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

Members present:
Mr AD Harper MP (Chair)
Mr MF McArdle MP
Mr MC Berkman MP
Mr BL O'Rourke MP
Ms JC Pugh MP

Staff present:
Mr R Hansen (Committee Secretary)
Mr Z Dadic (Assistant Committee Secretary)

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL 2019

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 7 FEBRUARY 2020

Brisbane

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The committee met at 4.00 pm.

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

MAHLER, Mr Karson, Manager, Legislative Policy Unit, Queensland Health

STEWART-KOSTER, Ms Rachel, Acting Manager, Legislative Policy Unit, Queensland Health

CHAIR: Welcome. Thank you for being here. I know that some of you have been observing today's hearing. Broadly there has been quite a bit of discussion around conversion therapy but we look forward to your briefing and feedback on some of the submitters' questions. At 4.30 the member for Rockhampton has to depart, but we will continue the hearing.

Prof. Allan: Thank you for the opportunity for the department to further brief the committee about the Health Legislation Amendment Bill 2019 and respond to issues raised in submissions. Before starting, I would like to advise the committee that I also hold the position of President of the Royal Australian and New Zealand College of Psychiatrists, but today I am appearing in my role as an executive director of Queensland Health and I will not be speaking on anything in relation to the college. I just add that I am quite adept at managing the potential conflicts of interest between those two roles so I hope you understand that.

I would like to address some of the issues raised by the stakeholders before I take questions. The majority of the submissions to the bill address the prohibition of the practice of conversion therapy by health service providers in Queensland. Submissions were made by clinical groups, faith based organisations, women's groups, peak bodies and individuals. A number of submitters, including professional bodies, strongly support the prohibition of conversion therapy by health service providers as an important step in protecting Queensland's LGBTI+ community. Some professional bodies strongly support the intent of the bill and provided feedback that the definition of conversion therapy and the examples in the bill could be clarified to ensure legitimate psychiatric or counselling treatments are not prohibited.

Other clinical groups and individual doctors did not support the bill in its current form. These submitters claim the bill could interfere with clinical judgement by promoting or mandating gender affirming treatment such as hormonal treatment or surgery. These submitters also expressed that legitimate clinical psychiatric or psychology assessments could be defined as conversion therapy particularly when treating gender dysphoria in children. From the department's perspective these concerns stem from a fundamental misunderstanding of the legislation. To be clear, nothing in the bill would prohibit any clinical decision or practice that is evidence based or otherwise has legitimate clinical purpose. In fact, the bill provides expressly that conversion therapy does not include any practice that a provider reasonably believes is necessary to provide safe and appropriate care or to comply with their professional and legal obligations.

The definition of conversion therapy is narrowly targeted at practices that are proven to be harmful and not evidence based. To that end, the definition of conversion therapy within the bill only applies if a practitioner engages in a practice with the aim of suppressing or changing a person's sexual orientation or gender identity. Put another way, the bill prohibits practices that are not based on clinical judgement but rather on the discredited and dangerous premise that a person's sexual orientation or gender identity is a disease or deviant behaviour which ought be suppressed or changed.

It is also important to emphasise that the purpose of the bill is to prohibit harmful conversion therapies. The bill does not, as some have suggested, promote a particular approach to the treatment of transgender individuals nor attempt to establish any clinical standards for the treatment of gender dysphoria or other conditions. The bill recognises that standards in this area are evolving and there is reasonable debate within the clinical community about the most appropriate approaches to treatment. This is also an important debate, but it is beyond the narrow scope and purpose of this bill.

Moving on, some submitters queried whether there was sufficient evidence of conversion therapy occurring in Queensland. They submitted that without empirical evidence about the prevalence of conversion therapy there is no pressing need for the bill. While it is difficult to obtain empirical data on the prevalence of conversion therapy due to the underground nature of these practices, the La Trobe University report estimates that 10 per cent of LGBTQI Australians are vulnerable to harmful conversion therapy practices. In addition, anecdotal evidence suggests that conversion therapy is occurring in Queensland, including by registered health practitioners and other service providers. Indeed, some of the submissions to this committee, including from health service providers, cite concerns that the bill will prevent gay people from seeking help to change their same-sex attraction. Some submitters stated that consenting adults should be free to seek help to change their sexual orientation. I think this demonstrates the need to send a clear message that conversion therapy is unacceptable.

Any discussion of evidence should also acknowledge there is an overwhelming consensus in the medical community that conversion therapy is a dangerous practice. Studies have shown that people who are subjected to conversion therapy are at increased risk of suicidality, self-harm and other adverse outcomes. Meanwhile, there is no credible evidence that these practices offer any therapeutic benefit or have any legitimate clinical purpose. In light of this evidence, many professional expert bodies, including the Australian Clinical Psychology Association, the Royal Australian and New Zealand College of Psychiatrists, the American Psychological Association, the American Medical Association and the World Health Organization, formally oppose the use of conversion therapy and acknowledge that these practices are harmful and unethical.

Finally, as the Queensland Human Rights Commission observed in its submission to the parliamentary committee, even though the practice of conversion therapy is not widespread, the potential harm and stigma to vulnerable members of our community warrants a strong legislative response. For these reasons the bill will make it an offence for any health service provider to perform conversion therapy. This prohibition will apply even if the person apparently consents to the practice or seeks out the practice. A person questioning their sexual orientation or gender identity is entitled to receive a service from a health practitioner that is safe and appropriate.

Faith based groups raised concern the bill could apply to school chaplains or school counsellors and will prevent religious schools from providing instruction and information about sexual health and sexual identity in line with religious beliefs. The bill only prohibits conversion therapy performed by a health service provider. In general, this means conversion therapy that is provided in the context of providing a health service. Prayer or religious teaching are not prohibited by the bill. There may be instances where the person providing the prayer or spiritual guidance is also providing a health service—for example, a doctor who provides prayer as a treatment or a patient who asks for medical advice about treatments for gender dysphoria. Whether this would be conversion therapy or not will depend on the circumstances of the case.

I would like to reiterate that the prohibition on conversion therapy will not apply to legitimate clinical decisions and interventions, it will apply only to the practices that aim to change or suppress a person's sexual orientation or gender identity. These practices are dangerous, contrary to evidence and have no place in the healthcare setting.

On the other amendments, only a small number of submissions related to amendments to the Hospital and Health Boards Act and the Ambulance Service Act's involvement to implement the recommendations of the expert panel into Queensland Health's governance framework. These submissions all supported the amendments to strengthen the commitment to the health equality of Aboriginal people and Torres Strait Islander people and the amendments to strengthen network governance in Queensland's public health system. The majority of submissions related to other amendments, including the removal of the pap smear register and the conditions of licencing for private health facilities. The submissions all supported these amendments.

There is just one other thing I wanted to raise before taking any questions and the conclusion. I wanted to respond to a procedural matter raised this morning by Dr Dilip Dhupelia on behalf of the Australian Medical Association Queensland. He asked the committee to correct the record of the first departmental hearing on the bill. He described an exchange at that meeting between the Director-General of Queensland Health, Dr John Wakefield, and the manager of legislative policy, Karson Mahler, during which the department stated the AMAQ attended the Ending Sexual Orientation Conversion Therapy Roundtable held by the Minister for Health and Minister for Ambulance Services in November 2018. I am advised that the AMAQ was not part of that round table and that the department has already corrected the record on this point in its response to the questions on notice taken at that hearing which includes a full list of stakeholders who were consulted and

invited to review the bill. I note that the AMAQ was invited to a subsequent briefing to review a consultation draft of the bill prior to its introduction. This invitation was sent by email to policy manager Jeff Allen. AMAQ did not respond to the invitation. The department has a record of the invitation and provided a copy to the AMAQ on Wednesday, 5 February at the AMAQ's request. We would be happy to provide a copy of that to the committee as well.

CHAIR: Thank you. That would be appreciated.

Prof. Allan: Thank you for the opportunity. I am happy to take any questions.

CHAIR: You would have heard today that both the AMAQ and the Queensland Law Society thought that that part of the bill dealing with conversion therapy sit with AHPRA or OHO for regulation. Can I get a view on that from the department?

Prof. Allan: I will give you a clinically based view from my experience. I would say two things: one is that AHPRA and OHO look at variations in medical practice, whether or not things that people do in medical practice meet proper standards, and they look at side effects of treatment and so on. The thing about what we are talking about here, conversion therapy, is that it is not a recognised medical practice. It has not been a recognised medical practice for 40 years or so. It should be beholden on every practitioner to know that this is not part of normal practice and is so far from the normal practice that I do not think it fits into those things that AHPRA and OHO would do. It has also been my experience with AHPRA and OHO that when they meet a circumstance where something is obviously of a criminal nature rather than a variation in practice they make that criminal referral anyway. That would be my view about where that sits, but I might ask one of my colleague if there is a further legal elaboration on that as well.

Mr Mahler: I think that we heard a number of quite compelling arguments today explaining why regulating this conduct purely through a health practitioner framework would not be sufficient. I should start by saying that nothing in the bill would prohibit OHO, AHPRA or the national boards from regulating conversion therapy. They would continue to have the ability to do that under professional standards and as a registration matter, but given the seriousness of the offence, the harm that it can cause for LGBTIQ individuals and, as Professor Allan says, the fact that the practice is not based on any kind of clinical justification and really is outside the sphere of health services or a health context, we think that there is a legitimate justification for, I think as Peter Black said, making a clear moral distinction that this is wrongful conduct, it is harmful, it has no scientific or medical basis and as such should be prohibited as a criminal offence.

On a more practical level, I think a number of stakeholders today made the point that the regulators really have fairly limited powers when it comes to complaints and investigations. If we think about a young person who might be subjected to conversion therapy, they may not come forward and make a complaint for many years. They may not realise they are a victim until many years later and by the time they make a complaint, if they make a complaint, the registered health practitioner or the unregistered health practitioner may have moved on, may no longer be providing a health service and there may be no remedy for that victim. That is another reason this does not, in the department's view, sit well within that sort of regulatory framework. That again also goes I think to the indictable nature of the offence which removes the limitations period and enables complaints, because it is treated as a criminal matter, to be brought years after the conduct occurred to ensure that where this is happening and it comes to light that there is a remedy available. Those are a couple of points of rationale for why it is appropriate for this to be treated differently from other practices which might be more in the realm of a departure from professional standards.

CHAIR: A number of submitters expressed concern about affirming treatment, which is also mentioned in the explanatory notes. Can you explain what the term 'affirming treatment' is in terms of how it is set in the explanatory notes?

Prof. Allan: Firstly, I do not think this bill is actually aimed at affirming treatments. It is just an example that is used and this is a setting in which people have talked about conversion therapy, but I do not think that that is the case. Obviously since I have been in the room I have heard a number of people give evidence that affirming treatment is a conversion therapy. That is not true. Affirmation treatment is around a young person with gender dysphoria and the basis of treatment is to say, 'Well, yes, you've got that gender dysphoria and I accept that you have this distress and I accept that you have this problem, so I'm affirming that you have this problem.' There is then a period of assessment of working things out with that person—and all of the things that are mentioned in the exceptions of the bill are examples of that kind of care, so a proper assessment; understanding the person's situation, and a multidisciplinary team would do that assessment; look at the family situation; look for co-morbid conditions to look at other treatments that are needed to happen—and then to work with

the person to work through those issues around their identity. I think we have also heard that there are parts of that which are watch and wait, so for some people there is that thought, 'Well, we just need to sit and watch and see how this goes and gather more evidence and think about it.' For other people that might move on to the things that people have talked about with various treatments.

CHAIR: Queensland Health has a gender clinic where this—

Prof. Allan: Queensland Health has two gender clinics. There is one in the Queensland Children's Hospital and there is another one for adults which is run out of the Royal Brisbane Hospital.

CHAIR: They would follow that path or line of—

Prof. Allan: My understanding as the Director of the Mental Health, Alcohol and Other Drugs Branch is they follow quite a conservative line and they follow guidelines around that.

Mr BERKMAN: Thanks for your time this afternoon. I feel it is incumbent on me because I asked the question in response to which there was the imputation made that the College of Psychiatrists's submission was somehow tainted by your dual role. I just thought I would give you the opportunity to respond to that if you would like, Professor.

Prof. Allan: I think it is not tainted obviously. There are two things about it. One is that I have a system whereby I manage conflicts of interest between my job for Queensland Health and my role as president of the college. That is something that I have discussed with the director-general. I have a written plan. That has been looked at by the Integrity Commissioner and okayed by this director-general and the previous director-general, so I am quite confident that I have a very clear statement about what is at issue. The College of Psychiatrists have prepared their submission. It has been sent by the president-elect and signed by the chair of the Queensland branch. Obviously I have read that as part of my role, so I do not really feel any issues around that. If you want me to comment on it, I can comment on it.

Mr BERKMAN: As much as anything, I just wanted to make sure that you had the opportunity to address the earlier response.

Prof. Allan: Thank you.

Mr BERKMAN: You have already touched on this to an extent, but there have been a number of assertions from different witnesses that there is no legitimate clinical practice or evidence based practice that leads ultimately to someone experiencing gender dysphoria transitioning. Can you comment on that?

Prof. Allan: Certainly there is no published Australian data apart from that La Trobe study which is interviews with a number of individuals. I know you have heard a lot of evidence about what happened at the round table and anecdotal evidence, so I will not repeat that. I had a look at the literature myself. There are two American studies. I think one was mentioned in the evidence given this morning from the Human Rights Commission—that is, a study of 27,000 people with gender dysphoria and they had asked them the question about whether they had even been exposed to conversion therapy and about 18 per cent said yes and they said that there was a 2.6 times rate of suicide. You asked a question about whether or not that was religious or treatment and they did not have an answer, and I actually went and had a look at that study. It is not available from the published data, but I have that here.

There is another study published in America of 245 people with a very similar set of outcomes and in that study they said that there was a mixture of people who had it in treatment settings and religious settings, but there is no breakdown of that data. There could be some further information about that. They were published in 2018 and 2019. Those are the most recent studies that I can see. The majority of work that is published around this was in the eighties so, as I mentioned, that is 40 years discredited. There was a lot of work published around the harms in the eighties and I do not think people have bothered to publish much around that since that time. I think that they thought this was not happening or because it is not a legitimate medical treatment it is not something that people count in their stats when they start talking about the treatments we provided. I used the word 'underground', but I think that is probably the case. Given that it is a discredited treatment, people are not going to report around that, so I think that is probably the reason.

CHAIR: Procedurally, can we get a copy of that?

Prof. Allan: I am happy to give you those.

CHAIR: Is leave granted? Leave is granted.

Prof. Allan: There are three studies, but one is a quote from another one. The data references two database studies.

CHAIR: Thank you.

Mr BERKMAN: There was a suggestion in the testimony from a couple of witnesses that the kind of looming threat of potential prosecution and uncertainty around the definitions of conversion therapy might simply deter practitioners from working in this space at all and might in fact have the perverse outcome of resulting in clinical treatment not being available or being available to fewer people. Does the department have any plans around that about addressing those concerns?

Prof. Allan: Obviously we need to see the progress of the bill and so on, but if it were passed we would have an education program. We would be offering information. I think that this is obviously a very sensitive topic and, as you have seen, it does flow into the other part about affirmation therapy and gender dysphoria, so we need to distinguish the two quite clearly. I have looked at this quite a number of times now. When I first read it I can understand why they would feel worried because it is talking about banning something where they worry about the crossover. Now having looked at it and talked to my colleagues and looked at this again, I feel that the provisions that relate to what is proper practice are quite clear and I think that that would be the way that it would operate. We would obviously need to, as we have seen from today, have quite an education and information position that will have to be taken around that.

Mr BERKMAN: If I recall correctly, I think you said that clinical practice standards around treatment of gender dysphoria are evolving.

Prof. Allan: Yes.

Mr BERKMAN: How do you see that playing into the definition of conversion therapy and in particular that exemption in subsection (3) that relies on professional—

Prof. Allan: I think that is good, because if we have agreed and accepted practice standards that is exactly what subsection (3) is talking about. To me that is a very good point. I do not think there would be any need to change what we are doing because that is exactly what it covers.

Mr BERKMAN: Thank you.

Ms PUGH: I am a ring-in today, but I have very much enjoyed my time on the committee. I understand that Queensland would be the first jurisdiction in Australia to do this. I understand that New Zealand does not have any legislation yet, and they usually beat us to the punch, I say as a half Kiwi very proudly—

Mr Mahler: They have introduced a bill but it has not been passed as far as I know.

Ms PUGH: They have introduced a bill; okay. I am just interested to hear about other jurisdictions around the world and what the impacts have been there, if any.

Prof. Allan: To my knowledge there are 18 US states that have banned conversion therapy. There are a number of European states, but I would have to take on notice the number of those so my colleagues can look at the legal numbers.

Ms PUGH: I would be interested to know what states in America they are, too.

Prof. Allan: If you look at the paper I tabled, there is a map and it is there.

Ms PUGH: Fantastic.

Mr Mahler: I think there have been some additional states very, very recently. The trend is that it is becoming widely prohibited across the United States. The way they are approaching it is a little bit different in some states. It depends on the state. Sometimes there is an unfair trade practice—that is one approach—and different emphases in terms of who would be covered. There is also legislation that is in effect in Malta, so they have prohibited the practice. That has been passed. There is a bill before the Seanad in Ireland, the Irish parliament. There are bills introduced in a number of other jurisdictions as well, and that has helped shape our thinking and has informed the development of this legislation.

Ms PUGH: Thank you.

CHAIR: Just to confirm, you can provide some of that by taking it on notice in terms of any other information?

Mr Mahler: Absolutely.

Mr McARDLE: Thank you for that, Professor. It is much appreciated. We will read that with gusto. I want to change tack. We have had conversion therapy all day and I think we are conversion therapied out at this point in time. I want to go to the HHSs and the Ambulance Service and look at the provisions contained in the bill. When you look at proposed clause 4, that relates to the QAS and they are required under that clause to collaborate with the HHS, and then we find later the reverse

occurs. Clause 9 says that the HHS must 'collaborate'—and that is the word that is used—with the QAS. I am just curious to know, and I raised the point this morning: we have one director-general and we have one minister who covers the portfolio, so it is a joint portfolio in essence covering two arms. Why do we need to have a law that says two bodies that you would have thought are working for the same outcome need to be told they have to work together? It is not a policy direction. It is not the DG issuing a statement. It is going to become law. Why have we taken that step?

Ms Stewart-Koster: That amendment came out of one of the recommendations of the expert panel report into Queensland's health governance framework and they recommended in that report that the Queensland Ambulance Service's role be acknowledged in legislation because at the moment they operate under two separate pieces of legislation, so there was simply an intention to reflect that there is that mutual requirement to collaborate. The QAS and the commissioner were consulted during that expert panel report and the commissioner was consulted on the development of the bill as well. The commissioner is also a member of the Queensland Health leadership board that the director-general has established to implement these recommendations of the expert panel. The commissioner is sitting on that leadership board and will be a part of those ongoing discussions and collaboration.

Mr McARDLE: You referred to the expert panel or review.

Ms Stewart-Koster: Yes.

Mr McARDLE: That just did not come up with the suggestion. It had to be based upon something, so what is it based upon that legislation is needed? It is not just acknowledging the role; it is stating that they have to 'collaborate'. That is a very strong term. What is the background to it?

Ms Stewart-Koster: The report was tabled at our last hearing. Hopefully you have had a chance to look at that. The report identified a number of changes. Legislation changes were just some of those. The overarching framework of changing the legislation is to set that high-level intention, but there will obviously be things that need to happen underneath. Collaboration is something that already exists but needs to probably improve. That has been recognised as part of that report. The leadership board will be working towards improving those collaborations.

Mr McARDLE: The collaboration already exists is your phrase, not mine.

Ms Stewart-Koster: That is based on information that we have and also testimony earlier on from the union that they see that collaboration exists but it could always be improved.

Mr McARDLE: We need law to make that happen.

Ms Stewart-Koster: The law is there to reflect the policy intent of the government as the high-level policy intent and then for work to happen underneath.

Mr McARDLE: We cannot get the Minister for Health, who is also the Minister for Ambulance Services, with the director-general and the commissioner and the LASNs and the HHS chairs together? We have to put it into law to make that happen? I do not quite understand. The word collaboration worries me. Would they not automatically be collaborating? They are saving lives.

Ms Stewart-Koster: All I can really say is that the changes have come out of that expert panel report and that was one of the recommendations, to make that change to the legislation.

Mr McARDLE: This is stage 1, is it not, of a review that is still ongoing within Queensland Health and the Ambulance Service?

Ms Stewart-Koster: The panel report made 28 recommendations. The Ambulance Service was one part of that. There is work ongoing in the department as a result to implement those 28 recommendations, some of which are in the bill and some of which are operational matters.

Mr McARDLE: What devolves from the collaboration from here? We have the law now that says collaboration has to occur. On a practical level, on a day-to-day basis in Cairns, what is going to happen operationally?

Ms Stewart-Koster: The director-general has recently established the Queensland Health Leadership Board which brings together expertise from across the whole system. There are representatives from the hospital and health services, from the hospital and health boards, from the QAS, from the Senate and clinical networks, nursing and midwifery, allied health, Aboriginal and Torres Strait Islander health and Health Consumers Queensland. The first meeting of that board is scheduled for 21 February. In addition to that, the executive leadership team has taken the rest of the recommendations and divided them into different streams of work. As an example, the Deputy Director-General of Healthcare Purchasing and System Performance has responsibility for some of those recommendations relating to system performance. The DDG will be working with hospital and

health services, particularly those in rural and remote areas, to develop more flexible service agreements which take into account their different demographic and service needs. There will be workshops held, starting from next week, to discuss potential options for how those flexible service agreements could be amended to assist those local HHSs. That is an example of how the panel recommendations are going to be rolled out.

Mr McARDLE: We need an act of parliament to make that happen? One of the provisions says that this act requires each hospital and health service to have regard to the need to ensure the effective and efficient use of public sector health system resources and the best interests of patients and other users of public sector health services throughout the state. How does Cairns and Hinterland HHS take into account Gold Coast HHS under that provision?

Ms Stewart-Koster: With the leadership board that has been set up that has representatives from the hospital and health services and the boards, so that will be a matter for them to work out how that will be operationalised and what changes will need to occur. That is all I can say at this point.

Mr McARDLE: I was quite surprised, and again I said this morning, that we only had one HHS make a submission. This is, from what you are saying to me, a fairly important thing. No LASN has made a submission. We have not had a submission from the Ambulance Service commissioner. Can you elaborate as to why that is the case, given the impact it will have?

Ms Stewart-Koster: All of the HHSs, all of the boards, the QAS and the commissioner were consulted not only throughout the expert panel report but also throughout the development of the bill. We worked with them extensively through the development of the bill, sought their feedback and incorporated that. When we were working with them, we sought their feedback and were satisfied that they were in support of these changes. I cannot speak to why they did not make a submission.

Mr McARDLE: I was keen to talk to the commissioner about the QAS because I would have thought he would have been keen to explain the deficiencies in the current system—there must be deficiencies—and for him to elaborate. I was keen to talk to him and also someone from one of the HHSs. They did not make a submission. That is fine; I accept that. What is the timeline to roll out this board and the outcomes?

Ms Stewart-Koster: The board's first meeting is on 21 February.

Mr McARDLE: I have that.

Ms Stewart-Koster: The executive leadership team has set up a program as part of their Rapid Results Program where they will be monitoring. The team will be setting up deliverables and milestones which will be reviewed and monitored along the way. It will be an ongoing piece of work.

Mr McARDLE: Will there be a traffic light indicator board used? Will there be published documents as to how this will work? What are the outcomes we are seeking? I do not quite understand that either. What are the outcomes we are talking about here?

Ms Stewart-Koster: The outcomes that will be monitored are the remainder of the panel's recommendations that were not the legislative changes. As to when they will be reported on, I do not have that information to hand.

Mr McARDLE: My recollection is the union said this morning—if I am wrong, I apologise—there could be a review within two years of this. I may have misheard them. Is that the case?

Ms Stewart-Koster: I do not have that information to hand as to where the two years came from, but I can take that question on notice.

Mr McARDLE: Would you mind? If it is two years, it seems to me a very short period of time to assess 16 HHSs and the LASNs to get an outcome. It is a massive task. It would take two years to implement in any meaningful sense a program of this nature, would that be right?

Ms Stewart-Koster: I cannot talk to that.

Mr McARDLE: Thank you.

CHAIR: It will be helpful if we could see those 28 recommendations to inform us.

Ms Stewart-Koster: They are in the report. I can re-table that if necessary.

CHAIR: We have it, thank you. It being nearly 4.40, I draw this public hearing to a close. Thank you very much for your contribution today and for better informing us of the department's response. I declare the hearing closed.

The committee adjourned at 4.37 pm.