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Via email: [HealthOCP@sa.gov.au](mailto:HealthOCP@sa.gov.au)

### **Feedback on the Mental Health and Wellbeing Bill 2025**

Thank you for the opportunity to provide feedback on the Mental Health and Wellbeing Bill 2025.

I provide this response in my capacity as the South Australian Public Advocate (PA) and as the Principal Community Visitor (PCV).

I congratulate you on the quality of the draft Bill and for the extensive consultation process that has been followed. I am particularly pleased to see included in the Bill:

1. presumption of decision-making capacity (s6(2)(a)),
2. explicit role for supported decision-making (s7),
3. definition of “restrictive practices” (s9) in line with Commonwealth disability and aged care legislation,
4. comprehensive guiding principle especially those affecting co-morbidities with drug and alcohol issues (s14(1)(m), and neurodevelopmental conditions (s14(1)(n)).
5. establishment of a person’s statement of preferences (s22)

It is also pleasing that the recent amendments regarding the Community Visitor Scheme are retained. I raise the following issues for your consideration. I have also prepared a table of suggested minor amendments to the draft Bill which would assist in the execution of my roles.

#### **Issue 1: Presumption of decision-making capacity**

s6(2)(a) states that a person “*is, in the absence of evidence or a law of the State to the contrary, presumed to have decision-making capacity...*”.

It would be useful to spell out that a guardianship order from SACAT or appointment of a substitute decision-maker under the ACD Act overrides the presumption of capacity in this Bill, assuming this is the case. If this is not the case, clarity about the interoperability of the *Mental Health Act*, the *Guardianship and Administration Act, 1993*, and the *Advance Care Directives Act, 2013* is required to ensure it is clear about which Act prevails.

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### Issue 2: Voluntary Patients

It is a problem when Public Advocate clients who require mental health services are unable to engage and fail to muster the necessary consent to be a voluntary patient (s29).

It would be beneficial for the words *“a person may, at their own request”* to be replaced with the words *“a person may, at their own request or the request of their guardian or substitute decision-maker.”* Currently a person who does not engage is not treated unless their condition exacerbates to the level that requires a treatment order.

### Issue 3: Supported Decision-Making

It is laudable that the Bill addresses supported decision-making and the principle is supported. However, the statement *“For the purposes of the laws of the State, and to the full extent of the extraterritorial legislative capacity of the State, a decision of a person with a mental illness made using supported decision-making will be taken to be a decision of the person”* in s7(4) is unclear in how it relates to decisions made through powers in other legislation.

First, it does not recognise that a substitute decision-maker appointed under the *Advance Care Directives Act, 2013*, or a guardian appointed under the *Guardianship and Administration Act, 1993* has primacy in decision-making, and it is not clear about which role takes precedence. Secondly, it poses no safeguards for the individual when a supporter acts in their own self-interest and is cajoling, influencing or coercing an individual rather than supporting them. Thirdly, it is not clear that a supporter acting in good faith is indemnified when a supported decision of the individual has deleterious consequences.

### Issue 4: Mental illness and disability

The *“Meaning of mental illness”* (s5) – *“a person will not be taken to have a mental illness merely because...(s5(2)(k)) the person has developmental disability of mind”* – is laudable in clarifying that intellectual and neurological disabilities are distinct from mental illness, even if the language is strangely archaic. More modern wording such as *“...a person will not be taken to have a mental illness... merely by reason of having a developmental disability”* would be clearer.

However, clarification is needed that people with *“developmental disability of mind”* can also experience mental illness. The excellent sentiment expressed in s14(1)(n), to address such co-morbidity, struggles against the phenomenon of *“overshadowing”*, whereby mental illness symptoms can be attributed to the disability and therefore not treated. Wording such as *“a person who has a developmental disability may also have a mental*

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*illness. In the application of this Act, symptoms of mental illness should not be attributed solely to the person's developmental disability" would be more appropriate.*

### **Issue 5: Personality Disorders**

There is no resolution to the difficulty of treating and supporting people with personality disorders (especially borderline personality disorder (BPD)). There is, understandably, no mention in the Bill of any particular mental health condition. However, "... *a reference to **mental illness** will be taken to be a reference to a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory*" s5(1).

This would appear to include BPD in scope and confirmation is sought that this is the case. Currently, BPD is deemed not in scope of the meaning of mental illness and not in scope for the meaning of "*disability*" under the NDIS Act 2013 (Cwth). This leaves a very challenged group of people without access to needed support or treatment.

### **Issue 6: Additional provisions relating to Tribunal Proceedings**

The words "Public Advocate" should be replaced with "*Public Advocate when appointed guardian of the person*" in relation to Tribunal matters (s67(7) and s189(1)(a)).

Under s21(1)(d) of the *Guardianship and Administration Act 1993* (GAA) the Public Advocate can "*speak for and negotiate on behalf of any mentally incapacitated person in the resolution of any problem faced by that person arising out of his or her mental incapacity*". In practice the Public Advocate performs this function only for clients under Public Advocate guardianship. The other provisions of s21(1) of the GAA relate to systemic advocacy for people with impaired decision-making ability, rather than individual advocacy.

### **Issue 7: New provisions that expand the remit of PCV oversight**

While the Bill strengthens human rights, it also introduces potential new functions for the PCV/Community Visitor Scheme (CVS) (i.e. right to communicate s18(3)(g), supported decision making (s17(2)(e)), Statement of Preferences (s22), Forensic Community Treatment Orders (Division 5). The new provisions may generate new points of enquiry and extended CVS visit times.

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### Specific Feedback

For ease of review, my detailed feedback/suggestions (as Public Advocate and Principal Community Visitor) are listed in the following tables (referencing the page and section of the *Mental Health and Wellbeing Bill 2025*):

Page number	Document section	Feedback/Suggestions – PUBLIC ADVOCATE
p18-19	s7(2) and s7(6) – Meaning of supported decision-making and supported decision	<p>Refer to the comments about Supported Decision-Making regarding the interoperability of other legislation and substitute decision makers above in Issue 3.</p> <p>s7(2) does not adequately address the primacy of substitute decision-makers or guardians appointed under other legislation, nor does it clearly articulate which role is intended to prevail where there is inconsistency between a supported decision-maker, a substitute decision-maker, or a guardian.</p> <p>s7(6) also references Part 7 of the <i>Advance Care Directives Act, 2013</i>, under which the Public Advocate is empowered to resolve disputes concerning advance care directives. The incorporation of this mechanism into the Mental Health Act framework appears to broaden the circumstances in which contested supported decisions may be referred to the Public Advocate for determination. While this may provide an important safeguard, it expands the Public Advocate’s dispute resolution function beyond its current scope</p>
p29	s18(3) – Right to communicate with others outside treatment centre etc	<p>The words “<i>communication by post</i>” are outdated and limiting, though reflective of the diversity of policies amongst Local Health Networks regarding use of personal communication devices. Consideration should be given to more inclusive language such as “<i>Communication by post or other means subject to the policies of the treatment centre.</i>”</p>
p41	s37(4)(a)(1) and s37(7)(d) – Level 2 child and young person’s community treatment orders	<p>The Public Advocate is listed among those who can apply to the tribunal for the making or revoking of a child or young person’s level 2 community treatment order. This is not a function that the Public Advocate currently performs and should not be in the Bill.</p> <p>The Public Advocate on rare occasions is appointed guardian for a young person with impaired decision-making capacity who is</p>

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		<p>close to turning 18. In general, the Public Advocate does not deal with children.</p> <p>The Guardian for Children and Young People may be a more appropriate alternative role for this responsibility.</p>
p45	S40(4)(a) and s40(7)(d) Level 3 child and young person's inpatient treatment orders	<p>The Public Advocate is listed among those who can apply to the tribunal for the making or revoking of a child or young person's level 3 inpatient treatment order. This is not a function that the Public Advocate performs and should not be in the Bill.</p> <p>The Public Advocate on rare occasions is appointed guardian for a young person with impaired decision-making capacity who is close to turning 18. In general, the Public Advocate does not deal with children.</p> <p>If this remains in the Bill, the Public Advocate does not have capacity to take on this additional role. The Guardian for Children and Young People may be a more appropriate alternative role for this responsibility.</p>
p53	S52(4)(a) and s52(7)(d) Level 2 child and young person's forensic community treatment orders	<p>The Public Advocate is listed among those who can apply to the tribunal for the making or revoking of a child or young person's level 2 forensic community treatment order. This is also not a function that the Public Advocate performs and should not be in the Bill.</p> <p>The Guardian for Children and Young People may be a more appropriate alternative role for this responsibility.</p>
p63	S67(7) – Level 2 community treatment orders	<p><i>“A registrar of the Tribunal must, not less than 2 months before the expiry of a level 2 community treatment order applying to a person that has a period of operation of more than 6 months, send to the applicant (if any) for the order, the Public Advocate and...”.</i></p> <p>This means the registry of the tribunal is obliged to notify the Public Advocate of <i>all</i> expiring level 2 community treatment orders, not just for those who are under guardianship of the Public Advocate. The words “Public Advocate” should be replaced with <i>“Public Advocate when appointed guardian of the person.”</i></p>
p93	s112(4) – Panel to review certain	As well as the Chief Psychiatrist, the Public Advocate, the Tribunal, the Principal Community Visitor, and the nominated

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	complex cases and prescribed persons	clinical direct of a treatment centre, the <i>“patient’s treating clinician”</i> should be included in the list. It is preferable that ‘must refer’ to the panel apply to clinical roles who have a responsibility to recommend, oversee, or administer Electro Convulsive Therapy (ECT) and the roles of Public Advocate and Principal Community Visitor are optional and be referenced as ‘may refer’ to the panel.
p117	s162 – Chief Psychiatrist may require information	<p>This section confers very broad powers on the Chief Psychiatrist to request information from prescribed public sector agencies, or any other entity prescribed by regulation. The breadth of the information to be provided potentially encompasses confidential and sensitive information regarding clients of the Public Advocate.</p> <p>It is requested that the Public Advocate be named specifically for exclusion under this provision, or be an agency that the Minister, by notice in writing, could exempt from the operations pursuant to s162(6).</p>
p132-135	S185(3)(c) and 186(b)(iii) and 189(1)(a) and 190(1)(c) – Review by tribunal of certain decisions	<p>The words “Public Advocate” should be replaced with the words <i>“Public Advocate when appointed as guardian of the person.”</i></p> <p>As drafted, the Public Advocate could be drawn into action that affects any patient, and this is beyond the practical remit of the Public Advocate and should be amended to narrow the scope.</p> <p>Section 189(1)(a) creates an entitlement for all persons who are subject of proceedings before the Tribunal to have the Public Advocate appear for them. This is a new obligation.</p>

Page number	Document section	Feedback/Suggestions – PRINCIPAL COMMUNITY VISITOR
p28	s17(2)(e) – Right to be supported by other persons	<p>Confers a new function on the Principal Community Visitor or community visitor to provide support to a person. The CVS does not currently provide decision-making support to individuals. This provision may lead to increased requests for support and expand the function of the CVS.</p> <p>It is preferable to exclude the specific reference to the PCV or community visitor and rely on section 17(2)(d) which is general</p>

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		about “... a person who provides advocacy services (whether on a professional or voluntary basis)” to cover the PCV role.
p28	s18 – Right to communicate with others outside treatment centre etc	It is noted that s18 strengthens the rights of people, including children and those subject to forensic community orders, to communicate with others, including ensuring they can make and receive communications without unreasonable restriction. Ensuring access to external advocates including the Principal Community Visitor is a new function and broadens the scope to include correctional settings.
p51 and p71	s51 & s52 Forensic community treatment orders for children and young people, s82 & s83 Forensic community treatment orders for adults	<p>The proposed Forensic Community Treatment orders relate to people in correctional settings and youth training centres. The CVS does not currently visit custodial settings operated by the Department of Correctional Services (DCS) or training centres operated by the Department of Human Services (DHS). If these sites are designated as “approved treatment centres” by the Chief Psychiatrist under s116 this would expand the scope of the CVS.</p> <p>It may be more appropriate that this role is performed by the Guardian for Children and Young People.</p> <p>Community Visitors are volunteers and not trained or experienced in working in correctional settings or training centres.</p> <p>For people in correctional settings, the Official Visitors within the DCS portfolio may be more appropriate to fulfil this role.</p>
p 106	s140(3) and s 140(4) – Principal Community Visitor	<p>The processes to remove or suspend the Principal Community Visitor which involves addresses from both Houses of Parliament seeking removal by the Governor are not replicated for other statutory officers.</p> <p>It would be more appropriate to model removal of the PCV on the provisions in the GAA for removal of the Public Advocate (s20(3) GAA), or similar provisions to terminate the Mental Health Commissioner in the Bill (s133(5)). Neither of these roles reference involvement of the Parliament prior to removal.</p> <p>It is noted that there are no similar termination provisions for the Chief Psychiatrist (s125(3)) and whilst there are variations in the functions of statutory roles in, it is unclear why there is</p>

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		such inconsistency in processes for removal or termination of incumbents in the statutory roles in the Mental Health Bill.
p111	s148 - Certain visits and inspections may be conducted by audiovisual or other electronic means	<p>There is provision for "<i>visits by audiovisual or other electronic means.</i>"</p> <p>The difficulty of visiting very small facilities in country areas could be included in the reasons for not physically visiting e.g. in s148(2) add "<i>(d) if the facility has under 6 beds and is located outside the metropolitan area</i>".</p>

Thank you for the opportunity to provide further comment on the draft Bill.

Yours sincerely



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