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 J Gilchrist (Assistant Committee Secretary)

PUBLIC BRIEFING—EXAMINATION OF THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2018

TRANSCRIPT OF PROCEEDINGS

MONDAY, 12 NOVEMBER 2018

Brisbane

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The committee met at 11.59 am.

CHAIR: I declare this meeting of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I acknowledge the traditional owners of the land on which we meet today. I am Aaron Harper, the chair of the committee and member for Thuringowa. With me today are: Mr Mark McArdle, the deputy chair and member for Caloundra; Mr Michael Berkman, the member for Maiwar; Mr Marty Hunt, the member for Nicklin; and Mr Barry O'Rourke, the member for Rockhampton. Joan Pease, the member for Lytton, will join us very shortly.

The purpose of today's meeting is to receive a briefing from officers of the Department of Health to assist us in our examination of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. The bill was referred to the committee on 31 October for examination. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. In this regard I remind members of the public that under the standing orders the public may not participate in proceedings and may be admitted to, or excluded from, the briefing at the discretion of the committee. The briefing is being broadcast live on Parliament TV. Hansard is transcribing the proceedings, which we will make available on our website soon. Those here today should note that the media may be present so it is possible you may be filmed or photographed. Responses to questions on notice taken should be provided to the committee secretariat by 12 pm on Monday, 19 November.

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: Would you like to make a brief opening statement on the bill before us?

Ms Forrester: We are here today to brief you on the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2018. The bill amends the Health Practitioner Regulation National Law, which I will refer to as the national law for the purpose of today's briefing. The national law commenced in 2010 following the agreement of the Council of Australian Governments to establish a national registration and accreditation scheme for health professionals. If enacted, the bill will amend the national law to implement two priority reforms agreed to by health ministers at the COAG Health Council on 12 October 2018.

First, the bill will change the operation of mandatory reporting requirements that apply in the situation where one health practitioner is treating another health practitioner. The purpose of these changes is to strike a better balance between improving access to treatment for practitioners with health conditions that potentially impact on their own practice while ensuring appropriate protections for consumers of health services. Second, the bill will also increase the penalties that apply if a person holds themselves out to be a registered health professional when they are not, improperly uses a protected title, claims someone is a health professional when they know they are not or contravenes a prohibition order. These changes will strengthen consumer protections and public confidence in the health system.

Any amendments to the national law must be agreed to by the health ministers of all states and territories and the Commonwealth at COAG Health Council before an amendment bill is introduced into Queensland parliament. On 12 October 2018, after extensive consideration of the issues over the past 18 months, COAG Health Council approved these amendments to the national law. As Queensland is the host jurisdiction for the national law, the amendments must be passed by the Queensland parliament. If the bill is enacted the amendments will automatically apply in all states and territories except Western Australia, which must pass corresponding legislation, and South Australia, which must make regulations to apply the changes. Western Australia has notified health ministers that it does not intend to adopt the mandatory reporting reforms in the bill.

In relation to the national law amendments dealing with mandatory reporting, the goal of mandatory reporting reforms is to ensure that health practitioners have the confidence to seek treatment for health conditions while maintaining public safety and public confidence in registered health professionals. Mandatory reporting requirements ensure that the Australian Health Practitioner Regulation Agency, the national boards and co-regulatory agencies such as Queensland's Health Ombudsman, are made aware of, and can take appropriate action to, protect the public if a registered health practitioner is engaging in conduct which could cause harm. The mandatory reporting provisions in the national law require employers and registered health practitioners to report certain conduct of other registered health practitioners which may place the public at risk. The conduct which must be reported is: practising while impaired; practising while intoxicated; practising in a way that significantly departs from standards; and engaging in sexual misconduct in connection with practice. The national law also contains requirements for reporting students who have an impairment in certain circumstances.

These changes have come about in response to increased concerns from stakeholders that mandatory reporting requirements may be a factor in discouraging patient practitioners who are unwell from seeking treatment for their health issues, especially mental health issues or drug and alcohol problems, for fear of being reported by their treating practitioner. These concerns are serious because seeking treatment and support for health conditions is critically important to ensuring the health and wellbeing of practitioners as well as the patients they care for. To address these concerns the bill makes several important changes to the mandatory reporting obligations of treating practitioners when they provide treatment to a practitioner patient.

First, the bill strengthens requirements for the reporting of sexual misconduct, including a new requirement to report risks of future sexual misconduct. This will ensure that if a treating practitioner becomes aware a practitioner patient is, for example, grooming a child or a patient, they would be required to report that to the regulator. Second, the bill contains a new, higher threshold which governs when a treating practitioner is required to report a practitioner patient for an impairment, intoxication or substandard practice. Under this new threshold a treating practitioner is only required to report this conduct if the public is being placed at substantial risk of harm. This is a higher standard, making it clear that the treating practitioner is not required to make a mandatory report unless the safety of patients or the public is assessed as being at substantial risk of harm.

Third, in deciding whether the threshold for reporting has been met, the bill allows the treating practitioner to make an holistic assessment of risk considering the patient's conduct as a whole. Fourth, when considering a patient's impairment, including mental illness, the bill provides guidance about the factors that a practitioner can take into account when determining the risk. These factors allow a treating practitioner to use their professional judgement and experience to consider the context of treatment and other efforts to manage a practitioner patient's impairment. A treating practitioner will have access to information about a person's health, mental state, actions and whether they have insight into their own conduct or health condition.

Taken together, these reforms send a clear message to practitioners and students that if they are engaged in treatment and willing to take steps to address their impairment, a treating practitioner is not automatically required to make a mandatory report unless there is an overriding risk to the public.

In 2014, Queensland modified the national law to recognise the special position of treating practitioners. Queensland's current approach is similar to the approach in the bill, as both use a threshold of substantial risk of harm to require reporting of impairment. However, to avoid confusion about the application of the current Queensland provision, and to ensure greater national consistency, Queensland has agreed to adopt the national law approach to mandatory reporting by treating practitioners. This means that all elements of the mandatory reporting reforms in the bill will apply in Queensland, including the guidance factors, which are not part of Queensland's current provisions.

To assist the committee I have a document setting out the current national law provisions, the Queensland provisions and the proposed provisions under the bill. I am happy to table that if it would assist the committee.

CHAIR: Absolutely. Thank you very much. Leave is granted.

Ms Forrester: The amendments will be supported by the development of appropriate guidance and educational materials for health practitioners. If the bill is passed, AHPRA will develop an education campaign so that registered health practitioners are aware of the significant changes in the bill which will support practitioners seeking treatment. The national boards and AHPRA will also revise their current guidelines for mandatory reporting to ensure they reflect the reforms and clearly set out how the new regime applies to treating practitioners.

This bill is the product of an extensive collaborative process of national reform and consultation. I would like to place on the record and extend my appreciation to stakeholders and community members whose diverse views and perspectives helped shape the bill. After considering all of the feedback, ministers consider that the bill strikes the right balance between ensuring health practitioners can seek help for health conditions while maintaining strong protections for health consumers by retaining mandatory reporting if the practitioner is placing the public at substantial risk of harm.

In relation to the second priority, the national law amendments also increase penalties. The bill strengthens patient and consumer protections under the national law by increasing the maximum penalties for persons who falsely hold themselves out as a registered health professional, use professional titles or contravene a prohibition order. These offences involve conduct that can result in serious harm. Anyone who falsely represents themselves as a registered health practitioner is engaging in very serious and deceptive conduct. Patients who find out their health practitioner is not properly registered would expect the regulator to take significant enforcement action. Given the seriousness of these offences, health ministers decided that the current penalties are inadequate; therefore, the bill will double the maximum monetary penalty for holding out and related offences to $60,000 for an individual and, where relevant, $120,000 for a body corporate. The bill also introduces a term of imprisonment of up to three years for these offences.

I would like to thank you for the opportunity to brief the committee.

CHAIR: Thank you very much for your opening statement. Again Queensland leads the way in terms of amending national law. This bill will provide overall confidence to consumers and address concerns in relation to being treated by a registered health professional. Do you have any idea of the number of health practitioners in Queensland you will be dealing with?

Ms Forrester: In 2017-18 there was a total of 139,056 registered health practitioners in Queensland. The largest registered group is nursing, which accounts for 74,338 practitioners; the second-largest group is medical at 23,027; and the smallest group, going to the other end of the scale, is Aboriginal and Torres Strait Islander health practitioners at 112.

CHAIR: The amendment before us is a substantial piece of legislation. Within each department there would be codes of conduct and a number of other things. As you are aware, this committee has oversight of the Health Ombudsman, so we are very aware of complaints management within Queensland. This will no doubt strengthen confidence for health consumers in Queensland. You said that you consulted widely with a range of stakeholders in that 18 months.

Ms Forrester: That is correct.

CHAIR: Putting aside Western Australia's and South Australia's current position, can you talk a little bit about who was engaged and who you think might be interested in potentially opposing such a bill in our journey going forward on this particular issue?

Ms Forrester: Certainly this is a bill where stakeholders have been strongly engaged and have expressed strong and sometimes quite divergent views. In terms of the consultation process that has been used to develop these particular amendments to the national law, the first round of consultation occurred in September 2017 and a discussion paper was released at that time, inviting submissions on four possible policy options for reforms to mandatory reporting by treating practitioners. Two national forums were held with practitioners and consumer stakeholders, and 47 written submissions were received in response to that consultation paper in September 2017.

Approximately half of the submissions that were received supported the Western Australian model, which is a model that involves a blanket exemption from mandatory reporting by treating practitioners. Instead, it relies on the practitioner's professional and ethical obligations to report if the public would be at risk of harm. The other half of the written submissions supported retaining mandatory reporting by treating practitioners for sexual misconduct, intoxication and substandard practice, but were divided on whether there should be mandatory reporting for impairment.

Health ministers considered the results of that consultation at a meeting that took place on 13 April 2018. Ministers agreed that there should be reforms to mandatory reporting by treating practitioners, but, apart from the Western Australian government, they did not support the Western Australian model. Ministers agreed that the reforms should ensure that the registered health practitioners can and should seek help when they need it, but it must also protect the public.

On 2 August 2018, the COAG Health Council agreed to release a draft bill containing mandatory reporting amendments to stakeholders for targeted consultation. The purpose of the consultation was to consider whether the bill adequately reflected the ministers' policy intent, rather than another round of consultation on the policy underpinning the reforms. In response to that

consultation, some stakeholders suggested that further refinements were possible. Ministers were informed of stakeholder feedback at the COAG Health Council meeting on 12 October. They carefully considered the feedback that was provided, but did not believe that the issues raised required further changes as ministers considered that the bill as it is presented strikes the right balance between ensuring health practitioners can seek help for health conditions while also maintaining strong protections for health consumers by retaining mandatory reporting if there is a substantial risk of harm.

Going to your specific question about the stakeholders who have been engaged on their different views, on balance there is a large group who would prefer a voluntary reporting requirement. That group includes the AMA, which has been quite vocal and public in their support of that position. Consumers want to be assured and know that the national law protects their right to be treated by practitioners who are not going to put them at substantial risk of harm through their practice. Therefore, that is indeed the challenge that ministers have faced. They have undertaken a number of rounds of consultation and I think constituents or people have engaged strongly in that consultation. Ministers have had to strike a balance between making changes to this mandatory reporting law as it applies to practitioner patients or when a health practitioner is a patient, and weigh that up against the need for consumers to feel that they have confidence in their practitioners and for the public to feel that they have confidence in the regulatory arrangements that support the health sector in Australia.

CHAIR: Thank you very much for that. I think that consultation discussion paper might be handy. Can we get that on notice, as it would help in navigating our way forward? It might underpin some of the work the committee has to do.

Ms Forrester: Certainly. There have been two consultation papers and we are happy to provide both on notice to the committee.

CHAIR: You talked about the substantial risk of harm. Can you elaborate on why the proposed substantial risk of harm threshold test for reporting is a superior test compared to the substantial risk of substantial harm test?

Ms Forrester: That was quite a topic of discussion through the consultation period. The challenge has been to find that test, that form of words, that does indeed provide enough guidance to the treating practitioner to enable them to make a judgement about when a mandatory report is required. The challenge between substantial risk of harm versus substantial risk of substantial harm comes down to considering the scenario that a treating practitioner might be in under the substantial risk of substantial harm scenario, and asking the question: would it be acceptable if a treating practitioner was treating their patient who is also a health practitioner and formed a view that there was a substantial risk that that person's patients might be placed at moderate harm?

The test 'substantial risk of substantial harm' actually enables no reporting in the case where a treating practitioner, with all the information that they have on treating that patient, forms that informed view that there is a substantial risk of moderate harm being caused to consumers. With that as the possibility under that scenario, that was not felt to strike the right balance and so the test has been settled at substantial risk of harm.

CHAIR: I look at this and see intoxication and a number of other risk factors. What about PTSD?

Ms Forrester: I think PTSD would actually fall into the impairment category. I think you have the table there?

CHAIR: Yes.

Ms Forrester: It is a good opportunity to talk through some of the issues, because impairment has been the issue of most heated debate. The current test is a practitioner has placed the public at risk of substantial harm. The Queensland provision is the practitioner is placing the public at substantial risk of harm by practising with an impairment. The proposed provision in the new bill is that the practitioner is placing the public at substantial risk of harm by practising with an impairment. Importantly, those guidance factors are incorporated into the bill and that is something quite new.

PTSD might involve a range of issues that a treating practitioner might need to consider or that the patient in this case might be experienced in dealing with. There might be some mental illness; there might be drug and alcohol issues. The approach that is adopted in the bill for impairment and intoxication and substandard practice is to allow a treating practitioner to consider those in a holistic way. It is not just trying to create silos in the decision-making process for the treating practitioner, but really trying to give them clear guidance in the law that if they are treating someone who has an impairment they need to take a holistic view of the person that they are treating.

That matters because it means that you can consider an impairment and by considering the guidance factors you can make a determination about the nature, the type and the extent of the impairment. It is not just does the person have an impairment; does the person have a mental illness; does the person have depression. That is not enough to require a mandatory report. You need to consider what is the nature, type and extent of the illness.

CHAIR: That is within the guidance factors?

Ms Forrester: Within the guidance factors. I will get those four guidance factors.

CHAIR: Can you read those?

Ms Forrester: The bill includes guidance to treating practitioners on the factors that they may consider, that is, the nature, extent and severity of the impairment; the steps the practitioner patient is taking or willing to take to manage the impairment; and the extent to which an impairment can be managed with appropriate treatment. Also, it allows the treating practitioner to consider other factors as relevant. The reasons that those are important is because the practitioner patient might be quite willing to engage in a range of treatments: of taking medication, if that is appropriate; of undertaking modification to their lifestyle; of making commitments to do a whole range of things that mean that their impairment might be quite well managed. We want the treating practitioner to have the ability to consider holistically the issues around impairment, intoxication and substandard practice and, using those guidance factors, we ask them to form a view about whether the practitioner, given all of those factors, is placing the public at substantial risk of harm.

CHAIR: That would be akin to the threshold test, considering all of those factors?

Ms Forrester: That is exactly right. The really important point here is that there is no automatic requirement for mandatory reporting if a practitioner went to their doctor and said, 'I have a mental illness'. There is no automatic requirement that that creates a mandatory reporting requirement. What it does is it triggers a need for the treating practitioner to consider impairment, taking account of all of those factors, including taking account of things such as how treatable the illness is. It might be very treatable and there might be a very well documented and evidence based treatment plan, and the practitioner who is unwell might be fully engaged and committed to that treatment plan. On that basis, the treating practitioner goes back and considers, 'All things considered, knowing this patient as I do, do I think that this practitioner is placing the public at substantial risk of harm by practising with an impairment?'

It is very much trying to give very clear guidance in the law that there is a range of factors that need to be considered and taken into account by the treating practitioner in making that judgement about whether the practitioner is placing the public at substantial risk of harm. Of course, if they do make that judgement then the law does require that there is a mandatory report made to AHPRA or, in the case of Queensland, to the OHO and in that case the regulators take further action as they deem appropriate. It is really asking the treating practitioner to use their knowledge and use their judgement. Guidance is clearly provided in the law as to what they should be considering. Then the question is put to the regulators which have the appropriate authority and response to consider matters further.

CHAIR: Thank you very much for clarifying that, Ms Forrester. We will move to questions. Member for Maiwar?

Mr BERKMAN: I am interested broadly in whether you can give us a sense, on an annual basis, of roughly how many overall reports are made under the mandatory reporting framework? How are they broken down?

Ms Forrester: We have the data on mandatory reporting available for 2016-17 from AHPRA. It is national data. Nationally, there were 6,898 or almost 6,900 notifications about registered health practitioners. That sounds like a lot, so I want to explain that those notifications include mandatory reports, but they also include voluntary reporting and importantly they also include complaints. That is the starting point.

Out of those, 12.3 per cent or 847 of the total were mandatory notifications. The mandatory notifications can be made by a range of people. They can be made by an employer, as employers have mandatory reporting obligations; they can also be made by another registered health practitioner, so a co-worker has mandatory reporting obligations; or they can be made by a treating practitioner. Unfortunately, the data does not break down that 12.3 per cent into the different categories of mandatory reporters, so I cannot be any more precise with that.

There is further detail about what the nature of those reports entail and how they step through the system. Eighty-two per cent of mandatory notifications were about medical practitioners or nurses. We looked at the data briefly at the start to understand why that might be. Forty-eight per cent of

mandatory notifications resulted in some form of regulatory action being taken against the health practitioner; 52 per cent did not result in action. Of the 847 mandatory notifications received, 73 per cent were about a significant departure from standards of clinical care; 17.5 per cent were about impairment; 5.4 per cent were about sexual misconduct; and four per cent were about practising while intoxicated.

The other issue that might be of interest to the committee is a 2016 study that was published by the *Medical Journal of Australia* which analysed 846 mandatory notifications made to AHPRA for the period 2011 to January 2013, a different time period. That study found that eight per cent of mandatory notifications were made by a treating practitioner. That is a piece of data that we do not have out of the AHPRA database. Seventy-eight per cent of treating practitioners who made mandatory notifications described their practitioner-patients as exhibiting diminished insight, dishonesty, disregard for patient safety or an intention to self-harm—that was in 50 out of 64 reports by treating practitioners—including 29 cases where the practitioner-patient lacked insight into the risks posed to patients by conditions such as mania, psychosis or dementia.

In 12 out of 50 cases the practitioner-patient was deliberately dishonest, most commonly by providing false information about an addiction or an attempt to obtain or misuse drugs, and in five out of 50 cases the practitioner-patient showed disregard for treatment advice or patient safety by not adhering to prescribed medicines or a plan to protect patients during recovery. They are small numbers but I think quite significant issues that the treating practitioners were referring for. I might stop there.

Mr BERKMAN: You mentioned that WA has no mandatory reporting at all.

Ms Forrester: That is correct. They have no mandatory reporting for treating practitioners. The mandatory reporting obligations apply to employers and health professionals, that is, to co-workers. The case that we are talking about and the amendments being proposed by this bill are about the relationship between a health practitioner who is also a treating practitioner. This is the challenge that stakeholders raised.

If we have a health practitioner who is experiencing challenges—they might have an impairment of some kind—we want them to be able to seek treatment from their doctor, to get the best treatment they possibly can, and to feel that they can fully disclose without fearing that they are going to automatically be reported to the regulator and potentially have to work through that sort of regulatory process. The concerns put forward by stakeholders are that there are cases where health professionals feel constrained in their ability to seek help and that that needs to change. That is what health ministers have put forward here in terms of proposing changes to mandatory reporting as it applies to the practitioner-patient for the treating patient arrangement.

Mr BERKMAN: The AMA preference for voluntary reporting you described before, that is just in relation to the practitioner-patient?

Ms Forrester: Yes, that is what we have been working on in this bill.

Mr BERKMAN: Yes, it is limited to that.

Ms PEASE: Further to what you were talking about with regard to mandatory reporting for health professionals, how is it envisaged that that information or the changes will be shared with the treating health practitioners?

Ms Forrester: AHPRA has been committed to updating their guidelines, so there will be an information campaign developed around the new guidelines, and the new arrangements put forward in the bill will be communicated. To do that they need to work with national boards, and when the national boards update the information they provide to practitioners they undertake consultation. There would be a round of consultation with health professionals. National boards would have a role in developing the information they felt would best support their health practitioners to understand and operate in a new environment, and AHPRA would update its guidelines. I think it is recognised that it is an important change and that these elements of the law are not what we want practitioners to be worried about, but we want them to have access to good information when they need it. That is the commitment that I think we are hearing from AHPRA.

Ms PEASE: I imagine that information being shared will encourage those people who do feel threatened about reporting health issues. They will be less threatened if they are part of the consultation process and given that information beforehand.

Ms Forrester: Yes. I think that is a really important point; if I may just speak to that briefly. In 2013 beyondblue undertook a national mental health survey of 2,252 doctors to explore the barriers experienced by doctors seeking treatment for mental health conditions. In descending order, the main

barriers that were identified through that study were: a lack of confidentiality or privacy, 52 per cent of respondents; embarrassment, 37 per cent; and the impact on registration and the right to practise, which is really where these reforms come in, was at 34.3 per cent. There is also a preference for self-help or no help, lack of time, and concerns about career development and progression.

I think this is looking at the bigger picture issue about wanting to encourage health practitioners and the whole of the community really to make sure they get help when they need it. These are important reforms. It is really important that the guidance provided helps practitioners understand what those reforms are. It is also important to understand that there is probably more work to be done to address the challenges that people across the community experience if they do have a mental illness. There are a range of factors that come into play that we need to work on to encourage people to get help when they need it.

Ms PEASE: You mentioned figures regarding health professionals like nurses, medical professionals and ATSI health workers. Where do allied health workers like physiotherapists, speech pathologists and radiographers fit into that?

Ms Forrester: They are certainly registered health professionals. In relation to physiotherapists, there are 6,089 physiotherapists. Which other groups did you refer to?

Ms PEASE: Do they fit into the registered health group?

Ms Forrester: Yes. I think we mentioned at the start there are 16 different registered health professions. I am sorry, you were not here.

Ms PEASE: That answers my questions, thank you very much.

Mr HUNT: I want to explore what this means in practical terms for a treating physician. First of all, is 'substantial risk of harm' defined in the act? Notwithstanding the full guidelines, is it defined?

Ms Forrester: No, it is not defined as a term in the act.

Mr HUNT: It is very broad in terms of how a treating health professional could interpret that phrase.

Ms Forrester: Yes, which is where the guidance would come in. We expect that guidance would be provided to assist the practitioner when they are assessing whether the public is at substantial risk of harm. The use of the term 'substantial' suggests that it is not a minor or trivial risk, that there is something that is quite significant there that is a substantial risk. It is not something that has a low probability of happening. There is a substantial probability of harm being caused.

Mr HUNT: What is the obligation on the health practitioner to investigate that which is brought before them? In terms of 'I have an alcohol problem; can you help me?' what is their obligation to try to establish the substantial risk of harm or otherwise?

Ms Forrester: What is their obligation to report?

Mr HUNT: No, to investigate. They may not get to the point where they consider there is a substantial risk of harm on the voluntary information given by the patient. What is the obligation on them under the act to flesh that out and investigate it to the point where they satisfy themselves that there is not a substantial risk of harm if something is brought before them such as impairment or intoxication?

Ms Law: The legislation currently and in the future will require the practitioner to have a reasonable belief that the threshold is met. That test is a commonly used legal test and there is a lot of guidance provided to practitioners about what that requires. It does require an objective element, in that would a reasonable person in the situation they are in feel that the threshold was met? There is also a subjective element. They would look at all of the factors that are before them in determining—

Mr HUNT: I understand the reasonable belief test. What I am getting at is their obligation to investigate. Patients will give information voluntarily. They may not get to a point where they have a reasonable belief but they may suspect that they could get there with further questioning, for example. What is the obligation on them to ask, 'Have you practised while intoxicated? How is it affecting your practice?' What is the obligation on them to investigate? I am getting to a practical point. When the treating physician finds themselves in the situation where they have had an impairment such as intoxication et cetera brought before them, there is an obligation on them to report if they reach that threshold. What is the obligation on them to investigate to the point they reach that threshold, if any?

Ms Forrester: The bill does not specify that the treating practitioner do anything other than act in accordance with the relationship that they have with their patient. There is nothing in the bill that places any onus on the treating practitioner to go further than the consultation that they have with their patient. There is nothing in the bill that requires them to seek out or investigate further information.

The law requires the person to act in good faith when they make a mandatory notification, but it also goes to the point that making the report or forming that judgement is a part of a process, so when the judgement is made the next step in the process is that the regulatory agencies get involved. It is really at that point that the actions you contemplate, such as seeking out more information and gathering a broader understanding of the situation, come into play. As the data suggests, there are a large number of cases where matters are not determined to be significant by the regulator.

Mr HUNT: From a treating practitioner's point of view, they put themselves at risk. If they do not reach the threshold and something occurs subsequent to that, for example, harm occurs to somebody, it comes back to them about what actions they took to establish that, what obligations they are under and what risks they are under. If a report is not made and someone is subsequently harmed and it comes back to them, have they committed an offence by not reporting? Are they covered under those circumstances?

Ms Forrester: The bill does not change the consequences for failing to make a mandatory report. There are no proposed changes to what currently exists. It is not an offence for a practitioner to fail to make a mandatory report when they should have, but it may be the subject of a performance or a conduct matter. That means that AHPRA could consider whether to take action against a treating practitioner if it came to AHPRA's attention that the treating practitioner failed to make a mandatory report in circumstances where it was expected that they should have. However, there is no offence provision in the act in that circumstance. As I say, it would be treated as a performance or conduct matter.

Mr HUNT: I guess that would come down to AHPRA's interpretation of 'substantial risk of harm' as opposed to the doctor's interpretation at the time.

Ms Forrester: I think it would come down to a wide range of factors about what the doctor knew versus what AHPRA might know. They may be two different sets of information. There is an expectation that people in this situation act in good faith.

Mr O'ROURKE: Are you able to provide a breakdown of the number of offences that have occurred under sections 113, 115 to 119, 121 to 123 and 196A of the national law in Queensland since the national law commenced in 2010?

Ms Forrester: I do not have that information with me. However, we are happy to take that on notice and seek that information for the committee.

Mr O'ROURKE: With regard to regional and remote communities, are there any concerns for health practitioners out there in regards to this law that have been raised?

Ms Forrester: Concerns in relation to—sorry, what elements?

Mr O'ROURKE: Just generally with regard to this bill in regional and remote communities. Have there been any particular concerns raised?

Ms Forrester: I am not aware of any concerns that have been raised through the consultation process in relation to regional or rural issues. No, not that I am aware of. I am happy to review the consultation materials that were provided, but that is something that has not come up specifically.

Mr McARDLE: Thank you, ladies, for being here again, like old friends getting back together again, renewing the bond. You mentioned 847 mandatory reports had been made for the 2016-17 year. Can you go back further than that with regard to data, because the bill has been in place for quite some time now? I am trying to get a trend as to what the number was and the reasons for that number increasing, decreasing or staying the same, to begin with?

Ms Forrester: Certainly. I am sorry, I do not have any other year's data with me. That is AHPRA data. We are certainly happy to seek additional information from them to see if they can give us that breakdown for previous years.

Mr McARDLE: Can you also provide, if at all possible, Queensland data—

Ms Forrester: Yes, we will seek that.

Mr McARDLE:—in particular.

Ms Forrester: I am happy to seek that information as well.

Mr McARDLE: I am also trying to get a sense of the location of the practitioners, that is, South-East Queensland, Central Queensland, Far North Queensland, et cetera. Is that possible?

Ms Forrester: I am not sure. I have not seen the breakdown by region. Again, we are happy—

Mr McARDLE: Or HHS, put it that way.

Ms Forrester:—or HHS. I have not seen that data.

Mr McARDLE: Is it possible you could take that on notice?

Ms Forrester: We will definitely take that on notice and see if AHPRA has that data available.

Mr McARDLE: Taking the member for Rockhampton's point, I am trying to assess where the greater problem is. You would think percentage-wise it would be south-east corner, but per capita I do not know—and across the state as well. Do you have any indication of the outcomes of the notifications across that data spectrum?

Ms Forrester: The outcomes?

Mr McARDLE: Yes, suspension, et cetera or maybe struck off?

Ms Forrester: I have an indication of outcomes from the data reported in the *Medical Journal of Australia* in 2016.

Mr McARDLE: That is probably not what I really want, though. Can you take that on notice? Is that possible?

Ms Forrester: Sure. We will see if the AHPRA data will go to that point as well.

Mr McARDLE: Can you give an indication of the publication of the outcomes of investigations outside OHO, AHPRA and the like? Is there a website somewhere that this data goes onto in order to inform the public, or is it mainly the AHPRA data that they look at or the OHO data or the Ombudsman data?

Ms Forrester: I would have thought it would be the AHPRA website, which is the single point really for information about registered health practitioners. You can go onto that website and see if there have been any conditions—

Mr McARDLE:—imposed upon practitioners.

Ms Forrester:—put on anyone's registration.

Mr McARDLE: Could you get that data for me across that spectrum from 2010 or 2011 when it came into place—I cannot recall exactly when—

Ms Forrester: Yes.

Mr McARDLE:—but for Queensland practitioners—location, what the notifications were and the outcome of notifications?

Ms Forrester: As well as the question about the websites?

Mr McARDLE: Yes, location.

Ms Forrester: Sure.

Mr McARDLE: If a doctor phones up a doctor's helpline, which I think is one of the issues the AMAQ raised, is the doctor they talk to on the other end of the telephone caught by this new bill if it becomes an act?

Ms Forrester: Yes, they would be.

Mr McARDLE: Can you explain to me when you look at the terms of the bill how the balance is struck between the necessity for a doctor to get treatment and the patient to be satisfied that that doctor is the one who should be treating them and the necessity for the doctor to be secure in his professional integrity moving forward as well? I am trying to get the balance between if I go as a doctor to a helpline, I then tell this person what is going on and they are caught by the bill. If I am a doctor suffering a problem, am I then under this bill prohibited, at least mentally, from taking a step to seek the help that is so needed? How does the bill deal with that?

Ms Forrester: In terms of the telephone advisory service?

Mr McARDLE: Generally speaking.

Ms Forrester: This is the balance—

Mr McARDLE: That is my question.

Ms Forrester:—that I am referring to that needs to be struck. If I take the example of the telephone helpline, that might actually help a little. Certainly in the last round of consultation some stakeholders did seek an exemption from mandatory reporting for the telephone advisory services given that they provide early intervention or referrals for practitioners. That issue had not been raised previously, so it came up quite late in the day. Nevertheless, it was considered. Practitioners providing those services are subject to current mandatory reporting requirements as they are considered to be

treating practitioners. The question really then is: as treating practitioners, they need to be able to make an assessment of risk against this new reporting threshold, so they would be, as you say, caught in this bill.

The conclusion of the considerations was that if enough information is provided to a practitioner in a telephone consultation to allow them to make that judgement that we have been talking about, which is that the practitioner they are speaking to is placing the public at substantial risk of harm by practising with an impairment, with an intoxication and substandard practice, then the public should have confidence that there will be a regulatory response to that. The fact that the consultation or the conversation is happening with a practitioner via telephone as opposed to a face-to-face consultation was not considered to be a different circumstance. That is one element of your question, which is that the bill treats the consultation the same if it is a telephone call or face to face. The second point, though, is why does this bill give any different assurance to practitioners that if they are well they should go and get—

Mr McARDLE: 'Encouragement' is a better way to put it.

Ms Forrester: There are a few things. One is we have adopted the same test across impairment, intoxication and substandard practice—so substantial risk of harm. That is hopefully going to be a bit more straightforward in terms of being able to communicate. The second really goes to that point I was speaking to before in relation to the bill enabling the treating practitioner to provide a holistic assessment. It does not just say 'consider impairment by itself, consider intoxication by itself, consider substandard practice by itself'. It recognises that these elements can be interrelated in a person's experience. It says to the treating practitioner, 'We want you to work with the patient and to consider all of these factors in a holistic sense. We want you to use your judgement using the guidance that is provided in the bill.' There is not an automatic requirement that a mandatory report is made if someone walks in and says, 'I have a mental illness and I need help.' That is not the case. This bill makes it very clear that the treating practitioner needs to use their judgement, work with the patient, use the guidance that is provided in the bill to assess the impairment given all of the factors and to then ask themselves, 'Is the practitioner placing the public at a substantial risk of harm?' Those are the factors—

Mr McARDLE: Would you say the word 'substantial' is significant in the assessment process? It is not just having a mental illness; it has to go further than that.

Ms Forrester: That is absolutely correct.

Mr McARDLE: It must be a substantial risk of harm beyond the simple fact of having a mental illness. It is quite distinct.

Ms Forrester: That is absolutely central to the changes that are being proposed by this bill. The treating practitioner needs to make that assessment considering all of the factors, including that the person may have a mental illness, they are here getting treatment, and, 'I understand that mental illness. I understand that the treatment is an effective treatment. I understand my patient. I understand that they are highly likely to comply with the treatment and the patient is talking to me about the things that they are going to do in their life as well to support themselves to get better. Taking all of those factors into account I can assess, using the guidance factors, that the practitioner might have a mental illness, but their practice is not going to place the public at substantial risk of harm.'

A mandatory report is not required. It is that unpacking of a scenario where a mandatory report is an automatic response to someone going in and saying they have a mental illness, but that is not case. This bill sets up a far more sophisticated approach to enable treating practitioners to work with their patients to consider a range of factors together about what the consequence is in terms of whether a practitioner is going to place the public at a substantial risk of harm.

Mr McARDLE: That would mean that the treating practitioner in this case seeing the ill practitioner would have an ongoing obligation to assess that practitioner to ensure that they comply with the requirements of any treatment order or treatment steps.

Ms Forrester: Absolutely. Things change over time. I do not think that is different to what would be in place now.

Mr McARDLE: I am not questioning that. I take it at some point in time if the ill practitioner fails to comply, that will then trigger potentially an automatic determination that there is a substantial risk based upon the fact that the practitioner has not complied with the treatment required.

Ms Forrester: Again, it is not automatic—

Mr McARDLE: I accept that.

Ms Forrester:—but it could change over time. If the practitioner had made an assessment at one point in time that the practitioner was well enough to be practising, and not practising and placing the public at a substantial risk of harm, but something changed, they certainly could at a subsequent time make a different assessment and conclude that there was now a substantial risk of harm and a mandatory report would be required.

Mr McARDLE: The member for Rockhampton alluded to the various penalties that are going to be increased under the relevant sections of the act. I would also be keen to look at how many matters have flowed through those sections of act. The explanatory notes mentioned that there are several cases in which magistrates have stated they are keen to impose—

Ms Forrester: That is correct.

Mr McARDLE:—a term of imprisonment. Can you undertake to table, say, three judgements of magistrates? I want to look at the facts of the cases and then read the magistrates' comments in relation to the penalties and how they are inadequate in relation to these matters.

Ms Forrester: Certainly. There are certainly cases that we can table. I am aware of at least one magistrate who has made exactly that comment, that if he had had the option to impose a term of imprisonment on a particular person, they certainly would have been taking that course of action.

Mr McARDLE: That was for holding out I take it—under the heading of holding out?

Ms Forrester: That was for a range of offences including holding out—this person holding themselves out to be a dentist, including using a restricted title and including carrying out restricted dental acts as well as possessing schedule 4 drugs.

Mr McARDLE: Can you table any more than just one, or not? You mentioned there are ‘several cases'.

Ms Forrester: I am certainly aware of one where the magistrate has made specific comments in relation to the imposed term of imprisonment that has been available. I am certainly happy to table other examples of penalties that have been applied to people in these sorts of cases so you can get a sense of what the nature of the issues are that are being considered and the responses that are currently available in terms of the penalties in the current act.

Mr McARDLE: Can you table more than one? Can you take that on notice to look at—just take it on notice; that is all.

Ms Forrester: We will get the details from AHPRA.

CHAIR: We are a little ahead of time, but I think you have given us the foundations in this briefing of the work we need to undertake as a committee in relation to the bill before us. I thank you both very much for your time today. A number of questions on notice were taken. I think you have the date. We look forward to getting that information from you. Thank you very much for giving us this public briefing.

The committee adjourned at 12.59 pm.