HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE

Members present:

Mr AD Harper MP (Chair)
Mr MC Berkman MP
Mr MA Hunt MP
Mr MF McArdle MP
Mr BL O'Rourke MP
Ms JE Pease MP

Staff present:

Mr R Hansen (Committee Secretary)
Mr R Bogaards (Inquiry Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2018

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 5 DECEMBER 2018

Brisbane

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The committee met at 11.25 am.

FORRESTER, Ms Kathleen, Deputy Director-General, Strategy, Policy and Planning Division, Department of Health

LAW, Ms Kirsten, Director, Legislative Policy Unit, Strategy, Policy and Planning Division, Department of Health

CHAIR: I declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I think you are familiar with all of the members here, so I do not need to go through the introductions.

Today's hearing is an important part of the committee's inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. This public briefing of the committee is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind you that intentionally misleading the committee is a serious offence.

You have been provided with a copy of the instructions for witnesses, so we will take those as read. This public briefing will be recorded and transcribed by Hansard so that the committee has a record of proceedings. You will be provided with a copy of the transcript. Ms Forrester and Ms Law, welcome. Would you like to make a brief opening statement before we move to questions? I am sure you have heard and taken quite a bit from the previous submitters today. We look forward to your contribution.

Ms Forrester: Thank you, Chair and members of the committee, for the invitation to return today and to talk to you about the submissions made by stakeholders on the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. As you know, the bill seeks to amend the mandatory reporting provisions of the national law to achieve greater consistency to ensure that practitioners feel confident seeking help and treatment for impairment while maintaining appropriate consumer protections and public confidence in the professional health registration system. This is an important reform and one that health ministers around the nation have given considerable thought to. While ministers are conscious of the need to encourage health practitioners to seek treatment, the reforms in the bill do retain legislative obligations for mandatory reporting so that practitioners who could potentially cause or be at substantial risk of causing harm to patients continue to be reported to the regulator. This ensures public protection and gives health consumers greater confidence in the health system.

For several years health ministers have heard from stakeholders representing health professionals of their desire for the Western Australian model for mandatory reporting to be adopted throughout Australia. Commonwealth, state and territory ministers, aside from the Western Australian minister, specifically considered the Western Australian model on multiple occasions and decided not to adopt it. Health ministers wanted to ensure any changes to mandatory reporting strike the right balance by retaining sufficient protections for health consumers while also addressing concerns that mandatory reporting is a barrier to health practitioners seeking treatment. Ministers also decided to retain mandatory reporting requirements for treating practitioners in legislation rather than leaving them solely to professional or ethical obligations.

The bill does include a higher threshold for reporting which sends a clear signal that treating practitioners are not required to automatically make a mandatory report if a practitioner has a health condition. The bill allows treating practitioners to use their professional judgement and expertise to consider the nature of a practitioner-patient's impairment and the proposed treatment plan. The reforms make it clear that not every impairment needs to be reported. The bill includes guidance factors which can be used to assist treating practitioners to determine whether a mandatory report should be made. A mandatory report is only required if the practitioner-patient's impairment reaches the threshold of substantial risk of harm.

The submissions made to the committee highlight the complexity of this issue. Chair, I think you just called it a difficult but not impossible task. I think that is well said. The comments and words that stand out from this morning that go to that difficult but not impossible task are: trust, decisions not taken, suicide, fear, misunderstanding, untreated mental illness, cultural challenges, ethics, and perceptions and misperceptions. It really is a very challenging field that we are proposing to make legislative changes to. I think you have heard that this morning in addition to seeing the written words in the submissions.

However, from the department's perspective, the views expressed by stakeholders do not raise any issues about mandatory reporting by treating practitioners that have not already been considered by health ministers. Some stakeholders consider the guidance factors in the bill were helpful. Some acknowledge the threshold for mandatory reporting under the bill will be higher than under the current national law. A number considered that the bill is a step in the right direction. Many stakeholders expressed their concerns and their opposition to the bill.

Queensland changed its mandatory reporting laws in 2014 to create an exemption for treating practitioners when a patient-practitioner has an impairment. Currently, Queensland only requires a treating practitioner to report another registered health practitioner's impairment if the impairment would place the public at substantial risk of harm. One way to consider the bill is that the higher standard for reporting impairment set by Queensland in 2014 is now being proposed for adoption into the national law.

The bill will also strengthen national consistency by seeing all states and territories other than Western Australia adopt a higher threshold of 'substantial risk of harm' that already applies to impairments in Queensland. Currently in Queensland treating practitioners are required to report other forms of notifiable conduct including intoxication, sexual misconduct and substandard practice.

For Queensland's registered health practitioners and consumers this bill will strengthen those 2014 amendments by clarifying the drafting, setting a consistent standard for mandatory reporting of notifiable conduct other than sexual misconduct, providing guidance factors for treating practitioners when considering impairment and ensuring that treating practitioners must report instances where they consider their practitioner patient is at risk of engaging in sexual misconduct. This will mean that there will only be two mandatory reporting regimes nationally rather than three, thereby promoting greater consistency. We believe this will improve the ability of national boards and AHPRA to run training, education and awareness on this issue.

With the committee's permission, I would like to take a further few minutes to address particular issues that have been raised by stakeholders. Some stakeholders have equated the making of a mandatory report to a career-ending event in which a practitioner will lose their livelihood. This is simply not the case. The outcome of each report is considered on its merits and a range of regulatory responses may be appropriate, depending on the circumstances of the case.

Some mandatory reports result in no regulatory action being taken against the practitioner. However, reports made to the regulator can be used to assess patterns of behaviour over time and particularly where the health impairment is worsening or becoming a higher risk to the public. Almost every step in this process is subject to either review or appeal to a tribunal.

A significant number of stakeholders also called for an education awareness campaign about the new arrangements for treating practitioners. The education and awareness campaign is a critical element of these reforms. It is clear from the submissions and from the evidence given this morning that much of the concern with the proposed mandatory reporting provisions in the bill stems from a misunderstanding that every health condition must be reported, regardless of its severity or effect. That is not the case.

The COAG Health Council has already directed AHPRA to, subject to the bill being passed, work with regulatory bodies and employers to develop a communication and awareness plan and inform practitioners of how the reforms will affect treating practitioners and practitioner-patients. The education and awareness plan will be rolled out in a timely way to coincide with the commencement of the reforms and over time. I expect this education and awareness campaign will reassure health practitioners that these reforms should give treating practitioners greater discretion not to make a mandatory report if they are satisfied that their practitioner-patient is adhering to treatment or taking steps to manage their impairment.

Finally, I note that for all practitioners it is important to break down the cultural and institutional barriers around talking about mental health. It is clear from the submissions and from the research quoted by many stakeholders that there is still much work to be done in changing attitudes and talking openly about mental health among health professionals. It is critical to change perceptions and to ensure that health practitioners are always encouraged to seek help for their own health conditions.

The submissions to the committee highlight that these reforms are one of a number of steps needed to remove the barriers to encouraging practitioners to seek help. It is incumbent on all of those involved in the health system to do what they can to change outdated attitudes. Thank you once again for inviting us to brief the committee today. We are happy to answer your questions.

CHAIR: Thank you very much. That is well put. I think changing outdated attitudes and perceptions is exactly what we need to do. Education through these reforms will be critical. I am glad you noted the fact that these issues can be career ending, because that is not the case. As we heard from AHPRA, zero deregistrations of people who have been investigated through mandatory reporting really solidifies your statement.

We do have some work to do in the mental health space. There is no doubt about that. Beyondblue is doing a fantastic job across-the-board by helping lift the stigma, with significant major surveys being done in that area. That needs to be a national conversation, not one just in Queensland. I have everything I need out of your responses to the submissions. I am going to move to questions from the deputy chair.

Mr McARDLE: I take you to page 10 of the explanatory notes under 'Consultation'. In September 2017 a paper was released inviting submissions on four options with regard to reporting. There were 47 submissions received. About one-half wanted to adopt the WA model. Let us say that is 22 or 23. Of the remaining 23 or 24, one-half want to adopt the WA model in relation to impairment. Of the 47, about one-half wanted to adopt WA model in toto. Of the balance, one-half want to adopt the WA model in relation to impairment but not in regard to the other matters referred to in the bill. That is a significant number of submitters who either fully endorse or partially endorse the WA model. Is there something wrong with the WA model that the committee is not aware of?

Ms Forrester: The challenge that ministers confront in this area is finding the balance between a regulatory regime that ensures both patient protections—so provides a way to ensure consumer safety at an individual level and also at a public confidence level—and clarity for practitioners that they should be comfortable and confident seeking treatment from their own health practitioner when they need it. I think the decisions are not always made on the weight of numbers.

There has been strong, consistent support over a long period of time from particular stakeholders to adopt the Western Australian model, but since 2010 ministers have supported the inclusion of mandatory reporting in the national law. Queensland is in a little different situation. This proposed reform seeks to change the current balance in the current legislative arrangement to get to a better place. They did not see that the right balance would be struck by adopting the Western Australian model.

Mr McARDLE: That is a statement of the proposed outcome of the Queensland bill. I understand that. What was wrong with the WA model which meant that, despite so many people endorsing it fully or in part, it could not be taken up? That would have been a process undertaken, I suspect, by your department or maybe even by you or by other people in the department. What were the points in the WA model that made it ineffective?

Ms Forrester: The Western Australia model relies on the professional ethics and expectations of the individual treating practitioner. Practitioners do have a legal duty to protect the public from harm. That is set out in their ethical and professional conducts. However, they are generally broad and do not provide guidance or detail about when a practitioner is expected to make a report. We have here today examples of the particular guidance that is provided by the various professional bodies in terms of making reports.

Mr McARDLE: Would you table those?

Ms Forrester: Absolutely. I might read for the committee the guidance that is provided. You will see that it is quite broad. In relation to, for example, the Medical Board it is about notifying the Medical Board if someone is treating a doctor whose ability to practise may be impaired and may thereby be placing patients at risk. That is the test. The tests are different for the different boards. The optometry board talks about taking steps to protect patients from risk of being placed at harm. The Nursing and Midwifery Board has a different test again.

In our national regulatory scheme we have all of the boards that play their very important roles working with their professions. Each of them has their various ethical obligations set out. Those ethical obligations are not consistent. They vary quite a bit. That is one issue. The law actually provides a consistent framework. That piece we have heard about this morning about providing consistency as a way of encouraging a better understanding is quite important.

The other thing that the bill goes to is providing guidance factors so that a treating practitioner can take a range of things into account. Again, that goes to consistency of approach and practice. That is an important point there. People are looking for that consistency. Ministers want the public to be reassured that if there is an issue then there is an appropriate regulator in place to respond and that the information is provided through to the regulator.

Mr McARDLE: You argue that the language is different; therefore, a different outcome is going to occur. I would argue that all language is different, to be quite frank. That is why we change laws. Mr Shepherd from the Queensland Nurses and Midwives' Union said today that he had spoken to a person from a unit in Queensland Health. He was going to provide us with the name and title of that person. I will paraphrase what he said. He said that there was not a significant difference between the reporting outcomes of the WA model and what is proposed to be put in place or the current regime. He said he was told that by somebody in the department. Is that correct? Is he telling us the correct thing in regard to that matter? Who was he talking to?

Ms Forrester: I understand he met with David Harmer, Senior Director, Strategy, Policy and Legislation Branch, as part of the consultation process. I believe what he would have been referring to is actually some observations that we have provided back to the committee in our summary and response to submissions.

Mr McARDLE: When you say you 'believe', were you there for that conversation?

Ms Forrester: I was not there for the conversation.

Mr McARDLE: So you really cannot talk about the conversation, can you?

Ms Forrester: I cannot talk about the conversation, but listening to the evidence—

Mr McARDLE: You can guess.

Ms Forrester: Listening to the evidence this morning, it did strike—

Mr McARDLE: Would Mr Harmer be available for the committee?

Ms Forrester: Yes, of course. He will certainly be here tomorrow. He would be happy to provide information to the committee about that discussion.

Mr McARDLE: Good—and also documentation?

Ms Forrester: Yes.

Mr McARDLE: Mr Shepherd appears to be referring by analogy to some documentation he was speaking to.

Ms Forrester: I will leave it to you to speak directly with Mr Harmer. I would also suggest that the points of discussion are incorporated into the department's response to the committee in terms of the summary of submissions. Drawing out what the data appears to be showing is, I think, the point that was being made.

Mr McARDLE: Was Mr Shepherd incorrect?

Ms Forrester: The data that is available suggests that the rate of mandatory reporting is relatively consistent across all jurisdictions.

CHAIR: You mentioned before about tabling some information on WA.

Ms Forrester: Certainly, yes.

CHAIR: We need to seek leave for that material to be approved to be tabled.

Ms Forrester: We can provide that on notice.

CHAIR: There being no objection, it is so approved to be tabled.

Mr BERKMAN: It is very clear that among the medical profession there has been broad support for the WA approach consistently over a long period. We have heard this morning that it is difficult to put together empirical data about the number of practitioners who are prevented from seeking assistance because of the fear of reprisal. The anecdotal evidence we have heard certainly suggests that the WA system is superior in terms of ensuring medical professionals' health outcomes are better. I am referring to the fact that we are hearing that medical professionals are seeking medical support from interstate because of the risks that they feel are posed by seeking that support here in Queensland.

Ms Forrester: I think it is very difficult to comment on anecdotal evidence.

Mr BERKMAN: Indeed.

Ms Forrester: Not wanting to cloud the consideration further, I think there could be many conversations about anecdotal evidence around patient concerns equally—we equally do not know.

Mr BERKMAN: I accept the point. That is why I am so reluctant to refer to any piece of anecdotal evidence. There are consistent representations from across the medical profession that the mandatory reporting of impairment presents a very real barrier to medical professionals seeking assistance.

Ms Forrester: Which is why ministers wanted to take a step forward, and this is the proposed step forward.

Mr BERKMAN: Indeed. The need for change is—

Ms Forrester: Accepted.

Mr BERKMAN:—beyond question, yes. What evidence is there that the WA approach is in fact inferior from a consumer perspective? As I understand it, you have said that the rates of mandatory reporting are relatively consistent across-the-board. Obviously there is recognition for the need for change, but there was a relative ambivalence from Ms Fox about what represents the best consumer outcomes here. I am wondering what the evidence base is.

Ms Forrester: It will be interesting to go back and read the transcript, but what I did hear Ms Fox allude to, though, was that trust alone is not enough.

Mr BERKMAN: Yes.

Ms Forrester: We are in a world where health ministers have made a determination that they wish to have a mandatory reporting regime. That has been a position that has been, as I say, in place since 2010 and has been tested quite consistently through the period up until now. The approach that is being put forward today is considered to be an improvement on what exists currently across states and territories. The test is higher, so the reporting threshold is higher. The legislation is clearer. This is a relatively small but complex issue with many elements to it, so the test that has been put forward seeks to get greater understanding through applying the same test, providing those guidance factors and promoting consistency across states and territories.

There is evidence I think that there is a multiplicity of factors that prevent practitioners from seeking assistance for mental health issues. Changes to legislation can go some way to addressing those concerns, but I think the evidence that the committee has seen in the submissions and heard this morning points to the fact that there is a raft of issues that need to be changed to fully address those concerns. Health ministers have settled on the view, on the basis of their experience, on the basis of what they as health ministers see and deal with on a day-to-day basis, that striking this balance—retaining mandatory reporting for treating practitioners with a higher threshold, with guidance factors where a report is not automatically required—is the right pathway for health practitioners at this point in time.

Ms PEASE: From listening to all of the people who have made submissions today, there seems to be a lack of clarity and understanding of what this piece of legislation is wanting to achieve. Would you agree with that?

Ms Forrester: I think we would agree with that. It is a complex piece of legislation. It is a small piece in a big bill, but there are a range of complexities. As I said in my opening statement, I think some of the complexity is around the structure of the bill, and we have sought to streamline that a little by adopting the same test. Some of it is around those very human elements and issues that I referred to about trust, about ethical considerations, about perception and misperception. I certainly do agree that there has been a lot of evidence put to the committee around perception and misperception of the arrangements that are in place now.

Ms PEASE: One of the things that the AMA presented was that simply changing where the word 'risk' is—in terms of 'risk of substantial harm' as opposed to 'substantial risk of harm'—changes the whole interpretation. Can you elaborate on that?

Ms Forrester: Ministers were looking for a change to the legislation that had the ultimate effect of encouraging practitioners to seek support when they needed it. One of the important things that the legislation does is set the test for when a mandatory report needs to be made. The intent of changing those terms to be a substantial risk of harm, as opposed to a risk of substantial harm, was to set that test at a higher level so that, as the test is set at a higher level, there would be fewer occasions where a mandatory report would be required. Certainly that is the intent—that the threshold is raised for a requirement to provide a mandatory report and in so doing create that increased level of assurance for health practitioners to seek treatment when they need to seek it.

Ms PEASE: That is certainly my interpretation when I read through the bill—that it actually discourages mandatory reporting for minor and less significant matters.

Ms Forrester: That is absolutely the intent. The current wording talks about a 'risk of substantial harm'. That could be any risk. It could be a trivial risk that potentially needs to be reported, whereas the intention with these changes is to ensure that it is only where a 'substantial risk of harm' is assessed as being present that a mandatory report would be made. The intention of this change is certainly to lift that threshold. I should say that, on the issue of impairment, for Queensland that is the current test. This was the change that Queensland made in 2014 to move to this as the reporting test.

Ms PEASE: Could you state what the current Queensland test is? Is it substantial risk of harm?

Ms Forrester: For impairment, the current test is 'the practitioner is placing the public at a substantial risk of harm by practising with an impairment'. Queensland took this step in 2014.

Mr HUNT: I would like some clarity around the assessment of risk and the considerations. Some stakeholders, as you have referred to in your departmental response, stated that it would be more appropriate and clearer for treating practitioners for the guidance factors to apply more broadly, specifically that the guidance factors should apply to assessing the risk of intoxication and departure from professional standards. In your response you said that the explanatory notes outline how the guidance factors for impairment can be used in considering issues of intoxication and departure from professional standards. The flow chart seems to indicate that you go straight from intoxication, if there is no impairment related to it, to an assessment of risk of harm, rather than considering the nature and extent of the intoxication, steps they have taken to manage it et cetera. The submissions indicated that those guidance factors should be more broadly applied. Why weren't they?

Ms Forrester: That is some people's view, but I will let my colleague set that out for you.

Ms Law: Those guidance factors in the legislation were developed specifically for impairment. They talk about treatment and that sort of thing. The intoxication factor that we are referring to talks about intoxication at work. It does not require there to be a long-term alcohol abuse issue or a substance dependence abuse issue. That is likely to fall within the category of impairment. What we are talking about here is a case of someone practising while they are under the influence. In that case, those factors about the nature, extent and severity of practising under the influence at work do not really fit. It is not about treatment or the steps that a practitioner is taking or willing to take to manage an impairment. Intoxication at work is very serious. If that has happened and there is a substantial risk of harm to the public, it is appropriate then that there is that report. If the intoxication is connected with an impairment—if we are talking about a situation where we have a practitioner who has a substance abuse problem—the treating practitioner can consider those guidance factors and determine whether that intoxication impairment is being treated appropriately and whether there is a need to report.

Mr HUNT: For example, if someone is suffering depression and self-medicates with alcohol, the impairment would be the depression?

Ms Law: That is right.

Mr HUNT: They then may consider the nature and extent of it and the steps being taken—if they are attending rehabilitation or whatever. They can take that into consideration in terms of determining whether or not to make a report?

Ms Law: Yes.

Mr HUNT: If the intoxication is a part of it—

Ms Law: If the intoxication is happening at work—if that impairment has resulted in a practitioner practising while they are intoxicated—that is very serious.

Mr HUNT: If they are intoxicated at work, as opposed to being intoxicated at night at home or whatever?

Ms Law: Absolutely. You might have an impairment that involves substance abuse that only affects you in your personal life. If you are practising while you are intoxicated, that is very serious.

Mr BERKMAN: The benefits of greater consistency are in large measure, as I understand it, at least slated back to the capacity to better educate and raise awareness of the standards within the profession. Consistency is fundamental to the profession broadly understanding what their obligations are.

Ms Forrester: Yes, and I would suggest that the proposed changes give us a consistent threshold test as well across the elements of notifiable conduct. I think that is quite helpful as a starting point when you are trying to explain legislation. Then the consistency is that we would move to a

situation from currently having three different mandatory reporting regimes for treating practitioners in operation—one in Queensland, one in Western Australia and one in the rest of the states—to two. I think that piece of consistency is important as well. It certainly would be the case that that would assist in the education and awareness campaign for all of the parties involved, both in producing materials and distributing them and in professional contacts and discussions that would go on across the nation.

Mr BERKMAN: A shift from three to two, yes, is simpler in that there are only a couple of them. From what we have heard so far in evidence from the profession, it seems to me as though there is still going to be a significant risk of those misapprehensions about the risks of seeking treatment remaining. I will leave that as an observation rather than expecting a response. Is it the case that there are plenty of other non-legislative means to achieve that kind of uniformity and consistency that do not necessarily involve mandatory reporting and could address that concern within the profession around seeking treatment?

Ms Forrester: We have a legislative regime in place now, so this is a step towards making it more consistent. Given the differences that exist within the bill now, it would be difficult to see what other means and options there were. I would suggest that the other means and options that we are contemplating in this conversation go to how we get cultural change in the community and in the profession about dealing with mental illness and addressing and arresting the rates of suicide in the profession and across the community. I think there are a range of other things that could beneficially take place. I do see this as definitely getting a greater degree of consistency into the law that will from that point support a range of other activities.

Mr BERKMAN: Apologies for the clumsily worded question.

CHAIR: That brings us to a close, if there are no other questions. Thank you very much, Ms Forrester and Ms Law, for your contribution here today. It has better informed us as a committee with this particular bill in front of us. We thank you for your time.

Ms Forrester: Thank you. We look forward to seeing the committee's report.

The committee adjourned at 12.02 pm.