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Mental Health and Wellbeing Bill 2025

Explanatory Discussion Paper



Government
of South Australia

SA Health

Contents

Acknowledgement of Country	3
Advice about Content and Support Services	3
Background	4
Preliminary.....	5
Decision-Making Capacity.....	5
Supported Decision-Making	5
Restrictive Practices.....	5
Consent for ECT and Restrictive Practices.....	6
Objects and Principles	6
Compassionate Care Principle.....	7
Statement of Preferences.....	8
Family Consultation and Carer Involvement.....	9
Principles that Support Family and Carer Engagement	9
Best Interests	10
Children and Young People.....	10
Consultation in Involuntary Care Decisions.....	10
Forensic Community Treatment Orders.....	10
Duration and Continuity	11
Communication Rights	11
Changes to Involuntary Treatment Order Requirements	11
Threshold for Harm	11
Decision-Making Capacity for Children	11
Written Reasons for Key Decisions	12
Enabling Care Closer to Home.....	12
Human Rights Coercion and Reduction Committee	12
Duty to Warn.....	13
Providing Feedback.....	14

Acknowledgement of Country

The Office of the Chief Psychiatrist acknowledges and respects Aboriginal peoples as the State's first peoples and nations and recognises Aboriginal peoples as traditional owners and occupants of the land and waters in South Australia.

We acknowledge their spiritual, social, cultural and economic practices connected to their lands and waters; that they maintain cultural heritage beliefs, languages and laws of ongoing importance; and that they continue to make a unique and irreplaceable contribution to the State.

We acknowledge that Aboriginal peoples have endured past injustice and dispossession of their traditional lands and waters.

Advice about Content and Support Services

This paper discusses topics that may be distressing. If this occurs, please speak to a person you know, a support person or a professional. In South Australia, support options include:

Service	Contact
Lifeline	13 11 14
Lived Experience Telephone Support	1800 013 755
Mental Health Triage (for emergencies)	13 14 65
Urgent Mental Health Care Centre	08 8448 9100 — 215 Grenfell St, Adelaide 5000
Kids Helpline	1800 55 1800
Beyond Blue	1300 224 636
Rebuild (trauma support for victims of crime)	1800 310 310
1800RESPECT (National DFV counselling)	1800 737 732

Background

In April 2022, the South Australian Law Reform Institute (SALRI) commenced a review of the Mental Health Act 2009. A Final Report, containing 61 recommendations, was tabled on 2 May 2023.

In November 2023, the Office of the Chief Psychiatrist (OCP) released a Discussion Paper seeking feedback on SALRI-linked proposals, including a rights-based principles framework and supported decision-making.

On 9 September 2024, the OCP released a Supplementary Discussion Paper to explore additional reforms, including new principles and emergency response measures. These changes were designed to strengthen the delivery of high-quality care and provide benefits for many people, extending well beyond the initial focus of risk.

This third Discussion Paper provides an overview of the draft *Mental Health and Wellbeing Bill 2025*, shaped by feedback received during previous consultations. It does not cover all changes to the Bill but highlights key areas where feedback is sought and aims to assist understanding of the Bill's provisions and their intended purpose.

It also sets out questions you may wish to consider when providing feedback. These questions relate to specific provisions of the Bill. There is no obligation to answer any or all of them.

You are invited to comment on any areas of the Bill that you:

- Are most interested in
- Have concerns about
- Support
- Propose amendments to
- Or wish to make specific comments on.

This Bill represents a milestone in mental health legislation for South Australia. Your views are greatly welcomed and appreciated.

Submissions close COB Friday 13 February 2026 and can be emailed to HealthOCP@sa.gov.au, or you are invited to complete the short survey on YourSAy.

The Office of the Chief Psychiatrist thanks the many individuals and groups who have participated in and contributed to this work. Thank you for sharing your views on this important legislation.

Preliminary

Part 1 of the *Mental Health and Wellbeing Bill 2025* establishes foundational elements, including its title, commencement, and interpretation of key terms. This section introduces new terminology and definitions that underpin the rights-based approach of the Bill and guides its application into practice.

Decision-Making Capacity

The Bill adopts a modern, rights-based definition of decision-making capacity (section 6). A person is presumed to have capacity unless proven otherwise, and capacity is assessed in relation to a specific decision rather than as a blanket judgment. A person has decision-making capacity if they can understand when a decision needs to be made, comprehend relevant facts and options, weigh consequences, and communicate their decision in any way. Importantly:

A person is not considered incapable merely because they make an unwise decision.

Capacity may fluctuate, and all reasonably practicable steps must be taken to support the person before concluding that capacity is impaired.

These provisions align with contemporary human rights standards and promote autonomy while ensuring safeguards for those who need support.

Supported Decision-Making

Section 7 introduces supported decision-making as a formal mechanism to empower individuals to make their own decisions with assistance from a designated support person. Supported decisions can include consent or refusal of treatment, admission decisions, and service-related choices.

A supported decision is legally recognised as the person's own decision, reinforcing autonomy and participation. However, supported decision-making cannot be used for certain high-risk decisions, such as consent to prescribed psychiatric treatments (e.g., ECT or neurosurgery). The Chief Psychiatrist will issue guidelines to ensure consistency and safeguard rights.

Restrictive Practices

Restrictive practices are newly defined in section 9 and include seclusion, chemical restraint, physical restraint, mechanical restraint, and environmental restraint.

These measures must only be used as a last resort when no less restrictive alternative is reasonably available. They must comply with restrictive practice guidelines issued by the Chief Psychiatrist and be applied in accordance with the guiding principles of the Act, particularly the principles of least restrictive care, dignity and autonomy, and safety.

Consent for ECT and Restrictive Practices

Electroconvulsive Therapy (ECT) is a prescribed psychiatric treatment that can only be administered with proper consent. However, consent to ECT does not include consent to the use of restrictive practices to administer the treatment. Currently, restrictive practices for ECT can only be authorised by the SACAT under section 32(1)(c) of the *Guardianship and Administration Act 1993* (GAA).

The Bill includes provisions so that authorisation from SACAT can be sought under the mental health legislation rather than requiring separate authorisation under the GAA. This change maintains existing safeguards, including SACAT oversight.

Consultation Questions for Consideration

- Are the criteria for assessing decision-making capacity (understanding, weighing options, communicating decisions) clear and appropriate?
- Do you have any concerns about how decision-making capacity will be assessed in practice?
- What additional safeguards or guidance should be included to ensure supported decision-making is implemented effectively?
- Are the definitions of restrictive practices (seclusion, chemical, physical, mechanical, environmental restraint) clear and comprehensive?

Refer to section 6 for Decision-Making Capacity, section 7 for Supported Decision-Making, section 9 for Restrictive Practices, and section 106 for Restrictive Practices where ECT is Administered.

Objects and Principles

The *Mental Health and Wellbeing Bill 2025* incorporate 23 guiding principles to embed a rights-based approach across prevention, early intervention, treatment, and recovery. These principles reflect feedback from previous consultations and aim to strengthen safety, autonomy, and quality of care.

While all principles are important, we acknowledge that the number may appear extensive. Operational guidance will be provided to support implementation. We welcome feedback on whether these principles should be refined or consolidated, and which principles you consider most critical.

Key new principles arising out of the supplementary consultation include:

Suicide Prevention Principle

Stakeholders strongly supported an explicit suicide prevention principle aligned with best practice, emphasising voluntary engagement, safety planning, and follow-up support. The Bill frames this principle in rights-based terms and requires a Chief Psychiatrist standard to guide implementation.

Severe Mental Health Conditions Principle

Consultation highlighted the need for visibility of high-acuity and complex needs, balanced with equity for all consumers. The principle aims to improve planning for tertiary care without narrowing access for others, supported by guidelines and training for consistent application.

Mental Health and Substance Use Principle

Broad support was expressed for integrated responses to co-occurring mental health and substance use conditions. The Bill promotes collaboration and requires care plans to include an offer of voluntary alcohol and other drug interventions when clinically relevant, without punitive consequences for nonengagement.

Mental Health and Neurodevelopmental Principle

Responses supported improved access and inclusion for people with autism or intellectual disability who also experience mental health conditions. The principle reinforces that Schedule 1 exclusions should not impede voluntary care and calls for responsive service design and workforce training.

Compassionate Care Principle

Consumers and staff emphasised the value of compassion in care delivery. The Bill proposes a principle that defines compassionate care in measurable terms, supported by organisational systems and reporting to promote person-centred care and staff wellbeing.

Together, these principles aim to ensure mental health services are safe, inclusive, and recovery-oriented, while respecting autonomy and human rights.

They also align with national and international standards, including the UN Convention on the Rights of Persons with Disabilities and the NDIS Quality and Safeguards Framework.

Consultation Questions for Consideration

- Are the principles reasonable and appropriate?
- Should any principles be consolidated?
- Are there principles you consider essential for inclusion?
- Do you have suggestions for improving clarity or implementation of the principles?

Refer to section 14 of the Bill.

Statement of Preferences

The Bill introduces the concept of a Statement of Preference as a key mechanism to promote autonomy and person-centred care in mental health services. This provision enables individuals aged 16 years or older, who have decision-making capacity or can express preferences through supported decision-making, to record their preferences regarding mental health care treatment and related matters.

A Statement of Preference is a written document that may include:

- Preferred types of treatment, including medications, therapies, or interventions to receive or avoid.
- Preferred treatment settings or facilities.
- Preferences regarding the involvement of family members, carers, or other nominated persons in treatment decisions.
- Communication needs and supports to facilitate participation in decision-making.
- Cultural, spiritual, or personal considerations relevant to care.
- Daily routines, dietary requirements, or other factors that support recovery and wellbeing.

While a Statement of Preference does not create legally enforceable rights and cannot override treatment orders, advance care directives, or decisions by authorised bodies, clinicians are expected to have regard to these preferences wherever consistent with the Act.

This approach reflects the guiding principles of dignity, autonomy, and supported decision-making, even in circumstances where compulsory treatment may apply. Statements can be revoked at any time and do not apply during periods when the person is subject to a treatment order or in custody, although professionals may still consider them as guidance

Consultation Questions for Consideration

- 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?

Refer to Division 3, sections 21-27 of the Bill.

Family Consultation and Carer Involvement

In addition to Statements of Preferences, which may include information about who the person would like to have involved in their care (including family members or carers), the Bill recognises the vital role of families and carers in supporting recovery and wellbeing.

While the Bill prioritises individual autonomy and rights, it also acknowledges that family involvement can enhance decision-making, continuity of care, and safety when consistent with the person's wishes and best interests.

Principles that Support Family and Carer Engagement

Relevant principles within the Bill include:

- **Family and Carers Principle:** acknowledges that family and carers, including children, of people receiving mental health and wellbeing services should be supported in their roles in decision-making regarding the person's examination, treatment, and recovery.
- **Compassionate Care Principle:** emphasises respect, empathy, and inclusion of those who provide informal support.
- **Supported Decision-Making** encourages the use of support persons, which may include family members, to assist individuals in making informed decisions.
- **Recovery-Oriented Care Principle:** recognises the importance of social and relational supports for achieving recovery goals.

Best Interests

A best interest decision is a supported decision which should consider the views of parents, guardians, carers, or family members where appropriate. This requirement ensures that decisions align with the guiding principles of dignity, autonomy, and supported decision-making.

Children and Young People

When making a treatment order for a child or young person, a medical practitioner, authorised mental health professional, or tribunal must consider the impact of the decision on the child or young person's family, as well as any relevant history.

Consultation in Involuntary Care Decisions

Under sections 38(6)(d) and 68(6)(d), clinicians are required, where possible, to consult family members or carers when making decisions about involuntary care. This includes obtaining relevant history about risks to the person or others, which may not be forthcoming from the patient. These provisions aim to ensure that decisions are informed, balanced, and protective of both the individual and the community.

Consultation Questions for Consideration

- 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?

Refer to sections 6-7 for Decision-Making Capacity and Supported Decision-Making, section 14 for Guiding Principles, section 15 for Best Interests, section 33 for Children and Young People, and sections 68(6)(d) and 38(6)(d) for Consultation During Involuntary Care Decisions.

Forensic Community Treatment Orders

The Bill introduces Forensic Community Treatment Orders (FCTOs) for individuals in correctional institutions or training centres. These orders aim to ensure continuity of care and oversight within forensic settings.

FCTOs apply to both children and young people and adults. They operate alongside existing correctional frameworks and are designed to provide treatment in the least restrictive manner while safeguarding rights.

Duration and Continuity

FCTOs are shorter than standard Community Treatment Orders (CTOs), lasting up to 42 days for a Level 1 order. The Bill includes provisions for review, variation, and revocation. Importantly, section 53 for children and young people, and section 84 for adults, ensure that if a person is released before the order expires, the FCTO automatically converts to a CTO, maintaining continuity of care post-release.

Communication Rights

Section 18 extends communication rights to individuals subject to forensic orders in correctional or training facilities. This ensures that individuals retain the right to communicate freely with external parties, including legal representatives, oversight bodies, and advocates, subject to reasonable security restrictions.

The creation of FCTOs reflect recommendations from the SALRI review, which advocated for forensic orders based on the NSW model.

Consultation Question for Consideration

- 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?

Refer to section 18 for Communication Rights, sections 49-53 for Children and Young People and sections 80-84 of the Bill for Adults.

Changes to Involuntary Treatment Order Requirements

Threshold for Harm

Earlier consultation indicated support for raising the threshold from harm to serious harm, narrowing the circumstances in which involuntary treatment can be imposed. Under the current Act, orders can be made where treatment is required for the person's own protection from harm or for the protection of others.

Decision-Making Capacity for Children

Under the current Act, an assessment of impaired decision-making capacity is required for all persons, including children under the age of 16. The Bill removes this requirement for children under 16, as it was considered inconsistent with consent legislation. For those aged 16 and over, impaired decision-making capacity remains a criterion.

Written Reasons for Key Decisions

The Bill introduces a clear obligation for psychiatrists or interim psychiatric practitioners to document written reasons not only when a treatment order is confirmed but when a treatment order is not confirmed after review and when a treatment order is revoked.

Enabling Care Closer to Home

The Bill provides greater flexibility in patient transport arrangements to support care closer to home where appropriate. Section 97(3) allows the deferral of transport under a patient transport request to enable local review of an inpatient treatment order, including by audiovisual telehealth, before transfer. This provision allows clinicians to review the person locally either in person or via telehealth before deciding whether interhospital transfer to an approved treatment centre is required.

Consultation Questions for Consideration

- Do you agree with removing the requirement to assess decision-making capacity for children under 16?
- Do you support the new requirement for psychiatrists and interim psychiatric practitioners to provide written reasons when orders are not confirmed or revoked?

Refer to the Inpatient Treatment Order and Community Treatment Order provisions within the Bill such as sections 38(1)(b) and 68(1)(b) for Serious Harm, section 90(6) for Written Reasons, and section 97(3) for Patient Transport Requests.

Human Rights Coercion and Reduction Committee

As part of the Supplementary Consultation, the Office of the Chief Psychiatrist received broad support for giving statutory status to the Human Rights Coercion and Reduction Committee, with clear powers, defined functions, and strong representation from people with lived experience.

In response to this feedback, the Bill provides for the statutory establishment of the Committee, defining its functions and membership to ensure integrated oversight and advice consistent with key human rights instruments.

The current non-statutory Committee includes statutory officers alongside professionals such as lawyers, advocates, academics, clinicians, and individuals with lived experience. Statutory members presently include the Commissioner for

Children and Young People, the Principal Community Visitor/Public Advocate, and the Mental Health Commissioner.

The existing committee has played a key role in applying human rights principles in practice. Under the Bill, the Statutory Committee will continue this work by promoting a human rights-based approach in mental health care, advising on safeguarding rights, and guiding policy development. Its functions include advocating for dignity and wellbeing, reducing restrictive practices such as seclusion and restraint, and reviewing matters referred by the Minister to ensure alignment with human rights standards.

Consultation Questions for Consideration

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

Refer to Division 5, sections 152-160 of the Bill.

Duty to Warn

The Bill introduces a significant shift by enshrining a duty to warn. Prescribed persons such as psychiatrists, authorised mental health professionals, and other designated clinicians, must take reasonable steps to warn individuals or notify authorities when they suspect, on reasonable grounds, that a person with a mental illness poses a serious threat to another person's life, health, or safety, or to public health or safety.

This duty must be discharged promptly and in accordance with regulatory requirements, including notifying SAPOL. Importantly, the Bill provides legal protection for practitioners acting in good faith and clarifies that compliance does not exhaust broader duties of care. It also introduces record-keeping obligations and outlines circumstances where exemptions may apply, such as when the person at risk is already aware of the threat.

Consultation Question for Consideration

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

Refer to Part 8 of the Bill, sections 94 and 95.

Providing Feedback

We welcome your feedback on the proposed Mental Health and Wellbeing Bill.

If you wish to provide feedback, please submit via YourSAy or email the Office of the Chief Psychiatrist at HealthOCP@sa.gov.au. Additional information about information sessions and webinars will be scheduled and advertised via YourSAy and the Office of the Chief Psychiatrist website.

We look forward to receiving your submission or online survey by close of business Friday, 13 February 2026.

For more information

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