HEALTH AND ENVIRONMENT COMMITTEE

Members present:
Mr AD Harper MP—Chair
Mr R Molhoek MP
Mr SSJ Andrew MP (virtual)
Ms AB King MP (virtual)
Mr ST O'Connor MP (virtual)
Ms JE Pease MP (virtual)

Staff present:
Ms R Easten—Committee Secretary
Ms E Nardo—Committee Support Officer

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2022

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 16 DECEMBER 2022

Brisbane

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The committee met at 11.01 am.

CHAIR: Good morning. I declare open this public briefing for the Health and Environment Committee's inquiry into the Health and Other Legislation Amendment Bill 2022. I am Aaron Harper, chair of the committee and member for Thuringowa. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all now share. With me today is Rob Molhoek, the member for Southport and deputy chair. We have a number of members dialling in this morning: Stephen Andrew, the member for Mirani; Ali King, the member for Pumicestone; Joan Pease, the member for Lytton; and Sam O'Connor, the member for Bonney.

On 29 November 2022 the Hon. Yvette D'Ath, Minister for Health and Ambulance Services, introduced the Health and Other Legislation Amendment Bill 2022 into the Queensland parliament and referred it to the committee for detailed consideration and report. The briefing today by Queensland Health officials is to explain the policy objectives and key provisions of the bill. Today's proceedings are subject to the parliament's standing rules and orders and are being recorded and broadcast live on the parliament's website. I remind committee members that officers are here to provide factual or technical information. Questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House. I now welcome representatives from Queensland Health.

BALDRY, Ms Hannah, Acting Director, Legislative Policy Unit, Queensland Health

EDMISTON, Ms Elizabeth, Acting Director, Legislative Projects, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

HARMER, Mr David, Senior Director, System Policy Branch, Strategy, Policy and Reform Division, Queensland Health

JOLDIĆ, Ms Jasmina PSM, Associate Director-General, Strategy, Policy and Reform Division, Queensland Health

REILLY, Dr John, Chief Psychiatrist and Chief Mental Health, Alcohol and Other Drugs Officer, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

Ms Joldić: Thank you for the opportunity to brief you on the Health and Other Legislation Amendment Bill 2022. It is with the deepest respect that I acknowledge the traditional custodians of the land on which we are meeting today, the Turrbal and Jagera people, and pay my respects to their elders past, present and emerging.

The bill amends seven acts in the health portfolio. It facilitates initiatives to improve and protect Queenslanders' health and support health service delivery, including through some technical amendments that improve the operation of health legislation. The bill also amends the Recording of Evidence Act 1962, which is administered by the Department of Justice and Attorney-General. I will briefly summarise the amendments in the bill and then provide the committee with additional information about the more substantial amendments.

The bill amends the Hospital and Health Boards Act 2011 to require hospital and health boards and hospital and health services to proactively consider the need to support the health, safety and wellbeing of their staff. It also amends the Hospital and Health Boards Act 2011 to reinforce the practice that health security officers should not direct a person to leave hospital and health service land if the person requires emergency medical treatment.

The bill amends the Public Health Act 2005 to modernise the Queensland Cancer Register and authorise schools to disclose student information to Queensland Health's vision-screening program. The bill amends the Recording of Evidence Act 1962 to establish a new statutory framework for recording the proceedings of prescribed tribunals and providing access to copies of records and

transcriptions of the proceedings. In addition, the bill amends the Mental Health Act 2016 to support the Mental Health Review Tribunal to conduct electronic recording of proceedings as well as to provide that a person may waive their right to representation other than in writing if the Mental Health Review Tribunal is satisfied this would not cause injustice to the person.

The Medicines and Poisons Act 2019 is another act amended by the bill. The main amendments to this act allow information contained on registers about approvals of persons working with medicines or poisons and administrative action taken against persons who have dealt with medicines or poisons in an improper way to be disclosed if it is in the public interest. Other amendments are operational and related to information sharing and pest management.

The bill amends the Transplantation and Anatomy Act 1979 so the consent process for human tissue donation that applies in public hospitals will also apply in private hospitals. This will remove impediments that can slow down or prevent successful organ donation. It also makes a second efficiency improvement within that act by removing the requirement for a Queensland doctor to be granted a ministerial permit before they can obtain tissue supplied under the Therapeutic Goods Administration's Special Access Scheme.

The bill amends the Water Fluoridation Act 2008 to replace the requirement that fluoridation decisions be notified specifically in a newspaper with a requirement for them to be made publicly available, which is more flexible. Finally, the bill makes technical amendments to the Radiation Safety Act 1999 to improve the operation of that act and its interaction with the Radiation Safety Regulation 2021. I will now revisit the more substantial amendments.

The bill will help to ensure that the physical and psychological health, safety and wellbeing of hospital and health services staff is a proactive consideration for services and their governing boards. The bill amends the act to require hospital and health boards and hospital and health services to have regard to the need to promote a culture and implement measures that support the health, safety and wellbeing of HHS staff. If the bill is passed, Queensland Health will work with the HHS boards and services to identify strategies that will support them to meet these new obligations. This may include identifying strategies to evaluate, implement, capture and communicate staff wellbeing activities. There are possible strategies that can complement and contribute to existing workplace health and safety obligations; for example, obligations under the work health and safety framework about identifying and managing health and safety risks. All staff in public health services, no matter their role, work in complex settings and experience unique challenges. This amendment recognises this and will support the public health system to prioritise staff wellbeing.

The bill amends the Public Health Act 2005 to authorise schools to disclose student information to Queensland Health's vision-screening program to support positive health and educational outcomes for children. Each year the vision-screening program screens around 45,000 Queensland prep students for amblyopia, known as lazy eye, and its risk factors. The early detection of vision problems ensures that a child can be treated early, reducing the impact of eye problems on their learning and development. Vision screening can only occur with family members' consent; however, in 2021 around 26 per cent of Queensland's prep students did not have a consent form returned. Based on average screening rates, this means that up to 1,400 prep students could have been undiagnosed with a visual abnormality. Currently, the vision-screening program relies on school families to follow up missing consent forms. If the bill is passed, the vision-screening program will be able to obtain student information from schools so it can directly contact the family to see if it would like to consent and answer any questions. This will reduce the administrative burden on school staff and nurses associated with following up consent forms and will maximise the number of children who are screened for preventable vision loss.

As I briefly mentioned earlier, the bill also amends the Public Health Act 2005 to modernise the Queensland Cancer Register. The Public Health Act requires a range of information to be notified to the register to inform research and other efforts to address the burden of cancer; however, the notification requirements in the act no longer reflect contemporary diagnostic techniques and cancer management. The bill extends notification requirements to diagnostic imaging practices and enables additional data to be collected from hospitals and pathology laboratories, which are existing notifiers.

The extended notification requirements will provide better data for research into the cause of cancer and programs to educate the Queensland community about the risks of cancer. Queensland Health has been consulting affected notifiers and if the bill is passed will continue to work with them to educate them on their obligations and update existing technical guidance on notification requirements. Existing notifiers such as hospitals can rely on existing processes to meet the new

requirements and they will have minimal operational impacts. A technological solution has been developed in collaboration with the CSIRO to reduce the impost of the proposed new requirements for diagnostic imaging practices, which are becoming notifiers for the first time.

Another key amendment in the bill is the amendment to the Recording of Evidence Act. My colleagues at the Department of Justice and Attorney-General have provided the following summary. The bill amends the Recording of Evidence Act to establish a new framework for recording the proceedings of prescribed tribunals and providing access to copies of recordings and transcriptions. The new framework preserves the requirement that all evidence, rulings, directions, addresses, summings-up and other matters in legal proceedings must be recorded but provides greater flexibility in who may carry out the recording of the proceedings in prescribed tribunals and how copies of recordings and transcriptions may be provided. Under the framework, a prescribed judicial person for a tribunal may arrange for the recording of the proceedings or the transcription of a record to be carried out by a member of the tribunal, staff of the tribunal or someone else such as an external service provider. The prescribed judicial person must also ensure that arrangements are in place to make copies of recordings or transcriptions available.

The new framework provides safeguards to protect the privacy of persons referred to in recordings or transcriptions by providing that access may be restricted under the Recording of Evidence Act or another act or by an order of a court, a tribunal or a judicial person. The tribunals to which the new framework will apply will be prescribed by regulation, and it is intended that the Mental Health Review Tribunal will be a prescribed tribunal.

The bill amends the Mental Health Act to support the Mental Health Review Tribunal to electronically record its proceedings. Electronic recording of proceedings already occurs in courts and the Queensland Civil and Administrative Tribunal. If the bill is passed, the Mental Health Review Tribunal intends to make electronic recording its default recording method. The amendments ensure that the Recording of Evidence Act applies appropriately to the sensitive and typically closed nature of Mental Health Review Tribunal proceedings. The bill limits the parties to which the tribunal can provide recordings or transcriptions and provides greater certainty around MHRT confidentiality obligations. The use of electronic record-keeping practices in the tribunal will promote fairness, accountability and accessibility in hearings about the treatment of vulnerable people.

The bill also amends the Mental Health Act to allow a person with capacity to waive their right to legal representation in non-written form if the tribunal is satisfied that this would not cause injustice to the person. The current requirement for waiver to be in writing can be an administrative burden for patients and can create a barrier to individuals exercising their rights. It can also result in proceedings having to be adjourned until the written waiver can be completed, which can delay access to important treatment. Given the importance of the right to representation, the amendment only allows a verbal waiver in place of written waivers if the tribunal is satisfied that this would not cause injustices to the person who wants to waive the right. This threshold is a safeguard for a non-written waiver while ensuring the tribunal has enough flexibility to engage with vulnerable patients whose health care might be impacted if the tribunal proceeds a certain way.

The last key amendment I would like to cover is an amendment to the Medicines and Poisons Act. Queensland Health maintains a register of licences and authorities granted to persons who may deal with medicines and poisons and a register about administrative actions taken against persons who have dealt with medicines and poisons in an inappropriate way. The bill amends the Medicines and Poisons Act to allow the public, wholesalers and retailers to verify whether a person they are dealing with has appropriate approvals to deal with medicines or poisons. The bill will provide that the chief executive of Queensland Health can: first, disclose information from the substance authority register directly to a person or publish information from the register on the department's website where it is in the public interest; and, secondly, disclose information from the administrative action register directly to a person where it is in the public interest.

The public test is a high bar that affords protection to health practitioners, primary producers and others with substance authorities while ensuring that public health risks can be avoided or mitigated. If the bill is passed, Queensland Health will create a suite of internal instruction documents to support departmental officers with chief executive delegation to assess what is in the public interest.

In conclusion, Chair, thank you for the opportunity to address the committee. The measures included in the bill that I have summarised are ultimately about supporting better public health outcomes for Queenslanders and ensuring legislation remains contemporary and effective. We are happy to take any questions, and I may refer to witnesses on either side of me for those answers.

CHAIR: Thank you very much, Ms Joldić, for that and for the information you have provided the committee. I am mindful that the parliament rose just over a week ago and that you are all here. The people who keep Queensland Health ticking are all on the front line, of course, just a week out from Christmas, but thank you all for being here today. It just reminds me that everything behind the scenes—the policy and the strategy area—keeps going as well. We do appreciate your coming in today and we do have some questions.

Mr MOLHOEK: I echo the chair's sentiments. Thanks for being here. It is a week before Christmas; I am sure you have other things you would rather be doing. We do appreciate the enduring and ongoing work of the health professionals across our public hospitals and the health system. It is pretty onerous for all of you and I know that it is quite stressful at times. I see that firsthand with my son, who, after three years as the Emerald district medical officer, is today moving to Toowoomba to take up a new role with Queensland Health. I have some questions around the health and wellbeing of our public health workforce. I am curious as to why these recommendations have come but, more importantly, what it actually means in a practical sense. What things will we see improve in terms of the health and wellbeing of our health service staff?

Ms Joldić: The HHB Act lists factors that HHSs and their governing boards must consider in performing their functions. The bill inserts one new factor, which is the requirement for HHSs and the boards to have regard to the need to promote a culture and implement measures to support the health, safety and wellbeing of staff of public sector and health service facilities. Health, safety and wellbeing includes physical, psychological and emotional wellbeing and cultural safety. By entrenching considerations of staff wellbeing within the HHB Act, the bill strengthens the protections for staff and encourages the HHSs to prioritise current and future staff wellbeing efforts. Compliance with the new obligations can complement and contribute to compliance with the work health and safety legislation. The bill does not create new compliance obligations or impact on that legislation.

Given what Queensland Health and the Queensland community have just been through in terms of the pandemic, we looked at opportunities to strengthen the emphasis on wellbeing—and that was elevated to the board level as well. The wellbeing of our staff was a key priority. It is not intended to be a compliance measure and it is not intended to be onerous, but the safety and wellbeing of our staff is at the forefront at every level in our HHSs.

Mr MOLHOEK: I think the intent behind this is incredibly admirable—and I understand why it is necessary—but in a practical sense I am curious. Given the challenges that Queensland Health is facing in terms of recruitment of people, a lot of the wellbeing issues for health workers are about the fact that they all are being asked to work longer and more often. Has any thought been given to labour force and workforce recruitment, particularly how we will meet some of the challenges in rural, remote and regional Queensland? Even in the last week we have seen media stories about shortages of doctors and allied health workers. I would have thought that getting this right is an important part of this.

Ms Joldić: I do not think it is an 'and/or', to be honest. I think we have an obligation to our current staff and we want to emphasise that we take health and wellbeing very seriously. Of course, the recruitment of our workforce is our priority. It is most certainty one of the top priorities we are currently working on. The health workforce and the workforce more broadly is not a challenge unique to Queensland; it is a challenge that we are seeing across Australia and globally. Please do not quote me, but I think around 300,000 vacancies in the health sector are being recorded just in the United States. We are doing significant planning internally on our workforce strategies for recruitment. We are absolutely prioritising the regions. They are a significant component of our system. A significant body of work is currently underway in the department to look at strategies that will help ameliorate the pressures our system is seeing from a workforce perspective.

Mr MOLHOEK: Will some of that include submissions or informing the federal government review that is being undertaken at the moment around migration policy? I understand from the inquiry that we conducted over a year ago that one of the big issues is that often we will find suitable candidates from overseas but it can take as much as two years to process all of the paperwork so they can actually come? It is actually migration policy that is the hold-up.

Ms Joldić: Absolutely. We are working very closely with the federal government at my level and other levels—at the bureaucratic level—to inform the work that is happening. It absolutely has to be a cooperation between the federal government and the state government. Some of the blockages do sit at that level. It is an agenda that is consistently being discussed at the chief executive level across the states. Workforce is a primary and key objective for us.

Mr MOLHOEK: Are the unions generally supportive of that approach, or are they concerned about flooding the country with too many foreign workers?

Ms Joldić: It is a fine balance.

Mr MOLHOEK: I have gone a little bit off track. We can create all the great culture we want, but if there are not enough people to fill the rosters it goes out the window.

Ms Joldić: Yes. It is a multipronged approach, and keeping the system in balance is a key. As mentioned, it is not wellbeing or more staff. We absolutely have to look after our staff currently in the system and find innovative ways to attract the workforce that we need. We are certainly working on both. I probably should not comment on the union component, but it is a fine balance. We are working with all of our stakeholders to ensure we have the workforce that we need right now but also doing proper and significant planning for the workforce we might require in the future.

Mr O'CONNOR: Can I ask about the reason to have this proactive obligation on the health service boards. Were there examples where you had boards from around the state that were not considering these factors in their planning and their policies and what they were doing in terms of management? Were there cases where issues had arisen which led to this requirement to have proactive consideration?

Ms Joldić: No, not necessarily. What we have been seeing is that our boards have actively prioritised the health and wellbeing of our staff. It was a bottom-up approach to understand what was happening at the local level—what considerations our boards are taking—and reflecting that in our legislation.

CHAIR: Our HHS has clinical excellence awards, where the board recognises those people who go above and beyond, rewards staff and acknowledges the hard work they do. I think this just builds on that.

Mr O'CONNOR: If you could get me an invite to the Gold Coast one, Chair, I would love it!

CHAIR: Thank you, member for Bonney. I am in a Christmas mood; I will let that one slide.

Mr O'CONNOR: I would love an invite to next year's awards. I would love to go!

CHAIR: I have a question with regard to clarifying when healthcare security officers direct persons to leave. If I can put it in context, I have been working in and around emergency departments for over 30 years. They are very complex places. People go there in times of urgent need. I mean no disrespect to any of the people who do a wonderful job in those areas of protecting staff, but some patients are incredibly complex. Some patients require some diagnostic interventions. Can I get you to unpack this? The bill amends the act to require that, in dealing with persons causing a public nuisance, a security officer must not give a direction to leave if the person requires emergency medical treatment that is immediately necessary to save their life or prevent serious impairment.

This becomes complex. I understand that if a person is under an emergency examination order by police or ambulance they are going to stay, but what if people come in with, let's say, organic growth and no-one has diagnosed that yet but they have very strange behaviour? How does the security officer judge that that person requires—and this is the scenario I am painting—a medical intervention and stops them from leaving? Are there instances that have come to arrive at this point? I want to unpack this a little bit and make sure we are not putting an additional burden on security officers.

Ms Joldić: I will start with a summary. The bill reinforces an existing practice and aligns it with the Human Rights Act. I will give you a bit of a spiel and then we can discuss the example you gave, Chair. The act authorises the healthcare security officers to direct a person to leave health services land or part of the land, for example, where the person is being disorderly or imposing a threat to the safety of another person. The power needs to be exercised carefully as the person may need medical care. Security officers communicate with healthcare staff about a person's medical needs. Often clinical staff only call for security assistance after assessing the person. The bill reinforces the existing practice and aligns with the Human Rights Act by providing that healthcare officers may not direct a person to leave if they require emergency medical treatment that is immediately necessary to save the person's life or to prevent serious impairment.

The clinical or medical assessment to determine what the person might need is always done and performed by a medical officer. It is the medical officer's decision when to call a security officer by the time they have assessed the patient on what medical treatment they might require. If the patient does not require—and, please, I will refer to my team—immediate medical treatment but the patient is difficult, the medical officer would call the security officer to assist with the patient and the challenging behaviours they are experiencing in the emergency department. Chair, as you said and

as you would know, our emergency departments are busy. There is a lot of staff in those departments and the line of communication is important. It is always the medical officer who will make the assessment around the person's medical needs.

Ms Baldry: What Jasmina has outlined is absolutely correct. The bill, if you look at the wording closely, does not require the security officer to make a determination that the person requires emergency medical treatment. It states that they cannot direct a person to leave if the person requires emergency medical treatment. That leaves it open for clinical staff to make that assessment and for there to be a communication between the security officer and staff, and that is what happens in practice at the moment.

CHAIR: Thank you for the clarification.

Ms Joldić: If I may add, the health and hospital services have not raised any concerns about the amendment as it aligns with existing practice.

Mr ANDREW: Thank you, everyone, for coming in today. Merry Christmas to you all. The bill makes changes that require better notifications surrounding the details of cancer screening procedures done in Queensland. I want to understand that a bit more and the amount that we are currently spending on these procedures each year. Will there be a considerable change in that? Obviously we will be bringing that up to a better standard.

Ms Joldić: The Cancer Register—we call it the QCR—is a comprehensive source of data about cancer in Queensland. It is used for important public health purposes, such as planning and resourcing cancer care, monitoring and evaluating treatment outcomes, and developing community education about preventing cancer and getting help. This data is obtained through mandatory reporting by public and private hospitals, pathology labs and residential care facilities. Currently the act requires the QCR to be notified if a person is attending a hospital for outpatient cancer treatment for the first time in a calendar year or if a person separates from a hospital—for example, because they have stopped treatment or because they have passed away. The bill modernises notification requirements to make it mandatory for hospitals to notify of all hospital treatment a person receives for cancer, regardless of whether treatment is received as an outpatient or inpatient or whether in the year the treatment is received.

Currently, pathology labs must notify the QCR if a test indicates that the person who is tested is suffering from or has suffered from cancer. The bill will extend this requirement so that it is also mandatory for pathology labs to notify all cancer related follow-up pathology tests. Diagnostic imaging practices—for example, radiology clinics or other health facilities that do scans such as MRIs, CT scans, ultrasounds and mammograms—are not QCR notifiers, so we are not seeing a holistic picture of cancer. The amendment that we are proposing is an amendment where we can see the full spectrum of cancer screening that happens and it will enable us to do better service planning.

Ms KING: I begin by thanking everybody who has appeared today for all that you do and I wish you all a merry Christmas. I was hoping to have explained, please, a little bit more of the underlying basis for the changes to the notification. It was notification of transplantation approvals and consents, was it not, to regularise the way they are dealt with between public and private hospitals? Could we have explained in a bit more detail the basis for it and what the changes will bring in that space, please?

Ms Joldić: The Transplantation and Anatomy Act provides the legal framework for the removal of human tissue for transplantation and other medical and specific purposes, post-mortem examination, sale of human tissue and regulation of schools of anatomy. The bill makes two operational changes to the act that will commence on proclamation. Change 1 is in relation to the consent process for removal of tissue in private hospitals. The bill makes the change that private hospitals have the same consent processes around tissue removal and organ donation as public hospitals. The next of kin is required to consent to the removal of the tissue from the deceased person, even if that person had registered for organ donation in their lifetime. Currently, a different process has to be followed depending on whether a person dies in a private or a public hospital. The private hospital process is more onerous. This has resulted in inefficiencies and may result in missed donation opportunities.

The most important element of this amendment is that the family members whose loved one dies in a private hospital will be able to provide verbal consent to the tissue being removed, confirmed by written consent later. Now only written consent is allowed in private hospitals for donation to proceed. This will have two main benefits: one, reducing stress for families involved; and, two, making the consent process more efficient and therefore increasing chances of successful tissue and organ donation. In summary, we are aligning the current practices of the public health system to the private health system so that we are basically removing the inefficiencies that currently exist.

Mr MOLHOEK: To clarify, the public health system is adopting what is currently practised in the private health system, or the other way around?

Ms Joldić: The other way around: the private system is adopting what happens in the public system. Sorry, I may have confused you with my answer.

Ms PEASE: Like my colleagues, I want to say thank you to everyone for coming in and participating today. I have a statement with regard to the issue around transplants. I am really delighted to hear that the private and public hospitals are going to be streamlined. I can speak from personal experience: my mother, when she passed away, was in a private hospital. She was a donor and she had made that commitment. However, it was so difficult that in the end we said no because it was such a difficult process to go through. I am really delighted to hear that we have progressed that change. It will make a big difference to the donor bank.

We were talking earlier about the workplace health program that all of the boards have to adopt. Can I get clarity that it is not one-size-fits-all—that each HHS board would have to develop their own, given that each HHS board would have different cultures and issues associated with it?

Ms Joldić: In the department we try to stay away from a one-size-fits-all approach because one size does not fit all. The proposal is that we will be working with all of the health and hospital boards to develop a framework that would suit the HHS and the staff. Of course, there are efficiencies in ensuring that we are on the same page and that we have the same frameworks, but they will need to be adopted and localised. That body of work will happen from the department in consultation and collaboration with the HHSs and the HHBs. Hannah, is there anything you would like to add to that?

Ms Baldry: No, I do not have anything to add, other than that the bill does not require particular requirements for each HHS. It keeps it broad. They will have to determine what is most suited to their service and where particular areas of improvement could be made.

Ms PEASE: My last question is with regard to the vision-screening requirement for schools. You talked about the problems that you had getting the consent forms back and, as a result, potentially prep kids were missing out on getting tested. I want to know a little bit more about that direct access to the family contact. Have there been any issues around privacy, how do you overcome those issues and concerns, and is there likely to be any pushback from the school or the family within the school environment?

Ms Joldić: I will elaborate. I will give you a bit of a lengthy response because we are very much focused on that. Children's Health Queensland coordinates a statewide vision-screening program—and I will continue to tell you how good this program is—that screens prep students in public, Catholic and state schools for preventable vision loss with the consent of a parent or a guardian. The free program connects children with help for vision issues early. Early help for vision issues is important, because vision loss is associated with learning challenges such as concentration and behaviour difficulties that affect education outcomes.

The vision-screening program currently relies on school staff to encourage families to return consent forms permitting their children to be screened. This burdens school staff and is a barrier to screening the maximum possible number of students. To improve the reach of the vision-screening program, the bill amends the Public Health Act to authorise schools to share student information with the vision-screening program. This will enable registered nurses from the program to compare lists of students against the records of who has returned a consent form so that they can directly contact families who have not returned a consent form, to help them make an informed decision about whether to take up the opportunity for vision screening. The act already authorises information sharing with school dental and immunisation programs that are run or engaged by our HHSs to support effective delivery of these programs. Our stakeholders are very supportive. Would you like me to take you through how the vision screening will work, or would you like me just to focus on information sharing?

Ms PEASE: No, it is fine. I think the benefit of it is tremendous; I am very supportive of it. I think it is a really progressive move to make sure that kids are given those opportunities, because we live in a busy world and parents often lose those forms or they get caught up and forget. I am delighted if people are accepting of it and hopefully it will progress and there will not be any pushback. That is my interest: has there been any pushback or is there acceptance of the sharing of information?

Ms Joldić: Our stakeholders have been very supportive. Ultimately, when it comes to information sharing, the principal of the school has the right not to provide the information—or the parent and guardian, of course, has the right not to provide the information. However, the information that the vision-screening program is able to ask school principals to provide is: name, date of birth,

sex of the student, group or class at school, information about whether the student identifies as a First Nations person, language spoken at home and the name and contact details of a parent and guardian. The Public Health Regulation 2018 already lists this information and allows it to be given to the school dental and immunisation programs. It brings it into line with current practice for other programs.

CHAIR: I want to get a better understanding around water fluoridation notifications. I will put this into context. The former chief health officer, now Governor of Queensland, Dr Jeannette Young, was adamant that we continue to talk about fluoridation of water. After her outstanding work in managing COVID, reducing smoking rates, reducing obesity and all of those other things, I said that I would take up the baton on this, so I was very interested when I saw this in this bill.

With regard to publication of fluoridation decisions, are decisions to add or cease to add fluoride to water supplies made frequently by individual local governments in Queensland or are fluoridation decisions usually unchanged for long periods of time? Before you answer that—and this might be something you can take on notice—what areas of Queensland currently do not have fluoridation? What are the benefits of fluoridation of water? I am really interested in this. I gave my commitment to the former chief health officer that I would have this discussion, so can you unpack that for me?

Mr MOLHOEK: Point of order, Chair. This is a bit outside the scope of the bill!

CHAIR: No, I am just interested.

Mr MOLHOEK: It is fine; I am just curious as to why you do not want to advertise in the paper anymore. I think I know the answer.

Mr Harmer: I cannot answer your question in terms of which local governments, but I can talk to the percentage of Queenslanders who have access to fluoridated water. I understand that approximately 28 per cent of Queenslanders currently do not have access to fluoridated drinking water. There are a number of local government areas that do not fluoridate water—my understanding is that it is 56 of 77—but, in terms of geography and water supply, it is important to understand that the vast majority of Queenslanders do have access to fluoridated water supply.

At the risk of stealing Ms Joldić's thunder, the answer to the question about papers is that they are in increasingly short supply. Many people are going out of business so there is not a paper to advertise in, so it is appropriate to develop a more modern approach to communicating these messages.

Ms Joldić: In a publicly accessible way.

Mr Harmer: The other observation I would make is: many of the amendments in this bill are just designed to modernise the legislation. In answer to what might be a forthcoming question, this amendment was really made in response to the modernising approach we are taking throughout this legislation, rather than there being a specific intention on the part of a particular local government to change its position. We are not reacting to a forthcoming decision, if that makes sense; we are simply modernising the legislation so that if a decision is made it can be communicated clearly to the public.

CHAIR: It is purely the responsibility of the local government of the area to manage the fluoridation of the water? Is there state oversight or is it purely local government?

Mr Harmer: It is the local government's decision. Prior to commencing fluoridation of a water supply, the relevant act requires that a local government satisfy itself that it is in the public interest to fluoridate water. That is under the Water Fluoridation Act, which is not something I am particularly familiar with. If you need specific detail, we would be happy to provide that on notice.

Ms Baldry: Queensland Health does have a regulation role in terms of water fluoridation. That is why we administer the legislation still. There is a compliance and monitoring role that the department undertakes.

Mr ANDREW: The bill will change the Mental Health Act to require proceedings to be electronically recorded and videoed. I wanted to know if the transcripts will be accessible by the public and/or interested legal parties.

Dr Reilly: In terms of the Mental Health Review Tribunal, there are a number of issues with regard to both recordings and transcripts for Mental Health Review Tribunal proceedings. Although they are now going to be considered along with other tribunals for the purposes of recording, which they have not been, there are certainly issues with regard to making the transcripts publicly available. Transcripts will certainly be available to legal parties where they are involved in the Mental Health Review Tribunal proceeding, but they will not be made widely publicly available. Although that is what would happen with most administrative tribunals, the nature of the sensitive healthcare information

being considered within the Mental Health Review Tribunal has historically been looked at separately. That is why that is going to continue and why we have had to deal with the Mental Health Review Tribunal differently to how other tribunals are dealt with.

Mr ANDREW: The bill facilitates a verbal waiver to legal representation as opposed to a written one. Will the verbal waiver be able to be substantiated if it is disputed at a later date? It is a big issue. If we are going to do a verbal waiver, can it be substantiated down the track?

Dr Reilly: I agree that it is a significant issue. That is why there has been a lot of consideration as to how it will be recorded if a patient with a hearing at the Mental Health Review Tribunal has made a decision that they do not wish to have representation. It is trying to protect the right for the patient to have the representation that they desire and not to have to record it in writing if they are making the decision also that they will not.

I can take you through some examples of how that would work if you like, but certainly there is a recognition that, because a written waiver is what we would normally expect, it is important to allow a verbal waiver if it is not going to cause an injustice for the patient. The tribunal does do that kind of consideration routinely. It still will be recorded either on the recording or, if the patient did not want it to be recorded, in writing by the tribunal. All of that, I think, is to highlight that the patient's right in particular is to have the fact that they are being kept in general as an involuntary patient reviewed by an independent tribunal of the treating team and it is trying to have the flexibility for that to occur whilst recognising the patient's decision-making around the waiver.

Mr MOLHOEK: Dr Reilly, some time ago a family came to see me. Their son sadly took his life. He had had a series of mental health episodes and had presented at hospital. The result was that he told his family to clear out and he had the right to make those decisions for himself. He presented incredibly well, from all accounts. He was masterful at putting on a great show, in a sense. He had himself released from hospital, went home and sadly took his life. In terms of people waiving certain obligations or aspects of this, how does the tribunal assess adequately whether someone should or should not waive those rights and whether that is in their best interests?

Dr Reilly: The tribunal is obviously considering a lot of issues, in considering that particular issue a bit more generally, within a review tribunal hearing. They are hearing from the patient and the treating team. If the patient has made a decision that they wish to waive their right to representation, they would be expected, in general, by the tribunal to have a reason for doing that and the tribunal then obviously has the ability to consider those reasons. It is essentially a balance of the rights at that point. There is obviously the right to representation, which we are certainly going out of our way to emphasise. If the patient is then saying, 'I really don't want to have that representation,' in particular if, through insisting upon representation, the patient then says, 'I don't want to be involved in this hearing and I'm going to leave,' that creates a problem from the perspective of their rights. The patient then would be potentially detained under the act for a continuing period because it is harder for the tribunal to make decisions, for instance, to take them off an involuntary treatment if the patient is then refusing to be involved in the hearing at that point. If the tribunal decides to adjourn, that is also delaying the patient's consideration at that point.

Mr MOLHOEK: So that is a safeguard of sorts?

Dr Reilly: It is essentially a safeguard to ensure that the person's rights, in relation to a review of their detention, are actually being considered by the tribunal.

Ms Edmiston: The member's question touched on the issue of capacity and when a person is assessed to have capacity to make those decisions that affect the safeguards they are entitled to. The Mental Health Review Tribunal is practised at assessing capacity in relation to a number of different types of decisions, including a person's decision to waive their right. It is important to note that capacity is time and decision specific, so a person may be assessed as not having capacity to, for example, consent to be treated for a serious eating disorder but the tribunal might still determine that they do in that circumstance have capacity to make a decision about waiving their right to legal representation. Dr Reilly has explained the reasons for allowing that flexibility to cater for those circumstances.

Mr MOLHOEK: I am assuming that the tribunal has the capacity to make the assessment as to the mental wellbeing of the individual. There are occasions that I have heard of where individuals who are, say, schizophrenic or having episodes actually have a very loving and supportive family around them who want to help but for all sorts of reasons do not want them there, and usually it is because of their fairly unbalanced state of mental health. I am sure there are occasions when it is more serious than that or there are real concerns, but it would seem that in cases of schizophrenia and other conditions it must be quite challenging to make that assessment.

Dr Reilly: The tribunal itself is composed of a legal member, a psychiatrist—or if there is not a psychiatrist available in some situations, another medical practitioner—and a person who is not a lawyer or a doctor. The tribunals are certainly very acutely aware of some of the sensitivities, the complexities and the risks associated with their decisions. They do spend a lot of time trying to understand the patient's perspective, but also they get quite detailed information from the clinical treating teams. That is one of the reasons the MHRT recording of information is sensitive, because they really go in detail into the mental health history, treatment and current status of the patient.

There are certainly situations such as you are highlighting where sometimes the patient may not want their family to be present. In general, treating teams have a capability to bring to bear what other information is available. That is certainly a significant issue which is often addressed by treating teams and which I think mental health review tribunals go out of their way to try to take into account. It is not a perfect process in all situations and we are not always going to get it absolutely right—either the treating team or arguably at times the tribunal itself—with regard to being aware of what all the risks might be. It is not always possible to take all of those different perspectives into account perfectly, so it is certainly challenging.

Mr MOLHOEK: I guess no system is perfect.

Ms KING: I was wondering if we would get a further explanation about the changes to the Radiation Safety Act that the bill proposes.

CHAIR: Just to put that in context, I was going to ask that too. The explanatory notes state that, if the bill is passed, the Radiation Safety Regulation 2021 will be amended to remove the offence and penalty for failure to ensure a person does not receive a greater than specified dose of ionising radiation. Can you explain the differences between the offence and penalty in the regulation at present and the offence and penalty that are proposed to be inserted into the act?

Ms Baldry: The first question is about why the offence is going into the act. Basically, from a drafting and fundamental legislative principles perspective, it is more appropriate for an offence head of power to be in an act than a regulation. It is basically a technical amendment that is moving the head of power for the offence into the act. The dose limit to stop someone from exposing someone to excess radiation will still be prescribed in the regulation. There is going to be an increase in the penalty that will be applicable. That will be increased from 20 to 100 penalty units. It has been increased to the maximum of 100 penalty units to better align with other similar offences in the act that have penalties ranging from 200 to 500 penalty units.

Under a regulation, the offence could only be a maximum of 20 penalty units. It was considered that this was insufficient given the seriousness of harm that could be caused to a person from radiation exposure. The new penalty is more appropriate and proportionate. It reflects the seriousness of the risk to human health from being exposed to radiation; however, it is balanced against the lower risk associated with exposure to radioactive material that is not a radioactive substance compared with offence provisions in the act that apply to materials that emit higher levels of radiation, so they are those offences that have 200 to 500 penalty units. Does that help answer the question? It is very technical.

CHAIR: Are you happy with that, member for Pumicestone?

Ms KING: Yes, indeed, Chair; thank you.

CHAIR: Are there any final questions from anyone online?

Mr MOLHOEK: No, I am okay.

Ms PEASE: Nothing from me.

CHAIR: Thank you to those who have joined us online. The member for Mirani apologised; he had to hop off the line to address something. Are there any questions on notice? Could you provide that information on fluoridation by the end of January?

Mr MOLHOEK: Just on the issue—this is sort of a supplementary question, I suppose—about the 28 per cent that do not, I seem to recall there are reasons some councils do not in terms of location, feasibility, water supply issues and water safety issues. There are some very small centres where water treatment facilities are quite small and it is quite difficult for them to guarantee. It is not just that 28 per cent of councils said no. I think there are some locations where it is just not practical or it is difficult to ensure they meet the standards because they might be pumping bore water into tanks and treating it or something. It would just be interesting to get a little bit of background information around why.

CHAIR: I appreciate that. In the Christmas spirit, that's a wrap.

Ms Joldić: On behalf of Queensland Health, thank you for all the support you have shown throughout the year to the health service. If you are celebrating Christmas, merry Christmas and happy—and most importantly healthy—New Year.

CHAIR: Thank you very much for coming in today. I do hope you get to enjoy some family time and quality time off. We look forward to working with you again next year when parliament resumes. We appreciate you being here today. I also very much appreciate that parliament continues as well. To our secretariat, Hansard and everyone who continues to keep this place ticking over just days before Christmas, thank you very much. I declare this public briefing closed.

The committee adjourned at 12.06 pm.