw heriau o ran defnyddio cyllidebau cyfun ac adrodd ar wariant ar wasanaethau i bobl ag anabledd dysgu a phobl awtistig?

[Testun rhydd 500 gair]

Pennod 10: Plant a Phobl Ifanc

Rydym eisiau cryfhau'r hawliau a'r gefnogaeth a gaiff plant a phobl ifanc pan fyddant yn dod o dan y Ddeddf.

Yn ogystal â newidiadau deddfwriaethol, y bydd pob un ohonynt ar gael i blant a phobl ifanc, byddwn yn sicrhau bod Cynlluniau Gofal a Thriniaeth yn cael eu darparu i bob plentyn a pherson ifanc sy'n derbyn gofal iechyd meddwl fel claf mewnol, pa un a ydynt yn cael eu cadw o dan y Ddeddf ai peidio.

Gweler Pennod 10 am drafodaeth ar argymhellion yr Adolygiad ynghylch asesu 'cymhwysedd' plant a phobl ifanc i gydsynio i'w triniaeth feddygol eu hunain a gwneud penderfyniadau am eu gofal a'u triniaeth heb ganiatâd na gwybodaeth gan rieni.

Dymunwn ystyried yr argymhellion hyn yn llawn fel rhan o'n hadolygiad o'r Cod Ymarfer.

Pennod 11: Profiadau cymunedau lleiafrifoedd ethnig

Mae anghydraddoldebau amlwg yn bodoli ar draws gwasanaethau iechyd meddwl ac o dan y Ddeddf o ran pobl o gymunedau BAME, yn enwedig pobl Ddu Affricanaidd a Charibïaidd. Rydym yn gwneud cyfres o ddiwygiadau i fynd i'r afael â'r anghydraddoldebau hyn:

- Cyflwyno Fframwaith Cydraddoldeb Hiliol ar gyfer Cleifion a Gofalwyr i wreiddio newid strwythurol a diwylliannol yn y ddarpariaeth gofal iechyd er mwyn gwella'r ffordd y mae cleifion o gefndiroedd ethnig amrywiol yn cael mynediad at ofal iechyd meddwl ac yn ei brofi.
- Datblygu eiriolaeth sy'n briodol yn ddiwylliannol ar gyfer pobl o bob cefndir ethnig a chymunedau, yn enwedig ar gyfer pobl Ddu Affricanaidd a Charibïaidd
- Ymchwil sy'n ceisio cefnogi'r broses o wella canlyniadau iechyd meddwl ar gyfer pobl o gymunedau lleiafrifoedd ethnig.

Caiff y diwygiadau hyn eu cefnogi gan waith sy'n cael ei arwain gan NHSEI i wella amrywiaeth y gweithlu iechyd meddwl a chan y diwygiadau ehangach sy'n cael eu trafod yn y Papur Gwyn.

Rhan 2: Diwygio Polisi ac Ymarfer o amgylch y Ddeddf Newydd i Wella Profiad y Claf

Mae'r adran hon o'r Papur Gwyn yn disgrifio'r gwaith y mae'r Llywodraeth a'r GIG yn ei wneud ar hyn o bryd ac i'r dyfodol i sicrhau newidiadau er mwyn i bobl gael gwell profiadau o ofal.

Trawsnewid gwasanaethau iechyd meddwl

Mae Cynllun Tymor Hir y GIG yn amlinellu'r uchelgais i drawsnewid gwasanaethau iechyd meddwl yn radical, er mwyn i gleifion gael gwell profiadau o ofal fel cleifion mewnol a gwell canlyniadau iechyd meddwl.

Mae'r trawsnewid hwn ar wasanaethau iechyd meddwl yn cael ei gefnogi gan fuddsoddiad ychwanegol sy'n codi i £2.3 biliwn bob blwyddyn erbyn 2023/24 ac mae'n cynnwys ffocws o'r newydd ar wasanaethau i bobl sydd â salwch meddwl difrifol ac ar wella'r ddarpariaeth gofal cymunedol. Mae'r uchelgeisiau yn cynnwys:

- cynyddu nifer y staff ar wardiau cleifion mewnol aciwt – fel gweithwyr cymorth gan gymheiriaid, seicolegwyr, therapyddion galwedigaethol er mwyn lleihau'r amser sy'n cael ei dreulio yn yr ysbyty a gwella canlyniadau
- cwtogi hyd arhosiad cleifion mewn sefydliadau iechyd meddwl aciwt i gleifion mewnol sy'n oedolion,
- sefydlu diwylliant dysgu ar draws y GIG fel bod comisiynwyr a darparwyr yn sicrhau, pan fydd pethau'n mynd o chwith, bod problemau'n cael eu hosgoi yn y dyfodol.
- sicrhau bod cymorth gofal mewn argyfwng iechyd meddwl ar gael i bawb bob amser drwy GIG 111 erbyn 2023 i 2024.
- ehangu gwasanaethau cymunedol i gefnogi 370,000 o oedolion sydd â salwch meddwl difrifol er mwyn darparu mwy o gymorth i bobl yn y gymuned cyn bod angen gofal mewn argyfwng neu ofal fel claf mewnol arnynt, gan gynnwys o dan y Ddeddf Iechyd Meddwl

Cefnogi pobl yn y gymuned

Yn ogystal ag uchelgeisiau'r Cynllun Tymor Hir i ehangu a gwella gofal iechyd meddwl cymunedol er mwyn mynd i'r afael â'r bylchau presennol ac atal derbyniadau y gellir eu hosgoi, rydym yn awyddus i sicrhau bod gan yr holl ddefnyddwyr gwasanaeth sydd mewn cysylltiad â thimau iechyd meddwl cymunedol, gofal cleifion mewnol a/neu wasanaethau cymdeithasol gynllun gofal o ansawdd uchel, wedi'i deilwra'n bersonol ar gyfer eu hanghenion.

Mae'r broses bresennol o ran darparu ôl-ofal yn y gymuned i gleifion sydd wedi cael eu rhyddhau o'r Ddeddf Iechyd Meddwl yn gallu bod yn ddryslyd ac mae anghysondebau yn y ffordd y caiff ei wneud. Rydym am gynhyrchu canllawiau cenedlaethol ar sut y dylid rhannu cyllidebau a chyfrifoldebau i dalu am ôl-ofal.

Gwella diwylliant wardiau ar gyfer cleifion a staff

Yn ogystal â gwella gwasanaethau iechyd meddwl, byddwn yn cymryd camau i greu'r diwylliant gorau ar wardiau i wella profiad cleifion. Rhan allweddol o hyn yw datblygu rhaglen Gwella Ansawdd sy'n canolbwyntio ar weithredu diwygiadau'r Ddeddf Iechyd Meddwl. Bydd hyn yn cael ei arwain gan NHSEI a'i nod fydd mynd i'r afael â materion sy'n ymwneud ag ansawdd, profiad cleifion, arweinyddiaeth a diwylliant.

Diogelwch a risg cleifion mewnol

Bydd diogelwch cleifion mewn gwasanaethau iechyd meddwl bob amser yn ystyriaeth hollbwysig. Ymrwymodd Cynllun Tymor Hir y GIG i Raglen Gwella Diogelwch Iechyd Meddwl newydd sy'n ceisio mynd i'r afael â materion diogelwch iechyd meddwl sydd â blaenoriaeth: diogelwch rhywiol i gleifion mewnol; lleihau ymarfer cyfyngol; a lleihau nifer yr achosion o hunanladdiadau a hunan-niweidio bwriadol.

Gallwch ddarllen Rhan 2 y Papur Gwyn i gael gwybod mwy am y gwaith sydd ar y gweill yn y meysydd blaenoriaeth hyn.

Byddwn yn gweithio i sicrhau nad yw mesurau diogelwch newydd i gleifion yn dod ar draul datblygu a chynnal amgylcheddau gwirioneddol therapiwtig sy'n helpu pobl i wella.

Gwella amgylchedd ffisegol y ward

Dylai sefydliadau cleifion mewnol gynnig amgylcheddau adsefydlu sy'n galluogi darparu gofal therapiwtig ac sy'n cefnogi adferiad cleifion.

Byddwn yn gwella amgylchedd ffisegol gwasanaethau iechyd meddwl, gan eu gwneud yn lleoedd llawer gwell i gleifion ac i staff. Fel rhan o hyn, byddwn yn rhoi diwedd ar ystafelloedd cysgu mawr, gan roi preifatrwydd eu hystafell eu hunain a'u hystafell ymolchi en-suite i gleifion. Mae'r Llywodraeth wedi rhwymo dros £400m at y diben hwn ac wedi nodi 1,200 o welyau a fydd yn cael eu huwchraddio fel hyn dros y pedair blynedd nesaf. Mae hwn yn gam pwysig tuag at wella diogelwch rhywiol mewn gwasanaethau iechyd meddwl ac at roi terfyn ar dorri amodau llety un-rhyw.

Rydym hefyd yn buddsoddi i adeiladu ysbytai iechyd meddwl newydd fel rhan o raglen adeiladu ysbytai'r Llywodraeth.

Rôl y Comisiwn Ansawdd Gofal

Mae'r Comisiwn Ansawdd Gofal wedi adrodd yn gyson bod llawer o bobl yn parhau i gael gofal nad yw'n canolbwyntio ar yr unigolyn ac nad yw'n gwarchod eu hawliau'n llwyr.

O ganlyniad i'r canfyddiadau hyn ac uchelgeisiau'r Cynllun Tymor Hir, bydd y Comisiwn yn adolygu sut mae'n asesu ffactorau sy'n cyfrannu at ansawdd gofal i gleifion mewnol, fel cynllun ffisegol wardiau, y gosodiadau a'r ffitiadau diogelwch a darparu llety un-rhyw.

Hefyd, bydd y Comisiwn yn gweithio gyda phobl sy'n defnyddio gwasanaethau, teuluoedd, darparwyr, staff rheng flaen a rhanddeiliaid eraill i wella'r ffordd y mae'n rheoleiddio gwasanaethau, gan ganolbwyntio'n benodol ar wella diwylliant wardiau, o ystyried y rôl hollbwysig y gall hyn ei chwarae yn adferiad claf.

Darllenwch Ran 2 y Papur Gwyn i ddysgu mwy am y gwaith arall y mae'r Comisiwn yn ei wneud er mwyn helpu i wella profiad cleifion mewn gwasanaethau iechyd meddwl. Gallwch hefyd ateb cwestiwn yr ymgynghoriad ar sut y gellid ymestyn rôl monitro'r Comisiwn.

Cwestiwn ymgynghori 35: Sut gallai'r Comisiwn Ansawdd Gofal gefnogi ansawdd (gan gynnwys diogelwch) gofal drwy ymestyn ei bwerau monitro?

[Testun rhydd – 500 gair]

Gwneud i ffwrdd â chelloedd yr heddlu fel 'lleoedd diogel'

Mae 'lle diogel' yn lle diogel dynodedig lle gellir mynd â phobl sy'n wynebu argyfwng iechyd meddwl a lle gellir cynnal asesiad iechyd meddwl.

Ar hyn o bryd, gellir mynd â phobl i gelloedd yr heddlu ar gyfer asesiad iechyd meddwl. Rydym am roi terfyn ar hyn a sicrhau, yn y dyfodol, yr eir â phawb sydd mewn argyfwng iechyd meddwl i amgylchedd clinigol, lle gallant gael y gofal a'r cymorth y mae arnynt eu hangen ar frys. Rydym wedi ymrwymo i ddiwygio'r Ddeddf Iechyd Meddwl i roi'r gorau i ddefnyddio celloedd yr heddlu fel mannau diogel erbyn 2023/24.

Galluogi trosglwyddo gwell oddi wrth yr heddlu i'r gwasanaethau iechyd

Ar hyn o bryd, mae'r heddlu'n mynd â mwy o bobl sy'n wynebu argyfwng iechyd meddwl i'r ysbyty nag ambiwlans.

Mae Cynllun Tymor Hir y GIG yn ymrwymo i fuddsoddi er mwyn gwella capasiti a gallu'r gwasanaethau ambiwlans i ddiwallu'r galw am wasanaeth iechyd meddwl, gan helpu i osgoi defnyddio'r heddlu i gludo cleifion.

Y gweithlu iechyd meddwl

Mae ehangu a datblygu'r gweithlu iechyd meddwl yn hanfodol er cyflawni ein hymrwymiad i foderneiddio'r Ddeddf Iechyd Meddwl. Bydd y Llywodraeth yn gweithio gyda NHSEI, Health Education England a rhanddeiliaid eraill i edrych ar ragor o ofynion cymorth cenedlaethol, gan gynnwys hyfforddi staff ar y newidiadau i'r Ddeddf, cydgynhyrchu ystyrlon a datblygu rolau arwain arbenigwr-drwy-brofiad o fewn darparwyr a systemau lleol.

Mae'r diwygiadau hyn, i raddau, yn cael eu cefnogi gan waith ehangach i ehangu a datblygu'r gweithlu iechyd meddwl fel rhan o Gynllun Tymor Hir y GIG. Fodd bynnag, rydym yn rhagweld y bydd angen ehangu'r gweithlu ymhellach er mwyn diwallu gofynion ychwanegol.

Rydym yn gweithio i gynyddu amrywiaeth y gweithlu iechyd meddwl i sicrhau ei fod yn diwallu anghenion y gymuned y mae'n ei gwasanaethu yn well. Mae hyn yn golygu gweithio i recriwtio mwy o bobl o gymunedau Du Affricanaidd a Charibïaidd i broffesiynau iechyd meddwl a'u cefnogi i godi i lefelau uwch.

Gwyddom fod gwella morâl staff yn bwysig er mwyn darparu gofal o ansawdd uchel i gleifion. Mae NHSEI yn gweithio i wella profiad staff ac felly brofiad cleifion drwy ei raglen Improving Health and Wellbeing.

Darllenwch Ran 2 y Papur Gwyn i gael rhagor o wybodaeth am ein cynlluniau i ehangu a datblygu'r gweithlu iechyd meddwl.

Data a digidol

Mae'r Llywodraeth wedi ymrwymo i weithio gyda'r holl sefydliadau sy'n ymwneud â gweithredu'r Ddeddf i sicrhau gwelliannau o ran casglu data ac o ran dulliau digidol newydd o ddarparu gwasanaethau. Mae hyn yn rhan hollbwysig o adeiladu gwasanaeth iechyd meddwl modern sy'n gallu ymateb yn fwy effeithlon i anghenion cleifion.

Mae'r uchelgais hwn wedi cael ei gyflymu yn ystod cyfnod y pandemig yn 2020, sydd wedi bod yn fodd i dynnu sylw at y manteision y gall digidol eu cynnig.

Asesiad Effaith

Ochr yn ochr â'r Papur Gwyn, rydym wedi cynhyrchu Asesiad Effaith lle rydym wedi amcangyfrif costau a manteision tebygol gweithredu'r newidiadau arfaethedig i'r Ddeddf.

Gallwch weld yr Asesiad Effaith yma (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/946264/mha-review-impact-assessment.pdf). Gallwch hefyd ateb y cwestiwn ymgynghori:

Cwestiwn ymgynghori 36: Yn yr asesiad effaith, rydym wedi amcangyfrif costau a manteision tebygol gweithredu'r newidiadau arfaethedig i'r Ddeddf. Byddem yn ddiolchgar am unrhyw ddata neu dystiolaeth ychwanegol a fyddai, yn eich barn chi, o gymorth i'r Adrannau i wella'r dulliau a ddefnyddiwyd a'r amcangyfrifon sy'n deillio o hynny. Mae gennym ddiddordeb mewn derbyn data rhifiadol, dadansoddiadau cenedlaethol a lleol, astudiaethau achos neu gyfrifon ansoddol, etc, a allai fod yn sail i effaith y cynigion ar y canlynol:

- Grwpiau proffesiynol gwahanol, yn benodol:
  - Sut y gallai'r cynigion effeithio ar lwyth gwaith presennol staff clinigol ac anghlinigol, Eiriolwyr Iechyd Meddwl Annibynnol, Gweithwyr Iechyd Meddwl Proffesiynol Cymeradwy, Tribiwnlysoedd Iechyd Meddwl, Meddygon a Benodir i Roi Ail Farn etc
  - A yw'r cynigion yn debygol o gael unrhyw effeithiau eraill ar grwpiau penodol â diddordeb nad ydynt wedi cael eu hystyried ar hyn o bryd
- Defnyddwyr gwasanaeth, eu teuluoedd a'u ffrindiau, yn benodol:
  - Sut gallai'r cynnig effeithio ar ganlyniadau iechyd
  - y gallu i ddychwelyd i'r gwaith neu effeithiau ar unrhyw weithgarwch dyddiol arall
  - A yw'r cynigion yn debygol o gael unrhyw effeithiau eraill ar grwpiau penodol â diddordeb nad ydynt wedi cael eu hystyried ar hyn o bryd
- Y system iechyd a gofal cymdeithasol a'r system gyfiawnder yn fwy cyffredinol.

Rhowch wybodaeth yn y bwlch isod.

[Testun rhydd 500 gair]

Ymateb i'r ymgynghoriad

Mae llawer o gwestiynau ac efallai na fyddwch yn dymuno ateb pob un ohonynt. Rydyn ni wedi creu [arolwg] er mwyn i chi allu ateb cynifer neu gyn lleied o gwestiynau ag y dymunwch chi.

Mae'r cwestiynau wedi'u rhannu'n adrannau/themâu. Bydd yr ymgynghoriad ar agor tan [XX mis blwyddyn]. Yr ymgynghoriadhwn yw ein hymgynghoriad ffurfiol â'r cyhoedd.

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1. Dogfen a gynhyrchwyd gan y Llywodraeth yw Papur Gwyn, sy'n nodi cynigion ar gyfer deddfwriaeth yn y dyfodol.
2. Ymdrinnir â'r swyddogaethau a gyflawnir yn Lloegr gan awdurdodaeth Iechyd Meddwl y Tribiwnlys Haen Gyntaf (a elwir fel arfer yn Dribiwnlys Iechyd Meddwl), gan dribiwnlys ar wahân yng Nghymru, sef Tribiwnlys Adolygu Iechyd Meddwl Cymru. Mae hwn yn Dribiwnlys Cymreig datganoledig o dan Lywydd Tribiwnlysoedd Cymru ac fe'i gweinyddir gan Lywodraeth Cymru. Mae'n bwysig nodi mai dim ond at y Tribiwnlys Iechyd Meddwl yn Lloegr y mae'r ymateb i'r argymhellion yn y Papur Gwyn hwn yn cyfeirio, ac nid at Dribiwnlys Adolygu Iechyd Meddwl Cymru.

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