STATE DEVELOPMENT AND REGIONAL INDUSTRIES COMMITTEE

Members present:
Mr CG Whiting MP—Chair
Mr MJ Hart MP (virtual)
Mr RI Katter MP (virtual)
Mr JE Madden MP
Mr JJ McDonald MP
Mr TJ Smith MP (virtual)

Staff present:
Ms S Galbraith—Committee Secretary
Mr Z Dadic—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2021

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 14 DECEMBER 2021

Brisbane

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The committee met at 10.00 am.

CHAIR: Good morning. I declare open this public briefing for the committee's consideration of the Health and Other Legislation Amendment Bill 2021. My name is Chris Whiting. I am the member for Bancroft and chair of the committee. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We are 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 share.

With me here today are: Mr Jim McDonald, deputy chair and member for Lockyer; Mr Jim Madden, member for Ipswich West; Mr Michael Hart, member for Burleigh, joining us today by videoconference; Mr Tom Smith, member for Bundaberg, joining us today by videoconference; and Mr Robbie Katter, member for Traeger, joining us today by teleconference.

This briefing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. Members of the public are reminded that they may be excluded from the briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Finally, please turn your mobile phones off or to silent mode. I welcome representatives from Queensland Health, the Department of Environment and Science and the Department of State Development, Infrastructure, Local Government and Planning.

ALLAN, Associate Professor John, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

CLUGSTON, Ms Bobbie, Director, Legislative Projects, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

HARMER, Mr David, Senior Director, Social Policy and Legislation Branch, Queensland Health

HUSSEY, Dr Karen, Deputy Director-General, Environmental Policy and Programs, Department of Environment and Science

LIDDY, Mr James, Director, Legislative Policy Unit, Queensland Health

CHAIR: Thank you for all appearing today. I will invite you to brief the committee after which the committee members will have some questions.

Mr Harmer: Thank you for the opportunity to speak to the committee about the Health and Other Legislation Amendment Bill 2021. I, too, would like to acknowledge the traditional owners of the land on which we are meeting today and pay respects to elders past, present and emerging.

My colleagues and I will be providing an overview of the amendments contained in this bill. With your permission, I will provide a brief outline of most amendments before handing to my colleague Associate Professor John Allan, who will lead us through the key amendments to the mental health legislation. Of course, we also have colleagues from the Department of Environment and Science with us today to speak to planning amendments if required.

I will begin with an overview of the key amendments in this bill. It includes amendments to the Ambulance Service Act 1991 to ensure the framework for managing confidential information is robust and clear and to remove an existing age limit for the commissioner of the Queensland Ambulance Service. The bill also amends the Hospital and Health Boards Act 2011 to enable more allied health professionals to Access Queensland Health's patient information system, referred to as the Viewer.

The bill amends the Public Health (Infection Control for Personal Appearance Services) Act to improve the operation of the act for businesses and local government for renewing business licences for higher risk personal appearance services. The bill proposes to amend the Radiation Safety Act 1999 to allow identity verification requirements for radiation related applications to be set out in departmental policies rather than in regulation. This will allow changes in identity requirements to be adopted more quickly when needed.

Amendments are proposed to the Termination of Pregnancy Act 2018 and to the Criminal Code Act 1899 to allow students registered under the Health Practitioner National Law undertaking a clinical placement with a health service to assist in a termination of pregnancy. The bill also amends the Transplantation and Anatomy Act 1979 to exclude human milk from the definition of 'tissue' in the act and to ensure there are no barriers to donated human milk being provided to sick and preterm infants. Finally, the bill makes minor consequential amendments to the Corrective Services Act 2006 and to the Water Supply (Safety and Reliability) Act 2008.

I want to provide some more detail about some of the substantive amendments, focusing first on the amendments in the Hospital and Health Boards Act relating to the Viewer. The bill will, if enacted, facilitate access to more allied health professionals in the Queensland health system using the Viewer. Easy access to comprehensive and holistic records by health professionals is critical to ensuring Queensland patients receive appropriate, tailored and high-quality health care. Practitioner access to records in the Viewer is especially important for patients who have multiple health issues and patients being transferred from acute care in hospitals to community settings.

Access to records is made possible through the Viewer. The Viewer displays consolidated information from Queensland Health's clinical and administrative systems like results, discharge summaries, medication records, alerts, future appointments and instructions for follow-up on the patient, so it is an invaluable tool for health practitioners. The Viewer provides secure access and is read only, so a patient's information cannot be inadvertently altered or removed.

Some types of allied health professionals already have access to the Viewer such as occupational therapists, optometrists, pharmacists and physiotherapists, to name a few. However, under the existing legislation, access to the Viewer is limited to health practitioners registered under the Health Practitioner National Law. This means that some allied health professionals in the community cannot efficiently access patient information that supports positive outcomes for their patients. Examples of health practitioners currently unable to access the Viewer include audiologists, social workers, dietitians and speech pathologists, among others. The bill will amend the act to allow these health professionals to access the Viewer, with the associated benefits for them in terms of their understanding of the patient's needs and for the patients in terms of the quality of care they receive.

If the bill is passed, it is intended to prescribe the categories of allied health professionals who will be permitted access along with their qualification requirements. As this change raises privacy considerations, I would like to stress that the existing legislative and operational safeguards for health professionals who already access the Viewer will apply to anyone who is given access to the Viewer through this process. These protections include robust processes for granting initial access, the monitoring and auditing of access and limiting individual practitioners' access to records for patients already clinically linked to the practitioner. Unauthorised access to or disclosure of patients' confidential information will continue to be an offence under the legislation and attract a significant fine. Allied health professionals are also subject to their usual legal, professional and ethical obligations. Together, these frameworks provide significant safeguards for people's privacy. In summary, this change will ensure that health professionals treating patients have access to accurate hospital records and can best tailor their care to meet patients' needs.

I will speak briefly to the Termination of Pregnancy Act amendments. In 2018, amendments were made to termination of pregnancy legislation in Queensland to modernise the framework and allow for safe terminations within Queensland. The bill will amend the act to allow students to assist with terminations while they are on a clinical placement. When students finish their study and enter health services as qualified health workers, they may need to provide termination services. Queensland needs a workforce, including a rural and regional workforce, that has the skills to assist women safely and lawfully. As is the case for practitioners currently authorised to perform

terminations, the bill allows students with a conscientious objection to refuse to participate in the termination process. Queensland Health has comprehensive clinical guidelines and supporting materials about terminations of pregnancy and procedures for conscientious objection. If the bill is passed, these resources will be updated to ensure that they apply to students on clinical placement.

I turn now to the amendment relating to the Ambulance Service Act. The bill's amendment to the Ambulance Service Act will support the Queensland Ambulance Service to focus on providing quality ambulance services and create a level playing field for the ambulance commissioner or those applying for the top job. The bill will remove the requirement for the commissioner of the Queensland Ambulance Service to be younger than 65. This is an outdated requirement that does not have a bearing on a person's ability to perform the role satisfactorily.

The bill will also make amendments to the framework for the Queensland Ambulance Service's management of confidential information so that that is clearer and can be applied practically. It achieves this by aligning the Ambulance Service Act with the confidentiality provisions of the Hospital and Health Boards Act. Currently, these acts contain slightly different requirements about when personal information can be disclosed, about the delegation of powers under the act and the scope of confidential information. Changes proposed in the bill reduce the risk that confidential information will be disclosed inappropriately and they remove uncertainty for officers required to make decisions about the use and disclosure of information.

Finally, before I hand to Associate Professor John Allan, I will speak briefly to the amendment to the Transplantation and Anatomy Act relating to donated milk. Sick and preterm infants in hospital are sometimes provided donated human milk to prevent or treat serious health conditions. The bill amends the act to clarify that human milk should not be considered tissue under that act. Donated milk does not need to be regulated by the Transplantation and Anatomy Act as it is already governed by our Food Act 2006. The change removes any doubt that donated milk can continue to be used as a therapeutic treatment for infants in need without triggering requirements for permits or other restrictions that would occur if the amendment remains in force. At that point, with your permission, I would like to hand to John Allan.

Prof. Allan: I also respectfully acknowledge the traditional owners of the land on which we are meeting today, the Jagera and Turrbal people, and pay my respects to elders past, present and emerging. Separately, I also acknowledge persons with a lived experience of mental illness, drug and alcohol issues or suicide issues and the contributions that these people make and continue to make in the development of the Queensland mental health and drug and alcohol system.

A responsive and robust mental health, alcohol and other drug system is essential, particularly during the COVID-19 pandemic when there has been unprecedented change and uncertainty in Queenslanders' lives. Equally as important is a system that recognises human rights, both of the persons who enter the mental health, alcohol and other drug systems and for the community more broadly. The Minister for Health and Ambulance Services has recently announced a parliamentary inquiry into mental health services to understand the needs and pressures on the system. I hope that people will engage with this inquiry to enable us to continue to build and improve the service system in Queensland. In the interim, the bill proposes important amendments that will improve processes for patients and continue to deliver rights based approaches to mental health care in Queensland.

I will start with the Mental Health Court. The Mental Health Court is an inquisitorial court that decides, among other things, whether a person was of unsound mind at the time of the offence or if they are currently fit for trial. The Mental Health Court's role is not to test the facts of the case; however, disputes of facts may arise in various ways during court proceedings. Currently the court is required to determine unsoundness of mind even when it has identified that a fact that was material to the opinion of an expert was in substantial doubt or dispute. The bill addresses this issue by extending the circumstances in which a matter may be returned to the criminal court to include matters where the Mental Health Court is satisfied that a fact that was material to the opinion of an expert was in substantial dispute. A matter can only be returned to the criminal court if a person is fit for trial. The amendment prevents unsafe findings and maintains the specialist court jurisdiction of the Mental Health Court.

I want to talk to the changes in electroconvulsive therapy, normally called ECT. The bill also introduces enhanced safeguards for ECT. ECT is used for some forms of mental health illness, such as severe depressive illness, as a treatment. It is an evidence based treatment supported by the Royal Australian and New Zealand College of Psychiatrists and many patients choose to have ECT voluntarily. Some do not, and this bill is about supporting them. The ECT provisions of the act are considered to already be compliant with the Human Rights Act 2019, but the bill includes additional requirements to install a stronger rights based approach, including that a person's views, wishes and

preferences must be considered. For ECT to be administered, the bill requires specific consideration of whether adults can give informed consent. The bill also adds safeguards for people on treatment authorities, forensic orders and treatment support orders by requiring Mental Health Review Tribunal approval for ECT. This is a new requirement and an important independent safeguard for these patients.

Moving on to transfer related amendments, the bill also addresses transfer of patients subject to various orders made under the Mental Health Act. It ensures that provisions of our transportation of absent patients are workable and align with least restrictive practices. It clarifies the requirements for interstate transfer of patients under orders, promotes a rights based approach for decisions about patient transfers between services and allows the Mental Health Review Tribunal to approve requests for international transfers of patients who have been placed under a forensic or treatment support order.

In relation to amendments to confidentiality and victim support, the bill makes confidentiality provisions clearer, extends the duty of confidentiality to experts, improves support for victims of unlawful acts and makes minor amendments to improve the overall operation of the Mental Health Act. I would be pleased to answer any questions you have about other amendments to the Mental Health Act in the bill. I will now hand you back to David Harmer.

Mr Harmer: The amendments that Associate Professor Allan and I have spoken to are really designed to ensure a positive healthcare experience and outcomes for the people of Queensland. We have not referred to an amendment to the Environmental Protection Act which is designed to facilitate the delivery of the government's commitment relating to satellite hospitals. I refer you to my colleague Dr Karen Hussey to outline the purpose of those amendments.

Dr Hussey: Thank you, David. Thank you very much for the opportunity to brief you today. I also would like to take the opportunity to acknowledge the traditional owners of the land on which we meet and pay my respects to elders and leaders past, present and emerging.

Relevant to the environment portfolio, the bill will amend the Environmental Protection Act 1994 to ensure that essential community infrastructure, such as satellite hospitals, can be constructed and operate outside the environmental nuisance limits under the EP Act provided it is regulated by an infrastructure designation made by the planning minister under the Planning Act 2016.

Environmental nuisance under the Environmental Protection Act is a type of environmental harm which does not reach the thresholds of being serious or material environmental harm. It includes emissions like dust and noise. Noise is also specifically regulated via noise standards which are administered and enforced by local governments. The Environmental Protection Act sets default noise standards, including for activities such as building works, but these can be varied by a local government under a local law.

The Environmental Protection Act also has an existing mechanism to prescribe matters that are not environmental nuisance because they are better managed in another way. This exemption mechanism, which is in schedule 1 of the Environmental Protection Act, means that the activities exempted are not environmental nuisance for the purposes of the offence provisions for both environmental nuisance and breaching a noise standard. Other exemptions from environmental nuisance include where there is a development approval under the Planning Act or where the nuisance is regulated under the Transport Infrastructure Act 1994.

If passed, the proposed amendment will operate in a similar way to these other exemptions so that activities that have been assessed and explicitly regulated by a requirement of an infrastructure designation by the planning minister under the Planning Act are exempt from the environmental nuisance and noise standards provisions.

I am joined today by Kerry Doss, Deputy Director-General and State Planner in the planning group of the Department of State Development, Infrastructure, Local Government and Planning, and his colleague Jesse Chadwick from the planning group. They will be happy to take questions about ministerial infrastructure designations under the Planning Act. I also have with me Kate Watkins from my department, as the content expert on the Environmental Protection Act, to help respond to any questions you may have in that regard.

CHAIR: We will come back to questions for the Department of Environment and Science and the Department of State Development, Infrastructure, Local Government and Planning at the end. We will start with questions of our representatives from Queensland Health. Are there any further statements you wish to make?

Mr Harmer: No thank you, Mr Chair.

CHAIR: I have some questions with regard to the changes to the Mental Health Act. One of the things that certainly grabbed my attention was improving the processes for ECT. I know that over many years in Queensland—and this is an area where we have needed to improve—we have been moving towards a rights based approach instead of a best practice approach. In Queensland it is something we could have perhaps done better—that is, fully informed patients about what was going on and what approach was being taken and explained the benefits or drawbacks of a particular approach. Is this part of an improved approach to mental health care within the state?

Prof. Allan: I think it is signalling a comprehensive approach to making sure we take human rights into account. Since the Human Rights Act 2019 we have reviewed all of our policies and our legislation to make sure we are consistent with that. Initially that has been the case. This amendment is really for a small number of people.

The anomaly was that for a person who was under a Mental Health Act order—so they were under a treatment authority and in hospital having treatment—part of that treatment would have been to have ECT for the treatment of depression or some other condition. If that person said that they consented and went through a consent process, that would happen. The feeling, in discussion with a lot of people and from looking at the act, was that maybe the rights and protections of the Human Rights Act had not been afforded to them by going to the tribunal. Normally if you are under an order and you did not consent to the treatment, your capacity to not consent and be reviewed would go to the Mental Health Review Tribunal. There was a small number of people that was not applying to. We thought to save the question of 'does it apply or not apply?' we should make sure we are taking every step to protect human rights. That is what that is about.

As to your question about the larger thing, I think we are very much looking at the best mental health care for people in Queensland. I hope that we have always given proper and appropriate attention to consent and information to people. I think we need to make absolutely sure that we do that properly.

CHAIR: That will be welcomed. I have a question that relates to page 6 of the explanatory notes, where it talks about introducing a safeguard into the process. The way I am reading that is that the MHRT considers the issue of informed consent and that is independent of the treating medical practitioner. Is that the safeguard we are talking about?

Prof. Allan: Yes.

CHAIR: Could you describe that process a bit more? For the people who read the transcript, could you explain a bit more the role of MHRT in the system generally?

Prof. Allan: MHRT plays an important role in the system. If you think about it from a human rights principle, doctors have a capacity to make orders that require people to have treatment or to stay in a particular place for treatment and follow those orders. That is based on whether or not the person is a danger to themselves or other people and whether or not they have capacity to engage in treatment. If they do not have capacity and there is an issue of danger to themselves or other people then they can go under an order. It is a principle that all of those orders will be reviewed by the Mental Health Review Tribunal on a regular basis to make sure that the reasons for doing that were correct and that if the person should not be on an order that should be discharged. That is part of it.

The second part is that ECT is a regulated treatment under the act which means that it has special attention paid to it, as do things like psychosurgery. The reason is that ECT is a well-proven treatment conducted under very stringent conditions. It is probably one of the most regulated treatments we have. Because there is a long history of public interest and concern about these treatments, it has always been the case that the Mental Health Review Tribunal reviews those people who are having ECT who are unable to consent.

A person may assent to treatment but because of their illness they may not be able to give consent because consent consists of two parts. One is to understand and explain what is going to happen and knowing the consequences. The second is to be able to make a reasoned decision—so have the capacity to give that consent and make the reasoned decision that you want to have that treatment. Many people understand it very well and assent to the idea that they would like to have the treatment but lack the formal capacity to consent. The Mental Health Review Tribunal checks that that person does not have that capacity and that the decision that is being made for them is being made appropriately, because if a person did have the capacity they would have the right to make various decisions about that. They check that and they look at the clinical situation of the person and the value of the treatment and so on in making those decisions about whether or not that would go ahead. Does that answer your question?

CHAIR: That is a very good explanation of that.

Mr McDONALD: You mentioned in your answer to the first question that there was a very small number of people. What number are we talking about?

Prof. Allan: We think it is about 30 over the period of time of the act—that is, over the last couple of years—as opposed to there being over 500 decisions in relation to ECT since the act came in. We think it is a very small number of people. The psychiatrists consider they probably have capacity. You might go and do a clinical assessment and say, 'Yes, I think so,' but because they are under an act that says they do not have capacity, if you looked at it through an external lens you would think that is a strange decision. We want to make sure we have a proper review of that decision.

Mr McDONALD: My sincere concern is about the application of best interest, as it currently is, and patient centred. For such a small number, I am wondering if we are going too far and causing great difficulty for the vast majority of people who just want to be taken care of. As you pointed out, they are vulnerable people who may not be able to answer questions about their complex problems.

Prof. Allan: You have hit right at the heart of the debate. That is exactly what the issues are. One of things that is important to understand is that under the Human Rights Act we can no longer act in a person's best interest. That is considered to be too paternal. The Human Rights Act instructs us to take the person's interests, as stated there, into account. You can argue with that from a medical point of view, that doctors like that paternalism—and that is part of the argument—

Mr McDONALD: And patients might like that, too.

Prof. Allan: And patients like that, too. We also have to be consistent with the law, so we have had to change that. This argument has been raised by the AMA, by the college, by other psychiatrists, by people I have worked with. We have all sat around and talked about it. I would probably say that personally I would have thought that a few years ago too—that is, doctors know best, get on with it, let us get it done, the person wants the treatment so let us just do it.

The issue that I have realised is that we do need to ensure we are quite meticulous about our attention to human rights, because if we say that it is okay for a doctor to make a decision at one point then we might lose some focus on human rights at another point. One of the main problems that I see in psychiatry is balancing the need for coercive treatment to help people versus the human rights to be free. I do not want to give a lecture on human rights, but I will probably end up doing so.

There are two important aspects of human rights. One is that there are positive human rights, which are about your right to get care and treatment and to have food, shelter and the basic necessities of life. Then there are some negative aspects which are about your right to be free of coercion, free of unlawful imprisonment and so on. All the time we have to balance those two things. You are raising, quite rightly, the notion of whether that is too much coercion for a person who really wants that, whereas I would say we are doing that because we are actually ensuring that the positive right will happen. We are using it to make sure that that right to treatment must happen and gets proper review. It is a good question.

Mr McDONALD: Mr Harmer, I have a question with regard to the Viewer. I am trying to understand why this needs legislative change and it is not put into place. Is it because of offences that might be committed? Why can this not just occur?

Mr Harmer: I will invite my colleague James Liddy to assist in a moment. Essentially, the current regulatory framework prescribes the people who can access the Viewer. It is not prescribed sufficiently broadly to encapsulate all of the people who probably need access to the Viewer. There is good reason for that. When the framework was first introduced the department was acutely aware that clinicians would be accessing personal information and there was a concern to ensure that the protections that were put in place worked and were effective. The Viewer has been operating for some time now. We have seen that the controls are appropriate and that we can protect people's privacy. By amending the framework we are able to allow more clinicians to access the Viewer, and that will assist them in their care for patients.

Mr Liddy: That is effectively right. The legislation at the moment says that only registered health practitioners can access the Viewer; that is, people who are registered under the Health Practitioner Regulation National Law, so people like doctors, nurses, midwives, physiotherapists et cetera. There are a range of practitioners who are not registered practitioners—some of the examples David gave in his opening statement include audiologists, dieticians, social workers and so forth—who are important professionals who work with people to give them health care. Depending on the treatment the person received in hospital, it may be very important for those people to understand the health care that the person has received.

Mr SMITH: Professor Allan, it might be beneficial for the committee and the public to get some recent history on how ECT has changed. When we think of ECT, obviously we think of the movies with the big straps, archaic mental wards and so forth. Could we maybe get an understanding of what ECT looks like in the current medical environment?

Prof. Allan: For everybody's benefit, ECT is an evidence based treatment. It consists of using electrical current that is passed across a person's head to induce an epileptic seizure, and as a result of that seizure there is a change to the chemical balance of the neurotransmitters. It makes more of those neurotransmitters available and it treats depression. Obviously you have seen in the movies where people are held down and that happens. Of course, all ECT today is done under anaesthesia. The person is asleep and they are given a muscle relaxant so the fit is very modified. The usual practice is to place a cuff on the hand so the anaesthetic and muscle relaxant do not get to some part, so it is a very controlled seizure, or to use a machine that now measures EEG, which measures the brain's electrical activity. That is done quite safely, but always there are issues around giving anaesthetic, making sure there are no medical complications et cetera.

The process of ECT has changed as well. In the past, to make that happen you had to use a large amount of current—so a reasonable amount of electricity—which would disturb other functions of the brain. The person would wake up maybe with a headache or confused or there could be some effect on memory. A lot of work has been put into understanding the nature of the electrical activity of the brain, so a much lower current is given in short, pulse bursts, so it sort of builds up and then makes the activity happen, rather than giving a massive amount of stimulus that overwhelms the person. That leads to a much quicker recovery with much fewer side effects and it is better for treatment.

The other thing is that it is no longer done on both sides. Usually it is done on one side of the brain. There have been a whole lot of technical developments, and that has come about through scientific endeavour, really beginning from the 1970s, through to very sophisticated paradigms to do that now. There is very strong evidence for that, so that has changed. During that whole time it will be done in a special room such as an operating theatre, a waiting room or a special suite in hospital with an anaesthetist, a nurse's supervision and so on, and recovery. It is usually done about three times a week, usually for about six to eight treatments—or maybe 10 or 12 treatments if there is particular resistance. It has a much better effect size, so it is more efficient than taking the medications.

The portion of the Mental Health Act we are talking about is where it is used as an emergency measure. Really, this is where there is no other treatment that would help that person in an emergency. Typically it is about a person who is severely depressed, they are actively suicidal, they have done something or are planning to do something, and they are often at a stage where they feel hopeless and helpless or covered by delusions, feeling they cannot get better, that they are rotting, or that God is punishing them. Sometimes people refuse to eat and drink so that their physical state actually becomes at risk as well. That is usually under the emergency ECT provisions, and then people go on and have that care and treatment. It is really about very serious problems, the very serious end of treatment—there are no other alternatives and so it can be done safely. Often, for a person who is indeed medically compromised it is actually much better to get on with treatment that will work fairly quickly and is less compromising than sitting around waiting and trying to force-feed and so on, so there are actually safety issues as well.

Mr SMITH: You said three times a week for 10 to 12 treatments. Does that mean it now counters out the chemical imbalance of depression for years in the future? Are there medical alternatives to going back to ECT?

Prof. Allan: That is a very important question. Some people who have the best responses to ECT recover well, do not want to take drugs and go away. The relapse rate post ECT without covering medication is shorter than the relapse time if you were having medication. It is preferable to take medication between episodes, but you can also do what is called maintenance ECT, which means having one ECT every month over a period of time. Some people with longstanding depression who have had a lot of recurrences choose to take that option. That is usually not one we are referring to in the act; that is usually voluntary. Can you have ECT a number of times? Yes, you can. People can have that for recurrences of depression. Given the improved safety profile and so on, it is reasonable to do so.

CHAIR: Member for Burleigh, do you have any questions?

Mr HART: I have heaps of questions, Chair, you would be surprised to know. Professor, just looking at the ability of the Mental Health Court to send matters back to the criminal court, I see that is if there is a case of a substantial dispute. Is there a definition in the bill of 'substantial dispute', and can you give us an example of a substantial dispute?

Prof. Allan: Just to clarify what is happening here, the court is comprised of a Supreme Court judge assisted by two psychiatrists and representation for the patient, the prosecution and the director of mental health, the Chief Psychiatrist, to help with the disposition. The court considers reports by a number of independent psychiatrists—not the two assisting psychiatrists. The number of psychiatrists depends upon the severity of the offence and the complexity of the case and so on, but there are at least two, sometimes three and sometimes more. The psychiatrists interview the patient and have available to them all of the material available to the prosecution. They will have the records of interview, the QP9s—which are forms the police fill out about crimes and so on—any other material and the case notes.

The role of the psychiatrist is to determine two things but in particular in this case to determine if at the time the person who committed the offence was of unsound mind. That means they did not know what they were doing, they could not control the act or they did not know it was wrong. It is very tightly defined. An example of that would be: if the person has a history of mental illness and they appear to be unwell, it is very difficult for the psychiatrist—who might see them a month or two after the event—to determine exactly what the mental state of the person was at the time of the event.

Often the medical records at the time will have some information if the person has just been released from hospital or something, or the police record of interview might contain things the person said that would make you think the person had a mental illness. For example, they might have done something and they might have said, 'I heard the voice of the devil tell me to do it.' So the defence would be that the person was acting under a delusion they could not control because the devil was controlling them. They talk about that. Then when they get to the court, the defence lawyers might say, 'Well, actually, my client says they never said that.' That might be the only thing that was happening that was recorded at that time that the psychiatrist is relying upon to go with all the other evidence they have about the history of mental illness before and after. It is not that they have a mental illness; it is whether the mental illness was so severe at that very point in time that it justifies a defence. If there is a dispute about a fact like that that does not have any other supporting evidence—there might be other things, but that is what they would send back.

Mr HART: Is there any definition of 'substantial dispute' in the bill?

Prof. Allan: Usually that is determined by the court; is it not, Bobbie?

Ms Clugston: No, 'substantial' is not defined in the bill. It will be up to the court to provide the case law around that to guide what the 'substantial' meaning will be—the test.

CHAIR: There is case law?

Ms Clugston: There was a comparable provision under the former Mental Health Act, so there is a reference point that the court can use to guide current cases. However, since the introduction of the new act the court has been building case law for all of the provisions and will continue to do so with this provision.

Mr HART: On the termination of pregnancy changes, and noting that trainees can have a conscientious objection, is there any requirement, or is there likely to be any requirement in the future, for trainees to perform a termination as part of their training?

Mr Liddy: When students are undertaking their studies, they undertake studies in a range of areas. It is not necessarily that every student will go into a situation where they may be involved in terminations. However, all students will study a range of conditions and medical procedures that they may not ultimately end up being involved in. It is about giving students the opportunity or the possibility to be involved in the full range of medical procedures that they may end up performing as a professional when they graduate. As Mr Harmer outlined earlier, the bill does have safeguards for practitioners and for students to allow them to conscientiously object to being involved in a termination. There is no requirement for any student to be involved in terminations if they do not wish to do so. They can have a conscientious objection and they are not required to do so. However, this amendment is aimed at ensuring that the full range of clinical training is open to students if they wish to partake.

Mr HART: Being involved in a termination is not part of anybody's training at this point in time?

CHAIR: It is not a requirement or a compulsion? Is that what you are asking, member for Burleigh?

Mr HART: That is right, yes.

Mr Harmer: The amendment is designed to permit students to assist in a termination. It is not currently permitted by the legislation; that is the purpose of the amendment.

CHAIR: I am seeing nothing in it that suggests that it be required or a compulsory part of training.

Mr Harmer: A student who, through their placement, is either afforded the opportunity or asked to assist in a termination of pregnancy will, as Mr Liddy said, have the right to conscientiously object if that is consistent with their personal beliefs, but they may be asked in the course of their training to participate in a termination.

Mr HART: That raises a number of questions with me, Chair, but I will move on from that. In respect of the Viewer, I have some concern about the level of access that these additional people may have to somebody's medical history. I do not want to single out a particular category that you mentioned before, but if people are given access to the Viewer are there levels they may be limited to, or do they have access to everything?

Mr Liddy: In general terms, the practitioner does have access to the person's entire Queensland Health records. It is not their entire medical history. We are not talking about GPs here. We are talking about if someone has had a hospitalisation or an interaction with Queensland Health. The practitioner does have access to the person's entire health records for the person's treatment in the hospital. However, patients do have the option to opt out of sharing their information for the Viewer, either entirely or limited to particular professions. For example, if a person is seeing a physiotherapist or a dietitian and they do not want their dietitian or physiotherapist to be able to access their records through the Viewer, the person is able to request that no physiotherapist or no dietitian is able to access their records, and Queensland Health is able to record that in the system to ensure that access is not permitted.

Mr HART: How do people know at the moment that you are about to change the rules?

Mr Liddy: We work with Health Consumers Queensland to provide a range of information to let people know that their information is shared and is available and that they can opt out. The method for opting out is to call 13HEALTH and speak to somebody on the telephone and explain what access you want to give to your medical records.

Mr HART: They would have already done that, and now we are going to change the level of access that people have or the people who can actually access it. How do we notify people that that is happening?

Mr Liddy: There will be a consumer engagement strategy, as I said. We will work with Health Consumers Queensland to make sure that health consumers are informed about these changes. It will be up to the individual patient to opt out if they do not want to have their records shared. I think it is important as well to note that these are trusted health practitioners in the community, that they are highly trained, that they are professionals, that they are members of professional organisations, that they have studied for many years, and that their job is to help people with their health and their safety. The purpose of giving them this information is really not so that they can go through someone's medical history; it is really so that the person then has access to information that may be very pertinent to the treatment they are giving. There are many examples. For example, an audiologist or a speech pathologist might be doing hearing processes or speech pathology with someone who has come out of hospital from throat surgery. It may be very pertinent for the speech pathologist to understand the operations, the medications and the testing that was done in hospital so that the speech pathologist can tailor the care that is needed for that individual person.

Mr HART: Is Queensland the first state to do this, or is this happening on a national basis?

Mr Liddy: I am not aware of whether other states and territories have an equivalent system. I would have to take that on notice.

CHAIR: I note in the explanatory notes, on pages 41 to 43, there is an extensive list of the amendments regarding the restrictions on the information able to be accessed. It is something we should probably have a look at later as well.

Mr MADDEN: My questions relate to the Termination of Pregnancy Act, which has already been discussed, and the Transplantation and Anatomy Act. Professor Allan, thank you for your discussion of the Human Rights Act that came into effect in January 2020. It was a groundbreaking act. For this bill the statement of compatibility runs to 18 pages. That gives an indication of how this bill has to be considered with regard to the Human Rights Act. With regard to the Termination of Pregnancy Act, as the member for Burleigh has discussed, this provides for students on clinical placement to assist with a termination. I have no knowledge of how student doctors participate. To what degree do they assist in a termination, and who makes that decision as to how much they assist?

Mr Liddy: I think it is the same general approach that applies to any type of medical procedure. All students on clinical placements are under supervision by an appointed supervisor. They are only able to do things that the supervisor permits them to do or asks them to do. In terms of the intricacies

of the extent to which they assist, I am not aware. Definitely, they are only acting under supervision and would only be asked to do things that are appropriate for their level of training. Really, it is about giving students the opportunity to be involved to see how things would work so that if in future that is something they are asked to do they are able to take on that responsibility.

Mr MADDEN: I am just wondering if they assist to the degree of metal on flesh at that level.

Mr Liddy: We would have to take that on notice.

Mr MADDEN: This is obviously a sensitive issue and it is something I am sure I will get questions about so I would appreciate it if you could take that on notice. With regard to the transplantation act, obviously we are talking about donated milk. You dealt with this to some degree in your opening statement, Mr Harmer. How does the current system work and how will it change as a result of this legislation?

Mr Harmer: By way of background, the Transplantation and Anatomy Act was developed and enacted in 1977. It is old legislation. It is designed to prohibit the trading in tissue or to regulate trading in tissue in certain circumstances. The challenge that this amendment seeks to address is that, by leaving unclear whether breast milk is tissue, you potentially require people to comply with the trading requirements of the act, which requires permits et cetera to allow the milk to be provided to infants. By amending the act to make clear that it is not tissue under the Transplantation and Anatomy Act, we can ensure that donated breast milk can be provided to infants who need it.

Mr MADDEN: It is obviously coming from a lady, but how does the procedure work that somebody donates milk?

Mr Harmer: Women who are lactating can donate milk. It is stored securely in the hospitals and then provided to the infants who need it. There are existing frameworks for doing that.

Mr Liddy: There are two services that provide this: the Australian Red Cross Lifeblood milk bank and the Mothers' Milk Bank. Those two services are currently operating. Really, though, this amendment is just about putting beyond doubt that it is not tissue under the Transplantation and Anatomy Act. The donation is currently happening, but there have been queries and concerns raised by some of these organisations to say, 'Are we doing the right thing?' We are just putting it beyond doubt.

Mr MADDEN: The change to the existing system keeps it within the current hospital system? We are not talking about any trade in breastmilk; we are simply talking about donated milk through these two institutions so that it can be used at hospitals?

Mr Liddy: That is right.

CHAIR: Member for Traeger?

Mr KATTER: No questions, Mr Chair.

CHAIR: It is probably an opportune moment to congratulate you on the birth of your daughter Rosie. Well done, Robbie.

Mr KATTER: That is very kind, thank you.

Mr HART: In terms of the Radiation Safety Act, I refer to the changes in ID requirements. I note that we were told in the briefing that it is going to be under a departmental policy. How will that be enforced if it is just a policy and not covered by regulation or legislation? Who will make those changes? Will that be a ministerial designation or done by the department?

Mr Liddy: The legislation will require the person to prove their identity to the satisfaction of the chief executive. That is the chief executive of Queensland Health, the director-general. That empowers the director-general to make the administrative arrangements that are appropriate for the person to prove their identity. In answer to your question, that means the director-general has to approve the policy arrangements.

Similar arrangements apply in other departments in relation to transport and police, when people are applying for different types of licences and registrations. We are aligning with what other departments are already doing. This is about moving towards a future where people can prove their identity online, because increasingly transactions are made online and people are able to prove their identity online. The Australian government is moving towards that. It is just taking out some of the prescriptive requirements from the regulation that will then mean greater flexibility for people to be able to prove their identity.

Mr HART: As far as I am aware, the transport department has a regulation that specifies how IDs are handled. Why can't we just have one regulation for every government department that sets out how IDs are covered? Has that not been considered?

CHAIR: I think that is more of a policy question, but the question is: is this already being done across other departments with a similar approach? Would that be right, member for Burleigh?

Mr HART: I am not aware of it being done across other departments. I think the transport department has a regulation that covers that.

CHAIR: Can anyone furnish us with an answer? Obviously we will not stray into policy about making that standard across all departments. If there is any other information you can provide, that would be welcome.

Mr Harmer: My understanding is that the regulation the member is probably referring to is the Transport Operations (Road Use Management—Driver Licensing) Regulation 2016. It is also my understanding that the approach on that regulation is essentially the same as what we are proposing here, so there is delegated authority to the chief executive under that regulation to set the particular evidentiary requirements for identity. We can confirm that on notice if required. It is not an uncommon thing in legislation to delegate decision-making requirements, particularly where there is a need to change them in response to emerging circumstances or new technologies in this way. I think it is reasonably common.

Mr HART: That is all very well. A number of members of parliament do not agree with delegation reaching this far. That is why I am asking these questions.

Mr Harmer: Obviously it is open to parliament to disallow a regulation or move a disallowance motion if that is considered appropriate. However, I think in this circumstance there is a head of power in the act which allows the making of the regulation which in turn allows the delegation authority. There are two opportunities for Queensland parliament to scrutinise and comment on the appropriateness of the regulation. In this circumstance we are really talking about regulating an industry that has been rapidly evolving over time in response to new and emerging technologies. I think it is appropriate that we ensure the people who are using these technologies are appropriately identified and are regulated appropriately.

CHAIR: Member for Burleigh, your point on having a standard across government is well made. Hopefully referring to the transport regulation should help that. Bearing in mind the time, I will go to the member for Bundaberg for a last question for the Queensland Health officials before us.

Mr SMITH: In relation to termination of pregnancy, are we talking about both medical and surgical terminations of pregnancy in terms of assisting?

Mr Liddy: I am not aware of the difference that you are speaking of between medical and surgical. Yes, all types of termination would be covered potentially.

Mr Harmer: A medical termination occurs following the administration of medicines, so surgical termination is probably the one where we are focusing on someone assisting. The answer to the question is: yes, it applies to both. In terms of the committee's practical understanding, someone assisting with a surgical termination is probably what we are focusing on for the purposes of this conversation.

Mr SMITH: Currently, for medical practitioners there is some form of professional development and skill updates to ensure they know how to perform termination-of-pregnancy surgery. I imagine there is ongoing training in terms of skill set for professional development.

Mr Harmer: There absolutely is. I think I mentioned in my opening that there are extensive guidelines and clinical guidelines associated with termination of pregnancy. They will be updated to ensure they apply appropriately to students who are assisting.

Mr SMITH: Finally, just to clarify the member for Burleigh's question, a medical student can learn about the procedure in university, but there is no requirement that they must assist in the termination of pregnancy to become qualified? They will learn about it, but there is no requirement on them to assist in a termination of pregnancy before they get qualified as a medical practitioner?

Mr Harmer: That is correct. If they are asked by their supervising practitioner to assist in a termination of pregnancy and they have a conscientious objection to doing that, they are able to state that and not participate.

CHAIR: Thank you to the team from Queensland Health. We will ask you to hang around a short while longer. I now ask members from the Department of Environment and Science and the department of planning to come forward.

CHADWICK, Mr Jesse, Director, Policy and Statutory Planning, Department of State Development, Infrastructure, Local Government and Planning

DOSS, Mr Kerry, Deputy Director-General, Department of State Development, Infrastructure, Local Government and Planning

HUSSEY, Dr Karen, Deputy Director-General, Environmental Policy and Programs, Department of Environment and Science

WATKINS, Ms Kate, Manager, Environmental Policy and Planning Branch, Environmental Policy and Programs, Department of Environment and Science

CHAIR: We have had an opening statement and I understand that no-one wants to add to that at the moment. Is it fine to go to questions or do you have anything further to add?

Mr Doss: We are absolutely fine with questions.

CHAIR: In relation to a development that is undergoing approval through a council process, the councillor or the council can propose conditions to address the issues that may be raised by the public for this development. By going through this process of the ministerial designation, we are not able to add on those conditions to assuage public concern or address issues that may have been raised publicly. Is that a deficiency with this particular proposal?

Mr Doss: In terms of the ability for a ministerial designation to look at requirements regarding environmental nuisance, if you look at the Environmental Protection Act as it currently stands there is the ability where noise is regulated under other legislation for other requirements to be put in place in terms of noise and other measures. That includes a development approval which might be given by a local government or by a state government department; a priority development area development approval, which is under the Economic Development Act; an exemption certificate under the Planning Act; or a priority development area exemption certificate. They all allow a local government, when the application is submitted with relevant information, to set standards other than those proposed in the Environmental Protection Act to allow noise to be managed in another way.

As an example, the standard requirements for construction works are that you carry out the activities between 6.30 am and 6.30 pm Monday to Saturday. In the normal case that would be appropriate, but where an application under a development application comes forward and says, 'We want to operate outside of these requirements,' the assessment manager, which is the local government, can actually put those requirements in and put appropriate controls in place.

Under a ministerial infrastructure designation, which is approved by the minister, the minister does not have those same powers. It makes sense that in certain cases you would be able to step outside the standard requirements of the Environmental Protection Act. As an example, we had a case recently at a hospital in Logan, which is approved under a ministerial infrastructure designation. They needed to carry out works on that site. The only way they could carry them out was to do so overnight, but that meant there would be audible noise outside that 6.30 am to 6.30 pm proposal. In a case such as this, the minister in considering those matters would be able to impose conditions with appropriate controls to allow that sort of activity to continue.

We have looked at this and the ability for a ministerial infrastructure designation to be made. Before the Planning Act came in during 2017 that power was across all government departments in the Queensland state government. Now that power to make a designation is centralised with the Minister for Planning. In hindsight, we would have included this in those provisions at that point in time.

CHAIR: That is probably the best example: ministerial designation for doing a hospital. They have to do work at night and they cannot because it is not exempt at this point. It is mainly noise we are talking about in this case; is it not?

Mr Doss: Yes.

Mr Chadwick: There is in fact under the act the ability to impose what the act refers to as requirements—not conditions—on a designation. With your permission—and it is only a short provision—I could read to you what the act permits. It says—

(2) A designation may include requirements about any or all of the following—

(a) works for the infrastructure (the height, shape, bulk, landscaping, or location of works, for example);

(b) the use of premises, for example—

(i) vehicular and pedestrian access to, and circulation on, premises; and

(ii) operating times for the use; and

that is specifically mentioned in the act—

(iii) ancillary uses;

(c) lessening the impact of the works or use ...

Breaching any of those requirements is an offence and it can attract a penalty of up to 4,500 penalty units, which is the same as an offence against a condition of a development approval.

CHAIR: That has answered my questions. One of the things I was looking at is the ability for the public to have a say in this. From what I understand, through the consultation the public can have an input into the ministerial designation.

Mr Doss: That is a very good point. In terms of when a ministerial designation is made, we are asking applicants to carry out best practice consultation. What we ask them to do, even before they decide to lodge a proposal for a ministerial infrastructure designation, is to go out and do pre consultation with the community and to get information from that community so they can build that into their proposal. What then happens is: the proposal is lodged with the department, and that has to be lodged with appropriate supporting information. In the case where an applicant was seeking to have requirements which sat outside the requirements of the Environmental Protection Act, we would require them in that case to provide justification as to why that could occur.

When we are considering the application proper, we require the application to be publicly notified. That includes a sign going on the land, a notice in a paper circulating in the locality and notices to adjoining owners. All of the information which supports the application is available on our website, so a member of the public would be able to look at that and look specifically at the requirements where they are looking to do something which is different to the standard requirements under the Environmental Protection Act. We believe that in the normal case we would just stick with what is required under the Environmental Protection Act. It would be by exception where we would be looking at alternative arrangements either during construction or during operation and we would really want that to be emphasised as part of the material that was available for public consultation. A member of the public is able to make a submission to the state government on that proposal and the minister is required to take into account the matters raised in those submissions in making his final decision on the ministerial infrastructure designation.

Mr McDONALD: Mr Doss, was it the Logan Hospital project that brought about this amendment or another project?

Mr Doss: We have had a number of discussions with proponents who have asked us about noise requirements. Probably the major example which brought this up was during the early stages of COVID last year, with changes around building works. We had a number of people approach us about being able to step outside the standard provisions of the Environmental Protection Act. In the case of development applications there was a way of being able to deal with that, but when it came to ministerial designations that is when our attention was drawn to this matter. Typically, what we try to do, because the ministerial infrastructure designation process is an assessment process in a lot of cases, is maintain some sort of parallel nature between what happens in development assessment and what happens under the ministerial infrastructure designation process. Wherever we might look to make changes to the development assessment process we would then look and see if that was also appropriate to do with the ministerial infrastructure designation process.

Mr McDONALD: Is there a requirement for the consultation process to occur with the local government or is it just best practice? I will declare that I have had 16 years in local government so I am concerned, and I am sure local government are concerned, about that undermining of local decisions in their planning.

Mr Doss: That is a really good point that you raise. It is actually specified in the requirements that the local government must be consulted on this matter. Also the landholder must be consulted. Those are the two highest points of consultation.

Mr McDONALD: Excellent. Thank you.

Mr MADDEN: Thank you very much for coming in today. I represent the electorate of Ipswich West and in the area of Ipswich we have a priority development area, with Ripley Valley, and we have a satellite hospital being built there. My questions relate to that priority development area. I just want to know how this legislation varies the operation of its legislation—when we are dealing with a priority development area and when we are not dealing with a priority development area.

Mr Doss: Where the legislation stands at the present time, where there is a development approval sought in a priority development area the assessment manager, which in most cases would be the CEO of Economic Development Queensland, can impose additional requirements in relation to how noise and other matters might be managed. They are able to do that now. Under a ministerial infrastructure designation that cannot occur. Ministerial infrastructure designations are able to be undertaken in a priority development area at the present time, but if we were looking at that we would not be able to look at alternative requirements with respect to environmental nuisance relating to noise.

Mr MADDEN: This legislation will allow you to do so?

Mr Doss: Certainly that will allow us to do so.

Mr MADDEN: That is a major change. You bypass that system and it makes it easier?

Mr Doss: It allows us to look at alternative ways of dealing with matters. As a for instance, again I go back to those standard requirements for construction—6.30 to 6.30 Monday to Saturday. That would be the way in which building noise is managed. This allows us to deal with it in another manner.

Mr MADDEN: Who is the decision-maker for that?

Mr Doss: The decision-maker for a ministerial infrastructure designation is the minister for planning, currently the Deputy Premier.

Mr HART: Deputy Director-General, I think you said that every minister could make an infrastructure designation before and now it is only the planning minister; is that correct?

Mr Doss: Yes, that is correct. The assessment of ministerial infrastructure designations was centralised under the planning group with the introduction of the Planning Act in 2017. The reason was to get standard processes and practices occurring.

Mr HART: Over the years, how many ministerial infrastructure designations would we have? Would it be 10, 100 or 1,000? Do you have any idea?

Mr Doss: I could not say off the top of my head, but I would think it would be in the hundreds, if not in the thousands. Any state school is generally dealt with under a ministerial designation. We are now seeing private proposals, private schools and the like, also being put forward under that. If you do a google search on ministerial infrastructure designations on the department's website, there is a register of designations already issued, designations under consultation at the present time and designations which are currently under assessment. It goes on for a number of pages.

Mr HART: I am struggling to get my head around this. How come this has not come up before?

CHAIR: It looks like it has but we have been doing workarounds; would that be correct?

Mr Doss: That is correct, Chair.

Mr HART: How have we been working around it?

Mr Doss: In some cases we have looked at a control we have called a temporary use licence, which is a control that we had in place during COVID. Those controls can be used at the present time. They fall away when the current provisions finish, and they are due to finish in April. In some cases where there is quite a conflict, we have been suggesting to proponents that they may consider going through a development application process. In some cases we have had to say we cannot deal with this matter under a ministerial designation.

CHAIR: There being no further questions, I thank everyone who has participated today. Thank you to Hansard and thank you to our secretariat. A transcript of these proceedings will be available on the committee's webpage in due course. We have three questions on notice. We will be in contact with you with regard to those. The answers would be required by Tuesday, 11 January 2022. I declare this public briefing closed.

The committee adjourned at 11.22 am.