Australian Psychological Society

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Office of the Chief Psychiatrist
South Australia
Department of Health and Wellbeing
PO Box 287
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Submitted via email to: HealthOCP@sa.gov.au

Dear Dr Brayley,

APS Submission to the draft Mental Health and Wellbeing Bill 2025 (SA)

Thank you for the opportunity to provide feedback on the exposure draft of the Mental Health and Wellbeing Bill 2025. The APS welcomes the progression of legislative reforms aimed at improving the mental health and wellbeing of South Australians, consistent with section 13 of the Bill.

The APS supports provisions that strengthen a rights-based, least-restrictive approach to mental health care, including the effective operation of supported decision-making and safeguards. We welcome ongoing engagement with the Office of the Chief Psychiatrist during implementation and evaluation of the legislation.

About the APS

The APS is the leading professional body for psychologists in Australia, representing clinicians, researchers, and academics working across public, private, community, forensic, and disability-inclusive mental health settings. Psychologists are uniquely positioned to support the development and application of rights-based mental health legislation, particularly in relation to supported-decision making, decision-making capacity, and safeguards.

The APS submission focuses on supported decision-making, decision-making capacity, coercion reduction, and related safeguards, with particular attention to implementation considerations that promote consistent, ethical, and least-restrictive practice.

We consent to this submission being made publicly available. Should further information be required, please contact the APS National Office on (03) 8662 3300 or via email at z.burgess@psychology.org.au

Yours sincerely,

Dr Zena Burgess, FAPS FAICD

Chief Executive Officer

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Australian Psychological Society Submission to the Draft Mental Health and Wellbeing Bill 2025 (SA)

The Australian Psychological Society (APS) provides the following response to the South Australian Office of the Chief Psychiatrist's consultation on the exposure draft of the Mental Health and Wellbeing Bill 2025 (SA).

Response to the Consultation Questions

Interpretation of key terms in line with rights-based approach

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

The capacity criteria in section 6 are clear, largely appropriate, and reflect contemporary theory and practice. Strengths include the presumption of capacity, explicit recognition of fluctuating capacity, and the requirement for all reasonable support steps be taken before finding impaired capacity. The Bill appropriately guards against conflating unwise decisions with incapacity and makes clear that compliance with treatment does not, of itself, establish decision-making capacity.

The comprehensive nature of the proposed criteria, however, may create complexities for interpretation and decision-making *about* decision-making capacity. The criteria are only effective if they can be considered and balanced in their totality by a clinician or other decision-maker. Cognitive and organisational limitations in clinical practice may make this difficult, leading to interpretations that diverge from the legislative intent. The potential harms of unintentionally having two sets of criteria (an explicit set, in legislation, and an implicit set, as understood by clinicians), needs to be understood and remedied before the legislation is implemented. We address this further below.

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

Implementation will depend heavily on the Chief Psychiatrist's Capacity Assessment Guidelines, with which the Bill requires decision-makers to have regard. Clear operational guidance and resourcing will be critical to promote consistent thresholds and consistent expectations about what constitutes "reasonably practicable" support steps across settings. Consideration should also be given to workforce training, decision support tools, documentation expectations, and audit/quality mechanisms to reduce variability in assessments.

Psychologists have an important and currently underutilised role in supported decision-making and in the cognitive, relational, and communication dimensions of decision-making. The APS recommends psychologists' involvement in the development and implementation of the capacity assessment and supported decision-making guidelines, informed by the evolving evidence base.

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

The supported decision-making (SDM) principles in the Bill are a welcome inclusion and reflect rights-based contemporary thinking, as supported by the APS in previous submissions. Again, the key challenge will be translating these into effective practice across clinical settings.

Additional safeguards, resourcing, and guidance should include clear expectations about how SDM is to be operationalised in practice, including intentional work to establish positive norms and organisational cultures that actively promote supported decision-making, rather than defaulting to substitute decision-making. Guidance is also needed on dispute resolution and escalation pathways where a support person and clinician disagree, to ensure decisions remain lawful, ethical, and centred on the person's rights and preferences.

Effective implementation will require workforce training and ongoing support, including supervision, monitoring, and quality assurance mechanisms. Without this, there is a risk of inconsistent or superficial application of SDM. Psychologists with expertise in behaviour, systems, and workplace change are particularly well placed to contribute to the design, implementation, and evaluation of SDM frameworks and supports.

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

The definitions of restrictive practices in the Bill appear to be largely clear and detailed.

The inclusion within the definition of environmental restraint regarding “removal of an individual from their immediate environment to an unlocked quiet room…” appropriately recognises that restriction can occur in the absence of physical barriers. Further guidance distinguishing voluntary withdrawal from directive or coercive removal would support consistent application. Such guidance could also prompt consideration of whether, in the context, the interaction would reasonably be experienced as coercive, having regard to factors such as power imbalance, staff direction, and implied consequences.

Objects and principles

Are the principles reasonable and appropriate?

Yes, the principles are well aligned with the stated objects of the Bill and appropriately reflect a rights-based, recovery-oriented approach to mental health care. Collectively, they provide a strong ethical and conceptual foundation for decision-making under this new legislation.

Should any principles be consolidated?

The principles address a range of important dimensions, including core human rights, specific populations and contexts, and systems-level behaviour. While some overlap exists, particularly between principles relating to prevention of harm, safety, and proportionality, there is a risk that over-consolidation could dilute the visibility and intent of these distinct considerations. Any consolidation should therefore be approached cautiously and only where it demonstrably improves clarity without weakening emphasis.

Are there principles you consider essential for inclusion?

No. The existing principles appear comprehensive and appropriately scoped.

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

Greater benefit is likely to be achieved through stronger operational clarity and implementation supports, rather than changes to the principles themselves. Given the number and breadth of principles, clinicians and decision-makers will require practical supports to apply them consistently and to navigate situations where principles may appear to be in tension.

This could include clear guidance, workforce training, alignment with the guidelines issued under the legislation, case examples, decision-making frameworks, and monitoring or quality assurance mechanisms. Such supports would assist in embedding the principles into everyday practice and reducing variability in their application.

Statement of preferences

Are the current exclusions (e.g., refusal of mandatory treatment) clear and appropriate?

Yes. The exclusions are clearly articulated and appear to provide an appropriate balance between respect for individual autonomy and the requirements for compulsory treatment under the Bill.

Should standard templates or guidance materials be developed to assist in drafting these statements?

Yes. Without standardised templates and guidance materials, there is a risk that Statements of Preferences will be vague, clinically uninformative, or applied inconsistently, reducing their practical value and becoming tokenistic rather than meaningful. Guidance materials would also support clinicians to engage with and apply statements more consistently in decision-making.

Individuals are likely to require structured prompting to articulate preferences clearly and in practical terms, including guidance on the types of considerations set out in section 23(1). This is particularly important from an equity perspective, given potential literacy, cognitive, communication, and cultural barriers.

Effective implementation will therefore require intentional design and resourcing of processes to support individuals to develop Statements of Preferences in an accessible and supported manner, including access to supported decision makers where appropriate. Workforce implications should be considered, including the potential role of independent health practitioners, separate from an individual's treating team, to assist in developing these statements and safeguard the integrity and independence of the process. A review of practices in other jurisdictions (e.g. the peer-led *My Rights, My Decisions* program in the ACT), may be informative in guiding effective implementation in the South Australian context.

Family consultation and carer involvement

Are additional safeguards needed to ensure family involvement respects the person's rights and preferences?

Yes. While this is implied through other principles in the Bill, explicit recognition that family consultation may be inappropriate in certain circumstances should be included. In particular, consultation should not occur where it poses a risk to the person's safety or wellbeing, such as in contexts involving family violence, coercion, or other forms of harm.

Although the Bill establishes a clear intent, additional operational guidance would assist clinicians in managing situations where the views of family members conflict with the person's rights, preferences, or expressed wishes. Clear guidance would promote consistency and reduce variability in how such conflicts are navigated in practice. Such guidance should also be informed by culturally-safe best practice, noting that expectations and practices about the involvement of family members can vary widely between and within cultures. While the Bill is shaped by a model of human rights which emphasises individual rights and autonomy, this needs to be carefully balanced against the view in the UN Convention on the Rights of Persons with Disabilities (CRPD) that any person exists within, and depends on, their social context[1].

Should operational guidelines define circumstances where family consultation is strongly recommended?

Yes. To support consistency and effective practice, operational guidelines should identify circumstances where family consultation is most likely to add value, clarify how consultation should occur when a person's decision-making capacity is fluctuating, and reinforce that "strongly recommended" does not equate to mandatory.

Forensic Community Treatment Orders (FCTOs)

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?

Yes, Forensic Community Treatment Orders should remain a distinct provision within the Bill. The differences in legal context, cohort characteristics, and risk environment between forensic and non-forensic populations warrant separate consideration and tailored safeguards. Maintaining a distinct framework recognises the intersection between mental health care and the unique requirements of the criminal justice system.

The inclusion of a mechanism to convert a Forensic Community Treatment Order to a Community Treatment Order upon release is a particular strength of the Bill. This supports continuity of care, facilitates transition from forensic to community settings, and aligns with recovery-oriented and least-restrictive principles.

Changes to Involuntary Treatment Order Requirements

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

The APS understands the rationale of this proposal for removing a requirement to assess impaired decision-making capacity for children under 16. An impairment-based capacity assessment is not well suited to younger children, as decision-making authority for this age group generally rests with parents or guardians. However, decision-making capacity should be considered for older children, particularly in the case of a 'mature minor' or *Gillick*-competent minor who may generally be able to make decisions in relation to their health. Noting the complexities of assessing both underlying developmentally based capacity and its impairment, we note as a general principle that children's involvement in decisions under the proposed legislation may be more appropriately addressed through participation and supported decision-making mechanisms rather than through a finding of impairment.

Any proposed reform should not result in a reduction in the consideration given to children's views, preferences, and evolving capacities. In the absence of an impairment assessment, there is a risk that decision-making may default to parental or guardian consent without consistent or meaningful engagement with the child, particularly in time-pressurised clinical environments.

A rights-based approach requires that children and young people are supported to participate in decisions that affect them in ways that are appropriate to their age, maturity, and circumstances. If the impairment-based capacity requirement is removed, this should be accompanied by clear and practical guidance on how children's views are to be elicited, considered and documented within mental health decision-making processes. Input from psychologists with experience with children, development, and family systems is critical in the development of this guidance.

Such guidance should promote consistent practice across settings and clarify how children's participation is to inform decisions alongside parental or guardian consent. Without explicit operational requirements, there is a risk that children's participation becomes variable and dependent on individual clinician practice rather than being systematically embedded in decision-making.

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

Yes. The APS supports this requirement. Providing written reasons when orders are not confirmed or are revoked strengthens transparency, accountability, and procedural fairness within involuntary treatment processes. Clear articulation of clinical reasoning supports reflective decision-making and promotes greater consistency in the application of statutory criteria.

Written responses also enhance trust in involuntary treatment processes for consumers, families, and supporters, and provide an important record to support review, oversight, and quality assurance. Clear documentation of decision-making is particularly important in high-impact decisions involving restrictions on autonomy. The APS considers this requirement an appropriate safeguard that aligns with the Bill's broader emphasis on rights-based practice, transparency, and the reduction of coercion.

Human Rights Coercion and Reduction Committee

What should the membership of the Statutory Committee comprise?

The functions of the Human Rights Coercion and Reduction Committee cannot be effectively discharged without sufficient psychologist representation. Psychologists provide essential expertise in behaviour change, trauma-informed practice, supported decision-making, and coercion that is not substitutable by other disciplines. To ensure balanced, rights-focused, and evidence-based deliberation, the Committee should include more than one psychologist with experience across acute, community, forensic, and disability-inclusive mental health settings.

Do you agree that the functions appropriately encapsulate the Committee's role?

The stated functions of the Committee appropriately include advising on the human rights implications of mental health policy and practice. However, consideration could be given to clarifying the Committee's role in identifying systemic risks to human rights, particularly where coercive practice arises despite formal alignment with rights-based principles. This would strengthen the Committee's capacity to contribute to meaningful coercion reduction in practice, not only at the level of policy intent.

Duty to Warn

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

The duty to warn requires careful scoping and clear operational guidance to ensure consistent and proportional application. While the intent of the provision is understood, aspects of the Bill would benefit from clarification to avoid unintended consequences in practice.

It is currently unclear which professional groups working outside the public mental health system will be captured as prescribed persons. Early clarification of scope is important to avoid unnecessary concern or inconsistent interpretation across settings, including private practice.

Key concepts such as "reasonable grounds" and "serious threat" will require clear guidance to support consistent thresholds across practitioners and service contexts. Without this, there is a risk of variable application and defensive practice. The APS recommends that a preliminary consultation process on the development of the regulations to be made under these provisions commence as soon as possible, and with input from all professions and professional associations affected.

Clarification is also required regarding the obligation to warn a person at risk. While the Bill appropriately qualifies this requirement by reasonableness and exemptions, there will be circumstances where direct contact by a practitioner is unsafe, impractical, or inappropriate. Clear guidance is needed on when notification to South Australia Police (SAPOL) alone is sufficient.

Finally, appropriate support, training, and guidance for practitioners will be essential to enable this duty to be discharged safely and, in a manner, consistent with the Bill's human rights and least-restrictive principles.

References

1. Bartlett, P. (2025). Beyond the liberal subject: Challenges in interpreting the CRPD, and the CRPD's challenges to human rights. *Human Rights Law Review*, *25*(2), ngaf005. https://doi.org/10.1093/hrlr/ngaf005