Submission

To	Office of the Chief Psychiatrist
Topic	Draft Mental Health and Wellbeing Bill
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About

We are an inclusive not-for-profit organisation working alongside more than 80,000 South Australians each year and have been creating positive change for South Australian communities for more than 120 years. We advocate for systems change across diverse social justice issues to shape public and social policy that delivers better outcomes for marginalised communities.

We support those in need to find the courage to move forward through enriching their lives and uniting the communities in which they live. By tackling the deep-seated challenges that affect people's lives, we are working to create systemic change and brighter futures for all South Australians.

Chrysalis Forensic Mental Health Service

Chrysalis is a short-term transitional accommodation and support service for people moving from extended stays in inpatient mental health wards (including James Nash House) back into the community. For many, this transition can feel overwhelming. Chrysalis provides a safe, structured environment where residents can regain stability, rebuild confidence, and prepare for independent living.

The nine-bed program offers 24/7 support from a dedicated team including support workers, a peer support worker, a social worker, and a team leader. Together, they help residents set goals, develop daily living skills, maintain good mental health, and make meaningful connections in their community. The service also supports residents to secure long-term housing and strengthen their capacity to live independently.

Residents are encouraged to participate in activities that promote emotional, social, and practical wellbeing—such as workshops, shared meals, and skill-building sessions. These experiences often help people rediscover strengths, build routines, and develop a sense of direction.

By the time residents move on from Chrysalis, the aim is not only that they have safe accommodation, but that they leave with greater confidence, improved wellbeing, and a clearer pathway toward independence, community connection, and long-term recovery.

All residents of the Chrysalis service:

- Live with a mental illness
- Have ongoing psychosocial support needs
- Display low-risk behaviour
- Have no alternate safe housing options
- Are able to reside independently
- Are medically stable
- Have no acute care needs

Family Mental Health Support Onkaparinga/ Southern Fleurieu, Kangaroo Island

This service provides support for people caring for a young person with mental health issues. We offer free counselling and information to families concerned about a young person aged under 18. Our goal is to help children and families to improve mental health, resilience and confidence.

Headspace Mount Gambier

Headspace provides information, support and services for young people aged 12-25 to work through mental health, physical health, work and study and alcohol and other drugs. We can connect clients with health workers to work through a range of issues.

Lifeline

Lifeline is committed to preventing suicide, supporting people in crisis, and promoting good mental health and emotional wellbeing. Every year, the service answers more than 36,000 calls from people experiencing crisis. Our dedicated team of Crisis Supporters are here to listen and offer support and, where appropriate, refer people to other services that can help.

Submission on Draft Mental Health and Wellbeing Bill

Uniting Communities thanks the Chief Psychiatrist for the opportunity to provide feedback on the draft *Mental Health and Wellbeing Bill*. We support the Bill's intent to embed a supported decision-making framework and to ensure that a person is only considered to have impaired decision-making capacity after all reasonably practicable supports have been provided. The Bill represents a positive improvement on the *Mental Health Act 2009*. However, crucial changes are required to ensure it is fit for purpose and achieves its intended outcomes as a rights-based, recovery-oriented piece of legislation.

Our key recommendations:

- **We recommend strengthening clause 6 (Meaning of decision-making capacity) to ensure the presumption of capacity is first and that the threshold for impaired capacity is applied consistently and in line with supported decision-making principles.**
- **Strengthen the supported decision-making provisions by ensuring assessors have access to dedicated peer support workers, and by establishing clear safeguards so capacity assessments are consistent, adequately supported, and not reliant on families.**
- **Clarify and strengthen clause 7 so that supported decision-making cannot be interpreted as substitute decision-making, and ensure clear safeguards, guidance, and workforce support to uphold the person's autonomy, will, and preferences.**
- **Amend subclause 13 (2) to include an explicit commitment to recovery-oriented practice, recognising the importance of long-term recovery, autonomy, and wellbeing.**
- **Amend subclause 13 (1)(c) to separate the rights of the person (with a mental health condition) from the views and interests of families and others, ensuring the Act remains person-centred and consistent with supported decision-making principles.**
- **Ensure that Statements of Preferences remain meaningful during treatment orders by requiring clinicians to review them in all circumstances.**
- **Retain the requirement to assess decision-making capacity for children under 16 to uphold their right to be heard, ensure their views are meaningfully considered, and maintain consistency with the Bill's presumption of capacity.**
- **Require the written reasons (for issuing orders) to include a clear explanation of the decision-making capacity assessment undertaken, including how the practitioner determined impaired capacity and what supports were provided.**
- **Extend automatic review requirements to all treatment orders and ensure SACAT is adequately resourced—potentially through a dedicated mental health stream—to prevent delays and support timely, effective oversight.**
- **Strengthen accountability by removing the subclauses that excuse non-compliance with required processes by stating that it "does not, of itself, affect the validity" ensuring that safeguards are meaningful and enforceable.**
- **Establish a legislative right to legal representation for children, young people, and adult consumers in all SACAT proceedings, supported by either an expanded legal representation scheme or a dedicated advocacy service.**

Consultation questions

Decision-making capacity and supported decision making

Are the criteria for assessing decision-making capacity (understanding, weighing options, communicating decisions) clear and appropriate?

We recommendation that clause 6- Meaning of decision-making capacity includes (2) first, as the presumption of decision-making capacity (a) should be central (and is the case in the current *Mental Health Act 2009*). This sets the parameters in practice when implementing the legislation.

We note that subclause 6(4) may be open to misinterpretation due to inconsistent wording across its paragraphs. Subclause 6(1) sets out a supported, functional test for decision-making capacity, recognising that a person may meet the criteria with appropriate assistance. In contrast, subclause 6(4) outlines the threshold for impaired capacity, but the drafting uses “any” in 6(4)(a)(i) and not in 6(4)(a)(ii)–(iii). This may inadvertently suggest a lower threshold for finding impaired capacity, particularly in relation to retaining or using information, despite the supported-decision-making principles in subclause 6(2) and 6(3).

To avoid misinterpretation, it would be helpful to clarify that the reference to “such information” in 6(4)(a)(ii) and (iii) is intended to mean *any relevant information*, consistent with 6(4)(a)(i). This would ensure that a person is not found to have impaired capacity merely because they cannot retain or use *some* information, but only where they cannot retain or use *any* relevant information even with support.

Subparagraph 6(2)(c) “*will only be taken to have impaired decision-making capacity if all reasonably practicable steps to support the person to make the relevant decision have been taken,*” is a positive addition.

Do you have any concerns about how decision-making capacity will be assessed in practice?

Traditional capacity testing often occurs without support, yet the Bill describes a supported process. There’s a risk that the nature or quality of support could unfairly influence outcomes, raising questions about safeguards and consistency. An increased number of dedicated peer and support worker/roles is needed to facilitate this support. Unfortunately, this process cannot rely solely on families to support such a complex legal process and family can also be caught up emotionally in multifaceted ways and may not always have the best interest of the individual in mind.

There’s uncertainty around how assessors are expected to determine decision-making capacity in time-constrained settings, especially when the process is meant to include supported decision-making, particularly if capacity is judged without adequate support or time. The definition may be difficult to apply consistently in practice, especially across diverse settings and populations. Robust frameworks and their accountability for adhering to them will be vital. This includes ensuring that assessments explore the underlying causes of a person’s presentation — for example, distinguishing between symptoms arising from dementia and those associated with a mental health condition.

What additional safeguards or guidance should be included to ensure supported decision-making is implemented effectively?

We believe significant improvements are required for clause 7, “Meaning of supported decision-making and supported decision.” While paragraph 7(5)(a) reflects the intent of supported decision-making by focusing on assisting a person to understand and make their own decision, paragraphs 7(5)(b)–(e) largely describe substitute decision-making functions. These provisions allow a support person to handle applications, communicate on behalf of the person, or deal with personal information (which happens far too often currently) - none of which reflect the collaborative practice of supported decision-making. We recommend that the wording in subclause 7(5) be adapted to more accurately reflect supported decision-making, ensuring that support focuses on enabling the person’s own decision-making rather than replacing it.

Because the paragraphs are connected by “or”, there is a real risk that the supported decision-making framework could be interpreted in practice as permitting a support person to act *in place of* the individual, rather than supporting the person to make their own decisions. This risks undermining the intent of the Bill and the supported decision-making principles set out in clause 6.

To strengthen the integrity of the supported decision-making model, we also recommend:
- 1. A new subclause is added requiring that any person providing decision-making support must do so in an unbiased way that upholds the guiding principles of the Act, including respect for autonomy, dignity, and the person’s expressed will and preferences.
- 2. Amending subclause 7(5) to include an explicit requirement to create conditions that enhance a person’s ability to make decisions, such as allowing for a change in environment or other adjustments that support calmer, clearer decision-making.

Without clear safeguards, there’s concern that individuals supporting decision-making could unduly influence or take advantage of the person they’re meant to assist. Clarity on appropriates practices and the authority they have is needed including within subsequent guidelines. In addition, the Bill or guidelines must clarify for services and others in the system:
  - What constitutes appropriate support
  - How to distinguish between helpful involvement and undue influence
  - What protections are in place to prevent exploitation or coercion

It is vital that assistance includes appropriate communication tools, which must be made available as part of supported decision-making — including non-verbal methods of communication where required. This aligns with subparagraph 16(b)(ii), which already recognises the need for communication assistance during examinations for people with complex communication needs, and this safeguard should be extended to all relevant settings.

Are the definitions of restrictive practices (seclusion, chemical, physical, mechanical, environmental restraint) clear and comprehensive?

We do not have further feedback in relation to the definition of restrictive practices.

Objects and Principles

We are concerned that the term *“severe”* has been removed from the objects of the Act, despite the SALRI review recommending its retention. We ask that further consideration be given to the potential unintended consequences of broadening the scope of the Act, noting that the primary intent of this legislation is to support people experiencing crisis and severe mental health conditions. Clarity on this point is essential to ensure that the Bill remains focused on those for whom compulsory or acute interventions are intended.

We recommend adding an additional subclause to the objects of the Bill—particularly within subclause (2)—that explicitly recognises the importance of recovery-oriented practice. This should include a commitment to supporting the long-term recovery, autonomy, and wellbeing of people with a mental illness. Consideration should be made to retaining some of the wording within the current objects of the *Mental health Act* 2009 - 6(a) that include strong language on rights, freedom and recovery.

We recommend that paragraph 13(1)(c) be divided into two separate subclauses. As currently drafted, it groups together, “the rights of people with a mental illness, as well as their families and others who may be affected…” This construction implies that the rights of families and others are equivalent to, or sit on the same level as, the rights of the person with a mental illness. In practice, there will be circumstances where the rights or expressed wishes of the person cannot be upheld simultaneously with the preferences of family or others involved. Given that this legislation is fundamentally about protecting the rights, dignity, and autonomy of the person with a mental illness, the Act should distinguish between:

- the rights of the person, and
- the views, interests, or involvement of families and others.

We recommend reframing the second part of the subclause to refer to *consideration of the views and interests* of families and others, rather than implying they hold equivalent rights within the statutory framework.
This change would ensure the Bill remains person-centred and consistent with supported decision-making principles, while still recognising the important role of families and supporters.

Are the principles reasonable and appropriate?

While we support the intent of the principles, the sheer number of them may make consistent application challenging in practice. Robust, detailed guidelines accompanying the Bill would assist in translating these principles into day-to-day decision-making. We also recommend regular, ongoing accreditation and training for both clinicians and staff from mental health services is implemented to ensure the principles and accompanying guidelines are well understood and consistently applied in practice.

Should any principles be consolidated?

See comments above.

Are there principles you consider essential for inclusion?

The following principles are essential in the legislation:

- The least restrictive principle
- The choice and control principle
- The supported decision-making principle
- The prevention of harm to persons principle
- The dignity of risk principle
- The safety principle

- The gender safety principle
- The recovery principle

In relation to the Recovery Principle, further detail similar to that provided in the Suicide Prevention Principle, could be provided that describes what recovery looks like.

Do you have suggestions for improving clarity or implementation of the principles?

As outlined above, providing greater detail within the Recovery Principle and developing robust accompanying guidelines will be essential to ensuring these principles are implemented consistently in practice. We strongly recommend removing paragraph 14(3)(b), which states that a failure to comply with the principles does not affect the validity of a decision. Retaining this subclause undermines the intent of the principles and risks reducing them to symbolic statements rather than meaningful obligations that guide practice.

Statement of Preferences

Are the current exclusions (e.g., refusal of mandatory treatment) clear and appropriate?
Should standard templates or guidance materials be developed to assist in drafting these statements?

While we do not hold concerns about the current exclusions, we are concerned about paragraph 25(1)(a), which provides that a Statement of Preferences has no effect when a person is subject to a treatment order. For Statements of Preferences to have meaningful influence, medical practitioners and mental health professionals must be required to familiarise themselves with a person's statement, even when a treatment order is in place. Without this requirement, the practical value of these statements is significantly diminished.

We also support the development of standard templates and accompanying guidance materials to assist people in creating Statements of Preferences and to promote consistency and clarity across the system.

Family and carer involvement

Are additional safeguards needed to ensure family involvement respects the person's rights and preferences?
Should operational guidelines define circumstances where family consultation is strongly recommended?

Family involvement in supported decision-making can be complex. While many families act with good intentions, their views may at times be driven by their own distress or self-preservation rather than the person's preferences or best interests. Safeguards are therefore needed wherever family members are involved in influencing or contributing to decisions. Initial consultation with family may be appropriate in many cases, but the primary consultation must always be with the individual (with the mental illness) themselves, including determining who they want involved. This recognises that some people do not want family participation, while others find family support invaluable, sometimes more so than support from paid workers. Please see page 4 on 'additional safeguards' for more information.

Forensic Community Treatment Orders

Should Forensic Community Treatment Orders remain as a distinct provision within the current structure of the Bill, or should they be incorporated into the Community Treatment Order sections?

As outlined in our original submission on the *Mental Health Act 2009*, we support SALRI's recommendation to introduce a Forensic Community Treatment Order (FCTO) due to the greater oversight and review of NSW's Forensic Community Treatment Orders compared to CTOs under the current MHA in South Australia.

Involuntary Treatment Order Requirements

Do you agree with removing the requirement to assess decision-making capacity for children under 16?

We recommend retaining this requirement. Removing it raises significant concerns regarding the human rights of children and young people. A child's views must be considered, particularly where they differ from those of their parents, and removing the capacity assessment risks silencing those views.

We are concerned that this change could result in children having no meaningful say in decisions that directly affect them, increasing the risk of harm through decisions made without their participation. Removing the provision appears to contradict section 33(b), which affirms "the right of the child or young person to be heard and to participate in decisions affecting them, including, if necessary, with appropriate supports."

There is also an internal inconsistency with paragraph 6(2)(a), which presumes a person has decision-making capacity regarding their health care and personal affairs unless there is evidence to the contrary. This presumption is not age-limited, and removing the capacity assessment for children under 16 appears to create a contradiction within the Bill.

Do you support the new requirement for psychiatrists and interim psychiatric practitioners to provide written reasons when orders are not confirmed or revoked?

We support this provision, as written reasons are an important safeguard and accountability measure. However, we recommend strengthening subclause 90(6) by requiring that any written statement of reasons also includes a clear explanation of the decision-making capacity assessment undertaken. This should outline how the psychiatrist or interim psychiatric practitioner determined that the person lacked decision-making capacity, including what supports were provided and how the criteria in clause 6 were applied. Without this level of transparency, it is difficult to ensure that capacity assessments are consistent, evidence-based, and aligned with the supported decision-making principles of the Bill.

Other comments

We recommend rewording the relevant paragraphs in each treatment order—such as paragraph 66(6)(d), which allows a psychiatrist or interim psychiatric practitioner to confirm or revoke an order without further examination if a person refuses or fails to attend an examination—to clarify that, where an order is confirmed, further follow-up should occur to pursue an additional examination. While flexibility is important in certain circumstances, efforts should still be made to conduct an examination whenever an order remains in force.

Human Rights Coercion and Reduction Committee

What should the membership of the Statutory Committee comprise?
Do you agree that the functions appropriately encapsulate the Committee's role?

We recommend that the Statutory Committee include representation from community-based mental health service providers, given their critical role in delivering non-coercive, recovery-oriented support and their practical insight into reducing the use of restrictive practices. We agree that the proposed functions appropriately capture the Committee's role.

Duty to warn

Do you consider that the balance regarding the "duty to warn" is appropriate?

We agree the balance is appropriate, including the inclusion to notify the South Australian Police.

Other concerns

Reviews of orders

We are pleased that additional requirements for automatic reviews of treatment orders have been included within this Bill, the absence of this provision was leading to prolonged use of orders currently. We recommend that all orders, including level 3 ITO (up to 12 months), extension of level 1 CTO (up to 42 days), including for child and young person, also receive review oversight similar to the rest of the orders within clause 183.

In light of these changes to treatment order reviews, the capacity of SACAT may delays reviews occurring as intended. The capacity of SACAT must be addressed alongside the introduction of these changes. SACAT could establish a specific mental health stream with the capacity, resourcing and expertise to undertake the reviews.

Remove these subclauses

We recommend removing the subclauses that excuse non-compliance with required processes by stating that it "does not, of itself, affect the validity" (e.g., subclauses 33(3), 36(8), 38(8), 39(7), 51(8), 55(3), 56(2), 66(8), 68(8), 69(7), 86(3), 87(2), 99(2)). Retaining these subclauses risks undermining the integrity and enforceability of the safeguards set out in the Bill. If procedural requirements can be disregarded without consequence, the protective intent of these provisions is significantly weakened.

Legal representation

As highlighted in our previous submission, there must be a legislative right to legal representation for children and young people subject to treatment orders in SACAT hearings. We also recommend extending the current legal representation scheme to all consumers involved in proceedings under the Bill - or establishing a dedicated advocacy service—while not extending this entitlement to interested parties. This approach ensures that the people whose rights are directly affected receive appropriate support and protection. The inclusion of a right to a peer advocate is welcome, but making this contingent on the consumer bearing the cost renders the provision ineffective unless it is properly funded.

Noncompliance

Non-compliance with a CTO should be explicitly addressed in the Bill (which was originally proposed in the consultation on the *Mental Health Act 2009*) and should include a requirement for the medical practitioner to educate themselves on the consumers perspective and rationale that is causing noncompliance and to accurately record the consumer’s reasons for noncompliance. In addition, the bill should require that every effort should be made to avoid the use of restrictive practices where there is non-compliance of a CTO by consulting with the consumer and providing appropriate support.

Conclusion

Uniting Communities appreciates the opportunity to provide feedback to the Chief Psychiatrist on the draft *Mental Health and Wellbeing Bill*. While we commend the State Government for the significant and positive reforms contained in the Bill, several critical issues must be addressed to ensure the legislation delivers on its intent: a rights-based, recovery-oriented, and genuinely supported decision-making framework. In particular, clarity of scope, strengthened safeguards, consistent application across settings, and adequate resourcing — including SACAT capacity and the supported decision-making workforce — will be essential to achieving meaningful reform for South Australians.