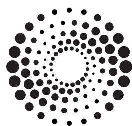
The Law Handbook

YOUR PRACTICAL GUIDE TO THE LAW IN NEW SOUTH WALES

15th EDITION



THOMSON REUTERS

REDFERN LEGAL CENTRE PUBLISHING

Published in Sydney
by Thomson Reuters (Professional) Australia Limited
ABN 64 058 914 668

19 Harris Street, Pyrmont NSW 2009
First edition published by Redfern Legal Centre as *The Legal Resources Book (NSW)* in 1978.
First published as *The Law Handbook* in 1983
Second edition 1986
Third edition 1988
Fourth edition 1991
Fifth edition 1995
Sixth edition 1997
Seventh edition 1999
Eighth edition 2002
Ninth edition 2004
Tenth edition 2007
Eleventh edition 2009
Twelfth edition 2012
Thirteenth edition 2014
Fourteenth edition 2016
Fifteenth edition 2019

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ISBN: 9780455243689

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This edition is up to date as of 1 October 2019.

The Law Handbook is part of a family of legal resource books published in other states:
Vic: *The Law Handbook* by Fitzroy Legal Service, ph: (03) 9419 3744
SA: *Law Handbook* by the Legal Services Commission of South Australia, ph: (08) 8111 5555
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NT: *The Northern Territory Law Handbook* by Northern Territory Legal Aid Commission,
Australasian Legal Information Institute and Darwin Community Legal Services, ph: (08) 8982 1111

Editor: Newgen Digitalworks
Product Developer: Karen Knowles

Printed by: Ligare Pty Ltd, Riverwood, NSW

This book has been printed on paper certified by the Programme for the Endorsement of Forest Certification (PEFC). PEFC is committed to sustainable forest management through third party forest certification of responsibly managed forests.

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Health Law

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General overview

[26.10] Health law in NSW is governed by specific legislation as well as other general laws. For example, public health legislation sets out requirements and establishes practices for the protection of the health and safety of the public. In cases of medical negligence, the *Civil Liability Act 2002* (NSW) sets out the required standard of care for professionals, including medical professionals. Privacy of medical information is governed by the *Health Records and Information Privacy Act 2002* (NSW) (*HRIP Act*) and the *Privacy Act 1988* (Cth) including Sch 1 of this Act which outlines the *15 Key Health Privacy Principles* (HPPs). Complaints about health care professionals and/or services provided can be made in accordance with the *Health Care Complaints Act 1993* (NSW).

Other related areas include mental health, guardianship and consent to treatment which are covered later in this chapter as well as in Chapter 16, Disability. Issues regarding discrimination based on a medical condition (disability) are covered later in this chapter, and in Chapter 17, Discrimination.

Public Health Act NSW

The *Public Health Act 2010* (NSW) is legislation designed to protect and promote public health. The key objectives of the *Public Health Act* are to:

- control the risk to public health;
- promote the control of infectious diseases;
- prevent the spread of infectious diseases;
- recognise the role of local governments in protecting public health.

Within the Act, provision is made to address general protections and precautions, notification and treatment, identity protection, public health orders, and other disease control measures.

Health Rights and Responsibilities

NSW Health Policy directive [PD2011_022] outlines the general rights and responsibilities of NSW Health services and staff, and patients and carers. Basic rights are detailed in the policy, including; Access, Safety, Respect, Communication, Participation, Privacy, and the Right to Comment. All health professionals delivering healthcare services within NSW Health must be made aware of these rights and responsibilities.

Consent for treatment

The established presumption is that every adult of sound mind has a right to determine what medical treatment they do or do not consent to. As part of their duty of care, health professionals must provide such information as is necessary for the patient to give consent to treatment, including information on all material risks of the proposed treatment. “Informed consent” refers to consent to medical treatment and the requirement to warn of material risk prior to treatment. Failure to do so may lead to civil liability for an adverse outcome, even if the treatment itself was not negligent.

Lack of capacity to consent

Where a person is unable to give consent, the consent can be obtained from a person responsible as provided for under the *Guardianship Act 1987* (NSW) or from a guardian appointed by the Guardianship Tribunal NSW. For children under the age of 14 years, consent can be obtained from the child’s parent or legal guardian, or if the child is in care, the person with parental responsibility can consent as provided for in the *Children and Young Person’s (Care and Protection) Act 1998* (NSW). Under the *Minors (Property and Contracts) Act 1970* (NSW), a child aged 14 years or over may consent to medical treatment, and the consent of the child will be effective in terms of defending an action relating to the treatment, if the child meets the Gillick definition of a “mature minor”. See also [7.740] for medical consent in children and young people.

Privacy

The *HRIP Act* outlines how New South Wales public sector agencies and health service providers that collect, hold or use health information, manage the health information of NSW public members. The purpose of this Act is to promote fair and responsible handling of health information.

Schedule 1 of the *HRIP Act* outlines the *15 Key Health Privacy Principles* (HPPs) which are the legal obligations which NSW public sector agencies and

private sector organisations must abide by when they collect, hold, use and disclose a person's health information. These principles detail how a person's health information must be collected, stored, used, and disclosed as well as rights of access to a person's individual health information.

The *Privacy and Personal Information Protection Act 1998* (NSW) (*PPIP Act*) outlines how New South Wales public sector agencies manage personal information and the functions of the NSW Privacy Commissioner. The *PPIP Act* includes 12 Information Protection Principles (IPPs) and sets out the role of the NSW Privacy Commissioner, and gives the Commissioner powers to investigate and mediate complaints made against an agency.

Certain lawful exemptions may exist for agencies in HIPPA itself; in a regulation or privacy code of practice made by the Attorney General; or in a Public Interest Direction, made by the Privacy Commissioner. These exemptions allow public sector agencies to modify the application of the Information Protection Principles (IPPs) in the PPIPA in certain circumstances with regard to:

- the definition of "personal information";
- an agency's specific functions;
- a particular agency;
- one or more of the Information Protection Principles (IPPs);
- the public register provisions.

Information and records

Under the *HRIP Act*, a person has a right to access health information about themselves that is held by any organisation both private and public that provides a health service to them.

When contacting an organisation to request access to health information, the request must be in writing, include identifying information about the patient and the information request, and how the information is to be accessed (review or copy). Authorisation must be given for any other third party to access health information. A fee may be charged.

The organisation must provide a decision within 28 calendar days from receiving a request for public sector agency and 45 calendar days for private sector health service provider. If the request is for medical records containing sensitive health information, such as records pertaining to mental health or a person's HIV status, a clinician may need to review the information prior to its release.

There are only limited circumstances when a provider may decline access if:

- access would pose a serious threat to the life/health of an individual; or
- would have an unreasonable impact on the privacy of other individuals; or
- the health information relates to existing/anticipated legal proceedings and access through court processes is not available; or
- it be unlawful; denying access is required/authorised by another law; or
- the request is a repeated request and has been reasonably declined previously or the information has already been provided;
- access would prejudice an investigation of possible unlawful activity or prejudice a law enforcement agency's functions.

Where the response provided is unsatisfactory, the fees are excessive, or the organisation has not responded within the specified timeframe, a complaint can be made to the NSW Privacy Commissioner within six months of the unsatisfactory act.

Similarly, the *PPIP Act* gives a person the right to see and ask for changes to be made to their personal or health information.

Complaints about health care services

Complaints about conduct/care

The *Health Care Complaints Act 1993* establishes the Health Care Complaints Commission as an independent body for the purposes of receiving and assessing complaints relating to health services and health service providers in New South Wales, resolving complaints; investigating and prosecuting serious complaints.

The HCCC receives and assesses complaints about the professional conduct of a health practitioner and/or the clinical care and treatment provided by an individual or organisation (both public and private). Complaints must be in writing and may be made about the care and treatment provided by or the professional conduct of a health service provider in NSW, including any registered practitioner, unregistered provider, and any organisation providing a health service.

The Commission is required to assess all complaints within 60 days. In complex cases or

where there is further information required to make a decision, the assessment process may take longer.

At the conclusion of an investigation, a full report outlining the allegations, the relevant evidence and the Commission's findings is prepared.

The *Health Care Complaints Act* provides for a right to review of the outcome of an assessment decision or an investigation outcome.

Like all organisations, the HCCC cannot make changes to medical records. In general, nothing can be removed from medical records. Any comments/information in a patient's records that are perceived to be unfavourable must be addressed directly with the health service provider.

The HCCC is unable to provide refunds or order compensation. In these situations, a complainant could seek a remedy by filing a common law action in medical negligence.

Complaints about breach of privacy

The *PPIP Act* provides for complaints to be made to the NSW Privacy Commissioner where a person reasonably believes a NSW public sector agency has misused their personal information or breached one of the IPPs.

To assess if an agency has complied with its privacy obligation, an application for an internal review with the organisation must be lodged within six months of the breach. In consultation with the NSW Privacy Commissioner, the organisation must complete its review of the complaint within 60 days (if practicable). Results will be provided in writing to the complainant as well as the NSW Privacy Commissioner. Remedies can include a formal apology; remedial action such as a payment of compensation; assurances that the breach will not reoccur to include administrative changes to ensure it will not occur again.

If the results of the review are unsatisfactory or have not been completed within 60 days, an application to the NSW Civil and Administrative Tribunal (NCAT) for a review of the conduct or decision complained about can be made within 28 days of receiving the results. NCAT may make orders that the agency change its practices, apologise, or take steps to remedy any damage. NCAT's decision is enforceable and may include an award for compensation.

MENTAL HEALTH

[26.20] The principal laws governing the care, treatment, recovery and control of people experiencing mental illness and other forms of disability of the mind in NSW are the *Mental Health Act 2007* (NSW), the *Mental Health (Forensic Provisions) Act 1990* (NSW) and the *NSW Trustee and Guardian Act 2009* (NSW). The following refers to those subject to these legislative schemes with reference to the *Mental Health Act* unless otherwise stated.

The Mental Health Act

Main provisions

Some of the significant provisions of the *Mental Health Act* are:

- a statutory definition of mental illness (s 4);
- definitions of mentally ill and mentally disordered persons (ss 14, 15);
- a requirement that a person not be detained in a mental health unit unless they are found to be either a mentally ill or mentally disordered person and no other care of a less restrictive kind is appropriate and reasonably available (s 12);
- community treatment orders (Ch 3, Pt 3);
- patient rights;
- strict procedures for involuntary admission;
- control and review of psychiatric treatments;
- banning of deep sleep and insulin coma therapy and psychosurgery (s 83);
- legal representation for patients;
- a wide jurisdiction for the Mental Health Review Tribunal, including regular review of all patients;
- designated carers and principal care providers to be informed of and involved in care, treatment and, discharge and planning decisions (ss 71–79).

Objects and principles

The objects of the *Mental Health Act* (s 3) are:

- to provide for the care and treatment of, and to promote the recovery of, persons who are mentally ill or mentally disordered; and
- to facilitate the care and treatment of those persons through community care facilities; and
- to facilitate the provision of hospital care for those people on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis; and
- while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care; and
- to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

Principles for care and treatment are listed at s 68. They include:

- people with a mental illness or a mental disorder receive the best possible care and treatment in the least restrictive environment enabling that care and treatment to be effectively given;
- treatment should be timely and of high quality;
- it should assist people to live, work and participate in the community;
- treatment should only be given for therapeutic purposes and never as punishment or for the convenience of others;
- information should be given about treatments and alternatives;
- any restrictions on the liberty of people receiving treatment and any interference with their rights, dignity and self-respect must be kept to a minimum;
- special needs of patients including those related to their age, gender, religion, culture, language, disability or sexuality should be recognised;
- people under the age of 18 should receive developmentally appropriate services;
- the cultural and spiritual beliefs of people who are Aboriginal or Torres Strait Islanders should be recognised;
- every effort should be made to involve people in the planning for their treatment and recovery and their views should be considered. This should include making every effort to obtain their consent when developing plans and to support people who lack the capacity to consent to understand the plans;
- people receiving treatment should be informed of their legal rights in a way that they are most likely to understand;
- the role of carers, including their rights to be kept informed, should be given effect.

Designated carers and Principal care providers

People receiving treatment for mental illness are in general entitled to the same confidentiality as those receiving treatment for any other health related condition. However, it has been recognised that family members are often very involved in their care, including providing the ongoing support after a hospital admission. In order to effectively provide this care, they need to have access to information about it. To enable this to happen, while still maintaining the general right to confidentiality, the Act provides for the appointment of designated carers and principal care providers.

The designated carer of a person is:

- the person's guardian;
- the parent of a child;
- a person nominated by the patient (if they are over 14 years old and not subject to a guardianship order).

If none of the above apply, the designated carer is:

- the person's spouse (including a same-sex spouse) if in a continuing relationship;
- a person primarily responsible for providing care (not commercially);
- a close friend or relative (s 71).

The principal care provider of a person is:

- the individual who is primarily responsible for providing support or care to the person (other than on a commercial basis) (s 72A(1));
- and may be determined by the authorised medical officer or the director of community treatment (s 72A(2)).

Nomination of designated carers

A person may nominate up to two persons to be designated carers (s 72(1)).

Exclusion of persons being given information

A person may exclude someone from being given information as a designated carer or principal care provider (s 72(2)). However, a person between the ages of 14 and 18 may not exclude a parent (s 72(3)). The principal care provider may also be a designated carer of a person (s 72A(5)).

Information to be given to the designated carers or principal care provider

A designated carer or principal care provider is to be notified:

- the person is detained (s 75(1)) and where the person has any matter before the Tribunal (s 78(1)(h)) including a proposed mental health inquiry (s 76(3));
- each type of medication including dosages being administered (on request) (s 73);

- absence of the person from a hospital without permission or failure to return from leave (s 78(1)(a));
- a proposed transfer (s 78(1)(b));
- discharge of the person from hospital (s 78(1)(c));
- reclassification of the person as a voluntary patient (s 78(1)(d));
- an application to the tribunal to approve ECT (s 78(1)(e));
- the person has any matter before the having surgery, or an application to perform surgery (s 78(1)(f), 78(1)(g)).

Requirement to consider information provided by carers and other people

When examining a patient for the purposes of determining whether to detain them as a mentally ill or mentally disordered person or to discharge them, a doctor is required to consider any information provided to them by the following persons:

- a designated carer, principal care provider, relative or friend of the person;
- any doctor or health professional who has treated the person;
- anyone who brought the person to hospital (s 72B).

Hospital treatment under the Mental Health Act

[26.30] Patients may be treated in a hospital under the *Mental Health Act* as:

- voluntary patients;
- assessable persons, who are people detained awaiting a mental health inquiry;
- involuntary patients, who have been detained following a mental health inquiry, or otherwise detained by the Mental Health Review Tribunal; and
- forensic or correctional patients who are patients involved in certain criminal law proceedings.

Mental health facilities

The Act does not speak of hospitals and community health centres, but refers to mental health facilities. This term covers both types of facility. For simplicity, the words "hospital" and "community health centre" are used in this chapter, but both refer to declared mental health facilities.

[26.40] Voluntary patients

A voluntary patient is a person who has admitted themselves to a hospital voluntarily or who has agreed to remain on a voluntary basis following some other kind of admission.

The criterion for admission on this basis is the view of an authorised medical officer that the person is likely to benefit from care or treatment as a voluntary patient (s 5).

People under 16

A person under 14 may not be admitted as or remain a voluntary patient over the objections of their parents. The parents of a person between 14 and 16 must be notified of an admission.

People under guardianship

A person under a guardianship may be admitted as a voluntary patient at the request of their guardian. They must be discharged at the request of the guardian (s 7). The guardian must be notified if the person is otherwise discharged (s 8(3)). It is unclear whether a patient admitted as a voluntary patient at the request of their guardian has a right to be discharged at their own request (this issue was discussed in *Sarah White v the Local Area Health Authority* [2015] NSWSC 417, but ultimately left undetermined).

Discharge

Voluntary patients may discharge themselves at any time (s 8(2)); however, an authorised medical officer may have the person detained if satisfied that they are a mentally ill or mentally disordered person (s 10). A voluntary patient may be detained for up to two hours to enable an authorised medical officer to exercise this function (s 10(3)).

Review

The Mental Health Review Tribunal must review a voluntary patient once every 12 months where the patient has been in continuous care for a period longer than 12 months. The Tribunal may order the discharge of a patient, which can be deferred for up to 14 days (s 9).

The Mental Health Review Tribunal

The Mental Health Review Tribunal has an extensive jurisdiction to hear matters relating to mentally ill people, including:

- conducting mental health inquiries;
- reviewing involuntary patients;
- community treatment orders;
- appeals against refusal to discharge;
- financial management applications;
- forensic and correctional patient reviews;
- electroconvulsive therapy (ECT) applications;
- applications for surgical operations where the patient cannot give consent.

A single legal member of the Tribunal who is qualified to be a deputy president conducts mental health inquiries and some appeals against refusal to discharge heard prior to the inquiry. The Tribunal sits as a panel of three in most other matters, including a lawyer, a psychiatrist and another person who is "suitably qualified" (*Mental Health Regulation 2013* (NSW), cl 19).

The Tribunal also has a role in supervising what takes place at psychiatric hospitals and providing education and information on the *Mental Health Act*.

Contact the Tribunal for more information. There are useful factsheets and other publications on the Tribunal's website. See [26.380] at the end of this chapter.

[26.50] Involuntary patients

People may only be detained in hospital under the *Mental Health Act* if they are considered to be mentally ill or mentally disordered persons. These terms are defined below.

Mentally ill persons

Under the *Mental Health Act* (s 14), a person is a mentally ill person if they suffer from a mental illness and owing to that illness there are reasonable grounds for believing that care, treatment or control of them is necessary for:

- the person's protection from serious harm; or
- the protection of others from serious harm.

In considering whether someone is a mentally ill person, their continuing condition, including any likely deterioration, is to be taken into account.

What is mental illness?

Section 4 of the *Mental Health Act* defines mental illness as a condition that seriously impairs (temporarily or permanently) the mental functioning of a person, and is characterised by the presence of one or more of the following:

- delusions;
- hallucinations;
- serious disorder of thought form;
- severe disturbance of mood;
- sustained or repeated irrational behaviour indicating the presence of any one or more of the above symptoms.

Mentally disordered persons

A person is considered to be mentally disordered (whether or not they suffer from a mental illness) if their behaviour is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control is necessary for:

- the person's own protection from serious physical harm; or
- the protection of others from serious physical harm (s 15).

Behaviour that does not indicate mental illness or disorder

Under s 16(1), a person is *not* mentally ill or mentally disordered merely because of:

- a particular political opinion, belief or activity;
- a particular religious opinion, belief or activity;
- a particular philosophy;

- a particular sexual preference or sexual orientation;
- sexual promiscuity or a particular sexual activity;
- immoral conduct;
- illegal conduct;
- a developmental disability;
- the consumption of alcohol or other drugs;
- anti-social behaviour;
- economic or social status or membership of a particular cultural or racial group.

When may someone be taken to a hospital?

A person may be taken to a hospital involuntarily:

- on the certificate of a medical practitioner or accredited person (this is called a *Schedule 1 admission* (s 19));
- after being brought to the facility by an authorised ambulance officer (s 20);
- after being apprehended by police (s 22);
- following an examination ordered by a magistrate or authorised officer (s 23);
- on a court order under s 33 of the*Mental Health (Forensic Provisions) Act* (s 24);
- after transfer from another health facility (s 25);
- on the written request of a designated carer, principal care provider, relative or friend where remoteness or urgency makes it impracticable to see a medical practitioner or accredited person (s 26).

Accredited persons

Accredited persons are appointed by the Director-General of Health. They are usually people with specialist mental health qualifications such as registered nurses.

In practice, most involuntary admissions occur:

- on the certificate of a doctor; or
- after apprehension by police; or
- on an order made by a magistrate.

Transport, entry of premises, sedation and searches

A person completing a Schedule 1 certificate or an ambulance officer may request police assistance to transport the patient to hospital (ss 19(3), 20(2)). A police officer to whose notice this request is brought must provide police assistance (s 21). A police officer may enter premises to apprehend the patient in order to transport them.

In addition to police, NSW Health staff and ambulance officers may transport patients to and between hospitals. Reasonable force may be used. A person may be sedated if it is necessary to safely transport them. The person may be searched if it is suspected that they are carrying something dangerous or likely to assist them to escape. A search is limited to requiring the person to remove outer clothing and inspecting them or quickly running hands over the outer clothing or passing an electric detector over them. Articles in the person's possession may also be opened and examined (s 81).

Procedure on admission to hospital

Explanation of rights

As soon as practicable after being taken to hospital involuntarily, or having their status changed to involuntary, a person must be given both an oral explanation and a written statement of their rights under the *Mental Health Act*. This must be in a language the person can understand (s 74).

Initial examination

A person must be examined by an authorised medical officer as soon as practicable (but not more than 12 hours) after arriving at a hospital or being classified as an involuntary patient (s 27(a)).

When the person cannot be detained

The person cannot be detained after the examination unless:

- the authorised medical officer has certified them to be a mentally ill or mentally disordered person; or
- they were brought to the hospital after allegedly committing an offence, in which case they may be detained and returned to the custody of the police.

The second examination

A person detained after examination by the authorised medical officer must be seen by a second doctor as soon as possible (s 27(b)). One of the two doctors conducting these examinations must be a psychiatrist.

The authorised medical officer must notify the Mental Health Review Tribunal and arrange for the person to be brought before the Tribunal for a mental health inquiry if:

- the second doctor certifies that they are mentally ill or disordered person; and
- at least one of the two doctors has certified the person to be mentally ill person (s 27(d)).

If the person ceases to be a mentally ill person

If at any stage the authorised medical officer believes that the person has ceased to be a mentally ill or mentally disordered person, they must be discharged. The person may be immediately admitted as a voluntary patient if they agree to such an admission (s 12).

The third examination

If the second doctor does not find the person to be mentally ill or disordered, a third examination must be conducted by a psychiatrist (s 27(c)).

If this psychiatrist finds the person to be mentally ill, they must be brought before the Tribunal for a mental health inquiry. The person must also be brought before the Tribunal if they find the person to be mentally disordered, and the person was found to be mentally ill by the authorised medical officer. Otherwise, the person must be released.

Use of audiovisual equipment or examination by an accredited person

For the purpose of determining whether a person is a mentally ill or mentally disordered person, if it is not reasonably practicable for an examination to be conducted in person by a medical practitioner, psychiatrist or accredited person, the examination may be conducted using an audiovisual link (s 27A).

Requirement to consult with a psychiatrist

A medical practitioner who is not a psychiatrist or an accredited person conducting an examination under s 27A is required to seek the advice of a psychiatrist before determining whether the person is a mentally ill or mentally disordered person if it is reasonably practicable to do so (s 27A(4)).

What treatment is allowed?

Patients admitted involuntarily may be treated against their will (s 84). The treatment must be limited to the prescription of the minimum medication necessary, so that they are able to communicate adequately with their representative for the mental health inquiry (s 29).

Patients considered to be a mentally ill person

Prior to a mental health inquiry being conducted before the Mental Health Review Tribunal, a person detained as a mentally ill person as outlined above is called an assessable person. They must be brought before the Tribunal for a mental health inquiry as soon as practicable after the second or third examination (if needed). A mental health inquiry is usually conducted around 10–14 days after admission. The Tribunal consider that to be sufficient time for the treating team to properly assess whether the person should continue to be detained in the facility or discharged and to develop appropriate community treatment or discharge planning.

Patients considered to be mentally disordered

If a person is found to be a mentally disordered person at two examinations, they may be detained as a mentally disordered person. They are not brought before a mental health inquiry. An assessable person may be reclassified as a mentally disordered person by an authorised medical officer.

A person may be detained in the hospital for no longer than three working days after being found to be a mentally disordered person at the second examination, and while detained must be examined at least once every 24 hours by an authorised medical officer.

A person may not be detained as a mentally disordered person on more than three occasions in any one calendar month (s 31).

The mental health inquiry

The Mental Health Review Tribunal conducts inquiries on a weekly or fortnightly basis depending on the size of the hospital pursuant to s 34 of the *Act*. The purpose of these inquiries is to determine whether or not, on the balance of probabilities, an assessable person brought before it is a mentally ill person (s 35). If not, the person must be discharged, although the operation of the discharge order may be deferred for up to 14 days. If so, the Tribunal must determine whether the person should remain in the hospital, be discharged into the care of a designated carer or principal care provider or be subject to a community treatment order.

These hearings are conducted by a single legal member of the Tribunal who is qualified to be a deputy president. They are conducted at the larger hospitals in Sydney in person, and at smaller and regional hospital by audiovisual link.

Patients' rights

Patients detained in hospital and/or being brought before an inquiry have a number of rights set out in the Act. These include the right:

- to be informed of their rights orally and in writing (s 74);
- to be informed that a mental health inquiry will be held (s 76);
- to have their designated carers and principal care provider notified of the admission and hearing (ss 75, 76);
- to be legally represented (or represented by another person with the approval of the Tribunal) (s 154). In mental health inquiries, the patient is to be represented unless they choose otherwise. Persons under the age of 16 years are to be represented in all Tribunal proceedings unless the Tribunal determines it is in their best interests to proceed without representation;
- to be given particulars of the type and dosages of medications given (on request, s 73);
- to be given the minimum medication, *consistent with proper care*, to ensure that they are not prevented from communicating adequately with their representative at the hearing (s 29);
- not to be over-medicated (s 85);
- not to be ill-treated (s 69);
- to have access to an interpreter, if necessary (s 158);
- to have access to medical records unless refused by the Tribunal. The patient's legal representative has an unconditional right to access the records (s 156);
- to wear street clothes (s 34(2)(a)).

Legal representation

Legal representation is almost exclusively provided by Legal Aid NSW through the Mental Health Advocacy Service. This is free. Patients can also use private lawyers or community legal centres.

What the Tribunal must ask about

As soon as practicable in the hearing, the Tribunal member must ask the patient whether he or she has been:

- given a statement of legal rights and entitlements (s 35(2A)(a));
- informed of the authorised medical officer's duty to notify the patient's designated carers and principal care provider (s 35(2A)(b)).

The Tribunal member must also ask the doctor whether:

- the notifications have been given (s 35(2B));
- the patient has been given medication likely to affect their ability to communicate (s 35(2)(c)).

What the Tribunal must consider

The Tribunal member must consider:

- the medical practitioners' reports and recommendations (s 35);
- the effects of any medication given;
- cultural factors relating to the patient;
- any other material placed before them.

The doctor's evidence

The treating doctor is usually asked to outline:

- the patient's condition;
- the order being sought;
- why less restrictive forms of treatment are not appropriate.

The doctor may then be questioned by the patient's solicitor.

Reports from other professionals

Other professionals involved in the patient's care (such as social workers or psychiatric nurses) may have prepared reports and/or be asked to speak.

Views of friends and relatives

Friends and relatives who are present are usually invited to express their opinions. The designated carers and principal care provider may, with the leave of the Tribunal, appear at the inquiry.

Views of the patient

The patient is always given an opportunity to express their views on what has been said and put forward any other matters they consider relevant.

Submission from the patient's solicitor

The patient's solicitor generally makes a brief submission setting out the patient's wishes and, if so instructed, arguing why the patient does not meet the definition of mentally ill person or why less restrictive care is appropriate and available.

Proceedings at the mental health inquiry

The proceedings are relatively informal, although they still have some of the features of court proceedings. Proceedings are recorded (s 159).

Adjournments

An adjournment can be sought by either the patient or the hospital.

The Tribunal may adjourn the inquiry for up to 14 days:

- after considering the doctors' certificates completed under the Act; and
- if it is satisfied that it is in the best interests of the patient to do so.

Without limiting the requirements above, the Tribunal may adjourn the inquiry if not satisfied that the patient has been informed of the requirement that their designated carers and principal care provider be notified of the hearing, and that all reasonable steps have been taken to give that notice.

During the period of adjournment, the person remains an assessable person and may be subject to involuntary treatment (s 36).

The Tribunal's decision

The Tribunal makes a decision and gives reasons for it.

If the person is found not to be mentally ill

If the Tribunal finds that the person is not a mentally ill person, they must be discharged, although this may be deferred for up to 14 days (s 35(3)).

If the person is found to be mentally ill

If the person is found to be a mentally ill person, the Tribunal may:

- order that they be discharged to the care of a designated carer or principal care provider;
- make a *community treatment order*;
- order that the person be detained in a mental health facility as an involuntary patient for a specified period of up to three months s 35(5).

Appeals

Notice of right to appeal

If the Tribunal determines at a mental health inquiry that a person should be detained as an involuntary patient, the person must be given a notice setting out their rights of appeal (s 77).

Request to be discharged to the authorised medical officer

A person detained at a mental health facility who seeks discharge must first make a request for discharge to the authorised medical officer. The request may be oral or in writing.

The authorised medical officer must discharge a detained person if they are not a mentally ill or mentally disordered person or less restrictive care is appropriate and available.

Appeal to the Mental Health Review Tribunal

A patient may appeal to the Mental Health Review Tribunal (s 44) if, following a request as outlined above, the authorised medical officer:

- refuses to discharge them; or
- does not consider their request within three working days.

The appeal may be made orally or in writing. The authorised office must provide a report to the Tribunal setting out the reasons for refusing to discharge the applicant. The Tribunal will usually consider the appeal within one week.

Appeal to the Supreme Court

Tribunal decisions may be appealed to the Supreme Court (s 163).

In addition, where the court receives evidence on oath that a person who is not a mentally ill person is being detained, it must order that the person be brought before it for examination (s 166).

Can the patient be transferred?

Involuntary patients can be transferred from one hospital to another. A patient may be transferred to a hospital other than a mental health facility if the person requires treatment for a condition other than mental illness (s 80). All reasonable steps must be taken to inform the person's designated carers and principal care provider of a proposed transfer (s 78(1)(b)). Notice must be given before the transfer except in an emergency (s 78(3)).

Can the person manage their own affairs?

If an order is made at a mental health inquiry to detain a person, the Tribunal must consider the patient's capacity to manage their affairs (*NSW Trustee and Guardian Act 2009*, s 44). If the Tribunal is satisfied that the person cannot manage their affairs, it must order that they be managed by the NSW Trustee.

Application for a financial management order

Applications for *financial management orders* can be made to:

- the Tribunal while the person is a patient; or
- the Supreme Court or the Civil and Administrative Tribunal of NSW (NCAT) Guardianship Division at any time.

Responsibility for managing the estate

The NSW Trustee is responsible for the management of a person's financial affairs following an order by the Mental Health Review Tribunal.

The Supreme Court and NCAT (Guardianship Division) may commit the management of a person's finances to the NSW Trustee or appoint another person.

Appeal against a financial management order

There is a right of appeal against the making of a financial management order to the NCAT Appeals Division, unless the order was made by the Supreme Court. If the order was made by the Mental Health Review Tribunal, the person must be advised of the right of appeal and written reasons for the order provided if requested.

Revocation of an order

The Guardianship Division of NCAT may review a financial management order it has made, and may revoke it if satisfied that the person has regained capacity to manage their affairs or that the order is not in the person's best interests.

The Mental Health Review Tribunal may revoke an order that it has made if the person is no longer a patient and it is satisfied that the person has regained capacity or that the revocation would be in their best interests.

The Supreme Court may revoke its own orders or those of any of the other judicial bodies.

Management of the estate

The estate must be managed so that the person's interests are protected. This includes the minimum possible restriction on their freedom of decision making and action, taking account of their views and encouraging them to live, as far as possible, a normal life in the community. Family relationships should be recognised and the person should be protected from neglect, abuse and exploitation (*NSW Trustee and Guardian Act 2009*, s 39).

Obligation to consult the family

The Trustee must determine whether any action regarding the estate of a managed person is of such a nature that the person's family should be consulted and if considered necessary consult with the family (*NSW Trustee and Guardian Act 2009*, s 72).

Appeal against the NSW Trustee's decisions

Decisions made by the NSW Trustee in connection with the exercise of management functions may be reviewed by NCAT (*NSW Trustee and Guardian Act 2009*, s 62).

Preservation of personal items

The Act requires that personal items be preserved as far as is reasonably practicable (*NSW Trustee and Guardian Act 2009*, s 75).

Voluntary management

A patient (not a protected person) who is not subject to a management order may request that their affairs be managed by the NSW Trustee. The NSW Trustee may terminate the management on the application of the patient (*NSW Trustee and Guardian Act 2009*, ss 53, 92).

Investment of clients' funds

Clients' funds can be invested in one of a number of investment funds in accordance with a financial plan that reflects a client's short and longer term financial needs. The investment funds include Australian Cash, Cash Plus and Fixed Interest, Listed Property and Shares, and International Bonds and Shares.

Money for day-to-day needs

Money to meet a client's day-to-day expenditure needs is maintained in the Cash Common Fund.

Fees, bonds and commissions

The NSW Trustee charges fees for the administration of estates. These are set out in the *NSW Trustee and Guardian Regulation 2008* (NSW).

The fee for the *establishing management* of the estate is 1% of the value of total assets (excluding residence, car etc) with a maximum fee of $3,000. Clients with estates of less than $25,000 pay no establishment fee. For those with between $25,001 and $75,000, the fee is reduced by $250. The fee for *ongoing management* is 1.4% pa, up to a maximum of $15,000. The value of the principal residence and some other assets are excluded.

Clients with less than $25,000 pay no account keeping fee, those with between $25,001 and $75,000 pay $5 per month. Clients with more than $75,000 are charged a fee of $10 per month.

The fee for the management of an investment in an investment fund is 0.1% of the value of the investment, deducted each month.

Where a *private manager* has been appointed, the *NSW Trustee and Guardian Regulation* provide support and oversight to the private manager. With approval, the private financial manager may charge for their work especially where professional services are provided. The *NSW Trustee and Guardian Regulation* charge the following fees:

- establishment fee of $500 is charged for estates in excess of $75,000, $250 for estates between $25,001 and $74,999 and nil for estates below $25,000;
- administration fee of $120 pa, $60 pa and nil are applied at the above levels;
- yearly *checking fee* of $100, $200 or $300 is charged depending on the estate's complexity. A fee of 0.1% pa is charged on the value of assets in NSW Trustee investment funds.

Fees for other services can be charged at rates fixed by the NSW Trustee.

Power of attorney

Any legally capable person may appoint an attorney, who may then conduct transactions on the person's behalf (see Legal documents in Chapter 1, About the Legal System for more about this). The power of attorney can remain valid even after the person has lost the capacity to manage their own affairs. This is called an enduring power of attorney.

During the period of a financial management, order any power of attorney is suspended (*Powers of Attorney Act 2003* (NSW), s 50(3)).

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a treatment that involves the passing of an electric current through a person's brain by means of electrodes placed on the temple. It is most commonly used for otherwise treatment resistant depression.

The Act lays down strict rules regarding the circumstances in which patients may be given electroconvulsive therapy (s 89).

Voluntary patients

Electroconvulsive therapy may be given to voluntary patients over the age of 16 years only with the person's informed consent. "Informed consent" is defined in s 91 of the *Act*, and must be freely given after full disclosure of benefits, side-effects and alternative treatments.

If an authorised medical officer is unsure whether a person is capable of giving informed consent, they may apply to the Mental Health Review Tribunal to determine whether that consent can be and has been given (s 93(3)).

Involuntary patients and patients under 16 years

An application may be made to the Mental Health Review Tribunal to approve the administration of electroconvulsive therapy to an involuntary patient or a person who is under the age of 16 years.

At least two medical practitioners, one of whom is a psychiatrist, must certify in writing that this is a reasonable and proper treatment and necessary or desirable for the safety or welfare of the patient (s 94). In the case of a person under 16 years, the psychiatrist must be experienced in the treatment of children and adolescents. The Tribunal must then hold an inquiry to determine:

- whether the patient is capable of giving informed consent to the treatment;
- whether that consent has been given;
- whether, in the absence of informed consent or if capable of giving informed consent but has refused the treatment is reasonable and proper and is necessary or desirable for the patient's safety or welfare.

The views of the patient as well as the medical evidence must be taken into account by the tribunal. In the case of a person under the age of 16 years, the views of the designated carers, principal care provider and parents of the person (if known) are to be considered.

If the tribunal authorises the treatment (known as an ECT determination), it must also specify the number of treatments approved. In general this is not to exceed 12, although provision is made for a higher number if the tribunal is satisfied this is justified by special circumstances (s 96).

Can the patient leave the hospital?

A patient may be allowed leave of absence from a hospital subject to conditions about time and place (s 47).

If the patient does not meet conditions

If the patient does not return at the end of the period or does not comply with the conditions of leave, they may be returned to the hospital by

police or others (ss 48, 49). All reasonable steps are to be taken to inform the person's designated carers and principal care provider if the patient is absent from a facility without leave or fails to return at the end of a period of leave (s 78(1)(a)).

Extension of orders

If near the end of an involuntary order made at a mental health inquiry it appears that a person will not be well enough to be discharged, the hospital must bring the patient before the Mental Health Review Tribunal for review (s 37).

What the Tribunal may do

The Tribunal conducts a further hearing, and may order that the person continue to be detained as an involuntary patient. The Tribunal must conduct reviews at least once every three months for the first 12 months that the person is an involuntary patient, and at least once every six months thereafter. The Tribunal may extend this later period to once every 12 months if it considers it appropriate (s 37).

Discharge of involuntary patients

An involuntary patient *must* be discharged by the authorised medical officer if:

- they believe that the person is no longer a mentally ill person; and/or
- they believe that care of a less restrictive kind is appropriate and reasonably available; or
- an order to that effect is made by the Mental Health Review Tribunal, or the Supreme Court.

The patient, their designated carers and principle care provider must be consulted in planning the person's discharge and subsequent treatment. The agencies involved in providing follow-up services must also be consulted, as must any dependents of the person. The patient and their carers must be provided with appropriate information about the follow-up care arranged (s 79).

Community treatment orders

A community treatment order (CTO) requires a person to accept care and treatment while residing in the community. A treatment plan sets out when and where they must attend to receive treatment and/or other services (s 54). Orders may be made for up to 12 months and may be renewed. They may be made by the Mental Health Review Tribunal or a magistrate in a Local Court during the course of criminal proceedings (*Mental Health (Forensic Provisions) Act*, s 33).

Who may apply for a community treatment order?

An application for a CTO may be made by a doctor at a hospital in which a person is detained, a doctor familiar with the person's history, the director of a community health centre or a person's designated carer or principal care provider (s 51; *Mental Health Regulation 2013*, cl 8). The applicant must notify the person in writing of the application, including a copy of the proposed treatment plan. If the applicant is not detained in a hospital, 14 days' notice must be given unless the person is the subject of a current CTO or the Tribunal determines it is in the person's best interests to hear the application sooner (s 52).

When can a community treatment order be made?

An application for a CTO may be made about a person in hospital or in the community. The Tribunal, when conducting a mental health inquiry may make a CTO following a finding that the person is a mentally ill person. The Tribunal does not have to make that finding when an application is made at a later stage during hospitalisation or when consecutive CTOs are sought. An application may be made, and determined by the Tribunal, during proceedings for an appeal under ss 44 and 51(6).

The Tribunal must find that the person would benefit from the order as the least restrictive alternative consistent with safe and effective care. It must be satisfied that a mental health facility has an appropriate treatment plan and is capable of implementing it. If the person has previously been diagnosed with mental illness, there must be a history of them refusing to accept appropriate treatment and relapsing into an active phase of the illness (s 53).

A CTO may be made in the absence of the affected person if they have been given notice of the hearing (s 55). The order is to be for a specified period of time, up to 12 months s 56.

Operation of a community treatment order

The person must comply with the order. The director of community treatment must take all reasonable steps to ensure that the treatment in the plan is given. Medication may be given without consent, but not by force. A person implementing the order may enter land, but not a dwelling, to administer treatment without consent. The person and their designated carers and principal care provider are entitled to be provided with details of medication administered under the order (s 57).

Breach of community treatment order

If a person fails to comply with the community treatment order after all reasonable steps to

implement, it have been taken and there is a significant risk of deterioration in their health, the director must:

- make a written record of the facts and reasons on which the above opinions are based; and
- have the person advised that further refusal to comply with the order will result in them being taken to a mental health facility and treated.

If the person still fails to comply, the director *may*:

- issue a breach notice requiring the person to attend for treatment and warning them that the assistance of police may be obtained to ensure compliance; and
- in the event of further non-compliance, issue a breach order that the person be taken to a mental health facility (ss 58–60).

A person taken to a community health centre or hospital following a breach of a community treatment order may be:

- treated in accordance with the order; and
- assessed for involuntary admission to hospital.

If the person accepts treatment, they will be released unless assessed to be a mentally ill or mentally disordered person. If not at a hospital and they refuse treatment, they may be taken to a hospital.

A person taken to a hospital following a breach of a community treatment order:

- must be assessed;
- may be given treatment in accordance with the CTO;
- may be detained in the hospital for the remaining duration of the order if a mentally ill person, or for up to three working days if a mentally disordered person.

A person detained under these provisions must be reviewed by the Mental Health Review Tribunal not later than three months from the date of detention (ss 61–64).

Variation, revocation and appeals

The Tribunal may vary or revoke a CTO if circumstances have changed or new information is available (s 65). The director of the mental health facility implementing the order may revoke it if of the opinion that the person is not likely to benefit from it (s 66). Before revoking a CTO, the director must consult the patient, and if reasonably practicable to do so, any designated carer and the principal care provider. The director must notify the Tribunal if s/he revokes a CTO or decides not to apply for a further order. The director must also notify the designated carers and principal care provider if the order is revoked or varied, an application for a further order is made or of a decision not to apply for a further order.

Appeals may be made to the Tribunal against the duration of Community Treatment Orders made by a magistrate that exceed six months or on a question of law or fact. Appeals may be made to the Supreme Court against the duration of orders made by the Tribunal that exceed six months or on a question of law or fact (s 67).

Legal assistance

The Mental Health Advocacy Service, which is part of Legal Aid NSW, provides free legal advice and representation for anyone appearing before a mental health inquiry and for most people appearing before other Mental Health Review Tribunal hearings.

The service is staffed by lawyers, a lay advocate and a social worker who routinely visit psychiatric hospitals and psychiatric units at public hospitals. It coordinates legal aid for all patients throughout the state and also deals with legal aid applications in guardianship matters.

Inquiries about mental health law can be directed to the service.

Official visitors

Official visitors are appointed by the Minister for Health to all area health services to visit all hospitals that accept involuntary patients in that area. They must also visit every community health centre in the area that can administer community treatment orders (s 131). They can investigate, negotiate and make recommendations on complaints. They have a duty to refer any matters raising significant public mental health issues or patient safety care or treatment issues to the Principal Official Visitor or other appropriate person or body.

Anyone concerned about any aspect of a hospital stay including treatment or facilities can talk to an official visitor. There is a box at each hospital and community

health centre where requests to see an official visitor may be left, and there is a contact phone number. Official visitors can also be contacted through the hospital or community health staff.

The Health Care Complaints Commission

Complaints can also be made to the Health Care Complaints Commission.

This is an independent body which investigates complaints about poor health care. It can take action on complaints ranging from declining to deal with them, through negotiation and local resolution to formal investigation and prosecution. Complaints should be discussed with an inquiry officer first, who can assist with putting a formal complaint in writing if necessary.

[26.60] Forensic and correctional patients

Forensic patients are people who have been found not guilty by reason of mental illness of serious criminal charges, people who have been found not fit to be tried and are awaiting a special hearing and people who have been given a limiting term following a special hearing. People who have been transferred from a prison to a hospital while on remand or serving a sentence of imprisonment are called *correctional patients*. The *Mental Health (Forensic Provisions) Act* and the *Mental Health Act* set out rules for the review and placement of forensic and correctional patients. In brief, these provide for the Tribunal to review the case of each patient initially and every six months thereafter. This period may be extended to up to 12 months if the Tribunal is satisfied that there has been no change in the person's condition, there is no need for a change in orders or that a review may be detrimental to the patient.

The Tribunal may make orders concerning the continued detention or release of a forensic patient. In addition, it may make an order allowing a forensic patient to be absent from a facility on leave subject to conditions. Where this is granted, it remains at the discretion of the superintendent of the facility as to whether and when such leave is taken.

The Tribunal may only order release or leave if satisfied that the safety of the patient or any member of the public would not be seriously endangered. The usual process is that limited leave under supervision is initially allowed, followed by more extensive periods of leave with less or no supervision and eventual release subject to strict conditions. This may take many years as placements in forensic hospitals are limited and conditional release may only be granted after the consideration of an independent risk assessment by a psychiatrist or other expert not involved in the patient's treatment.

A conditionally released forensic patient remains subject to six-monthly reviews and may be returned to detention if a condition of release is broken or their condition deteriorates. A person ceases to be a forensic patient on their release being made unconditional, or on the expiry of their limiting term. The limiting term of a forensic patient may be extended by the Supreme Court for up to five years if the court is satisfied that the patient would pose an unacceptable risk if he or she ceased to be a forensic patient and that risk could not be adequately managed by less restrictive means (*Mental Health (Forensic Provisions) Act*, Sch 1).

A correctional patient is a person who has been transferred from a correctional centre to a hospital (most commonly a prison hospital) while serving a sentence or on remand. This is done on the certificates of two doctors stating that the person is a mentally ill person, or that the person suffers from a mental condition for which treatment is available and consents to the transfer.

The Tribunal must review the case of a correctional patient as soon as practicable after the transfer, and every six months thereafter. Following the review, the Tribunal may make an order that the person remain in the hospital or be returned to the correctional centre. The patient must be transferred back to the correctional centre on request if they are not found to be a mentally ill person.

The Tribunal may reclassify a correctional patient or a forensic patient in the last six months of their sentence or limiting term as an involuntary patient. If this occurs, they may be released into the community on a community treatment order. A person ceases to be a correctional patient when their sentence expires or their custody order otherwise ends, or when they are returned to a correctional centre.

For more details about forensic and correctional patients, see *The Lawyers Practice Manual*, Ch 8.1.

[26.70] People facing charges that can be heard in the Local Court

People who have been charged with criminal offences which can be dealt with at the Local Court and who are suffering from mental illness or another mental condition may, in some circumstances, have their matters dealt with under s 32 or s 33 of the *Mental Health (Forensic Provisions) Act*.

Under s 33

Section 33 of the *Act* relates to those who appear to be mentally ill persons as defined by the *Mental Health Act*. If the magistrate considers it appropriate, they may direct that the person be taken to a hospital for assessment and, if found to be a mentally ill person, further detention and treatment as an involuntary patient. The process once the person arrives at hospital is as outlined for involuntary patients at [26.50]. If the hospital does detain and treat the person, the charges are deemed to be dismissed if they do not reappear in court in relation to the matter within six months. The magistrate's order may contain a provision that the person be returned to court if not found to be a mentally ill or mentally disordered person.

The magistrate may also make a community treatment order (see Community treatment orders at [26.50]) if the requirements for making such an order are satisfied, or may discharge the person, conditionally or unconditionally, into the care of a responsible person.

Under s 32

Section 32 relates to a person cognitively impaired or is suffering a mental illness or condition but who does not appear to be a mentally ill person as defined by the *Mental Health Act*. For an order to be made under this section, a report or reports are required demonstrating how the person is one to whom the section applies.

This section gives the magistrate a wide range of powers to dismiss the charge, either unconditionally or subject to conditions. The conditions are set out as part of the order in a treatment plan, which should form part of the professional report on which the order is based.

Conditions of a discharge under this section are enforceable and if the person fails to comply within six months they may be called back before the magistrate and dealt with as if the order under this section had not been made.

Psychiatric services

[26.80] Psychiatric services in NSW are provided by both the public and private sectors.

[26.90] Application of the Act

The *Mental Health Act* applies to both sectors to ensure that patients receive the best possible care and services. The establishment and administration of public and private hospitals are governed by Ch 5 of Pt 2 of the *Act*.

Role of medical superintendents

In all hospitals, the person ultimately responsible for a patient's care is the medical superintendent, who must be a medical practitioner.

Most functions under the Act are exercisable by an authorised medical officer, which means the medical superintendent and any doctor nominated by him or her.

Where to find treatment

People seeking treatment for mental health conditions should, depending on the need, go initially to:

- their general practitioner;
- the local community health centre;
- the local hospital accident and emergency department.

[26.100] Private psychiatric services

Private psychiatric services are provided by:

- private psychiatrists;
- private hospitals run by organisations independent of NSW Health.

These institutions usually treat only voluntary patients. People requiring involuntary admission are transferred to a public hospital or unit.

[26.110] Public psychiatric services

Hospital care has mostly moved away from the large, stand-alone institutions to psychiatric units in general hospitals. Care may also be provided in accident and emergency units and other medical wards where the patient's condition requires it.

Psychiatric hospital care is integrated with community mental health services. These include:

- community health centres (outpatient clinics);
- extended hours (or crisis) teams;
- mobile community treatment teams;
- rehabilitation facilities, including both day programs and accommodation services.

Community health centres throughout NSW have been gazetted under the Act as mental health facilities for the purposes of administering community treatment orders.

Hospital fees

In general hospitals

In a psychiatric unit attached to a general hospital, the first 35 days treatment, whether voluntary or involuntary, are free.

After this, treatment continues to be free if the hospital completes an acute care certificate. However if the patient has ceased to be acutely ill and is awaiting nursing home placement, they are charged a fee.

In psychiatric hospitals

In the major psychiatric hospitals, the first 60 days are free. After this, fees are charged unless an acute care certificate has been completed. The fee varies depending on the age of the patient and the benefit received.

[26.120] Multicultural health services

Interpreter services

Interpreter services in most languages are available through hospitals to assist communication. Anyone involved in proceedings (eg, medical practitioners, magistrates, social workers and patients) may request the service. There are specific provisions for the use of interpreters in the *Mental Health Act* (ss 70, 158).

The Transcultural Mental Health Centre

The Transcultural Mental Health Centre assists clients from non-English speaking backgrounds in relation to mental health care. This service aims to provide culturally and linguistically appropriate assessments and referral to suitable services.

Other issues affecting mentally ill people

[26.130] The rights of mentally ill people

People who suffer mental health problems have generally the same rights as anyone else in our society, including the right to liberty and self-determination unless detained or treated in accordance with the *Mental Health Act*.

[26.140] Voting

Under the NSW *Parliamentary Electorates and Elections Act 1912* (NSW) (s 25(a)), a person may not remain on the electoral roll or vote if, due to being of unsound mind, they are incapable of understanding the significance of enrolment and voting.

[26.150] Pensions and benefits

Centrelink payments

Mentally ill people who receive social security payments usually receive the Disability Support Pension or the Newstart Allowance.

Sickness allowance may be paid to people who are ill but who are usually employed and will be returning to their employment. If a person becomes unwell while on the Newstart Allowance, the presentation of a medical certificate to Centrelink will exempt the person from seeking employment for the time specified on the medical certificate.

Department of Veterans' Affairs payments

The Department of Veterans' Affairs will pay benefits such as repatriation benefits or war widow pension while the person is in hospital.

If there are problems

If the person has any difficulties with social security payments, they should contact their nearest Centrelink office, the Department of Veterans' Affairs or, if in hospital, the ward social worker.

[26.160] Making a will

There is no express bar to either a voluntary or involuntary patient or a person with a cognitive impairment making a will. The general law as to the person's capacity to make a will applies (see Chapter 40, Wills, Estates and Funerals).

Even although there is no law requiring it, it is advisable for a patient making a will to obtain a certificate from a medical practitioner stating that they have the capacity to understand what they are doing at the precise time of making the will.

The certificate should be attached to the will. In this way, possible disputes about the validity of the will later on may be avoided.

If the person subsequently becomes incapable, they cannot then alter their will or make a new will.

HIV

[26.170] Terminology

HIV – Human Immunodeficiency Virus. This virus is the cause of damage to the body's immune system and leads to AIDS defining illnesses.

AIDS – Acquired Immune Deficiency Syndrome – A person may be HIV positive without having AIDS. A person is only said to have AIDS if they become ill with one of a number of specified diagnosed clinical conditions, which include opportunistic infections, tumours, neurological disorders or wasting. Very few people are diagnosed with AIDS in Australia any more.

ART – Anti-retroviral Therapy (also referred to as Anti-Retroviral Treatment (HAART) or anti-retrovirals (ARVs)). Treatment is now so sophisticated that many people living with HIV will have similar or the same life expectancy and working life capacity as a person without HIV.

PLHIV/PHIV – People living with HIV/People with HIV. This expression is used instead of referring to someone as an HIV positive person.

Viral load – refers to the amount of HIV in a person's system. A person may have an **undetectable viral load** when the virus is at a level that is so low that it cannot be counted.

CD4 Count – CD4 cells decline in a person with HIV. A person with HIV is at risk of developing AIDS if their CD4 count falls below 200.

Words and expressions to avoid

The following terms may be offensive to some people, and should be avoided:

AIDS victim and AIDS sufferer – These imply that someone with HIV is powerless.

AIDS carrier – Dehumanises the person with HIV and implies that the virus is more contagious than it actually is.

Full blown AIDS – this expression is outdated, a person either has AIDS or they don't.

Medical issues and legal requirements

[26.180] HIV is a virus that attacks the immune system of the body. A person becomes infected if the virus gets into their bloodstream.

[26.190] How is HIV transmitted?

HIV can only be transmitted through exposure to blood or to some body fluids of a person who is infected with the virus. This can occur in three ways:

- sexual intercourse with a HIV positive partner; except where the person with HIV has an undetectable viral load;
- contact with HIV positive blood, for example, by sharing injecting equipment with a HIV positive person; or
- transmission from a HIV positive mother to her unborn child before or during birth, or afterwards during breastfeeding. Due to advances in medical care, in Australia mother to child transmission of HIV is extremely rare.

The risk of transmission of HIV can vary depending upon the person's health and the mode of transmission. Importantly, being on effective treatment for HIV, to the point where their viral load is undetectable, reduces the risk of transmission to nil.

How it is not transmitted

HIV cannot be transmitted through:

- casual everyday contact, through the air or by mosquitoes;
- contact with saliva, tears, vomit, sweat, urine or faeces;
- exposure of intact skin to HIV-contaminated body fluids such as blood.

This means that HIV cannot be transmitted through kissing, hugging, sneezing, spitting, coughing, breathing, touching or sharing eating utensils.

There are no documented cases in Australia of infection due to sporting injury or blood spray.

[26.200] Deciding to have a test

Under most circumstances, a person cannot be required to have an HIV test. There are certain limited circumstances where a test may be required by a third party, for instance when applying for some kinds of insurance, for immigration purposes or in very specific kinds of employment. These tests *must* be with the *informed consent* of the person involved. In *very limited* circumstances, a person can be ordered to have a test. See the sections below: "When can a third party require someone to have a test", and "When must a person have a test?"

Applicable legislation

Note that the applicable legislation governing testing of HIV, reporting obligations and other such matters in NSW is the *Public Health Act*.

Counselling

The *Public Health Act* requires health professionals to counsel a person before they make a decision about having an HIV test. The health professional should give full information about the test and what it means, and cover all the possible psychological, social, legal and medical consequences of a positive or negative test.

When test results are received

A person must also be counselled when they are given the results of their test, regardless of whether the result is positive or negative. A negative result should be accompanied by information on safe sex

practices and safe injecting drug use. A negative result does not necessarily indicate the absence of HIV. If possible exposure was within the last three months, antibodies may not be detected. If the suspected exposure is recent, the person should be encouraged to re-test in three months.

When the result is positive

When the result is positive, the doctor must give the person information on:

- how to minimise the risk of infecting other people with the virus (see *Public Health Regulations 2012* (NSW), reg 40);
- the public health implications of being HIV positive;
- the person's legal responsibilities (see *Public Health Act*, s 79).

A doctor who fails to do this commits a criminal offence punishable by a fine of up to 50 penalty units (see *Public Health Act*, s 78).

The doctor's legal duty of care

In the NSW Supreme Court case of *BT v Oei* [1999] NSWSC 1082, it was found that the doctor's negligent failure to properly advise his patient of a possible diagnosis of HIV and the need for an antibody test materially contributed to the transmission of the virus to a third party.

The NSW Supreme Court cases of *PD v Dr Nicholas Harvey* [2003] NSWSC 487 and *Idameneo (No 123) Pty Ltd v Gross* [2012] NSWCA 423 confirmed that failure to appropriately counsel and follow up with patients can give rise to a claim in negligence by those infected by the doctor's patient.

A duty is thus owed not only to the patient, but to those that may be infected by the patient if the infection was caused by a failure to counsel or follow up.

When can a third party require a person to have a test?

There are a number of circumstances where taking a test will be necessary, though the choice to take the test remains with the person taking the test. Examples are:

- when taking out life insurance and some forms of superannuation (see Chapter 29, Insurance; Chapter 37, Superannuation);
- when entering the defence forces;
- when performing certain kinds of surgical procedures;
- when applying to migrate to Australia (see Chapter 28, Immigration and Refugees).

Members of the defence forces

All applicants for the defence forces are tested on entry. Serving members can also be asked to be tested in certain circumstances (eg, when posted to or returning from overseas).

Those who test positive are normally not enlisted and may be discharged. The *Disability Discrimination Act 1992* (Cth) contains an exemption for combat-related duties (s 53), meaning that it is not unlawful to discriminate in the employment, engagement or appointment of persons with HIV to the Defence Force.

Healthcare workers

In NSW, healthcare workers (HCW) performing what are known as *exposure prone procedures* (EPPs) are required to know if they have a blood borne virus (BBV) including HIV. Under current NSW Health policy, if a HCW tests positive for a BBV, they are not required to inform their employer of this fact, however they are unable to perform EPPs. EPPs form a very small subset of medical procedures, and basically cover those procedures where the worker's hands are in a body cavity that is visually confined, and there is a risk of the worker's hands being cut (for instance from exposed bone). In December 2018, the Australian Government Department of Health policy on the "Management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses" changed to allow HCW with HIV to perform EPPs where: they have a viral load below 200 copies/mL (and are on effective ART or meet the definition of elite controller), are under the care and supervision of an HIV specialist who is aware of the guidelines, and undergoes HIV viral load monitoring every three months as part of the supervision (this exception does not apply to someone co-infected with another blood born virus). It is expected that the state policies will change in the near term to align with the national guidelines.

A HCW with HIV who is dismissed or has their duties changed due to their HIV status may be able to make a claim for discrimination, particularly where they are meeting the conditions outlined by the national policy outlined above.

There are no other restrictions on HIV-positive healthcare workers.

Prisoners
There is currently a voluntary testing regime for prisoners.

When must a person have a test?
Under the *Public Health Act*, a person can be required to take an HIV test by a written notice from the Director-General of the Health Department, if the Director-General suspects on reasonable grounds that the person has HIV or AIDS (s 61). The *Public Health Act* further requires the Director-General be satisfied that the person may be a risk to public health before ordering a test (s 61). Such powers have rarely been used by the Director-General.

If there was no informed consent
A person being tested for HIV needs to provide informed consent, that is, they must be counselled as described above. Except in the specified circumstances above, it is illegal to test someone without their consent.

Taking legal action
If a person's blood has been tested without their informed consent, they may have a right to take action against the health care professional or hospital. To succeed, they must show that they suffered some loss, damage or harm as a result of the test, in accordance with common law principles.

In addition, testing without consent may amount to a criminal act such as an assault.

Making a complaint
Even if the person cannot show any actual loss it may still be useful to consider whether the matter should be referred to the Health Care Complaints Commission.

The health care worker may be guilty of professional misconduct.

[26.210] Notification
Doctors are required by law to notify government health authorities of all cases of HIV or AIDS.

Laboratories are required to notify all positive HIV test results.

The purpose of notification
The purpose of notification is to collect information on the number of people with HIV and AIDS, their sex and age, their geographic distribution, and how they became infected. This enables a better understanding of the extent of the epidemic, and a better allocation of resources directed to prevention and care.

In NSW, such notification to government health authorities is by code only, with the name and address of the patient not disclosed.

[26.220] Confidentiality
Confidentiality is particularly important for people with HIV, because of the stigma attached to the condition and the possibility of discrimination if a person's HIV status is disclosed.

There are some privacy protections in the law, in relation to a person's personal information. The professional ethics of health care workers and other professionals also require that personal information be kept confidential.

Confidentiality in HIV testing
In NSW, the name or address of a person must not be shown on any request form for a HIV test. Instead, a code must be used to protect confidentiality (*Public Health Act*, s 56(1)). The code consists of the first two letters of the person's given and family names, their sex and date of birth.

Making a complaint

If a person believes that their medical practitioner has not complied with this requirement, they can make a complaint to the Health Care Complaints Commission (see [26.380]).

Breaches of confidentiality
Under NSW public health law, a breach of confidentiality by any service provider in relation to a person's HIV status may result in a criminal offence. Under s 56(3) of the *Public Health Act*:

> A person who, in the course of providing a service, including the conduct of a pathology test under section 55, acquires information that another person (**"the person concerned"**):
>
> (a) has been, is to be or is required to be tested for a Category 5 condition [which includes HIV or AIDS], or
>
> (b) is, or has had, a Category 5 condition,
>
> must take all reasonable steps to prevent that information from being disclosed to any other person.

Who must comply?

Section 56(3) applies to all service providers, not just health workers. It covers, for example, lawyers, pharmacists, youth services, refuges and hostels.

Penalty

Any service provider who does not comply with this provision is guilty of a criminal offence and faces a fine of up to 100 penalty units and/or imprisonment for six months.

There has been no prosecution under s 56 to the knowledge of the authors of this section.

In addition, NSW and federal laws cover respectively:

1. NSW public sector organisations (*PPIP Act*);
2. Health care providers in NSW (*HRIP Act*);
3. Federal public sector organisations, health care providers, and private sector organisations with an annual turnover of more than $3 million (*Privacy Act 1988* (Cth)).

All three of these Acts make disclosure of personal/medical information without consent unlawful; however, there exists a complex range of exceptions. Further, all three Acts generally require a relationship between a third party and the person concerned before a privacy obligation is raised, such as employer or health care provider. *None* of the Acts cover acts by private individuals or small businesses.

When information can or should be given

Information about another person

Generally, information about a person's HIV status can be given:

- with the consent of the person concerned;
- in connection with the administration of the *Public Health Act* or another Act;
- by order of a court;
- to someone providing care, treatment or counselling to the person, if the information is required in connection with providing it;
- in line with the primary purpose for which it was collected, provided such purpose was notified to the person from whom it was collected;
- to the Director-General of NSW Health, where there are reasonable grounds to suspect that failure to do so could put the health of the public at risk.

Information about a person's own HIV status

There is no general legal obligation for a person with HIV to tell employers, co-workers, health care workers or anyone else that they have HIV.

The following circumstances describe when a person with HIV may be required to disclose their status:

- engaging in sexual intercourse (see [26.230]);
- donating blood, organs or tissue (*Human Tissue Act 1983* (NSW), s 21C);
- applying for life insurance and some other insurance, and some forms of superannuation;
- applying for some types of visas;
- applying for certain types of commercial pilot licences;
- health care workers who are performing exposure prone procedures (EPPs) – a health care worker who is or has been performing EPPs has a responsibility to follow the new 'Australian national guidelines for the management of healthcare workers living with blood borne viruses and healthcare workers who perform exposure prone procedures at risk of exposure to blood borne viruses' and may be required to provide evidence of clearance from their treating physician to a designated person in their workplace.

Who should be told?

Many breaches of confidentiality occur because a person with HIV has told people – family, friends or workmates – who have told someone else. Anyone who wishes to maintain confidentiality needs to think carefully before telling others. It is a good idea to talk to a trained counsellor before disclosing HIV status.

What can be done?

Not much can be done about a breach of confidentiality by family or friends. There are no explicit protections in the law for this sort of disclosure. Actual loss or damage would have to be proved, and court action is likely to be a difficult process. In some instances, a public disclosure that incites hatred towards people with HIV may constitute vilification (see Vilification at [26.250]).

Avoiding breaches of confidentiality

Breaches of confidentiality are not caused only by gossip – it happens more often through accident, thoughtlessness or inadequate systems. It is therefore critical that records and filing systems are kept in such a way as to prevent accidental exposure, improper access or theft.

All services that are likely to come into contact with HIV-related information about an individual are required by law to adopt reasonable procedures to safeguard such information (*Public Health Act*, s 56(3)), and staff should be trained about their responsibilities.

Importance of confidentiality

In *PD*'s case (see The doctor's legal duty of care at [26.200]), the court stressed the paramount importance of maintaining confidentiality. PD's case involved the infection of a woman by her husband. Both husband and wife were patients at the same surgery. Even though the doctors in that case were held liable in negligence for infection of PD, the court held that the doctors could not have told PD directly of her husband's HIV-positive status and stressed that patient confidentiality had to be maintained.

[26.230] Criminal and Public Health offences

Under the NSW *Crimes Act 1900* (NSW), it is an offence to deliberately transmit or attempt to transmit HIV. This carries a sentence of up to 25 years' imprisonment. Alternatively, a person may be charged with recklessly causing grievous bodily harm, carrying a sentence of up to 10 years' imprisonment.

A person who knowingly or recklessly infects another person with HIV could be charged with a number of criminal offences. Depending on the circumstances, charges might range from "occasioning a grievous bodily disease", to assault. While some Australian jurisdictions also make it a criminal offence to expose a person to the risk of contracting HIV, there is no such offence in NSW.

Criminal prosecutions relating to HIV transmission are rare; however, there has been an increase in such cases in recent years. Using a condom or other risk reduction strategies – such as having an undetectable viral load – could be a defence against charges under the *Crimes Act 1900*.

Failure to take reasonable precautions against transmitting HIV to a sexual partner may also result in an offence under s 79 of the *Public Health Act*. Regulation 40 of the *Public Health Regulations 2012* specifies what precautions can be taken to minimize risk including:

- using a condom during sexual intercourse;
- seeking and receiving confirmation from a sexual partner that the sexual partner is on HIV pre-exposure prophylaxis medication;
- knowing that he or she has an HIV viral load of less than 200 copies/mL.

If the police bring proceedings under s 79 of the *Public Health Act*, such proceedings must be held in closed court (*Public Health Act*, s 80).

There remains tension between the use of public health legislation and criminal law in relation to the transmission of HIV. Public health legislation and policy provides a framework under which a person who is believed to be putting others at risk can be managed through the health system in a way that effects behavioural change (see Public health orders at [26.230]). Current opinion of HIV organisations and health professionals is that criminal law should be used only in cases where there was actual transmission *and* an intention to infect.

Public health orders

If a person has, or is believed to have, HIV or AIDS and is "behaving in a way that is endangering or likely to endanger the health of the public", NSW Health can make a *public health order* (*Public Health Act*, s 62) ordering the person to:

- stop doing something;
- undertake treatment, counselling or supervision; or
- be detained (in the most extreme cases).

Public health orders are rarely used, and most individuals with HIV comply with their obligations. There are strict limits as to duration, circumstances of detention and review. There are also rights of appeal, access to medical records and legal representation.

[26.240] Compensation for infection

In both *PD v Dr Nicholas Harvey* [2003] NSWSC 487 and *BT v Oei* [1999] NSWSC 1082, doctors have been held liable in negligence for a failure to counsel patients that has led to infection of a third party.

Government assistance

Both the federal and NSW governments have set up schemes to provide financial assistance to people

with medically acquired HIV and their dependants. These are administered by the Mark Fitzpatrick Trust.

Victims' compensation

If a person can establish that they were infected as a result of a crime, they may be able to claim compensation from NCAT (formerly the Victims Compensation Tribunal) (see Chapter 39, Victims Support).

Workers' compensation

Workers' compensation may be available if a person can establish that they were infected in the course of their work (eg, health care workers infected by needle-stick injury).

Civil action

A person who can prove, on the balance of probabilities, that they contracted HIV from someone who deliberately or negligently had unsafe sex with them may be able to sue that person for compensation.

Depending on the circumstances, this may be very difficult to prove.

To the best of our knowledge, there have only been two cases brought in NSW. *GB v Michael Aubrey* [2010] NSWDC, Sydney Registry (unreported) was successful and resulted in the plaintiff being awarded damages of $750,000, *D v C* [2010] NSWDC, Wollongong Registry (unreported) which was unsuccessful and resulted in the plaintiff having to pay costs to the sum of $30,000.

Issues for people with HIV

[26.250] Discrimination

Discrimination laws aim to ensure that people living with HIV, their relatives and associates, and those suspected of having HIV, are not treated less favourably as a result of actual or presumed HIV infection.

The *Anti-Discrimination Act 1977* (NSW) and the *Disability Discrimination Act* make it unlawful to discriminate against someone on the ground of their disability or a disability of any of their associates, thus also protecting carers, family and friends of people living with HIV.

Both laws define disability to include the presence in the body of an organism causing, or capable of causing, disease or illness. The definition includes a disability that presently exists, may exist in the future or is imputed to a person. Note, however, that discrimination is only unlawful where it occurs in certain contexts – employment, the provision of goods and services, education, membership of clubs and societies, and in arrangements for accommodation. Discrimination law does not, for instance, cover interpersonal relationships. Under federal law failure to make a "reasonable adjustment" (*Disability Discrimination Act*, s 5) for a person with a disability may also amount to discrimination, this is not a requirement under the state legislation. There are exemptions to this requirement, and depending upon the circumstances and reason for the discrimination there may also be defences available.

In addition, where discrimination is in the workplace, a person can also make a complaint under the *Fair Work Act 2009* (Cth).

Vilification

The *Anti-Discrimination Act* also prohibits HIV and AIDS vilification. Vilification is a public act that incites hatred towards, serious contempt for, or severe ridicule of a person or group of persons on the ground of the person's HIV status.

It is also a criminal offence to publicly threaten or incite violence towards a person on the grounds of their HIV/AIDS status (*Crimes Act 1900* (NSW) s 93Z).

Public disclosure of a person's HIV positive status may in certain circumstances amount to vilification. Such conduct may also amount to harassment as defined under the *Crimes Act 1900*, and allow for an application for an Apprehended Violence Order (AVO) either initiated by the police or privately. The court must not refuse to process a private application for an AVO that involves allegations of harassment relating to a person's HIV status (*Crimes (Domestic and Personal Violence) Act 2007* (NSW), s 53). Note however that in private AVO applications, the court can order one party to pay the other party's legal costs.

Making a complaint

Depending on the type of discrimination or vilification, complaints can be lodged with the NSW Anti-Discrimination Board (ADB), the Australian Human Rights Commission (AHRC) or the Fair Work Commission (FWC). Complaints must be made within the specified time limit, six months for the AHRC and 12 months for the ADB after the last act of discrimination, and 21 days for the FWC if the complaint includes termination of employment, and six years for discrimination in the work place.

For more on discrimination law and procedures, see Chapter 17, Discrimination.

[26.260] Employment and workplace issues

The vast majority of occupations and workplaces do not involve a risk of acquiring or transmitting HIV between workers, or to members of the public who come into contact with workers in the course of their work. In most jobs, therefore, HIV status is not relevant and a person with HIV is not required to disclose their HIV status to an employer for work place health or safety reasons. Employees with HIV are only required to disclose their HIV status in very limited circumstances (see [26.220]).

All workplaces should have a blood borne virus policy, which includes HIV, including:

- clear infection control procedures;
- recognition of the importance of confidentiality;
- education for workers and management.

Sex workers in NSW with HIV are subject to the same laws as any other person with HIV, for example, s 79 of the *Public Health Act* around taking reasonable precautions against transmitting HIV to a sexual partner (see [26.230]). An owner or occupier of a building or place who knowingly permits another person to have sexual intercourse for the purpose of prostitution and they are not taking reasonable precautions against protecting sexual partners from contracting HIV are also guilty of an offence under s 79 of the *Public Health Act*.

Workers at risk

Workers at increased risk of occupational infection are those who come into direct physical contact with infected tissues, blood and certain other body fluids. However, risk is minimal if standard precautions also known as universal precautions are followed. These are procedures that should be followed whenever there is a possibility of contact with blood or bodily fluids. The idea behind standard precautions is that it is impossible to know for sure if someone has a blood borne virus such as HIV, hepatitis B or hepatitis C, and that is why precautions should always be taken when coming into contact with any person's blood or bodily fluids.

Must a person tell their employer?

As a general rule, an employee is not obliged to inform their employer or co-workers that they have HIV, and most employers cannot require employees to have an HIV test. In addition, requiring employees to disclose health information irrelevant to the work performed can also be a breach of applicable privacy laws.

In some cases, employees may need to make a declaration about their health (including HIV status) in order to get access to disability or death benefits in a superannuation fund. However, this information should go to the superannuation fund rather than the employer.

[26.270] Superannuation

There are several types of superannuation benefits that a person may be able to get when they cease work.

Claiming benefits

Is there total and permanent disability?

A person may make a claim for their superannuation benefits prior to retirement age if they cease work for reasons of total and permanent disability. In this case, two doctors (usually) must sign certificates stating that the person is unlikely ever to return to work.

Someone wanting to leave work because of illness should check that their doctors are prepared to sign such a statement. A person who retires because of illness will not be able to make a claim if their doctors do not agree that they are too ill to work. Additionally, it is normally necessary that a person is determined to be totally and permanently disabled within six months of ceasing employment. A different (and much harder) test applies where a person becomes disabled while not actually in employment.

Withdrawing a person's own contributions

A person's own contributions to a superannuation fund can be withdrawn at any time for contributions

made before 1 July 1999. Contributions made after that date are treated in the same way as employer contributions; in general, they are not available until the person:

- reaches an age between 55 and 60 (depending on their date of birth);
- retires at an age greater than 55; or
- retires early due to total and permanent disability.

Early access to benefits

In cases of severe financial hardship or, sometimes, to meet medical expenses, part of the funds may be able to be withdrawn even if the person does not leave work, or if they have left work and are not considered totally and permanently disabled (see Early access to superannuation benefits at [37.210] in Chapter 37, Superannuation).

Death and disability insurance

There are two main categories of death and disability insurance associated with superannuation funds:

- individual assessment funds;
- automatic acceptance funds.

Individual assessment funds

People who join individual assessment funds are assessed about their general health and health risk factors when joining the fund.

Each person is generally required to complete a questionnaire and may have to undergo a medical examination, and will be required to declare the fact if they have been diagnosed with HIV. This will usually result in refusal of coverage for disability benefits.

If a person was diagnosed with HIV when they joined the fund, and fails to declare that they are HIV positive, they may not be entitled to disability benefits, although this is not always the case.

If a person had not been diagnosed with HIV when they joined the fund, and if they answered all health questions honestly, they should be entitled to disability benefits even if they are later found to be HIV positive.

Automatic acceptance funds

In automatic acceptance funds, there is no health questionnaire or medical examination – all applicants are accepted for disability cover, regardless of their health. Therefore, even if a person has HIV when they join, they should be entitled to disability benefits.

Most superannuation schemes automatically pay insurance premiums for a minimum amount of insurance for total and permanent disability into an automatic acceptance fund. Most people therefore have some insurance for total and permanent incapacity, even though they may not be aware of it.

HIV exclusion clauses

Some automatic acceptance super funds have an HIV exclusion clause that excludes cover for HIV-positive persons, or HIV-related disability or death benefits in the first two years of employment. There is a strong argument that such clauses are in breach of either the Commonwealth *Disability Discrimination Act* or the NSW *Anti-Discrimination Act* (see Chapter 17, Discrimination).

Claiming for total and permanent incapacity

There is no clear point at which a person with HIV is said to have become “totally and permanently incapacitated” – this varies from one person to another. Generally, a person who has progressed to an advanced stage of the illness or where they have developed cognitive impairment such as HIV Associate Dementia (HAD) or HIV Associated Neurocognitive Disorder (HAND) will usually be able to establish total and permanent incapacity. However, some people with advanced illness are still quite capable of working, while others whose illness has not progressed so far are already incapacitated.

If a person feels they are not able to continue working for the foreseeable future in any profession that they are trained for, and their doctor agrees, this will usually be enough to start a claim for total and permanent disability.

Difficulties in claiming

The development of combination therapy has meant that insurers no longer view HIV as automatically meaning a person will be unable to work, and it has become much harder to claim insurance for total and permanent incapacity. In fact, some people who made claims in the past and who were genuinely unable to work have returned to work after commencing anti-retroviral drugs.

Insurers now want to be certain that a person to whom they pay benefits is unlikely to work again,

and this usually means that the person will be sent for review to independent doctors nominated by the insurer.

If a person is unable to work full-time but does have the capacity to work part-time, they will probably fail the test.

Time limits

There is usually *a time limit for claiming disability benefits*, and it is generally a good idea to initiate a claim as soon as possible. However, note that most funds have a waiting period (see below) during which a claim will not be processed by the fund.

How to claim

The person should tell their employer that they are stopping work for medical reasons, and ask for a claim form for disability benefits. The employer does not have to be told that the person has HIV or AIDS.

When completing the claim form, the person must make it clear that they are no longer able to work, and explain why. Medical reports confirming that the person has HIV and can no longer work should be supplied.

These forms can be sent straight to the superannuation fund, and do not have to be given to the employer.

The waiting period

Many funds have a waiting period of six months from stopping work to being able to receive benefits for total and permanent incapacity.

In the past, most schemes were prepared to waive this requirement in the case of HIV. Now with the development of combination therapies, insurers are unlikely to waive the waiting period unless the applicant suffers from a terminal condition.

Delays in deciding claims

Claims can take a long time to be decided – even years – and payment will only be made when the insurer is certain that the person has no work capacity, and will never regain work capacity.

Making a complaint

A person can make a formal complaint, or even take legal action against a fund if there is an unreasonable delay in making a decision.

Death benefits

Most – not all – superannuation policies include death benefits. This is usually a lump sum payable to the spouse or dependants of a person who dies while a member of a fund, or within three or six months after leaving it.

Who is a spouse?

"Spouse" includes a de facto spouse, and includes a same sex spouse. However, in the case of same sex or de facto partners, they are required to be in a relationship with the deceased at the time of his or her death in order to make a claim.

Death benefit nominations

Upon entering a fund, a member is usually asked to nominate a person or persons from within a specific class (parents, partners, children and siblings) to receive the death benefit, if death occurs.

Such nominations should be taken into consideration by the trustees of the fund when paying out a death benefit, but trustees are not required to follow such nominations unless made in the form of a *binding nomination*. Most funds have provision for making a binding nomination. Nominations are normally only valid for three years. In the absence of such *binding nominations*, trustees can consider claims put forward by other parties.

Superannuation can also be re-directed to a person's estate using a binding nomination, at which time it can be bequeathed to any person the testator wishes. Superannuation cannot otherwise be divested by will, so it is essential to lodge (and periodically renew) binding nominations.

What if disability benefits have been paid?

Usually, if disability benefits have been paid, no death benefits will be payable.

If a claim is rejected

The fund's decision is not necessarily final. If a claim is rejected, the claimant may be able to:

- ask the fund to reconsider its decision, and provide further supporting evidence;
- complain to the Superannuation Complaints Tribunal within two years of the initial decision;
- complain to the Australian Human Rights Commission;
- sue the trustees of the fund, or perhaps its insurers, to claim the benefit.

Time limits apply to the lodging of complaints.

For more about how superannuation is affected by HIV status, contact the HIV/AIDS Legal Centre. For more on superannuation generally, see Chapter 37, Superannuation.

[26.280] Insurance

Disclosure obligations

Under the *Insurance Contracts Act 1984* (Cth) (which covers contracts entered into on or after 1 January 1986), a person is legally obliged to disclose all information relevant to the insurer when taking out insurance.

What information is relevant depends on the entire context of the insurance provided, as it can often include an HIV diagnosis, even where the insurance on the surface appears unrelated to HIV status. It is therefore an important question to consider as failure to disclose this information may give the insurance company a reason not to pay a claim.

In addition, it may defeat any other rights a claimant may have under, for example, discrimination law.

Health insurance

In Australia, basic medical and hospital cover is provided under the Medicare system and is available to all citizens, permanent residents and applicants awaiting a determination for certain permanent visas.

Additional cover through private insurers in most cases excludes cover for a period of 12 months for pre-existing medical conditions (see Health insurance in Chapter 29, Insurance). Citizens and permanent residents cannot be refused health insurance on the basis of their HIV status or any other pre-existing condition. However, temporary residents may be refused; if a temporary resident applying for health insurance is asked about pre-existing conditions, including HIV, they should disclose their HIV status or the insurer may refuse to accept a claim if they later discover that this information was withheld.

Life and disability insurance

An insurer must pay any HIV or AIDS-related claim unless:

- the insured person did not disclose the relevant information on their application;
- the policy specifically excludes HIV or AIDS-related conditions.

Companies offering life and disability insurance need to be told whether the person applying for insurance has been involved in any HIV risk activities or is in what they consider to be a *risk group*. Most insurance contracts (except life) are renewed annually, and the duty of disclosure arises each time the policy is renewed.

A person may be required to take an HIV test before being insured if they disclose that they have been involved in any activity that could be described as high risk behaviour for HIV.

For insurance above a particular amount, a person may be required to have an HIV test regardless of any risk activity.

If a person has HIV

If a person applying for insurance has HIV, insurance companies may refuse to insure that person or, alternatively, offer insurance which excludes HIV-related conditions so that the insured would only receive benefits if their death or disability was unrelated to HIV.

Under both the State and Federal Discrimination Acts, an insurer may lawfully deny someone access to insurance where there is actuarial or statistical data to support such a decision. In practice, it is almost impossible for people with declared HIV to obtain life or disability insurance. However, advances in medicine arguably no longer support a blanket denial of access and therefore a person refused in such circumstances may have a claim against the insurer for unlawful discrimination.

Travel insurance

Most travel insurance excludes cover for HIV and sexually transmitted diseases; however it should cover other insurable events (such as lost baggage, accidents etc). Where travel insurance is refused on the basis of a person's HIV status, this may amount to discrimination.

[26.290] Wills, powers of attorney and guardianship

Because of the possibility of illness and incapacity, it is important for people with HIV to consider the future while they are in good health. This may involve:

- making a will;
- arranging for an enduring power of attorney;
- appointing an enduring guardian.

For more on wills, enduring guardianships and enduring powers of attorney law and procedures, see Chapter 40, Wills, Estates and Funerals and Chapter 16, Disability Law.

Avoiding challenges to the will

There have been challenges, particularly from family members, to the wills of people with HIV on the basis that the testator (will-maker) had HIV Associated Dementia (HAD) or HIV Associated Neurocognitive Disorder (HAND) when they made the will.

To protect against this, if there is likely to be any question as to capacity, it is advisable to have the will-maker's medical practitioner certify their mental capacity at the time they made the will.

[26.300] Pensions and benefits

Sickness allowance and disability support pension

Centrelink offers three types of payment that may specifically apply to people who are unable to work due to medical conditions, which may include HIV:

- sickness allowance (if you are temporarily incapacitated and have study or work to return to);
- newstart allowance (if you are temporarily incapacitated and do not have study or work to return to);
- the disability support pension (DSP).

Eligibility for the DSP depends on the applicant's degree of incapacity as determined by the impairment tables made in accordance with s 26 of the *Social Security Act 1991* (Cth) and their stability on treatment. There is no longer a specific table for HIV, a person with HIV will only be eligible to claim if their symptoms result in impairments under other tables (for further details, see [36.70]).

If a claim is rejected

If Centrelink refuses a claim for a pension or benefits, appeals can be made within specific time limits, firstly internally (within 13 weeks) and then to the relevant tribunal or court as necessary.

Carer payment/allowance

In addition, carer's payment/carer's allowance may be available to a person caring for someone with advanced HIV (for further details, see [36.80]).

[26.310] Housing

It is unlawful under federal and NSW discrimination law to either evict someone or refuse them accommodation because they have or are believed to have HIV.

In order to make out a complaint, it will be necessary to show that the adverse treatment was connected to the (prospective) tenant's HIV status. The exception to this is if the person providing the accommodation or their near relative lives in the property, and it consists of no more than six people (*Anti-Discrimination Act*, s 49N).

Housing assistance

Housing NSW prioritises allocation of public housing or financial support for housing to vulnerable people including those with complex health problems such as HIV.

[26.320] Debts

Lawyers acting on behalf of people with HIV have had some success in having debts, such as those run up on credit cards, written off or at least reduced and a satisfactory instalment arrangement reached on the basis of their client's ill-health and consequent inability to repay the total debt incurred. There has also been some success in having the debts written off on the basis of mental health problems caused by HIV and/or the medication which has resulted in the person making irrational decisions and requests for increased credit limit where the financial intuitions should have realised that it was not appropriate to grant the increased limits.

[26.330] Court and Tribunal matters and suppression of a person's HIV status

In certain circumstances, it will be necessary to ask a court or tribunal to suppress a person's HIV status. HIV remains a condition that is stigmatised in the community, and as such, a person with HIV may be very concerned about any disclosure of their status in a court or tribunal. For matters heard in NSW courts, an application for suppression can be made under the *Court Suppression and*

Non-Publication Orders Act 2010 (NSW). For discrete issues, for example, a plea in mitigation in the Local Court, where a person's HIV status might be relevant, disclosure of their HIV status in court may be an issue. This can usually be dealt with by handing material up to the magistrate or judge with any relevant submissions as to why their HIV status should not be disclosed.

In addition, there are other specific legislative instruments that provide for suppression and/or closed courts. For example, any proceedings conducted under Pt 5 of Div 1 of the *Public Health Act* must be conducted in a closed court (s 80), and in relation to hearings of the NSW Civil and Administrative Tribunal (which hears discrimination claims), s 49 of the *Civil and Administrative Tribunal Act 2013* (NSW) gives the Tribunal the power to grant a range of suppression orders on the application of a party or on its own motion.

[26.340] Use of cannabis

Some people with HIV are known to use cannabis for therapeutic purposes. It is recognised that cannabis is beneficial for pain relief, increasing appetite, reducing the amount of weight loss and counteracting nausea. There is an increasing amount of medical and scientific evidence in support of the benefits of cannabis to a person with HIV.

If a defendant can provide the court with a medical report from their treating doctor advocating the medicinal use of the substance in their particular case, this may provide a basis for the court to treat the charge leniently. Such a letter could simply confirm that the patient suffers from nausea, loss of appetite, weight loss or chronic pain, supporting the client's submission that he or she uses cannabis to alleviate these symptoms.

In NSW, a medical practitioner registered with the NSW Department of Justice may prescribe marijuana for people aged over 18 years, with a defined terminal illness.

[26.350] Mental health and criminal charges

A diagnosis of HIV affects people in different ways, and can result in depression, anxiety and difficulty in coping (HIV adjustment disorder). Clients will be referred by their treating specialists to appropriate support services or mental health specialists. Further, HIV can result in HIV-associated dementia, a mental illness that results in a person having some significant difficulty in managing their lives, but which can be managed with appropriate support and medication in place.

When a client with HIV presents with criminal charges, their legal representative should explore whether the client is suffering from a mental illness or developmental disability. In such circumstances, requesting that the court deal with the matter by way of s 32 or s 33 of the *Mental Health (Forensic Provisions) Act* may well be the most appropriate course of action. Supporting documentation and a treatment plan should be requested from the client's treating doctors and/or social worker (for further information, see [16.120] and [26.70]).

[26.360] Sentencing

A person's HIV status may be relevant in sentencing in a number of ways. For example, for minor offences that are out of character, or drug/alcohol related offences, a recent diagnosis of HIV may have affected a person's coping skills and resulted in offending behaviour that will likely not be repeated once they have engaged with appropriate services and counselling. Letters of support should be obtained from treating doctors in such circumstances.

Accused persons – prisoners, people in custody and sentencing

The State owes a duty of care to people in custody, including providing access to health care. People living with HIV who face criminal charges cannot assume that they will have access to antiretroviral and other medications if incarcerated, or that their right to confidentiality regarding their HIV status will be observed.

People with HIV cannot assume that the police will understand that they need to strictly adhere to their medication regime; that medical professionals who are consulted will understand the medication needs; or that the courts will accept that any custodial sentence may have a lasting and detrimental effect upon their life.

Police bail refused – short term custody

It is vitally important for people who are reliant on medication to convey this to the police and/or custody officer. There is no obligation upon

an accused person to disclose their HIV status to police. A person with HIV and on treatment should clearly, and non-aggressively, inform police that they have a serious and chronic illness that requires treatment so that police can assist them to obtain their medication. If an accused person notifies police of their need to access medication prior to being refused bail, the police may be able to assist them to obtain their medication from home, otherwise the medication will need to be obtained from an emergency department of a hospital.

Corrective Services custody

Should a person be bail refused for a longer period of time or be given a custodial sentence the health needs of an accused or a convicted person in the custody of Corrective Services are assessed and met by Justice Health. A person in custody with HIV does not need to disclose their HIV status to Corrective Services but they should do so directly to Justice Health staff. Justice Health has a number of limitations on provision of services to people living with HIV. There is a relatively small population of people with HIV in NSW prisons. Not surprisingly, there are limited visits by HIV specialist doctors to correctional facilities.

It is important for inmates' health that they are not transferred between facilities to avoid disruption in HIV treatment.

Justice Health can only supply Pharmaceutical Benefits Scheme (PBS) certified drugs. Therefore people on trial programs, including those who are drug resistant, will not be able to access treatment while in custody.

Disclosure in court and sentencing

Within the court system, there is an assumption and principle of open justice. Courts are slow to allow suppression of material before them, such as a person's HIV status, in conformity with that principle. While there are indirect ways to bring HIV status, relevantly, to the court's attention, where the issue is before the court there will always be a risk of wide public disclosure of HIV status through its processes.

Due to the significant health risks that people living with HIV face in custody it may be important that their HIV status be drawn to the court's attention for consideration in bail applications and sentencing. However, it is understood that due to the stigma attached to HIV, people living with HIV may be reluctant to disclose their status to their legal representative and/or an open court. This is a hurdle that an accused/convicted person must cross so as to prevent possible lasting damage to their already vulnerable health. The courts are only able to consider what is put before them. If the court is unaware of a person's HIV status, the health consequences can be severe and lifelong.

If a prison sentence is a possibility, submissions on behalf of a person with HIV should highlight:

- the probable impact of prison on the person's health, taking into account:
  - their current state of health;
  - threats to immune function posed by a prison environment;
  - any special problems that may be confronted by a person with HIV in the prison environment;
  - any adverse effects on health as a result of being denied access to appropriate medical treatment;
- the availability of any non-custodial sentencing alternatives that can take the person's health into account.

Arguments that a determinate sentence should not amount to a life sentence have not previously been upheld in Australian courts, however it is clear that in determining sentencing and/or grant of bail an accused/convicted person's health may be considered as a "mitigating factor" in sentencing and as a need for an accused to be released for another lawful purpose. As his Honour Chief Justice King stated in *R v Smith* (1987) 44 SASR 587:

> Generally speaking ill health will be a factor tending to mitigate punishment only when it appears that imprisonment will be a greater burden on the offender by reason of his state of health or when there is a serious risk of imprisonment having a gravely adverse effect on the offender's health

Smith's case involved a person with HIV and has continued to be followed to date.

Following sentencing, should an inmate with HIV come to the realisation that there is a likelihood that their incarceration may result in their death from HIV-related illness or co-morbidities, the courts have indicated that it is too late to be dealt with. It is therefore important that legal representatives are able to properly represent their clients not only by persuasively arguing for the best outcome from a legal perspective but also

in mitigating against disclosure of a person's HIV status in open court.

Additionally, for non-custodial sentencing in some circumstances, attention could be drawn to the impact that the person's HIV status may have had upon the commission of the crime. Where the person is under significant stress following a new diagnosis or where the medication and/or their condition has impacted upon their cognition in some circumstances consideration of requesting that the matter be dealt with by way of a s 32 application may be warranted.

[26.370] Immigration

All visas are subject to health criteria. Some temporary and all permanent visa applicants will have to undergo health checks, which may include an HIV test. All permanent visa applicants over 15 years of age must undergo an HIV test with BUPA, if in Australia, or a Panel Doctor as listed on the Department of Home Affairs' website, if offshore. Some applicants under 15 years may also have to undergo an HIV test including where there is reason to test, such as a child whose parents have HIV, or adopted children.

The department can refuse to grant a visa if the applicant refuses to undergo the health assessments. The department can also refuse to grant a visa to an applicant who refuses to sign an undertaking that they will report as directed to obtain further medical examinations once in Australia or once the visa is granted.

The health criteria

There are three main points which applicants are assessed against. Applicants must not:

- be a threat to public health or a danger to the community;
- have a condition that would prejudice access to health care or community services;
- have a condition that would be a "significant cost to the Australian community in terms of health care and community services" (*Migration Regulations 1994* (Cth), Sch 4, Pt 1, cll 4005(1)(c)(ii)(A), 4007(1)(c)(ii)(A)) (the *significant cost* test).

Only the *significant cost* test is applicable to PLHIV. HIV is not considered to be a disease or condition that is a threat to public health, nor in our experience would a PLHIV be deemed to prejudice access to health care or community services.

The *"significant cost"* test is applied to all applicants, with the exception of persons in need of medical treatment applying for Medical Treatment Visas (excluding support persons), and Protection Visas (on-shore refugees) where an altered health criteria is applied.

All permanent applicants, and some temporary applicants, who test positive for HIV will be deemed to be a *significant cost*. Any cost that amounts to $49,000 or more for the duration of the visa is considered to be a significant cost.

Permanent visas

There are only limited circumstances in which PLHIV can obtain a permanent visa for Australia as a result of being deemed to be a *"significant cost"*. These limited circumstances are where a *4007* health criteria applies allowing the applicant to request a waiver of the health criteria by demonstrating that the estimated cost, while significant, is not undue. This is done by demonstrating that compelling and compassionate circumstances exist which warrant a waiver of the health criteria. Waivers can be sought for the following types of visas:

- partner visas (including spouse, de facto (same or opposite sex) and prospective spouse, where the applicant is in a relationship with an Australian citizen or permanent resident, or eligible New Zealand citizen;
- New Zealand Family Relative visa subclass 461;
- dependant child visas (including adopted children, excluding orphan relative);
- offshore refugee/woman-at-risk/humanitarian type applications; and
- Employer Nomination Scheme (186) and Regional Sponsored Migration Scheme (187), where the applicant is applying under the Temporary Residents Transition Stream of those visa subclasses, and in very limited circumstances some other skilled visas.
- Skilled Independent Visa (189) New Zealand Stream.

PLHIV who apply for any other type of permanent visa subject to the *4005* health criteria will have their visa refused.

In addition, protection visa applicants (ie, onshore refugee applications) do not have health criteria, but undertakings to obtain further medical examinations or treatment will generally be imposed.

Temporary visas

As only costs estimated over $49,000 will result in a *significant* cost, the term of the visa and whether or not the applicant is on treatment will be a consideration in whether there is a "significant cost". It may be that person with HIV can obtain the temporary visa for which they are applying by doing such things as reducing the term of the visa, demonstrating that they are not on or likely to require treatment for the duration of the visa, being on a drug trial program or demonstrating that they are consistently and reliably obtaining their medication from abroad/ have their medication for the duration of the visa. Demonstrating that the applicant can pay for the medication is not a valid argument, as the costing is considered "regardless of whether the health care or community services will actually be used in connection with the applicant".

The temporary visas that the potential cost is always a consideration include, provisional temporary visas which lead to the grant of a permanent visa including parent, partner, child, and carer and a select group of skilled visas which will require the applicant to undergo health assessments to the same standard as a permanent visa as they will (most likely) be remaining permanently in Australia. See Gazette notice IMMI11/032 for a complete list.

Note: For some temporary visa applicants "sub sub-paragraph (1)(c)(ii)(A)" as paraphrased above may not apply. This is because for applications made on or before 4 November 2011 the potential cost of antiretrovirals should not be taken into consideration.

Visa applicants and disclosure

There is no obligation for visa applicants with HIV to disclose their HIV status to an employer, even if that employer is sponsoring them for a visa of any kind, unless otherwise required by law.

Please visit HIV/AIDS Legal Centre website www.halc.org.au.

Contact points

[26.380] If you have a hearing or speech impairment and/or you use a TTY, you can ring any number through the National Relay Service by phoning **133 677** (TTY users, chargeable calls) or **1800 555 677** (TTY users, to call an 1800 number) or **1300 555 727** (Speak and Listen, chargeable calls) or **1800 555 727** (Speak and Listen, to call an 1800 number). For more information, see www.communications.gov.au.

Non-English speakers can contact the Translating and Interpreting Service (TIS National) on **131 450** to use an interpreter over the telephone to ring any number. For more information or to book an interpreter online, see www.tisnational.gov.au.

Changes are expected to the websites for many NSW government departments that were not available at the time of printing. See www.service.nsw.gov.au for further details.

General

Australasian Centre for Disability Law
www.disabilitylaw.org.au
ph: 1800 800 708

Australasian Legal Information Institute (AustLII)
www.austlii.edu.au

Australian Institute of Health and Welfare
www.aihw.gov.au

Australian Prudential Regulation Authority (APRA)
www.apra.gov.au
ph: 1300 558 849 or (02) 9210 3000

Commonwealth Ombudsman
www.ombudsman.gov.au
ph: 1300 362 072

Communities and Justice, Department of – previously Department of Family and Community Services (FACS)
www.dcj.nsw.gov.au
ph: 9377 6000
Child Protection Helpline
ph: 132 111

Guardianship Division of NCAT
www.ncat.nsw.gov.au
ph: 1300 006 228

Health, Department of (Cth)
www.health.gov.au
ph: 1800 020 103 or 6289 1555

Health Care Complaints Commission (HCCC)
www.hccc.nsw.gov.au
ph: 1800 043 159 or 9219 7444

Healthcare Interpreter Service
www.health.nsw.gov.au/multicultural/Pages/heath-care-interpreting-and-translating-services
ph: 9391 9000

Health Communication Network (Medical Director)
www.medicaldirector.com
ph: 1800 622 678

Human Services, Department of (Cth)
www.humanservices.gov.au

Intellectual Disability Rights Service
www.idrs.org.au
ph: 1300 665 908 or 9265 6300

Medicare
www.humanservices.gov.au/individuals/medicare
ph: 13 20 11
Aboriginal and Torres Strait Islander access line
ph: 1800 556 955

National Health and Medical Research Council (NHMRC)
www.nhmrc.gov.au
ph: 1300 064 672

NSW Health
www.health.nsw.gov.au
ph: 9391 9000

Pharmaceutical Benefits Scheme
www.pbs.gov.au
ph: 1800 020 613

Private Health Insurance Ombudsman
www.ombudsman.gov.au/How-we-can-help/private-health-insurance
ph: 1300 362 072

Public Interest Advocacy Centre
www.piac.asn.au
ph: 8898 6500

Rape Crisis Centre NSW
www.nswrapecrisis.com.au
ph: 1800 424 017

Seniors Enquiry Line (previously Seniors Information Service)
www.seniorsenquiryline.com.au/resources/new-south-wales-sis/
ph: 1300 135 500

Shopfront Youth Legal Centre
www.theshopfront.org
ph: 9322 4808

Sydney Sexual Health Centre
www.sshc.org.au
ph: 9382 7440

The Gender Centre
www.gendercentre.org.au
ph: 9519 7599

Workers Health Centre
www.workershealth.com.au
ph: 9749 7666

Mental health

Aftercare
www.aftercare.com.au
ph: 1300 001 907

Dementia Australia (previously Alzheimers Australia)
www.dementia.org.au
ph: 9805 0100
National Dementia Helpline
ph: 1800 100 500

Disability Complaints Service
See People with Disability.

Flourish Australia
www.flourishaustralia.org.au
ph: 1300 779 270

HETI Higher Education (previously NSW Institute of Psychiatry)
www.heti.edu.au
ph: 9844 6333

Mental Health Advocacy Service
www.legalaid.nsw.gov.au
ph: 9745 4277

Mental Health Australia
www.mhaustralia.org
ph: 6285 3100

Mental Health Carers NSW (previously Association of Relatives and friends of the Mentally Ill)
www.mentalhealthcarersnsw.org/
administration
ph: 9332 0777
Carers connection line
ph: 1300 554 660

National Mental Health Commission
www.mentalhealthcommission.gov.au
ph: 8229 7550

Mental Health Co-ordinating Council
www.mhcc.org.au
ph: 9555 8388

Mental Health Review Tribunal
www.mhrt.nsw.gov.au
ph: 1800 815 511 or 9816 5955

NSW Institute of Psychiatry – see now HETI Higher Education

NSW Trustee and Guardian
www.tag.nsw.gov.au
ph: 1300 364 103

One Door Mental Health (previously Schizophrenia Fellowship of NSW)
ph: 1800 843 539

People with Disability
(including Disability Complaints Service)
www.pwd.org.au
ph: 1800 422 015 or 9370 3100

Private Guardian Support Unit
www.publicguardian.justice.nsw.gov.au/ – follow links for Private Guardian support
ph: 1800 451 510 or 8688 6060

Public Guardian
www.publicguardian.justice.nsw.gov.au
ph: 1300 451 510 or 8688 2650

Schizophrenia Fellowship of NSW – see now One Door Mental Health

Transcultural Mental Health Centre
www.dhi.health.nsw.gov.au/transcultural-mental-health-centre
ph: 1800 011 511 or 9912 3850

Way Ahead Mental Health Association NSW
www.wayahead.org.au
ph: 1300 794 991

HIV

ACON (formerly known as the AIDS Council of NSW)
www.acon.org.au
ph: 1800 063 060 or 9206 2000
Northern Rivers
ph: 1800 633 637 or 6622 1555
Hunter
ph: 1800 063 060 or 4962 7700
ACON Regional Outreach
ph: 1800 063 060 or 9206 2114

AIDS Dementia and HIV Psychiatry Service (Adahps)
www.health.nsw.gov.au/adahps
ph: 9382 8600

Australian Federation of AIDS Organisations (AFAO)
www.afao.org.au
ph: 9557 9399

Bobby Goldsmith Foundation
www.bgf.org.au
ph: 1800 651 010 or 9283 8666

Heterosexual HIV/AIDS Service (Pozhet)
www.pozhet.org.au
ph: 1800 812 404

HIV Information Line (The Albion Centre)
ph: 1800 451 600 or 9332 9700

HIV/AIDS Legal Centre NSW (HALC)
www.halc.org.au
ph: 9206 2060

Positive Life NSW
www.positivelife.org.au
ph: 1800 245 677 or 9206 2177

SWOP (Sex Workers' Outreach Project)
www.swop.org.au
ph: 9206 2166 or 1800 622 902

WayAhead (Mental Health Association NSW)
wayahead.org.au
ph: 9339 6000