Parliamentary Committees



Health Legislation Amendment Bill 2019

Report No. 32, 56th Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
February 2020

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

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Acknowledgements

The committee acknowledges the assistance provided by Queensland Health.

* In accordance with SO 202, Ms Jess Pugh MP, Member for Mount Ommaney, was appointed to the committee for the public hearing and public briefing held on 7 February 2020 as a substitute member for Ms Pease MP who was unable to attend.

Contents

Abbreviations

AEA	Adventist Education Australia
ADA Australia	Aged and Disability Advocacy Australia
ACS	Associated Christian Schools
AACS	Australian Association of Christian Schools
AASW	Australian Association of Social Workers
ACNP	Australian College of Nurse Practitioners
AHHA	Australian Healthcare and Hospitals Association
AHPRA	Australian Health Practitioner Regulation Agency
AMAQ	Australian Medical Association Queensland
Bill	Health Legislation Amendment Bill 2019
CSA	Christian Schools Australia
CSCF	Clinical Services Capability Framework
committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
DNR	Do Not Resuscitate
LSA	*Legislative Standards Act 1992*
NAPP	National Association of Practising Psychiatrists
NSQHS Standards	National Safety and Quality Health Service Standards
OHO	Office of the Health Ombudsman
QAIHC	Queensland Aboriginal and Islander Health Council
QuAC	Queensland Council for LGBTI Health (formerly known as the Queensland Aids Council)
QHRC	Queensland Human Rights Commission
QNMU	Queensland Nurses' and Midwives' Union
RACP	Royal Australasian College of Physicians
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SO	Standing Orders

All Acts are Queensland Acts unless otherwise specified.

Chair's foreword

This report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the Health Legislation Amendment Bill 2019.

The Bill proposes amendments to the *Ambulance Service Act 1991*, *Hospital and Health Boards Act 2011*, *Queensland Mental Health Commission Act 2013*, *Private Health Facilities Act 1999*, *Public Health Act 2005*, Private Health Facilities Regulation 2016 and Public Health Regulation 2018.

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

Three areas of reform proposed in this Bill warrant particular mention.

Amendments to the Hospital and Health Boards Act and the Ambulance Service Act are designed to strengthen the governance of the State's public health system. This is a massive health system that comprises the Department of Health, the Queensland Ambulance Service and the sixteen hospital and health services that deliver health services to Queenslanders. The amendments proposed in the Bill give effect to recommendations from an independent expert panel appointed by the Government. Submitters and witnesses for our inquiry unanimously supported the proposed amendments to strengthen coordination and cooperation across the system and improve outcomes for patients as well as staff.

The Bill also amends the Hospital and Health Boards Act to give Aboriginal and Torres Strait Islander peoples a direct and fairer say in how health services are delivered by each of the State's hospital and health services. The amendments will require that Aboriginal and Torres Strait Islander representatives are appointed to all sixteen hospital and health service boards. This is a significant and highly symbolic reform to improve the delivery of health services for all Queenslanders.

And finally, the Bill proposes amendments to the Public Health Act to prohibit for the first time in Australia the provision of conversion therapies by health service providers. The term 'conversion therapy' covers a raft of treatments that attempt to change or supress a person's sexual orientation or gender identity. The committee heard throughout the inquiry that these often clandestine therapies are condemned by health and other bodies around the world for the psychological harm, higher rates of suicidality, self-harm and other adverse health outcomes they cause their victims. As noted in the explanatory notes, the proposed prohibition of conversion therapies is to protect Queensland's LGBTIQ community from harm and to send a strong message that being a LGBTIQ person is not a disorder that requires treatment or correction.

The committee has recommended amendments to clause 28 of the Bill to provide greater clarity and certainty as to what treatment and care provided by health service providers are to be covered by the proposed prohibition. We believe this will make the provisions proposed in the Bill more effective.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill. I also thank our Parliamentary Service staff and Queensland Health.

I commend this report to the House.

Aaron Harper MP

Chair

Recommendations

1 Introduction

1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention
- Disability Services and Seniors.

Section 93(1) of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles.[2]

Further information about the committee can be found on the committee's website.[3]

The Health Legislation Amendment Bill 2019 (Bill) was introduced into the Legislative Assembly and referred to the committee on 28 November 2019. The committee is to report to the Legislative Assembly by 21 February 2020.

1.2 Inquiry process

The committee publicised its call for written submissions on the Bill on 4 December 2019. This was via emails to: 67 stakeholders identified by Queensland Health from their work developing the Bill, a further 435 stakeholders identified by the secretariat; and 4,102 groups and individuals who subscribe to the committee's regular email update service. The committee accepted 152 written submissions, including 15 received after the closing date. A list of public submissions is provided at **Appendix A.** Queensland Health provided the committee with written responses to the key issues identified within the submissions. This correspondence from Queensland Health is published on the committee's web site.[4]

The committee received a public briefing about the Bill from Queensland Health on 9 December 2019. A second public briefing took place with Queensland Health on 7 February 2020. A list of officials who attended the briefings is provided at **Appendix B**.

The committee conducted a public hearing in Brisbane on 7 February 2020. A list of witnesses who appeared at this hearing is provided at **Appendix C**.

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1 *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

2 Legislative Assembly of Queensland, Standing Rules and Orders of the Legislative Assembly, Schedule 6.

3 See: https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC.

4 Queensland Health, correspondence dated 3 February 2020, providing the Department's response to submissions received for the Bill, https://www.parliament.qld.gov.au/documents/committees/HCDSDFVPC/2019/HealthLAB2019/cor-3Feb2020.pdf

The submissions, correspondence from Queensland Health, and transcripts of the briefings and hearing are available from the inquiry webpage.

1.3 Policy objectives of the Bill

The Bill proposes to amend five health portfolio Acts and two Regulations to implement a number of policy initiatives and improve the operation of the legislation. More specifically, the Bill amends:

- the *Hospital and Health Boards Act 2011* to:
    - strengthen networked governance in Queensland's public health system by:
        a. requiring Hospital and Health Services and Hospital and Health Boards to have regard to the effective and efficient use of resources for the public sector health system as a whole, and the best interests of patients and other users of health services throughout Queensland; and
    - strengthen the commitment to health equity for Aboriginal people and Torres Strait Islander people and strengthen the capability and effectiveness of Hospital and Health Boards by:
        b. including as a guiding principle a commitment to achieving health equity and delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people;
        c. requiring each Hospital and Health Service to have a strategy for achieving health equity for Aboriginal people and Torres Strait Islander people; and
        d. requiring each Hospital and Health Board to have one or more Aboriginal persons and/or Torres Strait Islander persons as members;
    - allow the Patient Safety and Quality Improvement Service within Queensland Health to disclose root cause analysis reports about reportable events to quality assurance committees; and
    - make minor technical amendments;
- the *Ambulance Service Act 1991*, to complement the amendment to the Hospital and Health Boards Act, to recognise the Queensland Ambulance Service and Hospital and Health Services have mutual obligations to collaborate;
- the *Public Health Act 2005* to:
    - prohibit the practice of conversion therapy by health service providers in Queensland;
    - repeal redundant provisions for the Queensland Pap Smear Register, which has been replaced by the National Cancer Screening Register; and
    - correct a minor drafting error in the legislative requirements for Water Risk Management Plans;
- the Public Health Regulation 2018, to repeal redundant provisions for the Queensland Pap Smear Register;
- the *Private Health Facilities Act 1999*, to align the conditions of licence for private health facilities in Queensland with requirements under the nationally adopted Australian Health Service Safety and Quality Accreditation Scheme;
- the Private Health Facilities Regulation 2016, to support amendments to the Private Health Facilities Act to align conditions of licence for private health facilities in Queensland; and

- the *Queensland Mental Health Commission Act 2013*, to clarify the Mental Health Commission's powers to employ staff and to allow the Commissioner to be appointed for a term of up to five years.[5]

1.4 Consultation on the Bill

In regards to consultation by Queensland Health for the Bill the department engaged directly with stakeholders for the various amendments. Four submissions were critical of the lack of public awareness about the Bill as well as the timing and duration of the submission period allowed by the committee for lodging submissions.[6] The AMAQ also wrote to the committee raising concerns and requesting more time to consult their members and formulate their submission.

Christian Schools Australia (CSA), Adventist Education Australia (AEA), Associated Christian Schools (ACS) and Australian Association of Christian Schools (AACS) argued in their joint submission for an extensive public inquiry to inform the public consultation process, rather than a short parliamentary committee inquiry over the Christmas/New Year period.[7] Similarly, Feminist Legal Inc in their submission protested '…the inadequate exposure given to the Bill and the time frame for submissions falling as it does over the Christmas and New Year period'.[8] Hon Greg Donnelly MLC in his submission criticised the committee's timetable and submission period:

> *It is my view that the timetable set down for making submissions to this important inquiry is completely unreasonable. The Health Legislation Amendment Bill 2019 was only introduced into the Queensland Parliament on 28th November 2019. The Public Briefing to the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee took place on 9th December. Answers to Questions on Notice from the Public Briefing were returned on 16th December. Christmas Day fell nine days later and the truth of the matter is that many people are still on their Christmas/New Year's break.*[9]

The committee continued to consider and accept submissions on the Bill as late as 3 February 2020, a month after the published closing date. As noted above, 15 of the 152 submissions the committee accepted had been lodged after the published closing date. In addition to submissions on the Bill, the committee received correspondence from the Australian Christian Lobby with comments on the conversion therapy provisions of the Bill attributed to over 1,100 of the lobby's supporters.

The following section discusses Queensland Health's consultation for the development of the conversion therapies provisions of the Bill, and specific concerns about these processes raised with the committee by stakeholders.

1.5 Consultation for the conversion therapy provisions

According to the explanatory notes[10] and the department's advice to the committee, consultation for the development of conversion therapy provisions of the Bill (clause 28) comprised:

- the Ending Sexual Orientation Conversion Therapy Roundtable convened by the Minister for Health and Minister for Ambulance Services on 28 November 2018. The roundtable '…concluded that the Government should consider legislation making it an offence for health

5 Explanatory notes, pp 1-2.

6 See submissions 79, 104, 116, 125.

7 Submission 79, p 5.

8 Submission 104, p 1.

9 Submission 116, p 1.

10 Explanatory notes, p 19.

practitioners to perform conversion therapy'.[11] The roundtable was attended by representatives of 17 organisations

- 'outreach' by the department to individual stakeholders,[12] and
- a briefing held by Queensland Health on 15 November 2019 at which attendees were invited to comment on a consultation draft of the Bill. [13,14]

From this information, it appears that peak professional bodies such as the Australian Counselling Association, Australian Medical Association Queensland, the Australian Psychological Society, the National Association of Practising Psychiatrists and The Royal Australian and New Zealand College of Psychiatrists were not invited to be part of the Roundtable in 2018.

A list of organisations represented at the roundtable in November 2018, as well as those invited to the department's briefing held on 15 November 2019, is provided at **Appendix D**.

Comments by submitters

A number of submissions commented on the consultation processes for the development of the conversion therapy provisions of the Bill.[15] The Queensland Human Rights Commission supported the roundtable process:

> *It is encouraging to see that the feedback from the Roundtable has been properly considered and incorporated into the Bill.*[16]

Professor Dianne Kenny in her submission was highly critical of the roundtable from which the conversion therapy section of the Bill originated. Professor Kenny noted that the roundtable had been advertised as '…sexual orientation conversion therapy, with no mention of gender identity, however the Bill focuses on gender identity'.[17]

The International Women's Day (IWD) Association, Brisbane Meanjin in their submission also questioned whether gender identity had been considered at the roundtable, and noted the exclusion of key stakeholders that they believed should have been involved including: independent organisations representing the interests of children; professional mental health organisations; detransitioners; groups representing women's sex based rights; groups representing the interests of people with intersex conditions; and lesbian groups.[18]

In response to the points raised by Professor Kenny and (IWD) Association, Brisbane Meanjin, Queensland Health advised the committee:

> *A key theme of the Ending Sexual Orientation Conversion Therapy Roundtable was that conversion therapy is increasingly focusing on transgender persons and that efforts to address these practices should reflect a broad understanding of conversion therapy that includes efforts to change or suppress a person's gender identity.*[19]

In its advice to the committee on other issues raised in the submission about the consultation processes, Queensland Health stated:

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11 Explanatory notes, p 5.

12 Queensland Health, correspondence dated 3 February 2020, p 7.

13 Explanatory notes, p 19.

14 Queensland Health, correspondence dated 3 February 2020, p 7.

15 See submissions 16, 56, 79, 95, 96, 104, 106, 108.

16 Submission 16, p 2.

17 Submission 56, p.1.

18 Submission 95, p 2.

19 Queensland Health, correspondence dated 3 February 2020, p 8.

Queensland Health considers that the consultation process was adequate and provided a meaningful opportunity for input from a broad and diverse cross-section of interested stakeholders. Key definitions, concepts and other provisions were informed by, and developed in consultation with, a range of government stakeholders, private individuals and organisations with relevant expertise, including peak professional bodies, members of the medical community, health complaints bodies and regulators, religious groups, academics, experts in LGBTIQ issues, and persons with lived experience.[20]

Committee comment

From the issues raised by submitters and the department's advice on those issues, it appears that the consultation processes adopted by the department for the conversion therapy provisions of the Bill did not achieve an appropriate level of engagement with the professions that would be directly and particularly affected by the proposed conversion therapy ban proposed in clause 28.

1.6 Estimated cost for government implementation

According to the explanatory notes to the Bill, the costs to government associated with the Bill will be met from existing budget allocations.[21]

1.7 Should the Bill be passed?

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

After examination of the Bill, including consideration of the policy objectives to be implemented, stakeholders' views and information provided by the Queensland Health, the committee recommends that the Bill be passed/not be passed/passed with the amendments proposed in this report

Recommendation 1

The committee recommends the Health Legislation Amendment Bill 2019 be passed with the amendments proposed at Recommendations 2.

[20] Queensland Health, correspondence dated 3 February 2020, p 6.

[21] Explanatory notes, p 11.

2 Examination of the Bill

This section discusses issues raised during the committee's examination of the Bill.

2.1 Strengthening commitment to health equity for Aboriginal people and Torres Strait Islander people

Seven submitters commented on proposed amendments to the *Hospital and Health Boards Act 2011* in clauses 2, 5, 6, 8, 11, 12, 13, 14, 15, 18 & 19 of the Bill to strengthen the commitment to health equity for Aboriginal and Torres Strait Islander people and to strengthen the capability and effectiveness of hospital and health boards.[22]

Submissions from Queensland Human Rights Commission (QHRC), Australian Healthcare and Hospitals Association (AHHA), Royal Australasian College of Physicians (RACP), Queensland Nurses' and Midwives' Union (QNMU) and Queensland Aboriginal and Islander Health Council (QAIHC) supported the proposed amendments.[23]

Several submissions also commented on specific aspects of the Bill that could be strengthened or improved. These comments are discussed below.

2.1.1 Continuing engagement with Aboriginal and Torres Strait Islander people

Health Consumers Queensland recommended that time is taken to continue to consult and directly engage with Aboriginal and Torres Strait Islander people and community groups as the legislation is implemented.[24]

In its advice to the committee on this issue, Queensland Health stated that:

> *Stakeholders were consulted on the proposed amendments during the development of the Bill. These stakeholders included Aboriginal and Torres Strait Islander individuals and community groups, including Associate Professor (Adjunct) Adrian Marrie, Queensland Aboriginal and Islander Health Council (QAIHC), Apunipima Cape York Health Council, and Institute for Urban Indigenous Health.*
>
> *Queensland Health will continue to consult with relevant stakeholders throughout the implementation of these amendments.*[25]

2.1.2 Use of the term 'Aboriginal and Torres Strait Islander people' by the Government

The Queensland Aboriginal and Islander Health Council, the peak body for the 26 Aboriginal and Torres Strait Islander Community Controlled Health Organisations in Queensland, recommended that the Government use the term 'Aboriginal and Torres Strait Islander people' to reflect the multiple and distinct groups of peoples in Queensland.[26]

In its advice to the committee on this issue, Queensland Health stated that:

> *The Bill adopts the terminology of 'Aboriginal people and Torres Strait Islander people' to reflect the distinct and diverse nations and peoples in Queensland. This terminology is used throughout the Bill. The amendments in clause 6 of the Bill change the terminology from 'Indigenous health' and 'Indigenous Australians' to 'Aboriginal and Torres Strait Islander health' and 'Aboriginal people and Torres Strait Islander people'. This ensures the language used in section 4 of the Hospital and Health Boards Act is consistent with the amendments in the Bill that strengthen the*

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22 See submissions 16, 31, 34, 46, 68, 105, 110.

23 See submissions 16, 31, 34, 105 and 110.

24 Submission 46, p.4.

25 Queensland Health, correspondence dated 3 February 2020, p 26.

26 Submission 110, p 1.

commitment to health equity for Aboriginal people and Torres Strait Islander people, and the capability and effectiveness of Hospital and Health Boards.[27]

2.1.3 Cultural safety and unconscious bias training for non-Indigenous board members

The RACP recommended 'incorporating cultural safety and unconscious bias training for non-Indigenous board members and ensuring mechanisms are in place to prevent institutional and interpersonal racism'. The college also submitted that support for Aboriginal persons and/or Torres Strait Islander board members should be available throughout their time as board members.[28]

In its advice to the committee on these issues, Queensland Health stated:

Consistent with its commitment to embedding cultural capability within Boards, Queensland Health is reviewing its induction and training material for Board members to support implementation of these amendments. Queensland Health will work with stakeholders to develop culturally appropriate recruitment and induction processes.

The requirement in the Bill for Aboriginal and/or Torres Strait Islander representation on Boards does not limit the responsibility for achieving Aboriginal and Torres Strait Islander health equity to those members. The Bill includes achieving health equity for Aboriginal people and Torres Strait Islander people as a guiding principle for all Hospital and Health Services. Achieving Aboriginal and Torres Strait Islander health equity will be an overall commitment and responsibility of Hospital and Health Boards, Hospital and Health Services and the Queensland Government. Queensland Health notes RACP's recommendation on cultural safety.

Queensland Health already supports cultural safety in the delivery of public sector health services through the Queensland Health Aboriginal and Torres Strait Islander Cultural Practice Program (CPP) in accordance with Queensland Health's Aboriginal and Torres Strait Islander Cultural Capability Framework and Statement of Action towards Closing the Gap in health outcomes. The CPP is a foundational level training package for all Queensland Health staff. Even though the CPP does not directly provide cultural safety training, it aims to build cultural capability by increasing knowledge, and skills of clinical and non-clinical staff. It is through building capability that strategies for cultural safety can be implemented.[29]

2.1.4 Indigenous Health Practitioner and Indigenous consumer representative on HHS boards

The Australian College of Nurse Practitioners (ACNP) recommended that equity for Aboriginal people and Torres Strait Islander people would be improved through inclusion and Board representation, which should include an Indigenous Health Practitioner and Indigenous consumer representative.[30]

In its advice to the committee on these issues, Queensland Health stated:

The intention is that by requiring one or more members to be an Aboriginal person or Torres Strait Islander person, the Bill provides flexibility so that each Board can be responsive to the needs of the community within its HHS area, rather than mandating a number or mix which may not be representative of the community. Queensland Health's Board recruitment strategy will also be used to ensure a representative mix on the Board.

In addition to the requirement that Boards have one or more Aboriginal or Torres Strait Islander members, clause 11 of the Bill makes clear that the Minister may recommend a person for appointment to a Board if the person has the skills, knowledge and experience in Aboriginal and Torres Strait Islander health and community issues. This amendment puts beyond doubt that

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27 Queensland Health, correspondence dated 3 February 2020, p 27.

28 Submission 34, p 2.

29 Queensland Health, correspondence dated 3 February 2020, p 27.

30 Submission 68, p 1.

expertise in Aboriginal and Torres Strait Islander health and the Aboriginal and Torres Strait Islander community is relevant to the effective and efficient performance of a Hospital and Health Service's functions.

Hospital and Health Boards can also appoint Aboriginal and Torres Strait Islander advisory councils to provide specialist advice and support for strategic initiatives relating to Aboriginal and Torres Strait Islander health equity. Membership of advisory councils may include Aboriginal and Torres Strait Islander health practitioners and/or consumers at the discretion of the B Torres Strait Islander Advisory Council to provide strategic advice to promote the inclusion, involvement and diversity of views of Aboriginal people and Torres Strait Islander people.[31]

2.1.5 Health Equity Strategies

Health Consumers Queensland recommended that there be a requirement that Health Equity Strategies are developed directly with Aboriginal and Torres Strait Islander people and communities.[32]

In its advice to the committee on this issue, Queensland Health stated that:

Under clause 13 of the Bill, Hospital and Health Services will be required to consult when developing and giving effect to the Health Equity Strategy. Stakeholders who must be consulted will be prescribed by regulation. It is intended that the prescribed stakeholders will include Aboriginal Health Service's service delivery area. This will ensure Hospital and Health Services can engage with stakeholders to co-design a strategy that is responsive to the community it services.[33]

Health Consumers Queensland and the ACNP recommended that Health Equity Strategies deal with specific matters.

Health Consumers Queensland recommended that Health Equity Strategies 'refer to the social determinants of health (and not just the role of the health system itself to improve health outcomes)', and that 'they recognise the importance of health literacy'.[34]

The Australian College of Nurse Practitioners recommended that Health Equity Strategies include the importance of cultural safety.[35]

In its advice to the committee, Queensland Health stated:

Under clause 13 of the Bill, Health Equity Strategies must satisfy any requirements for the strategy prescribed by regulation. The regulation will prescribe specific matters that must be included in the Health Equity Strategy. Stakeholders will be consulted on the detailed requirements for Health Equity Strategies. Consultation will be undertaken during drafting of the amending Regulation in the first half of 2020.[36]

Health Consumers Queensland and QNMU recommended that Health Equity Strategies are subject to regular review and reporting.[37]

Health Consumers Queensland further recommended that HHSs publish their prevailing Health Equity Strategy, as well as the results of the suggested periodic reviews and any planned remedial action, and

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31 Queensland Health, correspondence dated 3 February 2020, p 28.

32 Submission 46, p 4.

33 Queensland Health, correspondence dated 3 February 2020, p 28.

34 Submission 46, p 4.

35 Submission 68, p 1.

36 Queensland Health, correspondence dated 3 February 2020, pp 28-29.

37 Submission 46, p 4; Submission No 68, p 1.

that strategies are subject to periodic review of their effectiveness in achieving genuine improvements in the health outcomes for Aboriginal and Torres Strait Islander people/community groups.[38]

The QNMU recommends that HHSs be encouraged to report outcomes from Health Equity Strategies annually.[39]

In its advice to the committee on this issue, Queensland Health stated that:

> *Health Equity Strategies will be published. Clause 13 of the Bill adds Health Equity Strategies as engagement strategies that Hospital and Health Services must develop and publish under section 40 of the Hospital and Health Boards Act. Under section 40(3) of the Hospital and Health Boards Act, Hospital and Health services must make all strategies publicly available, for example, by publishing on the Service's website. There are existing mechanisms under the Hospital and Health Boards Act to review and report on Health Equity Strategies. Under clause 14 of the Bill, a Hospital and Health Service will be required to review its Health Equity Strategy every three years. If the strategy is amended as a result of the review, the Hospital and Health Service must make the amended strategy publicly available. When reviewing its Health Equity Strategy, the Hospital and Health Service must consult with persons prescribed in regulation. It is intended that the prescribed persons will include Aboriginal people and Torres Strait Islander people and community groups within the Hospital and Health Service's service delivery area. As such, it is not intended that the Health Equity Strategies will be subject to additional review or reporting requirements.*[40]

Committee comment

The committee welcomes the amendments to the *Hospital and Health Boards Act 2011* proposed in the Bill to strengthen the commitment within the health portfolio to health equity for Aboriginal people and Torres Strait Islander people. The committee also welcomes Queensland Health's commitment to continue to consult with stakeholders throughout the implementation of the amendments.

2.2 Strengthening network governance in Queensland's public health system

Seven submitters commented on proposed amendments in clauses 3, 4, 7, 9, 10 to the *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* to strengthen network governance.[41]

In their submissions: the United Voice, Industrial Union of Employees, Queensland; Australian Healthcare and Hospitals Association; Health Consumers Queensland; ACNP; and QNMU supported the amendments to strengthen network governance in Queensland's public health system.[42]

Several submissions also commented on specific aspects of the Bill that could be strengthened or improved.

Inconsistency between terminologies

The Children's Health Queensland Hospital and Health Service submission raised concerns about the inconsistency between the terminology of 'users of public sector health services' in section 13 of the Hospital and Health Boards Act, and 'patients and other users of public sector health services' in clauses 7, 9 and 10 of the Bill. The submission also queried who is captured by 'other users'.[43]

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38 Submission 46, p 4.

39 Submission 68, p 1.

40 Queensland Health, correspondence dated 3 February 2020, p 29.

41 See submissions 17, 27, 29, 31, 46, 68, 105.

42 See submissions 27, 31, 46, 68 and 105.

43 Submission 17, p 1.

In its advice to the committee on this issue, Queensland Health stated that:

> *Clauses 7, 9 and 10 of the Bill give effect to the recommendation of the Expert Panel that the Hospital and Health Boards Act be amended to reflect that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system. These amendments emphasise that Queensland Health is a networked system, where each part of the system has mutual and reciprocal obligations to take a state-wide perspective.*
>
> *Clauses 7, 9 and 10 have been drafted broadly to ensure a Hospital and Health Service's duty to take a state-wide perspective is not limited or construed narrowly. Users of public sector health services will include patients of health services but may also include, for example, the families of patients, and general public consumers of health information generated by public sector health services.*
>
> *Guidance for Hospital and Health Services will be provided as part of the implementation of the governance amendments more broadly. It is anticipated that this guidance will be accessed through the Queensland Health Leadership Board.*[44]

Uploading of personal information to the Viewer to be accessible to the QAS, acute care and aged care systems

Aged and Disability Advocacy Australia (ADA Australia) recommended that information about a person's treatment preferences and choices, such as Advanced Health Directives and Do Not Resuscitate orders, are uploaded into Queensland Health's Viewer and that this information is available to the Queensland Ambulance Service, acute care and aged care systems.[45] The ADA advised the committee:

> *Where older people have independently specified choices such as Do Not Resuscitate (DNR) ADA Australia is keen to ensure that this information is uploaded onto the HHS patient record system and is readily available to the QAS staff, who might, in the absence of access to a patients treatment preferences, commence treatment, potentially in breach of an individual's expressed wishes, as reflected in their AHD.*[46]

In its advice to the committee on this issue, Queensland Health stated that:

> *The Viewer is Queensland Health's read-only web-based application that displays a consolidated view of patients' clinical and demographic information, sourced from a variety of Queensland Health clinical and administrative systems.*
>
> *Under the Hospital and Health Boards Act 2011, all health practitioners employed by Queensland Health, including Queensland Ambulance Service paramedics, have access to The Viewer. Presently, access is not available to these paramedics during transit. Queensland Health is undertaking work to ensure that access will be available to paramedics at all times, including when they are travelling.*
>
> *The Hospital and Health Boards Act 2011 also provides that other health practitioners prescribed by a regulation can access The Viewer. The Hospital and Health Boards Regulation 2012 prescribes private medical practitioners for this purpose. Queensland Health is undertaking work to amend the Regulation to prescribe additional registered health practitioners, including paramedics employed by a private company, with access to The Viewer.*
>
> *Queensland Health funds the Office of Advance Care Planning, which is a free service that provides a state-wide, standardised clinical approach to receiving, reviewing and uploading*

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44 Queensland Health, correspondence dated 3 February 2020, pp 30-31.

45 Submission 29, p 2.

46 Submission 29, p 2.

advance care planning documents. A key function of this Office is to receive copies of Advance Health Directive, Statement of Choices, Enduring Power of Attorney, Queensland Civil and Administrative Tribunal Orders and revocation documents and upload these to the person's electronic record on The Viewer. Statutory and non-statutory advance care planning documents, including Advance Health Directives, contain information about a person's wishes regarding life-sustaining measures such as cardiopulmonary resuscitation.

Documents are received from individuals, hospitals, health services, GPs and residential aged care facilities across Queensland.[47]

Extending amendments to other health entities that make decisions which affect patient care

Health Consumers Queensland recommended that the amendments extend beyond the Department, HHSs and QAS to include other relevant statutory agencies including Health and Wellbeing Queensland, the Office of the Health Ombudsman and the Queensland Mental Health Commission as they make decisions on a daily basis that impact on patient care.[48]

In its advice to the committee on this issue, Queensland Health stated that:

Queensland Health notes that the Hospital and Health Boards Act already requires the Department to consider issues from a state-wide perspective, for example, section 45 of the Act. It is not intended to extend the legislative obligations to agencies such as Health and Wellbeing Queensland, the Office of the Health Ombudsman and the Queensland Mental Health Commission, as the primary focus of the amendments is on the delivery of public sector health services as defined under the Hospital and Health Boards Act.[49]

Need for benchmarks or criteria to support implementation of the amendments by HHSs

Two submitters recommended that the amendments be supported by detailed benchmarks or criteria to support implementation by HHSs.[50]

Health Consumers Queensland also recommended:

- *the concept of 'best interests of patients' be supported by objective criteria/indicators/benchmarks to guide HHSs' proper application of the concept*
- *the proposed amendments [clauses 7, 9 & 10] be strengthened by a feedback loop to identify when decisions are not being made in the 'best interests of patients', with a clear process to remedy such situations (including at a system-wide level), and*
- *that health consumers and their carers be involved in the implementation and subsequent evaluation of these amendments.*[51]

The QNMU recommended that further consideration should be given to the consequences of non-compliance with the provisions.[52]

In its advice to the committee on the recommendations made by Health Consumers Queensland and the QNMU, Queensland Health stated that:

The amendments are designed to ensure that the overarching legislative framework for Queensland's public health system reflects the policy intent that Queensland Health operate as a networked system. The amendments will require HHSs and QAS to take a system approach in

47 Queensland Health, correspondence dated 3 February 2020, p 31.

48 Submission 46, p 4.

49 Queensland Health, correspondence dated 3 February 2020, p 32.

50 Submissions 46, 105.

51 Submission 46, p 4.

52 Submission 105, p 4.

performing their functions. The legislation itself is not the mechanism by which networked governance will be delivered.

As the Expert Panel of the Governance Advice provided, the legislative changes must be underpinned by cultural and behavioural changes in order to achieve a networked system. There are existing mechanisms established at all levels of the system to measure and monitor public health and patient outcomes, including measures of access, patient safety and quality, and broader wellbeing measures. As such, it is not intended that the compliance with the legislative obligations to take a system perspective and consider the best interests of patients will be measured or monitored.

Rather, Queensland Health's system leaders are working collaboratively on cultural and operational changes arising out of the Governance Advice, which will support the system to move to a more networked approach. Staff and key stakeholders will be consulted on relevant actions and plans arising out of this work. The Queensland Health Leadership Board, which includes consumers and nursing representation, will have broad oversight of the efforts to move to a networked system.[53]

Involvement of health consumers and carers in the implementation and evaluation of the amendments

Health Consumers Queensland recommended that health consumers and their carers be involved in the implementation and subsequent evaluation of these amendments.[54]

In its advice to the committee on this recommendation by Health Consumers Queensland, Queensland Health stated that:

…Queensland Health's system leaders are working collaboratively on cultural and operational changes arising out of the Governance Advice to support the system to move to a more networked approach. It is anticipated that the Queensland Health Leadership Board, which has health consumer representation, will monitor the implementation of the governance advice recommendations. Staff and key stakeholders (including health consumers) will be consulted on relevant actions and plans arising out of this work.[55]

Consultation with nursing groups on the amendments

The ACNP noted in their submission that no nursing groups were included in the consultation for these amendments.[56]

In its advice to the committee on this issue, Queensland Health noted:

In preparing its advice, the Expert Panel consulted with a range of government and non-government stakeholders. The Queensland Nurses' and Midwives' Union, the Office of the Chief Nursing and Midwifery Officer within Queensland Health were consulted. Unions representing Queensland Health employees, including the Queensland Nurses' and Midwives' Union were consulted on the proposed changes to the Hospital and Health Boards Act and the Ambulance Service Act.[57]

53 Queensland Health, correspondence dated 3 February 2020, pp 32-33.

54 Submission 46, p 4.

55 Queensland Health, correspondence dated 3 February 2020, p 33.

56 Submission 68, p 1.

57 Queensland Health, correspondence dated 3 February 2020, p 33.

Review of the effectiveness of the provisions

The ACNP also recommended that the effectiveness of the provisions be reviewed after two years.[58]

In its advice to the committee on this recommendation, Queensland Health told the committee:

> *It is not intended that there will be a formal review of the provisions. Queensland Health's system leaders will work collaboratively to implement the cultural and operational changes needed to give effect to a more networked approach. These will be monitored and reviewed as needed by relevant leaders.*[59]

Committee comment

The committee welcomes the amendments to the *Ambulance Service Act 1991* and the *Hospital and Health Boards Act 2011* proposed in the Bill to strengthen network governance within the public health system and ensure cooperation and collaboration between hospital and health services and with the Queensland Ambulance Service.

2.3 Provision of root cause analysis reports to quality assurance committees

This amendment to the *Hospital and Health Boards Act 2011*at clause 16 would allow the Patient Safety and Quality Improvement Service within Queensland Health to give root cause analysis reports to quality assurance committees. Health Consumers Queensland and the Australian College of Nurse Practitioners (ACNP) supported the proposed amendments.[60]

The ACNP submitted that they '…support all measures to improve patient safety and the quality of health that ensures patient confidentiality is considered.'[61] Health Consumers Queensland stated in their submission they hoped the proposed amendments will also address situations where more than one HHS is involved in a Root Cause Analysis because of the clinical pathway that occurred i.e. transferring a patient between HHSs for care, and support more involvement of the directly affected consumers in the root cause analysis process, including provisions on how the person and their family are communicated with following the completion of a Root Cause Analysis.[62]

In its advice to the committee on this issue, Queensland Health noted:

> *…this is outside the scope of the Bill which is limited to providing root cause analysis to the Patient Safety and Quality Improvement Service.*
>
> *Queensland Health, through its Best practice guide to clinical incident management, encourages root cause analysis teams to involve all relevant stakeholders when reviewing and analysing the provision of health services, this may include Hospital and Health Services, Retrieval Services Queensland, Queensland Ambulance Service as well as other health service providers. Section 115 of the Hospital and Health Boards Act provides the authority for a Hospital and Health Service and where relevant, Queensland Health, to give a copy of a root cause analysis report or information contained in a root cause analysis report to a person who has sufficient personal interest. A person who has sufficient personal interest includes family members and carers.*
>
> *The Patient Safety and Quality Improvement Service in Queensland Health has developed a factsheet titled Clinical Incident Management, Patient/family/carer perspective. The factsheet is referred to throughout the public sector health system and encourages the participation of*

58 Submission 104, p 4.

59 Submission 104, p 4.

60 See submissions 46, 68.

61 Submission 68, p 1.

62 Submission 46, p 5.

patients in the root cause analysis process. The factsheet includes information about open disclosure patients and staff manage the consequences of a clinical incident.[63]

Committee comment

The committee supports the amendments to the *Hospital and Health Boards Act 2011* proposed in clause 16 to allow the Patient Safety and Quality Improvement Service within Queensland Health to give root cause analysis reports to quality assurance committees.

2.4 Alignment with National Safety and Quality Standards

The amendments in clauses 20, 21, 22, 23 and, 24 and Schedule 1 align the conditions of licence for private health facilities in Queensland with the requirements of the National Accreditation Scheme.

Four submitters: Australian Healthcare and Hospitals Association; Health Consumers Queensland; Australian College of Nurse Practitioners (ACNP); and the Queensland Nurses' and Midwives' Union commented on and supported the proposed amendments to the *Private Health Facilities Act 2011*.[64]

The QNMU raised a number of issues with the committee where it believed the Bill could be strengthened or improved.

Enforceability of licensing conditions

The QNMU raised concerns that licencing conditions for private health facilities lack enforceability under the Private Health Facilities Act and regulation, and recommended that the Bill further considers the consequences of non-compliance with licencing standards:

the QNMU finds the current Queensland licencing conditions lack enforceability under the provisions of the Private Health Facilities Act and regulation. Robust and appropriate licencing provisions are necessary to ensure public safety. We suggest that the bill further considers the consequences of non-compliance with licencing standards. [65]

In its advice to the committee on this issue, Queensland Health noted:

Queensland Health notes this proposal is outside the scope of the Bill which is limited to aligning the Private Health Facilities Act with the national accreditation scheme.

There are existing mechanisms under the Private Health Facilities Act to ensure compliance with licensing standards. Part 7 of the Act provides that the Chief Health Officer may suspend or cancel a licence on prescribed grounds, including that the licence holder is not a suitable person to hold the licence, or contravenes a condition of the licence in a way that may adversely and materially affect the wellbeing of a patient.

The Private Health Regulation Unit within Queensland Health undertakes regular on-site compliance inspections of all licensed facilities in Queensland to monitor compliance with regulatory obligations. At a minimum, facilities are inspected every 24 months. The frequency of routine onsite compliance inspections is informed by assessment of a number of factors, including but not limited to:

- *change in ownership or management of facility;*
- *rapid expansion of services and/or provision of high-risk services;*
- *history of compliance issues and/or response to previous compliance issues,*
- *including results of National Safety and Quality Health Service accreditation; and*

63 Queensland Health, correspondence dated 3 February 2020, p 34.

64 See submissions 31, 46, 68, 105.

65 Submission 105, p 6.

- *issues in patient data e.g. clinical indicator data, low volume complex surgery.*

In addition, triggered compliance inspections are conducted as necessary. The following indicators inform the scheduling of a triggered inspection:

- *commencement of a new clinical service or increase in the level of an existing clinical service;*
- *significant structural alterations or new building works; and*
- *where information (e.g. accreditation assessment results, serious complaint) suggests that a licensee may be acting in contravention of the conditions of licencing.*

If non-compliance is identified, the Private Health Regulation Unit takes appropriate regulatory action based on the circumstances in order to manage risk proportionately and achieve the best possible outcome for the community.[66]

Recognition of and compliance with professional standards and guidelines

The QNMU recommended that the Bill consider that recognition and compliance with professional standards and guidelines (including nursing and midwifery professional standards and guidelines) is a condition of licencing:

There are inconsistencies with the application of professional standards, such as the Clinical Services Capability Framework (CSCF) and Critical Care standards. We recommend that the bill consider that recognition and compliance with professional standards and guidelines (including nursing and midwifery professional standards and guidelines) is a condition of licencing.[67]

In its advice to the committee on this issue, Queensland Health noted:

Queensland Health notes this proposal is outside the scope of the Bill which is limited to aligning the Private Health Facilities Act with the national accreditation scheme.[68]

Public reporting of issues with the issuing of licenses

QNMU recommended that compliance issues with issuing a licence are publicly reported and published by the Nursing and Midwifery Colleges and Associations.[69]

In its advice to the committee on this issue, Queensland Health noted:

…this proposal is outside the scope of the Bill which is limited to aligning the Private Health Facilities Act with the national accreditation scheme.

Queensland Health notes that the Health Transparency Act 2019 will require private health facilities to report information about their accreditation and performance against the National Safety and Quality Health Service Standards to Queensland Health. Information about whether a private health facility is accredited against the Standards will be published on a dedicated website that is accessible by the public. Reporting and publication of information under the Health Transparency Act will commence from 2020.[70]

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66 Queensland Health, correspondence dated 3 February 2020, pp 35-36.

67 Submission 105, p 6.

68 Queensland Health, correspondence dated 3 February 2020, p 36.

69 Submission 105, p 6.

70 Queensland Health, correspondence dated 3 February 2020, pp 36-37.

Committee comment

The committee supports the proposed amendments to the *Private Health Facilities Act 2011* to align the conditions of licence for private health facilities in Queensland with the requirements of the National Accreditation Scheme.

2.5 Water risk management plans

Only one submission addressed clause 27 which amends the *Public Health Act 2005*. The proposed amendments correct an error in s 61D of the Act to require water risk management plans to state procedures for responding to both the results of monitoring and the results of testing for the presence of a hazard in the water distribution system.

The ACNP submission supported the proposed amendment.[71]

Committee comment

The committee supports the proposed amendment to the *Public Health Act 2005* to correct an error in s 61D.

2.6 Prohibition of conversion therapies

The majority of submissions to the committee (146) addressed the proposed amendments in clause 28 to the *Public Health Act 2005* to prohibit conversion therapies by health services providers (Part 5 Chapter 5B). Given that Queensland is the first jurisdiction to propose such legislation as well as the controversial nature of the issue for health professionals, a relatively large number of submissions were received from doctors and psychiatrists, particularly those practicing outside Queensland.

While submitters overwhelmingly support protecting people from coercive and brutal conversion therapies, most were critical of the provisions contained in clause 28. The following sections discuss the issues raised by submitters.

Clause 28 amendments are also discussed in Part 3 of this report in relation to fundamental legislative principles issues.

2.6.1 Meaning of conversion therapy

Twenty submissions expressed concern that the definition of conversion therapy at clause 28 new section 213F is too broad or that the scope of practices covered by the definition is, or may be, unclear and interfere with legitimate counselling and other care that health practitioners provide their patients. Submissions suggested that this could have unintended consequences, such as limiting treatment options for persons with symptoms of gender dysphoria and their families.[72]

Professor Patrick Parkinson AM, Head of the TC Beirne School of Law at the University of Queensland, noted in his personal submission:

> *The actus reus of the offence, that is the deed or action which constitutes the offence, is to provide "conversion therapy". This is a treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity. Examples are given, and these include other clinical interventions, including counselling, that encourage a person to change the person's sexual orientation or gender identity. This is very broadly expressed. Even encouraging a young person to change their sexual orientation or gender identity is to be unlawful, even if no therapy is provided to endeavour to assist them to change.*[73]

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71 Submission 68, p 2.

72 See submissions 1, 40, 45, 54, 55, 74, 79, 107, 125, 131, 132, 136, 137, 139, 145, 146, 147, 149, 150, 153.

73 Submission 40, p 17.

The Queensland Law Society also took issue with the lack of certainty in the definition as to what is or is not conversion therapy, and warned of unintended consequences:

> *A broad definition of "conversion therapy" may have unintended consequences. The current drafting of section 213F is extremely broad and does not provide sufficient certainty as to what conduct is targeted and what practices are excluded.*[74]

The QLS explained their concerns in detail in their evidence at the committee's public hearing:

> *…the bill attempts to approach the prohibition of conversion therapy in a three-step process. The first step is to define as 'conversion therapy' any treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity, as those terms are very broadly defined. Given that there is then a provision creating an offence for performing conversion therapy, the structure of the bill is such that it at first prohibits and makes criminal any conversion therapy. It then goes on to try to limit the scope of that offence by saying that other things are not conversion therapy, and paragraph (2) does that but it does it in very general terms. Conversion therapy is not something which 'assists a person who is undergoing a gender transition' or which 'provides acceptance, support and understanding of a person'. It may very well be that the examples given in paragraph (1) come into conflict with the statements of what is not conversion therapy in paragraph (2), and that would create a problem for the courts to attempt to resolve.*
>
> *Paragraph (3) provides some reassurance to practitioners for work that they have performed in their reasonable professional judgement. We have some concerns about the structure of paragraph (3) because, firstly, the offence will apply to many people beyond the regulated health professions. It applies to anybody within the very broad definition of 'health service provider' which is anybody who is holding themselves out as providing a service which assists with somebody's health and wellbeing. Outside the scope of the regulated professions, how does one assess the reasonable professional judgement of a yoga instructor or a massage therapist? It is unlikely to provide much assistance to those sorts of people. Also, the reasonable professional judgement is not a reasonable professional judgement about what is in the best interests of the patient, but it is a reasonable professional judgement as to what is necessary to provide a health service in a manner that is safe and appropriate. That test of necessity, rather than what might be desirable or what might be best practice, may raise the bar higher for a defendant than the draftsman actually intended it to do.*
>
> *With all of those problems of construction, from the point of view of a prosecutor, this would be an offence that would be very difficult to prosecute because the scope of the—they are not defences—exceptions to what is prohibited conversion therapy is so broad. From a defence lawyer's point of view, there is enormous scope to bring the very practices that the bill seeks to prohibit within the scope of the exceptions. From the point of view of a lawyer advising a health practitioner as to whether or not what they propose to do might breach this provision, that will be very difficult, at least until the courts have provided some interpretation around the bill. The prudent advice to avoid any risk of being prosecuted would be to cease providing any services which might arguably result in a breach of paragraph (1). It is more a matter of construction and drafting that raises our concerns. As a piece of criminal legislation, if it is going to be enforced and followed, it is unworkable—almost hopelessly unworkable in our view.*[75]

In their joint submission, Christian Schools Australia (CSA), Adventist Education Australia (AEA), Associated Christian Schools (ACS), Australian Association of Christian Schools (AACS) raised concerns

[74] Submission 137, p 1.

[75] Public hearing transcript, Brisbane, 7 February 2020, p 58.

about the scope of the definition which references the definition for health service provided in the *Health Ombudsman Act 2013*:

> *… the definition of 'health service provider' is extremely broad, encompassing not only registered health practitioners as commonly understood but also any "individual who provides a health service". A "health service" to be broadly defined as any "service that is, or purports to be, a service for maintaining, improving, restoring or managing people's health and wellbeing". There are no limits on where this service is provided, with schools included in the ambit of the definition according to Mr Mahler in the Public Briefing, see page 8.*[76]

The Australian Association of Social Workers (AASW) raise particular concerns in relation to section 213E as it relates to social workers:

> *…the legislation refers to 'health service provider' as specified in the Health Ombudsman Act 2013, section 8. Social work, as with some other professions, are not currently registered in Australia. It is unclear if Section 8 (a) (ii) another individual who provides a health service or (b) an entity, other than an individual who provides a health service, would include social workers. The lack of registration of social workers in Queensland and Australia is thus problematic.*[77]

Other submissions supported the broad definition of the term 'conversion therapy'.

The Queensland Aids Council noted a broad definition of conversion therapy is appropriate because conversion therapy is increasingly aimed at suppressing or changing not only sexual orientation but also gender identity which, the council states, is becoming more common. The Queensland Aids Council also considered that the definition is sufficiently tailored so as not to prohibit supportive or affirming practices or legitimate clinical interventions, such as a psychiatrist or other health service provider providing safe, evidence-based and clinically appropriate care to people with gender dysphoria, including children.[78]

> *Although the focus of conversion therapy used to be on 'changing' a person's sexual orientation, gender identity conversion therapy is becoming more common.*[79]

The AASW recommended that the language in new section 213F(2)(a) and (b) be changed to reflect more gender affirming terminology by using the phrase 'gender affirmation' rather than 'gender transition', to reflect that gender affirmation is a more accurate representation of what is happening for the individual.[80]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recommended that a definition of gender transition be included in the Bill to ensure interpretation is clear:

> *We also recommend the definition of gender transition be included to ensure the interpretation is clear. Gender transition refers to the process through which an individual changes or affirms their gender-related identity, appearance, mannerisms or other gender-related characteristics.*[81]

Regarding the RANZCP's recommendation, Queensland Health advised the committee:

> *The Bill does not define 'gender transition'. This term is used in new sections 213F(2)(a) and (b) to define certain practices that do not constitute conversion therapy. It is intended that the term be interpreted broadly and in a manner that reflects current and emerging clinical practice.*

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[76] Submission 79, p 4.

[77] Submission 131, p 5.

[78] Submission 139, p 2.

[79] Submission 139, p 2.

[80] Submission 131, p 5.

[81] Submission 152, p 2.

Including a definition for this term is not recommended as doing so could unnecessarily constrain its meaning as understanding of gender identity and approaches to treatment for gender dysphoria continue to evolve.[82]

In its advice to the committee on the other issues raised by submitters concerning the definition of gender therapy in the Bill, Queensland Health noted:

Queensland Health considers that the scope of practices defined as conversion therapy is appropriate and sufficiently clear as to the types of treatments and practices that will be prohibited by the Bill.

The definition of conversion therapy is narrowly tailored to practices whose aim is to change or suppress a person's sexual orientation or gender identity. These practices are based on the false and dangerous premise that a person's sexual orientation or gender identity is not acceptable or is a disease or condition that needs to be corrected.

These ideas have been thoroughly discredited within the clinical and scientific community, and practices based on them have no basis in evidence, have been proven to be harmful and have no place in the provision of health services in Queensland.

The definition of conversion therapy does not apply to treatments or practices that are evidence-based or that have a reasonable clinical justification. This is clear from the basic definition of conversion therapy (new s. 213F(1)), the examples of practices that are specifically excluded from that definition (new s. 213F(2)) and the additional exception for actions that are based on a health service provider's reasonable professional judgment that a practice is necessary to provide a health service in a manner that is safe and appropriate or that complies with the provider's legal or professional obligations (new s. 213F(3)).

The exception for professional judgment recognises that there are different views within the clinical community about the appropriate treatment of persons with symptoms of gender dysphoria and other mental health issues related to sexual orientation and gender identity, and that clinical standards in this area are still evolving. The exception provides ample discretion to health service providers and does not restrict their ability to provide LGBTIQ patients with safe and clinically appropriate care.[83]

To address concerns about the 'ambiguous wording' of the definition of conversion therapy, AMAQ recommended amendments to ensure 'clarity and certainty' for its members:

… firstly to section 213F(1), we consider the need for precision in the definition sections of legislation is critical. Precision allows for persons who are interpreting legislation, whether health practitioners or not, to have absolute certainty about what they can do and what they cannot do. Therefore, we call on the definition to be changed to, 'conversion therapy is a treatment for which the only intent is to attempt to change or suppress a person's sexual orientation or gender identity.'

Secondly, to section 213F(2), we recommend that for clarity we support the position of NAPP and seek the following additional examples to be added: treatments and practices that provide empathetic acknowledgement and evidence based support and understanding for the facilitation of an individual's coping, social support, identity exploration and development, and, importantly, treatment of any identified psychiatric co-morbidity.

…

82 Queensland Health, correspondence dated 10 February 2020, p 7.

83 Queensland Health, correspondence dated 3 February 2020, pp 8-9.

Thirdly, we recommend that the following wording, which is currently in the explanatory notes, be incorporated into clause 213F(3)—

> *The exclusion will protect practitioners who, acting reasonably, in good faith and in accordance with relevant professional standards, treat a patient in a manner that could be subjectively perceived as not affirming or supporting their sexual orientation or gender identity. For example, a doctor may advise against surgery because a patient has a pre-existing condition that means the surgery is not safe. A doctor may also be required to advise a patient about potential side effects of drugs. In cases such as these, health service providers will be able to rely on the reasonable professional judgment exception to ensure that the health services provided are delivered in a safe and clinically appropriate manner.*

The question that our members and our counsel have asked is as follows: if it is in the explanatory notes why is it not in the legislation? [84]

In its advice on the issues raised in the AMAQ submission, Queensland Health told the committee:

Queensland Health has strong reservations regarding AMAQ's proposal to amend the definition of conversion therapy to require a sole purpose or intent. In the Department's view, this would render the legislation unenforceable in most cases and would provide inadequate protections for LGBTIQ individuals, which is inconsistent with the intent of the legislation. It is highly unusual for an offence provision to require proof of a sole purpose, as people usually have mixed motives for their actions, and it would be extremely difficult to establish a person's sole intent beyond a reasonable doubt. For example, in the clinical context to which the Bill applies, health service providers who perform conversion therapy could escape prosecution by claiming that they believed, notwithstanding the clear evidence to the contrary, that performing conversion therapy on the patient would help improve their mental health, coping skills or overall wellbeing.[85]

2.6.2 Evidence of conversion therapy occurring in Queensland

Submitters disagreed on whether there is evidence of conversion therapies being provided in Queensland. The opinions regarding this that were expressed to the committee are presented below.

The LGBTI Legal Service advised that there was evidence of such practices occurring in Queensland with their submission stating:

... conversion therapy practices continue to exist in Australia today with around ten organisations known to be still operating, including at least two providing services in Queensland. Such practices are often offered by unregulated health practitioners with modern conversion therapy practices seeking to present as more 'ethical' and include aversion therapy, counselling, psychotherapy, support groups, and exorcisms. Further, conversion therapy was once often referred to as 'gay conversion therapy', but modern manifestations of such practices also target the suppression of the gender identities of transgender and gender diverse people within the community. Despite the majority of leading medical organisations rejecting their utility, such practices continue to operate causing significant and long-lasting trauma and mental health impacts to often vulnerable members of the LGBTI community.[86]

The Queensland Aids Council stated that 'QuAC is concerned that there is evidence of conversion therapy taking place in Queensland, particularly in faith-based environments, but also anecdotally amongst some health professionals, including psychologists, GPs and counsellors.[87]

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84 Public hearing transcript, Brisbane, 7 February 2020, pp 14-5.

85 Queensland Health, correspondence dated 10 February 2020, P 3.

86 Submission 99, p 2.

87 Submission 139, p 2.

Three submitters stated that there is no evidence that conversion therapy is being conducted in Queensland and therefore there is no pressing need for its inclusion in the Bill.[88]

Fair Go for Queensland Women advised:

> *We note that the documents referred to in the Explanatory Notes do not provide current evidence of conversion therapy practices being undertaken by health service providers in Queensland, or significant occurrences in Queensland. We query the necessity of this legislation on that basis.*
>
> *One of the documents referred to as evidence in the Explanatory Notes specifically states that no studies have been undertaken to identify prevalence of conversion therapy in Australia as it pertains to 'gender identity'. Given this, we ask the necessity of this legislation and upon what grounds the Bill provisions related to gender identity is presented.*[89]

The Queensland Law Society stated:

> *There is nothing in the explanatory notes about the extent or use of conversion therapy in Queensland.*
>
> *QLS is concerned about the lack of any cogent data to support treating this conduct as a criminal law issue, particularly in the absence of evidence as to…the extent to which health service providers are practising conversion therapy…*[90]

The submission from AMAQ was critical of the conversion therapy provisions of the Bill.[91]

The Queensland Human Rights Commission submission argued that as harm is reported by individuals who have received conversion therapy, regardless of the prevalence, the extent of harm alone justifies a strong legislative response.[92]

In its advice to the committee on this issue, Queensland Health noted:

> *It is difficult to measure the prevalence of conversion therapy due to the underground nature of the practice. However, despite there being limited data on conversion therapy practices in Queensland, there are strong indications that some health service providers are engaging in conversion therapy in Queensland.*
>
> *The La Trobe University Report refers to one Brisbane based organisation that has been a strong proponent of sexual orientation change and offers to refer people to qualified counsellors who are members of an accredited professional or counselling association. Anecdotally, Queensland Health has also received reports of health service providers engaging in conversion therapy. Further, submissions received by the Committee express the view that counselling and other practices to modify or suppress same-sex attraction are beneficial and should be permitted to continue.*
>
> *Queensland Health notes that several submissions state that therapy to assist people to suppress same-sex orientation is beneficial and should be permitted to continue.*
>
> *While the practice of conversion therapy may not be widespread amongst health practitioners, as noted by the Queensland Human Rights Commission the harms the practice causes and the desirability of sending a strong message that conversion therapy is unacceptable justify the introduction of the offence.*[93]

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88 See submissions 108, 137, 153.

89 Submission 108, p 1.

90 Submission 137, p 2.

91 Submission 153, pp 3-4.

92 Submission 16, p 3.

93 Queensland Health, correspondence dated 3 February 2020, p 19.

2.6.3 Application of the prohibition of conversion therapies to health service providers

Twenty-three submissions raised concerns that the definition of 'health service provider' is likely to extend beyond medical practitioners to psychologists, psychiatrists, counsellors of all types, pastors, Christian charities and school chaplains.[94]

These submission raised the following issues:

- the prohibition will make criminals of those who are willing to offer genuine professional advice which is in the best interest of their patient
- the definition of conversion therapy in section 8 of the *Health Ombudsman Act 2013* is vague and could be construed by activists to include charities, churches and family members and
- The definition may cause parents to fear being fined for speaking with their child (who identifies as part of the LGBTIQ community) regarding gender dysphoria, gender reassignment surgery and other issues affecting their child's wellbeing.

At the committee's public hearing on 7 February 2020, the Queensland Law Society raised further concerns about the conversion therapy offence provisions:

> *…it appears that the offence will apply to a health service provider, whether that is a registered regulated one or not, when that person is participating in religious activities. There has been some evidence about that to this committee from Dr Wakefield and from the department in its response to the submissions. The effect of that evidence has been that whether a person is acting as a health service provider or is acting in another capacity will depend upon the factual context of their actions, so if the dentist goes down to church on Sunday then he is not acting as a dentist. The suggestion has been in the evidence that this offence will not apply to them, but that is not set out in the wording of the offence. The wording of the offence applies to a person who is a health service provider. It does not say a person who is a health service provider in the course of providing health services; it just applies to a person who is a health service provider. We would suggest that that reassurance which has been given to this committee about whether the offence will apply to people when they are acting in another capacity is perhaps misconceived.*[95]

In its advice to the committee on submissions, Queensland Health noted:

> *The definition of health service provider includes registered health practitioners, including doctors, nurses and psychiatrists, and unregistered health practitioners, including counsellors. The intention of the Bill is to include a wide range of health practitioners in the definition of health service provider as reports suggest that, to the extent conversion therapy occurs in clinical contexts in Queensland, it is performed by registered and unregistered health service providers.*
>
> *However, the Bill only prohibits conversion therapy when performed a by a health service provider. In general, this means conversion therapy is only prohibited to the extent that it involves the provision of a health service. Religious or spiritual interventions, such as prayer or religious guidance or teaching, are not prohibited by the Bill, even if these practices aim to change or suppress a person's sexual orientation or gender identity. Subject to the comments below, it is unlikely that the actions of a Christian charity, pastor or school chaplain would be considered conversion therapy for the purposes of the Bill.*
>
> *There may be instances where a person providing a faith-based conversion therapy is also providing a health service. For example, a doctor who administers a prayer-based treatment to a patient who has sought medical advice about treatments for gender dysphoria may be committing an offence. However, whether a practice is purely religious or spiritual, and is therefore permitted, or involves the provision of a health service will depend on the facts and*

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94 See submissions 55, 62, 63, 64, 65, 66, 69, 74, 78, 80, 82, 83, 84, 87, 88, 93, 98, 102, 104, 106, 115, 133, 138.

95 Public hearing transcript, Brisbane, 7 February 2020, P 57.

circumstances of the case. Factors that may influence whether a practice is religious or spiritual or a health service include:

- *The setting where the practice is performed (for example, an office, clinic or church);*
- *Whether the person performing the practice does so in a professional capacity or in their personal capacity as an advocate of religious or spiritual teachings; and*
- *Whether the person performing the practice makes health related claims, such as that the individual has a disease or disorder that can be cured by the practice, or that the individuals' experience of stress, mental health issues or other health issues will be alleviated by the practice.*[96]

Submissions also stated that the proposed prohibition of conversion therapies will prevent homosexuals and those who are confused about their gender from accessing help they may be seeking.[97]

In its advice to the committee on this issue, Queensland Health noted:

The Bill promotes access to safe and appropriate treatment for these individuals by sending a strong signal that gender dysphoria and other mental health issues related to sexual orientation and gender identity are not abnormal and providing assurance that health services aimed at treating these issues will be informed by evidence and clinical practice.[98]

2.6.4 Definitions of 'sexual orientation' and 'gender identity'

A number of submissions recommended that gender identity or concepts of gender should be removed from the Bill. Some submissions called for the separation of issues of sexual orientation and gender identity, arguing there are differences between the two concepts that should not be considered together.[99]

Fair Go for Queensland Women stated:

We submit that gender identity practices are, in and of themselves, conversion practices that arise from a perception that the individual is 'not ok' as they are and they must change.

We submit that there are robust discussions that need to occur prior to consideration that 'gender identity' be endorsed as a legislatively unassailable concept and by extension, affirmative practices in relation to 'gender identity', as this Bill suggests.[100]

The Coalition of Activist Lesbians (Australia) submission stated:

We are concerned that sexual orientation and gender identity are combined into the same clauses of this Bill. This results in significant tension in the Bill because harsh medical treatments are outlawed for sexual orientation conversion, while extreme surgery and dangerous hormones are condoned and supported for children, in the case of gender identity.[101]

At the committee's public hearing, Ms Anna McCormack of the International Women's Day (IWD) Association, Brisbane Meanjin stated:

…I cannot imagine people supporting conversion therapy of lesbians and gays, but to put in the same sentence affirmation of conversion therapy for people with gender dysphoria is just wrong.

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96 Queensland Health, correspondence dated 3 February 2020, pp 19-20.

97 See submissions 18, 28, 70, 71, 72, 73, 76, 77, 91, 94, 102.

98 Queensland Health, correspondence dated 3 February 2020, p 21.

99 See, for example, submissions 96, 100, 101, 104, 108,120.

100 Submission 108, p 1.

101 Submission 120, p 3.

These two elements need to be separated out. We need to stop. We need to consider better what is happening with the gender identity section of this act.[102]

The RANZCP proposed that the definition of sexual orientation in the Bill at new section 213E should be amended to reflect the *Sex Discrimination Act 1984* (Cth):

sexual orientation means a person's sexual orientation towards:(a) persons of the same sex; or (b) persons of a different sex; or (c) persons of the same sex and persons of a different sex.[103]

In its advice on the RANZP proposal, Queensland Health advised the committee:

The definition of sexual orientation in the Bill was developed in consultation with LGBTIQ stakeholders and expert bodies, including the Queensland Human Rights Commission, and is considered appropriate. Feedback from stakeholders suggests that the definition used in the Sex Discrimination Act 1984 (Cth) is outdated. For example, it does not explicitly acknowledge the emotional and affectional aspects of sexual orientation. It is also ambiguous because it uses the term that it defines ('sexual orientation means a person's sexual orientation towards…').[104]

The Queensland Law Society also flagged concerns about the definitions in their evidence at the public hearing:

The bill defines its terms in very broad scope and that the gender identity of a person includes such things as other expressions of the person's gender, including their name, dress, speech and behaviour. The definition of 'sexual orientation' is defined to mean—

... the person's capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different gender, the same gender or more than 1 gender.

One reading of that is that it is a person's capacity for sexual and emotional and affectional attraction to anyone, regardless of their gender. When you come to the definition of conversion therapy being a change to that, it is at least arguable that any intervention or attempts to change a person's sexual behaviour or who they are attracted to is captured by this bill rather than simply therapy which is designed to change the gender to which they are attracted or to suppress an attraction. It could even be arguable that that definition is so broad as to capture the work that is done in prisons with sex offenders and with sex offenders who have attraction to people who are under the legal age of consent. That is not the intention of the bill, but the wording is not sufficient to make it clear. In the Australian Medical Association's submission they suggest adopting the definition of 'sexual orientation' from the Sex Discrimination Act. That seems to be a better and clearer definition which fits the intention of what this legislation is trying to achieve.[105]

In its advice to the committee on the other issues raised by submitters with the definitions at new section 213E, Queensland Health noted:

Queensland Health considers that it is both appropriate and necessary to include gender identity in the definition of conversion therapy. A key theme of the Ending Sexual Orientation Conversion Therapy Roundtable was that conversion therapy is increasingly focusing on transgender persons and that efforts to address these practices should reflect a broad understanding of conversion therapy that includes efforts to change or suppress a person's gender identity.

The United Kingdom's 2018 National LGBT Survey reported that transgender respondents were twice as likely as cisgender respondents to have been offered conversion therapy. The La Trobe

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102 Public hearing transcript, Brisbane, 7 February 2020, p 43.

103 Submission 152, p 2.

104 Queensland Health, correspondence dated 10 February 2020, p 7.

105 Public hearing transcript, Brisbane, 7 February 2020, p 58.

University Report says that, as Australia's religious demographics are similar to those in the United Kingdom, it is reasonable to suggest that the experience of LGBT Australians is comparable to the LGBT community in the United Kingdom.

Queensland Health acknowledges that sexual orientation and gender identity are separate concepts and note that this is demonstrated in the Bill through the separate definition of these terms. Although sexual orientation and gender identity are separate concepts, evidence shows that conversion therapy can be aimed at changing or suppressing a person's sexual orientation or gender identity. The evidence also shows that conversion therapy practices are ineffective and harmful, regardless of whether the practice targets a person's sexual orientation or gender identity.

Excluding gender identity from the definition of conversion therapy would fail to adequately address the risk posed by conversion therapy and would leave Queensland's transgender and gender diverse community exposed to the harms caused by conversion therapy.

Omitting gender identity may also send the message that conversion therapy is acceptable or even evidence-based when performed on transgender or gender diverse people, however, there is no evidence that conversion therapy can change a person's gender identity and there is evidence that attempts to change or suppress a person's gender identity are harmful.

Queensland Health does not accept that "gender identity" is a form of conversion. The definition of conversion therapy in the Bill acknowledges that gender identity is a person's internal and individual experience of gender and does not relate the concept of gender identity to gender stereotypes.

2.6.5 Concerns the Bill may promote gender-affirming treatment

Sixteen submissions raised concerns that the Bill at cl. 28, new ss. 213F and 213G requires medical practitioners to affirm and promote a transgender lifestyle or to affirm gender confusion. Some submissions raised this concern particularly in relation to children.[106]

Thirty submissions raised concerns that the Bill may require or mandate doctors to provide hormone treatment or surgical treatment, and/or prevents doctors from adopting a 'watchful waiting' approach.[107] Some submissions also expressed concern that as a result of the prohibition under the Bill, health providers may be more likely to encourage gender reassignment or other permanent transition treatments.

Dr Kerri Barnes's submission stated:

The proposed legislation will prevent children and adolescents with gender dysphoria from accessing proven treatments of individual and family psychotherapy and counselling, and condemns them instead to a life-long administration of hormones and the possibility of major surgery, including castration. Even the proponents for hormonal intervention themselves admit that they do not know whether their interventions improve outcomes for the children that undergo them. Conversely, we know that puberty blocking medications and cross sex hormones medications have lasting side effects on the developing brain.[108]

Dr Hayley Thomas's submission stated:

I'm concerned that the Bill may discourage adopting a 'watch and wait' approach in children whose gender identity and sexual orientation is still developing. This could result in increased

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106 See submissions 2, 5, 6, 7, 10, 16, 22, 25, 104, 129, 130, 143, 145, 149, 150, 151.

107 See submissions 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 23, 24, 28, 30, 41, 50, 54, 75, 92, 94, 97, 100, 103, 104, 108, 112, 114, 123, 128, 129, 136, 140, 141, 143.

108 Submission 97, p 1.

and earlier use of hormonal and other methods for gender transition, which may not be in the best interests of the child in the longer term.[109]

Emeritus Professor Kim Oates AM wrote:

Because of the data about deleterious side effects of hormonal therapy in some cases, I write to request the Parliament not to oblige therapists to pursue the hormonal intervention as the only form of intervention and to permit psychotherapeutic support for selected cases, as this has been shown to be effective.

Gender dysphoria is a real condition. As a paediatrician, I am deeply committed to good mental health and physical in all children, including families where gender dysphoria occurs.

I thank the Parliament for its concern about the welfare of children with gender dysphoria but wish to register my strong disagreement with its commitment to the claims of benefit from the life-long administration of large doses of hormones and the possibility of serious surgery.[110]

At the public hearing into the Bill, further concerns about the Bill promoting gender-affirming treatment were raised. Professor Dianna Kenny stated:

The proposed Public Health Act 2005 amendments define 'conversion therapy' as 'treatments and practices that attempt to change or suppress a person's sexual orientation or gender identity'. The proposed chapter 5B 'Conversion therapies', if passed into law, will have a highly detrimental impact on health service providers caring for and advising individuals on matters related to their gender identity. It will provide gender dysphoric young people with no options other than gender-affirming therapy. If passed, it will create an important precedent for other Australian jurisdictions.

No legislation founded on false premises can be justified or implemented. This legislation is fatally flawed because it is underpinned by a gender identity ideology that conflates gender, which is a social construct, with sex, which is an unalterable biological fact. It asserts that gender identity is fixed and immutable during the early part of the life span. It supports those attempting to establish a fixed transgender identity in young people who are in the exploratory phase of their sexual and gender identity development. We know that the majority with gender dysphoria in early adolescence will desist by young adulthood.[111]

In its advice to the committee on this issue, Queensland Health noted:

The Bill does not require medical practitioners to perform or provide any treatments. The Bill does not play a role in setting clinical standards or dictating the appropriate treatment for recognised medical conditions or promote one recognised treatment above another.

The Bill targets practices that attempt to change or suppress a person's sexual orientation or gender identity. Clinically, a person's sexual orientation or gender identity is not considered to be a disease or disorder that requires treatment.

The definition of conversion therapy expressly excludes a practice that 'facilitates a person's coping skills, social support and ***identity exploration and development****' (emphasis added). Identity exploration and development includes the exploration and/or identification of one's sexual orientation or gender identity. Practices that support a person struggling with their sexual orientation or gender identity and help a person identify and/or cope with their sexual orientation or gender identity will not be conversion therapy, provided a particular sexual*

109 Submission 94, p 1.

110 Submission 126, p 1.

111 Public hearing transcript, Brisbane, 7 February 2020, p 52.

orientation or gender identity is not promoted as the correct or only acceptable sexual orientation or gender identity.

Gender dysphoria is a recognised medical condition. Gender dysphoria is the distress that may be felt by people whose gender identity differs from the sex assigned to them at birth. The Bill does not dictate the appropriate treatment for gender dysphoria in adults or children nor does it prevent medical professionals assessing or diagnosing a person with gender dysphoria, including making an alternate diagnosis. The assessment and diagnosis of a person with gender dysphoria also do not constitute conversion therapy. The Bill expressly refers to this as one of the practices that is not included in the definition of conversion therapy.

Further, the definition of conversion therapy excludes a practice that, in the health service provider's reasonable professional judgment, is necessary to provide a health service in a manner that is safe or appropriate or comply with the provider's legal or professional obligations. A medical condition may be treated or managed by a variety of accepted and proven treatments or other practices and the appropriate treatment in each case will differ depending on a variety of factors. The professional judgment exemption recognises that doctors must make treatment decisions on a case by case basis and ensures that doctors acting in accordance with accepted practice will not be committing an offence.

The effect of these provisions is that legitimate treatments and evidence-based practices used to assess, diagnose or treat mental health issues, including gender dysphoria, are not considered conversion therapy. Nothing in the Bill requires a medical professional or other health service provider to perform gender-reassignment surgery or provide another treatment without first assessing, diagnosing and, if appropriate, treating a patient's gender dysphoria, co-morbidities or other issues.[112]

2.6.6 Implications for the treatment of gender dysphoria in children

Twenty-six submissions noted that the definition of conversion therapy in the Bill could prohibit legitimate clinical interventions, such as psychiatric treatments, that are indicated to assess or explore mental health or other issues related to sexual orientation and gender identity.[113] Some submissions recommended the definition clearly exclude practices that are informed by evidence or that are otherwise supported by clinical practice.

At the public hearing, Dean of Law at the Queensland University, Professor Patrick Parkinson AM, appearing in private capacity told the committee of the importance of access to therapy for children and adolescents with gender confusion, and the effects he believed the Bill will have on therapists practising in the area:

These young people desperately need therapy. They need good, expert mental health care…The problem with this bill—and I say this with all sincerity; I am sure it is well intentioned—is that it will drive away the expert therapists that these young people so desperately need, people with great expertise, great experience. They will consider it just too risky to continue working with these troubled teenagers. I would have to give that advice if I was asked. I would have to advise them that continuing this work of helping young people to understand where their problems may be coming from other than being born in the wrong body risks prosecution.[114]

Professor Parkinson also commented on the defences included in the definition of conversion therapy at new section 213F(3) in clause 28 of the Bill:

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112 Queensland Health, correspondence dated 3 February 2020, pp 12-13.

113 Submissions 1, 4, 7, 8, 9, 10, 11, 12, 13, 14, 15, 18, 19, 20, 22, 23, 24, 40, 56, 106, 107, 109, 117, 119, 143.

114 Public hearing transcript, Brisbane, 7 February 2020, p 30.

> *Queensland Health properly referred to the various defences in the bill. They are well drafted defences and they will protect health practitioners who make reasonable clinical judgements and assessments—I do not dispute that—but it does not solve the problem. The bill will have a severe chilling effect. If someone tells you the cliff edge is dangerous, the ground may crumble beneath your feet and you could fall to your death, you will not go as close to the cliff edge as you think is reasonably safe. You will avoid the cliff entirely, and this is the risk. If a therapist tries to help a young person understand that their mental health problems may have different causes, different ideologies and different solutions to the ones the young person has identified, they risk the young person running off to the police and claiming that the psychiatrist or psychologist has engaged in conversion therapy and then that health professional will have to go through all of the stress of police interviews, the long wait to see if they will be prosecuted, possibly the stress of being charged and having to mount a defence.*[115]

Seven submissions commented on the examples included in new section 213F of practices that would or would not be covered by the definition of conversion therapy in the Bill.[116]

Some of the submissions disagreed with the use of psychotherapy and psychoanalysis in the examples provided with the definition of conversion therapy. The submissions highlighted that psychotherapy and psychoanalysis are not necessarily conversion therapies, nor are they generally associated with aversion techniques. These practices could include supportive and clinically acceptable forms of treatment, such as supportive cognitive behaviour, psychodynamic or psychoanalytic therapy.

Regarding comments in the explanatory notes that give examples of therapies prohibited under the Bill, Drs Joseph De Zordi and Thomas Campbell in their joint submission state:

> *This is a strawman argument. A bogus bogeyman is presented, to smear well meaning and reasonable therapists/ doctors/ counsellors. I know of no one who has ever done this (torture with electricity or drugs) This would be an extreme historical aberration, which is nowadays non existent. This example is used, dishonestly conflated with mild reasonable strategies (counselling, advice, knowledge, religious education), to help vulnerable individuals. Counselling is not a unilateral therapy, typically it is a partnership, between patient and a therapist. The patient should be offered all options and long term sequelae of sex change should be explained in detail. To withhold this is in fact a travesty, a betrayal of patient care, and an affront to the principal of informed consent.* [117]

Regarding comments in the explanatory notes describing treatments that are <u>not</u> prohibited, Drs Joseph De Zordi and Thomas Campbell in their joint submission stated:

> *So the actual act of cognitive and physical transition (conversion), is deemed to not be conversion, whereas reasonable strategies to offer emotional support, counselling to help an individual reconsider undergoing a destructive conversion, are now considered to be acts of criminality! This Bill is an abuse of the power of politicians to enforce a bizarre ideology about gender and stifle the professional freedom of doctors. It must be rejected.*[118]

In its advice to the committee on these issues, Queensland Health noted:

> *The definition of conversion therapy does not prohibit legitimate treatments or practices, including techniques such as psychoanalysis, counselling or conditioning techniques that a health service provider reasonably considers are clinically appropriate.*

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115 Public hearing transcript, Brisbane, 7 February 2020, p 30.

116 Submissions 1, 106, 107, 109, 135, 139, 144.

117 Submission 106, p 3.

118 Submission 106, p 4.

> *The Bill only prohibits practices that aim to change or suppress a person's sexual orientation or gender identity on the basis that there is something 'wrong' with the person that needs to be treated or cured. Treatments or practices that are based on these ideas are prohibited because they are not supported by evidence, are inconsistent with widely accepted clinical practice and have been proven to be harmful.*[119]

2.6.7 Consent to treatment and capacity

Thirteen submissions expressed the view that individuals should have the right to consent to conversion therapy.[120] For example, Merryl Williams advised the committee that, 'Anybody who seeks gay conversion therapy have the right to do so. It is THEIR choice just as importantly as THEIR choice to have gender reassignment.'[121]

The submission from Renew Ministries stated:

> *For those individuals, especially adults, who decide to self-determine their own outcomes regarding their sexual orientation through pastoral care, Christian counsellors, and reading material, the proposal of banning any form of help, would not be beneficial. We ask instead that laws be put in place that people voluntarily seeking help, might be treated with respect, rather than dictated to as to the kind of direction that they want to choose. If anything within the definition of conversion therapy is banned, they may not legally be able to follow their own convictions.*[122]

The National Association of Practising Psychiatrists (NAPP) noted that the legislation should be primarily directed to children (up to age 18) and adults who do not have the capacity to provide informed consent.[123]

Dr Richard Wong questioned whether children will be able to fully understand the decisions they are making regarding the possibility of side effects and the experimental nature of hormonal treatments.[124] Dr Wong's submission stated:

> *It is stated that even proponents for hormonal intervention confess to lack of knowledge of the outcome of the above. Given such a potentially life-changing treatment, and that more expert sources state that a lot of children submitted to this proposed treatment have been found to suffer from co-morbid mental disorders such as autism, it gives concern, great concern, as to how adequate the children's ability to fully understand such a profound decision they are making, regarding the possibility of side effects, and the experimental nature of the regime.*[125]

In its advice to the committee on this issue, Queensland Health noted:

> *The legislation applies to all conversion therapy performed by health service providers, even if the person subjected to the therapy apparently consents to or seeks out the conversion therapy. Adults who apparently undergo conversion therapy willingly later report feeling coerced or pressured by family members, religious leaders or a fear of rejection by their communities. The health consequences for these people may be severe and long lasting.*

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119 Queensland Health, correspondence dated 3 February 2020, p 9.

120 See submissions 1, 19, 33, 55, 61, 93, 103, 119, 124, 136, 143, 146, 147.

121 Submission 19, p 1.

122 Submission 93, pp 1-2.

123 Submission 1, p 3.

124 Submission 103, p 1.

125 Submission 103, p 1.

A 2018 report by La Trobe University on conversion therapy in Australia contains accounts of LGBTIQ survivors who experienced thoughts of self-harm and other adverse mental health outcomes after undergoing conversion therapy as adults.

People who turn to a health service provider when struggling with or questioning their sexual orientation or gender identity have a reasonable expectation that any service provided or offered will be evidence based, safe and effective. Given the potential harms, lack of clinical benefit and difficulty in obtaining meaningful consent, it is appropriate that the Bill prohibit conversion therapy being performed on any person.[126]

2.6.8 Human rights

The Queensland Human Rights Commission noted in its submission that the Bill is consistent with human rights. According to the commission's submission, the Bill 'aligns with the Commission's vision of making human rights real for everyone in Queensland'.[127] Further, the commission stated that '…the Bill is consistent with Queensland's international obligations to uphold the human rights of everyone, regardless of sexuality or gender identity.'[128] As well, it '…is consistent with the purposes set out in the *Anti-Discrimination Act 1991* in promoting the equality of opportunity for everyone and ensuring that all Queenslanders live free from discrimination.'[129]

Other submitters, however, raised concerns that the Bill may be inconsistent with human rights, including:

- freedom of belief and/or expression
- rights of parents to have a say in their child's future, and
- denying individuals an opportunity to explore the possibility of an orientation change.[130]

The AASW Qld Branch further recommended that the Bill should prohibit conversion therapy in other settings as well as by health service providers to protect the human rights and the health and wellbeing of individuals.[131]

In its advice to the committee on this issue, Queensland Health noted:

Queensland Health has considered the human rights implications of the Bill and considers that the Bill is consistent with human rights. The Bill strikes an appropriate balance between protecting the right to freedom of thought, conscience, religion and belief against protecting the rights of children and the LGBTI community to freedom from torture and cruel, inhumane and degrading treatment, and to access health services that are appropriate and free from discrimination.

The Bill prohibits the performance of conversion therapy by health service providers. The Bill does not prohibit religious or spiritual conversion therapy practices occurring outside the provision of a health service. The Bill also does not prohibit any person, including a health service provider, from holding or expressing views and beliefs about sexual orientation, gender identity or conversion therapy.

Prohibiting conversion therapy in health settings is appropriate given the known harms of conversion therapy and the lack of evidence of the effectiveness or therapeutic benefit of

126 Queensland Health, correspondence dated 3 February 2020, p 18.

127 Submission 16, p 2.

128 Submission 16, p 3.

129 Submission 16, p 4.

130 See submissions 19, 33, 55, 74, 95, 98, 114, 119, 120, 130, 131, 136, 143.

131 Submission 131, p 9.

conversion therapy. If the prohibition on conversion therapy does impose any limitation on the freedom of thought, conscience, religion and belief of health service providers, it is justified on this basis.

This position is supported by the Queensland Human Rights Commission, which stated in its submission that 'the Bill avoids any disproportionate incursion into right to freedom of thought, conscience, religion and belief.'

The Bill does not limit the rights of families and children to protection. Families and parents can continue to discuss and teach their beliefs regarding sexual orientation and gender identity to their children.

The Bill protects the rights and best interests of children by imposing stronger penalties on a health service provider if the subject of the conversion therapy is a child. This recognises that children are vulnerable and deserve extra protection from unethical, harmful practices. [132]

2.6.9 Alternative approaches to regulating conversion therapies

A number of submissions suggested that, instead of being designated a criminal offence, conversion therapy should be regulated in a similar manner to other practices by health service providers. The Queensland Law Society suggested that conversion therapy could be dealt with through disciplinary or other regulatory action by the Office of the Health Ombudsman (OHO), which regulates health service providers in Queensland, and Australian Health Practitioner Regulation Agency (AHPRA) and National Boards, which regulate the performance and conduct of persons who are registered in a health profession.[133]

Several witnesses at the public hearing into the Bill also stated their preference for these matters to remain with the regulator rather than being introduced into the Criminal Code.

Dr Dilip Dhupelia, President of AMAQ advised:

…we recommend in sections 213H and 213I the removal of the indictable nature of the offences for health professionals. AMA Queensland believes there are insufficient grounds, nor evidence supporting data, for offences contained within the bill to be prosecuted under the Criminal Code and believes these offences should be managed by health regulators as previously outlined.[134]

Dr Philip Morris, President of the National Association of Practising Psychiatrists said:

There is clearly insufficient evidence of a problem in Queensland with conversion therapies among registered health practitioners to justify part 5 clause 28 of the legislation. Legislative best practice, and I would say this applies to all Australian parliaments, requires robust research and evidence to support the changes, especially when the legislation proposes criminalising a practice that will have a penalty up to 18 months imprisonment. Placing violations of the prohibition of conversion therapies in the Criminal Code is both draconian and unnecessary.[135]

Luke Murphy, President of the Queensland Law Society stated:

The society agrees that conversion therapy is a reprehensible practice. We refer in particular to the submissions made by the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society which submit that conversion therapies are harmful and not

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132 Queensland Health, correspondence dated 3 February 2020, p 22.

133 See submissions 136, 137, 143.

134 Public hearing transcript, Brisbane, 7 February 2020, p 15.

135 Public hearing transcript, Brisbane, 7 February 2020, p 47.

evidence based. Whilst we are therefore supportive of the policy intent behind the provisions, we have some specific reservations about the creation of the new criminal offence.[136]

The Queensland Law Society also commented on this issue at the public hearing:

As a general policy, it is the society's view that law reform and particularly the creation of criminal offences should be based upon evidence informing policy and there appears to be a scant amount of evidence as to the extent to which health service providers in Queensland are practising conversion therapy and why the existing laws, whether the existing criminal law or professional disciplinary offences, do not currently address the conduct that the bill contemplates. Usually, where outdated and harmful therapeutic practices are used in medicine, these are almost always dealt with by way of health practitioner regulation and not by criminal offences.[137]

In its advice to the committee on this issue, Queensland Health noted:

AHPRA and the National Boards regulate registered health practitioners under the National Law. In addition, AHPRA can prosecute people for offences under the National Law, including offences relating to holding oneself out as a health practitioner. In Queensland, the Office of the Health Ombudsman regulates registered and unregistered health service providers, in conjunction with AHPRA and the National Boards.

Neither the National Law nor the Health Ombudsman Act specifically regulate conversion therapy.

Regulators can take steps against a health service provider if a risk to public health and safety is identified. As noted above, there is reliable evidence that some health service providers in Queensland are providing conversion therapy despite existing oversight by the Health Ombudsman and National Boards and professional obligations. The current powers of regulators are insufficient to combat conversion therapy. Although regulators can take steps against a health service provider if a risk to public health and safety is identified, regulators may not feel confident to pursue a registered health practitioner for performing conversion therapy because the underground nature of the practice may make them difficult to investigate using traditional regulatory tools. In particular, victims of conversion therapy may be unwilling or may take several years to make a complaint, by which time the practitioner may no longer be registered or providing any health services. There may therefore be no basis for regulatory action or no effective remedy available to the regulatory in the event that the alleged conduct were established.

The penalties that can be imposed by regulators are generally limited to registration action for registered practitioners (for example, suspension of registration) or the imposition of an interim prohibition order that will prevent an unregistered practitioner from practising for a period of time. With the exception of the offences under the National Law, there is no ability for regulators to impose criminal sanctions.

In theory, the powers of AHPRA, the National Boards or the Office of Health Ombudsman could be expanded to specifically address conversion therapy. However, regulating conversion therapy in the same manner as other, accepted treatments and health practices may give the impression that there is a 'safe' or acceptable way to perform conversion therapy. This is not the case. In addition, these entities have expertise in regulating health services that are evidence-based or that are at least generally accepted as mainstream health services or treatments, even if there is no or limited evidence that they are effective.

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136 Public hearing transcript, Brisbane, 7 February 2020, p 57.

137 Public hearing transcript, Brisbane, 7 February 2020, p 57.

By contrast, conversion therapy is not based in evidence and, to the contrary, has been proven to be harmful and is widely condemned by professional bodies as a practice that has no place in health services. Prohibiting conversion therapy and making it a criminal offence sends the message that conversion therapy is not a health service or treatment and that the practice is unacceptable.[138]

Committee comment

The committee acknowledges the evidence provided during the inquiry that therapies which attempt to change or supress a person's gender orientation or gender identity have caused harm – significant harm for those subjected to them. On this basis, the committee appreciates the intent of the Bill to legislate to prohibit conversion therapies.

While the intent of the provisions in clause 28 are supported, it is not clear whether they will achieve what they are intended to. The definition for conversion therapies the Bill proposes to insert into the Public Health Act may, on the evidence presented during the inquiry, have significant unintended consequences. These issues need to be resolved in consultation with stakeholders who would be directly affected, particularly medical practitioners who provide evidence-based care and counselling for patients who are experiencing gender concerns or dysphoria.

The proposed inclusion of definitions related to sexual orientation and gender identity would also benefit from wider consultation with stakeholders, particularly groups representing all sections of the LGBTIQ+ community.

In discussion of potential fundamental legislative principles issues with clause 28 at Part 3 of this report, the committee has recommended that the Minister clarify what information his department would provide to health service providers to ensure health service providers are aware of the types of therapies that are acceptable and that are considered to be conversion therapies which are not acceptable.

Recommendation 2

That new section 213F in clause 28 of the Bill be amended to provide greater clarity and certainty as to what treatment and care provided by health service providers are to be covered and what services are not to be covered by the conversion therapy ban.

2.7 Pap smear register

Three submitters - Health Consumers Queensland, the ACNP, and the QNMU - commented on proposed amendments contained in clauses 29 - 33 to repeal redundant provisions in the *Public Health Act 2005* and the Public Health Regulation 2018 relating to the Pap Smear Register with the cervical screening history of women.[139] The Queensland register has been replaced by a national register.

All three submitters supported the proposed amendments.

Committee comment

The committee supports the proposed amendments to the *Public Health Act 2005* and the Public health Regulation 2018 to repeal redundant provisions relating to the Pap Smear register.

2.8 Terms and conditions – Mental Health Commissioner

Three submitters - Health Consumers Queensland, the ACNP, and the QNMU - commented on proposed amendments to the *Queensland Mental Health Commission Act 2013* contained in clauses

138 Queensland Health, correspondence dated 3 February 2020, p 24.

139 See submissions 46, 68, 105.

34 – 40.[140] The amendments clarify that the Commissioner has the function to employ staff, and increase the maximum term of appointment for the Commissioner to five years.

All three submitters supported the proposed amendments.

Proposal to employ a Chief Mental Health Nurse

The QNMU suggested that the Mental Health Commissioner employ a Chief Mental Health Nurse under the authority of the Commission to represent and promote the Mental Health nursing profession. According to the QNMU:

> *A Chief Mental Health Nurse will represent and promote the Mental Health nursing profession, specifically through professional leadership, advocating for best practice standards and workforce planning, in concert with Queensland's Chief Nursing and Midwifery Officer (Victoria State Government, n.d).*[141]

Queensland Health advised the committee that the QNMU's proposal is outside the scope of the Bill.[142]

Committee comment

The committee supports the proposed amendments to the *Queensland Mental Health Commission Act 2013* to clarify the Commissioner's functions and extend the maximum term of appointment for the Commissioner to five years.

2.9 Other minor amendments

Clause 17 makes a minor amendment to s 139A of the *Hospital and Health Boards Act 2011* which defines persons who are designated persons under the confidentiality provisions of the Act.

No submitters commented on this clause.

Committee comment

The committee supports the proposed minor amendments to the *Hospital and Health Boards Act 2011*.

[140] See submissions 46, 68,105.

[141] Submission 105, p 6.

[142] Queensland Health, correspondence dated 3 February 2020, p 38.

3 Compliance with the *Legislative Standards Act 1992*

3.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals
- the institution of Parliament.

The committee has examined the application of the fundamental legislative principles to the Bill. The committee brings the following to the attention of the Legislative Assembly.

3.1.1 Rights and liberties of individuals

Section 4(2)(a) of the *Legislative Standards Act 1992* requires that legislation has sufficient regard to the rights and liberties of individuals.

3.1.1.1 Does the Bill have sufficient regard to the rights and liberties of individuals?

Right to privacy regarding personal information

Clause 16 inserts new section 112 (4A) of the *Hospital and Health Boards Act* to allow the Patient Safety and Quality Improvement Service, as the administrative unit of Queensland Health responsible for coordinating improvements in the safety and quality of health services, to give root cause analysis (RCA) reports to a quality assurance committee for an authorised purpose of that committee.

Section 112(2) provides that the commissioning authority of an RCA must give a copy of the RCA report to a prescribed patient safety entity for an authorised purpose for the entity. Consistent with this requirement, the chief executive of Queensland Health has issued a health service directive under section 47 of the Hospital and Health Boards Act requiring the commissioning authority of Hospital and Health Service RCAs to provide copies of RCA reports to the Patient Safety and Quality Improvement Service.

Quality assurance committees assist Queensland Health and Hospital and Health Services by providing expert insight and recommendations following the completion of an RCA. These committees are already entitled to receive copies of RCA reports for their authorised purposes under section 112(2) of the Act.

Clause 16 expands the circumstances in which certain private, and likely sensitive, information may be disclosed. AS such, the provision raises an issue of fundamental legislative principle relating to the rights and liberties of individuals.

The right to privacy, and the disclosure of private or confidential information, are relevant to a consideration of whether legislation has sufficient regard to the rights and liberties of the individual.

Quality assurance committees are already entitled to receive copies of RCA reports for their authorised purposes under section 112(2) of the Act. In this light, the explanatory notes give this justification for the provision:

> *The amendment is not a substantive change of policy, but a process improvement. By providing that the Patient Safety and Quality Improvement Service can provide RCA reports, clause 16 of the Bill will provide quality assurance committees with timely access to reports so that Hospital and Health Services can benefit from the expertise quality assurance committees may provide, including recommendations for improving the safety and quality of healthcare.*[143]

[143] Explanatory notes, p 11.

The explanatory notes refer to safeguards to protect confidential information that are in place in the *Hospital and Health Boards Act*.[144] *Section 84 of the Act imposes a duty of confidentiality on members of quality assurance committees (and persons who assist such committees),* prescribing an *unauthorised disclosure to be an offence, with a maximum penalty of 100 penalty units.*

Committee comment

Given that the provision essentially extends an existing process, and noting the safeguard in place in the Act, the committee is satisfied that there are sufficient protections for the privacy of the individual and whether the provisions for disclosure of information have sufficient regard to the rights and liberties of individuals.

3.1.1.2 Does the Bill have sufficient regard to the rights and liberties of individuals?

- *New offences, proportionality and relevance of penalties.*

Clause 28 inserts new section 213H in the *Public Health Act 2005*, to prohibit health service providers from performing conversion therapy. There is a maximum penalty of:

- if the person who is subject to conversion therapy is a vulnerable person, 150 penalty units or 18 months imprisonment or both.
- otherwise, 100 penalty units, 12 months' imprisonment or both.

The creation of new offences and penalties affects the rights and liberties of individuals.

From the perspective of the fundamental legislative principles, there are two aspects to consider.

The first is whether the restriction on rights and liberties involved in the proscription of ordinary activity through the creation of a new offence is justified.

The second is whether the level of penalties - and other consequences - for an offence is proportionate and relevant to the actions to which the consequences relate. A penalty should be proportionate to the offence:

> *In the context of supporting fundamental legislative principles, the desirable attitude should be to maximise the reasonableness, appropriateness and proportionality of the legislative provisions devised to give effect to policy.*
>
> *… Legislation should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other.*[145]

The explanatory notes state:

> *There is no evidence of any benefits from conversion therapy, nor that sexual orientation or gender identity can be changed through therapeutic or other interventions. To the contrary, clinical and social science research has produced overwhelming evidence that conversion therapy is psychologically harmful and correlated with higher rates of suicidality, self-harm and other adverse health outcomes.*[146]

Elsewhere, the explanatory notes give this justification for the creation of the offence:

> *The prohibition on conversion therapy is considered justified, as it is necessary to protect people from the harm caused by conversion therapy. Health service providers have an ethical obligation not to engage in practices that cause harm. There is a considerable body of evidence showing that conversion therapy is harmful and does not offer clinical or therapeutic benefits.*

144 Explanatory notes, p 12.

145 Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook*, p 120.

146 Explanatory notes, p 4.

> *The United Nations General Assembly states that conversion therapies have been found to be 'unethical, unscientific and ineffective'. This is supported by the 2018 La Trobe University report* Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia*, which found significant negative health outcomes for individuals who have undergone conversion therapy.*
>
> *…*
>
> *It is therefore appropriate to ensure that these practices are not engaged in by health service providers, and that the rights of the LGBTIQ community are protected, even if the prohibition may result in a limitation on the rights of health service providers who perform conversion therapy.*[147]

The explanatory notes state the offence and the level of penalties:

> *… are justified as an appropriate response to the harm caused by conversion therapy and the need to ensure these practices are not carried out in a health care context. A term of imprisonment is necessary to send the message that conversion therapy is not condoned by the Queensland Government and to ensure the offence is a strong deterrent.*[148]

In relation to the issue of internal proportionality of the penalties, the explanatory notes state:

> *It is appropriate to impose a higher penalty where the subject of the conversion therapy is a vulnerable person. A higher penalty acknowledges that vulnerable people, including children, people without legal capacity or people with an impairment that may limit their understanding of the treatment, are especially susceptible to these unproven and unethical practices.*[149]

Prison terms at these levels can result in other consequences for offending practitioners. Under the *Health Practitioner Regulation National Law*, a registered health practitioner is required to notify their relevant registration body if charged with an offence punishable by 12 months imprisonment or more. Ultimately, this could result in registration consequences for the practitioner. The explanatory notes see this additional consequence as justified *as a further disincentive for health practitioners to engage in conversion therapy.*[150]

The committee also noted the range of measures already available to the Australian Health Practitioner Regulatory Agency (AHPRA) and National Boards, and to the Health Ombudsman, to deal broadly with health services and providers providing health services that are deemed to pose public health and safety risks. These measures include for the Health Ombudsman to take immediate registration action (section 58 of the *Health Ombudsman Act 2013*) and to issue a prohibition order to address an immediate concern (section 68).

The committee's request for advice

The committee wrote to Queensland Health on 17 January 2020 requesting advice on four points to assist its consideration of the new offence and associated penalties, and other possible consequences regarding registration for health service providers. The committee's points for advice and Queensland Health's responses dated 31 January 2020 are discussed below:

1. **Can the department assure the committee it is necessary to create a new criminal offence and associated penalties for health service providers that provide conversion therapies given the lack of documented evidence that health service providers are currently providing conversion therapies in Queensland and the extensive measures already available to AHPRA under the**

147 Explanatory notes, p 13.

148 Explanatory notes, p 13.

149 Explanatory notes, p 14.

150 Explanatory notes, p 14.

Health Practitioner Regulation National Law **and to the Health Ombudsman under the** ***Health Ombudsman Act 2013*** **which could be used to deal with providers of conversion therapies that pose public health and safety risks?**

Queensland Health's response

Evidence that health service providers are currently providing conversion therapies in Queensland

It is difficult to measure the prevalence of conversion therapy due to the underground nature of these practices. Health service providers are unlikely to advertise a service that many professional bodies have stated is harmful and unethical and that could result in professional sanctions. Research also shows that victims and their families may not realise they are being harmed or may be reluctant to make a complaint.

Nevertheless, the La Trobe University Report, Preventing Harm Promoting Justice: Responding to LGBT conversion therapy in Australia estimated that 10% of LGBT Australians are vulnerable to harmful conversion therapy practices. The report cited survey results from the United Kingdom, a comparable jurisdiction, indicating that 7% of respondents (and 13% of transgender and gender-diverse respondents) had received or been offered conversion therapy.

To build on and further develop this evidence, specifically in the Queensland context, Queensland Health is funding a research and education project in support of the legislative amendments to more closely examine the extent and impact of conversion therapies in Queensland, including in health care settings.

Despite limited quantitative data on conversion therapy practices, there are strong indications that some health service providers are engaging in conversion therapy in Queensland. For example, the La Trobe University Report refers to a Brisbane based organisation that has been a strong proponent of sexual orientation change and "advertises commercial one-on-one counselling and group courses for people `struggling with unwanted same sex attraction"'.[151]

'Anecdotal evidence also suggests that health service providers, including registered health practitioners, continue to provide conversion therapy in Queensland. For example, a general practitioner who attended a Queensland Health briefing on the Bill stated he was aware of registered psychologists who are providing conversion therapy in Queensland. Queensland Health officers have received confidential advice from other registered health practitioners that corroborates this statement. Further, some submissions to the Committee on the Bill express the view that counselling and other practices to modify or suppress same-sex attraction are beneficial and should be permitted to continue.

Finally, in its submission to the Committee dated 12 December 2019, the Queensland Human Rights Commission observed that, "Regardless of the prevalence of conversion therapy practices, the extent of the harm alone justifies a strong legislative response".

Current powers of AHPRA and the Health Ombudsman to regulate conversion therapy

AHPRA and the National Boards regulate registered health practitioners under the National Law. In addition, AHPRA can prosecute people for offences under the National Law, including offences relating to holding oneself out as a health practitioner. In Queensland, the Office of the Health Ombudsman regulates registered and unregistered health service providers, in conjunction with AHPRA and the National Boards. Neither the National Law nor the Health Ombudsman Act

[151] La Trobe Report, p. 16 -17. [The full citation for this report is: Timothy W. Jones, Anna Brown, Lee Carnie, Gillian Fletcher and William Leonard, *Preventing Harm, Promoting Justice: Responding to LGBT Conversion Therapy in Australia*, GLHV@ARCSHS, La Trobe University and Human Rights Law Centre, 2018.]

specifically regulate conversion therapy. Regulators can take steps against a health service provider if a risk to public health and safety is identified.

As noted above, there is reliable evidence that some health service providers in Queensland are providing conversion therapy despite existing oversight by the Health Ombudsman and National Boards and professional obligations. The current powers of regulators are insufficient to combat conversion therapy. Although regulators can take steps against a health service provider if a risk to public health and safety is identified, regulators may not feel confident to pursue a registered health practitioner for performing conversion therapy because the harms caused by conversion therapy are not well understood, the underground nature of the practice may make it difficult to investigate, and people receiving conversion therapy may be unwilling to make a complaint. Further, the penalties that can be imposed by regulators are also generally limited to registration action for registered practitioners (for example, suspension of registration) or the imposition of an interim prohibition order that will prevent an unregistered practitioner from practising for a period of time. With the exception of the offences under the National Law, there is no ability for regulators to impose criminal sanctions.

In theory, the powers of AHPRA, the National Boards or the Office of Health Ombudsman could be expanded to specifically address conversion therapy. However, regulating conversion therapy in the same manner as other, accepted treatments and health practices may give the impression that there is a `safe' or acceptable way to perform conversion therapy. This is not the case. In addition, these entities have expertise in regulating health services that are evidence-based or that are at least generally accepted as mainstream health services or treatments, even if there is no or limited evidence they are effective. By contrast, conversion therapy is not based in evidence and, to the contrary, has been proven to be harmful and is widely condemned by professional bodies as a practice that has no place in health services.[152]

Prohibiting conversion therapy and making it a criminal offence sends the message that conversion therapy is not a health service or treatment and that the practice is unacceptable.

Necessity of offence and penalties

In circumstances where it is believed that health service providers are engaging in conversion therapy, even if it is only a small number, it is appropriate to introduce an offence to prohibit the practice given the potential harms. It is also appropriate to make the offence a criminal offence, rather than extend the jurisdiction of regulators such as AHPRA and the Office of the Health Ombudsman. As discussed above, conversion therapy is not a legitimate or accepted 'therapy' or treatment. Existing regulatory oversight and professional obligations have not proven sufficient to deter health service providers from performing conversion therapy in Queensland. A stronger legislative response is therefore required to protect the LGBTIQ community from the harms and stigma associated with conversion therapy. [153]

2. For the maximum penalties proposed at new section 213H, what is the justification for imposing significant prison terms of up to 18 months if the conversion therapies are provided to a vulnerable person, otherwise up to 12 months, given the relatively low level financial penalties that are proposed for the offence?

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152 The underlying premise of conversion therapies is that lesbian, gay, bisexual and transgender (LGBT) people are psychologically damaged and suffer from disorders for which treatment to restore 'normality' is required. Clinically, and to an increasing extent socially and culturally, people of diverse sexual orientation and gender identity are understood within the spectrum of human diversity and are not considered to have a disease or disorder that requires treatment. [Footnote from Queensland Health, correspondence dated 31 January 2020]

153 Queensland Health, correspondence dated 31 January 2020, pp 1-3.

Queensland Health's response

The terms of imprisonment are justified as an appropriate response to the harm caused by conversion therapy and the need to ensure that these practices are not engaged in by health service providers. A significant term of imprisonment is required to send a strong message that conversion therapy is not a health treatment, that it is harmful and is not condoned in Queensland. It is appropriate for a higher penalty to be imposed for those who perform conversion therapy on children and vulnerable people as these people may be more likely to be subjected to conversion therapy against their will, for example, because a carer or parent takes them to a conversion therapy provider. It is also appropriate that any charge of performing conversion therapy is brought to the attention of AHPRA and the National Boards to enable them to take registration action where appropriate.

The Public Health Act 2005 imposes a range of financial penalties. Some are as high as 3,000 penalty units, while others are as low as 20 penalty units. The higher penalties are for offences that may apply to large corporate entities, for example, the operator of a health care facility (section 156H) or a drinking water service provider (section 57E). Lower penalties apply for offences that are more likely to be committed by an individual, for example, under section 143 a person who recklessly puts someone else at risk of contracting a controlled notifiable condition is liable for a penalty of 200 penalty units or 18 months imprisonment.

As it is likely that any charges for the new offence will brought against an individual, it is appropriate that the financial penalties be set at the lower end of the spectrum while maintaining the maximum prison terms. This will also allow courts to impose a range of penalties depending on the severity of the offending. [154]

3. **Given how conversion therapy is defined in the Bill and is linked to 'sexual orientation' and 'gender identity' which the Bill also defines for the first time and that, if passed, Queensland will be the first jurisdiction to legislate to prohibit conversion therapy in Australia, what education and/or training or guidelines will health service providers receive so as to understand the parameters and nuances of health services related to gender identity and sexual orientation that may be considered conversion therapies and are therefore covered by the new offence proposed in the Bill?**

Queensland Health's response

Queensland Health has commenced implementation planning to support the objectives of the new legislation, if passed. Immediate actions include developing and disseminating community. Specific guidance will be developed for health service providers regarding the legislative change and its impact on practice obligations.

Appropriate materials will be developed in consultation with a range of individuals and organisations with relevant expertise, including peak professional bodies, members of the medical community and experts in LGBTIQ health issues, and be made readily accessible to health service providers. [155]

4. **If the Bill is passed, what punitive actions will the department take with health service providers found to be providing conversion therapies? Will the department first issue warnings or 'show cause' notices, or will it proceed directly to prosecute providers in such circumstances?**

[154] Queensland Health, correspondence dated 31 January 2020, p 4.

[155] Queensland Health, correspondence dated 31 January 2020, p 5.

Queensland Health's response

The Queensland Police Service (QPS) will be responsible for investigating allegations that a health service provider has provided conversion therapy. The Director of Public Prosecutions (DPP) will decide whether to prosecute a person for the offence.

The Department will not take any punitive actions or prosecute health service providers under the Bill. If the Department were to receive a notification or complaint regarding allegations that a health service provider was performing conversion therapy, it would pass the information on to the QPS for investigation in line with standard police procedure. Similarly, any decision to prosecute would be made by the DPP in line with prosecution guidelines. [156]

Committee comment

The committee is satisfied that the new penalties for health service providers who provide conversion therapies are reasonable and proportionate.

In relation to the committee's question about education and/or training or guidelines health service providers would receive to understand what is covered by the conversion therapies ban, and the department's advice to the committee on this point which is discussed above, the committee believes that honourable members would benefit from further clarification by the Minister as to what 'appropriate materials' he envisage would be provided if the Bill is passed.

The committee considers that this information exercise would be crucial to the effectiveness of the proposed ban.

Recommendation 3

That the Minister informs the House, if the Bill is passed, what education and/or training or guidelines that he envisages would be provided to health service providers to assist them to understand what care and treatment provided to patients would be covered by the definition of conversion therapy in new section 213G and the offence provisions in new section 213H proposed in clause 28 of the Bill.

Does the Bill have sufficient regard to the rights and liberties of individuals?

- *Offences and penalties*

Clause 27 amends section 61D of the *Public Health Act 2005*, which relates to water management plans.

Under section 61C of that Act, the responsible person for a 'prescribed facility' (essentially hospitals and residential aged care facilities) must ensure there is a water risk management plan for the facility that complies with section 61D. There is a maximum penalty of 500 penalty units.

As section 61D currently stands, a water risk management plan must include procedures for responding to:

- the results of monitoring that indicate the failure of measures taken to control assessed risks assessed regarding hazards, hazard sources and hazardous events relevant to water, or
- the results of testing that indicate the presence of a hazard in water within the prescribed facility's water distribution system[157]

The effect of the amendment is to require a plan to respond to *both* criteria prescribed by section 61D, rather than either one. There is no change to the existing maximum penalty of 500 penalty units ($66,725.00)

[156] Queensland Health, correspondence dated 31 January 2020, p 5.

[157] Underlining added.

The amendment might be seen as creating a lower threshold for committing an offence against section 61D, an offence that carries a significant penalty. As such it could be argued that the provision breaches the fundamental legislative principle that legislation must have sufficient regard to individuals' rights and liberties, regarding offences.[158]

Regarding clause 27, the explanatory notes state:

> *The existing offence provisions are necessary to encourage compliance with the requirements relating to water risk management plans, mandatory notification and periodic reporting requirements. The penalty is designed to reflect the significant responsibility hospitals and residential aged care facilities have for proactively managing and controlling the health risks to their patients and residents.*
>
> *The amendment of section 61D is not intended to create or extend liability. Rather, it clarifies the intent of the legislation that plans should comprehensively cover how facilities will respond to risks to water quality.*
>
> *The proposed amendments are necessary to manage the potential risks to vulnerable Queenslanders associated with the use of water, and the security of water supply, in Queensland hospitals and residential aged care facilities. Given this, they are justified on the basis that they strike an acceptable balance between the need to adequately protect and promote the health of the public, and the rights and liberties of an individual.*[159]

Committee comment

The committee is satisfied that any breach of fundamental legislative principle in requiring a water risk management plan to respond to the results of both monitoring and testing, as prescribed by section 61D of the *Public Health Act 2005* to manage the potential risks to vulnerable Queenslanders associated with the use of water and the security of water supply in hospitals and residential aged care facilities is reasonable and justified.

3.1.2 Does the Bill have sufficient regard for the institution of parliament

– Section 4(2)(b) Legislative Standards Act 1992

Clause 21 amends section 48(1) of the *Private Health Facilities Act 1999*, which sets out conditions regarding quality assurance that are to be included in a licence for a private health facility licence. Clause 21 replaces the existing requirements with an obligation to:

> *comply with an accreditation scheme that relates to safety and quality matters and is prescribed by regulation.*

In turn, **schedule 1** of the Bill amends section 8 of the Private Health Facilities Regulation, which prescribes the Australian Health Service Safety and Quality Accreditation Scheme (AHSSQAS) to be the accreditation scheme for the purposes of section 48(1)(b).

The amended section 8 then defines the AHSSQAS as the scheme formulated by the Australian Commission on Safety and Quality in Health Care under the *National Health Reform Act 2011* (Cwlth), and incorporating the National Safety and Quality Health Service Standards (NSQHS Standards).

In turn, the NSQHS Standards are defined in the amended section 8 as the National Safety and Quality Health Service Standards, 2nd edition, formulated by the Commission under the *National Health Reform Act 2011* (Cwth).

The amendments are to align the conditions of a licence for a private health facility with requirements under the nationally adopted Australian Health Service Safety and Quality Accreditation Scheme. The

158 *Legislative* Standards *Act 1992*, section 4(2)(a).

159 Explanatory notes, p 12.

NSQHS Standards were developed to provide a nationally consistent level of care to be expected from health services. All States and Territories agreed that hospitals and day procedure services would be accredited to the NSQHS Standards from January 2013.

The explanatory notes suggest an issue of fundamental legislative principle issue arises this way:

> *Prescribing the accreditation scheme which incorporates an external document, the NSQHS Standards, may be seen to breach section 4(5)(e) of the Legislative Standards Act which requires subordinate legislation to have sufficient regard to the institution of Parliament by allowing the sub-delegation of a power by an Act only in appropriate cases and to appropriate persons and if authorised by an Act.*[160]

The committee notes, however, that the amendment of the regulation is being made in a piece of principal legislation – in the Bill itself – not in subordinate legislation. Thus, the issue of fundamental legislative principle set out in section 4(5)(e) of the *Legislative Standards Act 1992* (which applies to subordinate legislation) and referred to in the explanatory notes does not arise.

In any event, the committee notes the following statements in the explanatory notes:

> *The potential breach of a fundamental legislative principle is justified by the rigour surrounding the development of the NSQHS Standards, their adoption as part of a national agreement and the requirement for Ministerial approval of any changes to the National Accreditation Scheme or the NSQHS Standards.*[161]

The explanatory notes then set out at some length the process of development of those standards and conclude:

> *It is considered that the rigour surrounding the development of the NSQHS Standards and their adoption as part of a national agreement, justifies the need to sub-delegate by referring to external documents in the Private Health Facilities Regulation*.[162]

Committee comment

The committee is satisfied that no issue of fundamental legislative principle arises here and the Bill has sufficient regard to the institution of Parliament.

It is the parliament itself which will consider whether or not to enact the proposed amendment, so no issue of regard for the institution of parliament arises.

3.2 Explanatory notes

Part 4 of the *Legislative Standards Act 1992* requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

Committee comment

Explanatory notes were tabled with the introduction of the Bill. The notes are fairly detailed and contain the information required by Part 4 and a sufficient level of background information and commentary to facilitate understanding of the Bill's aims and origins.

160 Explanatory notes, p 15.

161 Explanatory notes, p 15.

162 Explanatory notes, p 15.

Appendix A – Submitters

Sub #	Submitter
001	National Association of Practising Psychiatrists
002	Martin Butler
003	Number not used
004	Ken Coppard
005	Melissa Wallis
006	Patricia Hatherly
007	Russell Grigg
008	Robert Caliendo
009	Mike Supel
010	Lynda Tweedie
011	Peter Stavrinou
012	Peter Simmons
013	Margaret Powell
014	Sandra Hodson
015	Cecil Chapman
016	Queensland Human Rights Commission
017	Children's Health Queensland
018	Robyn Sloane
019	Merryl Williams
020	Dr Chris Breytenbach
021	Jill Hall
022	Peter Myers
023	James O'Brien
024	Stuart Mills
025	Margaret Johnson
026	Stan Beattie
027	United Voice, Industrial Union of Employees, Queensland
028	David and Marilyn Rowsome
029	Aged and Disability Advocacy Australia (ADA Australia)
030	David and Debra Heathcote
031	Australian Healthcare and Hospital Association (AHHA)
032	Australian Psychological Society
033	FamilyVoice Australia
034	Royal Australasian College of Physicians (RACP)
035	Christian Medical and Dental Fellowship of Australia (CMDFA)
036	Dr Ian Murdoch
037	Dr Bruce Hayes
038	Richard Julian Chittleborough
039	Dr Geoff Masters

040 Professor Patrick Parkinson AM
041 Sasha Lukich
042 Ian Kilminster
043 Brenda Rudolph
044 Ronald W Edwards
045 Queensland Baptists
046 Health Consumers Queensland Ltd
047 Margaret Maag
048 Dr Rachel Chan Moy Fat
049 Brian Bennett
050 Alice Satterthwaite
051 Ian Thomson
052 Ron Brennan
053 Confidential
054 Nicole Hargreaves
055 Associated Christian Schools Ltd
056 Professor Dianna Kenny
057 Confidential
058 Dr Graham McLennan
059 Joan Haliburn
060 Joan Knijnenburg
061 Cecily Mac Alpine
062 Alan and Marie Alford
063 Katy Kucks
064 Helen Selke
065 Juanita Brown-Duthie
066 Diane and Rick Whittle
067 Brendan Scarce
068 Australian College of Nurse Practitioners
069 Joy Andrew
070 Neroli Mooney
071 Margaret Ochsner
072 Peter and Morvyth Howard
073 Stephen and Carol Porter
074 Gwen Stainsby
075 G Lloyd Goulter
076 Anne Window
077 Julie Migliorisi
078 Rhyll Hansen
079 Christian Schools Australia (CSA), Adventist Schools Australia (ASA), Associated Christian Schools (ACS), Australian Association of Christian Schools (AACS)
080 Lois Lewis

081 Chris and Sharon Mason
082 Barry and Anne Mulquin
083 Karen Mitchell
084 Name withheld
085 Dr Angela Wang
086 Dr James Yun
087 Helen Cozynsen
088 Kenneth Hill
089 Confidential
090 Joan Thomson
091 Shirley Hogg
092 Dr Christopher Middleton
093 Renew Ministries
094 Dr Hayley Thomas
095 International Women's Day (IWD) Association, Brisbane Meanjin
096 Name withheld
097 Dr Kerri Barnes
098 Marie Harding-Smith
099 LGBTI Legal Service Inc
100 Catherine Sutcliffe
101 Helmut Klaus
102 Ben and Ariel Drew
103 Dr Richard Wong
104 Feminist Legal Clinic Inc
105 Queensland Nurses and Midwives' Union (QNMU)
106 Dr Joseph De Zordi and Dr Thomas Campbell
107 Dr Cary Breakey
108 Fair Go for Queensland Women
109 Dr Robert Chazan
110 Queensland Aboriginal and Islander Health Council
111 Dr Andrew Hughes
112 Dr Robert Pollnitz
113 Number not used
114 Victorian Women's Guild
115 Cliff and Kaye Hollings
116 Hon Greg Donnelly MLC
117 Dr Peter Parry
118 Dorothy Amey
119 Dr David van Gend
120 Coalition of Activist Lesbians (COAL)
121 Confidential
122 Andrew Jones

123 Trish Robins
124 Stephen Brennan
125 Judith Ann Hunter
126 Kim Oates AM
127 Peter R Farrington
128 Dr Rosemary Isaacs
129 Name withheld
130 Name withheld
131 Australian Association of Social Workers (AASW) Queensland Branch
132 Dr John Hayes
133 Suzanne Hill
134 Dr Robert J Rawson OAM
135 Office of Health Ombudsman
136 Australian Christian Lobby
137 Queensland Law Society
138 Peter and Heather Mitchelhill
139 Queensland AIDS Council (QuAC)
140 Name withheld
141 Name withheld
142 Confidential
143 Coalition Against Unsafe Sexual Education (CAUSE)
144 Queensland Psychoanalytic Psychotherapy Association Inc. (QPPA)
145 Cathryn Warburton
146 Annette Hill
147 Norma Hill
148 Peter Kington
149 Wilberforce Foundation
150 Alon Barnes
151 Helen Beeley
152 The Royal Australian & New Zealand College of Psychiatrists (RANZCP) Queensland Branch
153 AMA Queensland

Appendix B – Officials at public departmental briefings

Monday 9 December 2019

Queensland Health

- Dr John Wakefield, Director-General
- Ms Tricia Matthias, Acting Director, Legislative Policy Unit
- Mr Karson Mahler, Manager, Legislative Policy Unit

Friday 7 February 2020

Queensland Health

- Associate Professor John Allan, Executive Director, Mental Health, Alcohol and Other Drugs Branch
- Mr Karson Mahler, Manager, Legislative Policy Unit
- Ms Rachel Stewart-Koster, Acting Manager, Legislative Policy Unit

Appendix C – Witnesses at public hearing

Friday 7 February 2020

Brave Network, SOGICE Survivors and Equal Voices (Melbourne Branch)

- Nathan Despott
- Roe Johnson

The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

- Dr Vikas Moudgil, Member of RANZCP Queensland Branch Committee

United Voice, Industrial Union of Employees, Queensland

- Dermot Peverill, Industrial Officer
- Debbie Gillott, Ambulance Lead Organiser
- Torrin Nelson, Queensland Ambulance Service Paramedic

AMA Queensland

- Dr Dilip Dhupelia, President
- Dr Peter Parry, Child and Adolescent Psychiatrist
- Dr Cary Breakey, Child and Adolescent Psychiatrist

Queensland Aboriginal and Islander Health Council

- Angela Young, General Manager Policy and Research

Queensland Humans Rights Commission

- Neroli Holmes, Deputy Commissioner
- Sean Costello, Principal Lawyer

Professor Patrick Parkinson AM

LGBTI Legal Service Inc.

- Matilda Alexander, President
- Emile McPhee, Vice President

International Women's Day (IWD) Association, Brisbane Meanjin

- Anna McCormack, Convenor
- Helen Daintree, Member

National Association of Practising Psychiatrists

Dr Philip Morris, President

Professor Dianna Kenny

Queensland Law Society

- Luke Murphy, President
- Ken Mackenzie, Deputy Chair, Criminal Law Committee
- Andrew Forbes, Deputy Chair, Occupational Discipline Law Committee

Queensland Council for LGBTI Health (formerly the Queensland AIDS Council)

- Peter Black, President

Professor John Whitehall

Appendix D – Participants in the 2018 roundtable and 2019 briefing for the conversion therapy provisions[163]

Queensland Health advised the committee that the following organisations were part of the Minister's Ending Sexual Orientation Conversion Therapy Roundtable which occurred in November 2018:

- ACT Health Directorate
- Amnesty International
- Anglican Diocese of Brisbane
- Anti-discrimination Commission (Human Rights Commission Queensland)
- Centre for Human Potential
- Department of Education
- Department of Justice and Attorney General
- Equal Voices
- Evandale Practice
- Gar'ban'djee'lum Network
- Holdsworth House Medical Practice
- Human Rights Law Centre
- LGBTI Legal Service Inc
- Office of the Health Ombudsman
- Queensland Aboriginal and Torres Strait Islander Health Council
- Queensland University of Technology
- St Francis' College Brisbane, Charles Sturt University

Queensland Health advised the committee that the following organisations attended the department briefing on a consultation draft of the Bill on 15 November 2019. (The organisations who are part of the Minister's Ending Sexual Orientation Conversion Therapy Roundtable are indicated in brackets.)

- Aboriginal and Torres Strait Islander Legal Service (Qld)
- Australian Health Practitioner Regulation Agency
- Australian Association of Social Workers
- Centre for Human Potential (*Roundtable member*)
- LGBTI Legal Service Inc (*Roundtable member*)
- Office of the Health Ombudsman (*Roundtable member*)
- Queensland Law Society
- Queensland Nurses and Midwives Union
- Queensland Human Rights Commission (*Roundtable member*)
- Queensland University of Technology (*Roundtable member*)
- Stonewall Medical Centre

In addition, Queensland Health advised the committee that the following organisations were invited to the department's briefing on a consultation draft of the Bill on 15 November 2019, but were unable to attend. (The organisations who are part of the Minister's Ending Sexual Orientation Conversion Therapy Roundtable are indicated in brackets.)

- Amnesty International (*Roundtable member*)

163 Queensland Health, correspondence dated 3 February 2020, pp 6-7.

- Anglican Diocese of Brisbane (*Roundtable member*)
- Australian Counselling Association
- Australian Medical Association Queensland
- Australian Psychological Society
- Bar Association of Queensland
- Equal Voices (*Roundtable member*)
- Evandale Practice (*Roundtable member*)
- Gar'ban'djee'lum Network (*Roundtable member*)
- Health Consumers Queensland
- Holdsworth House Medical Practice (*Roundtable member*)
- Human Rights Law Centre (*Roundtable member*)
- Members of the Ending Sexual Orientation Conversion Therapy Roundtable (*individuals who are part of the Roundtable in a confidential capacity*)
- Members of the Queensland Lesbian Gay Bisexual Transgender Intersex Roundtable, convened by the Department of Communities, Disability Services and Seniors
- Psychotherapy and Counselling Federation of Australia
- Queensland Aboriginal and Islander Health Council (*Roundtable member*)
- Queensland Children's Gender Service
- Queensland Council for Civil Liberties
- St Francis' College Brisbane, Charles Sturt University (*Roundtable member*)
- Women's Legal Service Queensland.

Dissenting Report and Statement of Reservation

HEALTH LEGISLATION AMENDMENT BILL 2019

DISSENTING REPORT

BY THE LNP MEMBERS OF THE COMMITTEE

The LNP Members are very concerned about Clause 28 of the bill, contained in Part 5, headed "Amendment of Public Health Act 2015", and relating to "Conversion therapies".

We make it clear that conversion therapy has been condemned as a practice, which we agree with, yet a Bill before the House must be assessed on the facts and the evidence.

In light of our concerns, we believe there are two courses open:

1. The Minister can withdraw clause 28, which would not impact upon the balance of the Bill, or
2. The Parliament could vote clause 28 down, again, which would not impact upon the balance of the Bill.

There are a number of reasons why either should occur.

Firstly, in submissions and throughout the public hearing, there was very little evidence produced that conversion therapy is being practiced by a "health service provider" as the Bill targets in 213 H(1).

Statements of scarce evidence as to conversion therapy being performed by health service providers were made by Dr Dhupelia, AMAQ Queensland President; Ms Neroli Holmes, Deputy Commissioner, Queensland Human Rights Commission, when referring to AHPRA records; Dr Philip Morris, President, National Association of Practising Psychiatrists; and Queensland's Health Ombudsman. If the issue, as far as it relates to a "health service provider" cannot be supported by evidence as occurring in this state or indeed in Australia, why is a bill being presented to the House to rectify a non-existent problem.

Secondly, when you consider the testimony of Mr Despott in relation to provision of conversion therapy, he makes this comment:

> "When we think of what happens today, like I said, 99 per cent of the conversion practices we see happen in this realm of pastoral care."

He qualifies the statement "pastoral care" by saying:

> "I'm just not referring to pastors but they would be included. I'm talking about a situation where there is one person seeking support from another or being offered support from another, and that person has some kind of authority or there is a power differential or there is some understanding that they have some ability to help and care for that person."

This leads to the obvious conclusion that people outside the term "health service provider" are involved in providing conversion therapies.

However, the Bill does not ban conversion therapy being performed by all people. It only deals with a "health service provider". If, as is accepted, conversion therapies produce dreadful outcomes, why would Parliament pass a Bill that prohibits only certain people from doing so, allowing others to continue their practice? An argument may be raised that by banning the practice by health service providers, it will send a clear message to others. That is a nonsense and there is simply no evidence that that would be the outcome in this situation. In fact an equal argument could be mounted that imposing a prohibition on health service providers only, could embolden other people to continue the practice as it could be seen as a de facto approval of their actions. One hint as to why only health service providers are named is contained in the evidence of Mr Costello of the Human Rights Commission, when he says:

> "I think one of the reasons why the pastoral care setting had been excluded, is to try to limit the limitation on the freedom of religion in the Human Rights Act."

We cannot state whether or not that is true; however, it may explain why the prohibition is in part only. However, if it is right, is this the true intent of the Human Rights Act? Is this the proper exercise of the provisions of the Human Rights Act, to in effect, endorse a process that globally has been seen to cause significant psychological damage to people and in particular, children.

Thirdly, for those who provide conversion therapy to a "vulnerable person", they may suffer a term of imprisonment of up to 18 months. Any imposition of a criminal nature must be considered against the evidence of the existence of the crime, and must be proportional hereto. That is not the case in this situation.

The imposition of a criminal sanction is a severe penalty. The Office of the Health Ombudsman and its legislation deals with health service providers both registered and unregistered (pursuant to ss7 and 8 of the Health Ombudsman Act 2013) and has within its jurisdiction the power to mete out severe penalties in conjunction with other Health Regulatory Bodies, Colleges and the police through our judicial system.

No reason has been given why a criminal penalty is to be imposed when sanctions already exist.

Fourthly, experts suggested that there should be a significant body of research undertaken before any legislative action is taken. Professor Parkinson stated:

> "The only inquiry I would like to see is a medical one – one which non-investigative psychologists and psychiatrists – great experts – and paediatricians can look together collaboratively and as far as possible, build a consensus around the proper treatment of children and young people, explore the dangers of puberty blockers, the dangers across cross-sex hormones, and the risks to children and young people of a wrong diagnosis of being transgender. This is the sort of inquiry I would like to see. It is not a legal issue."

Dr Morris agreed that the Bill was "premature", whilst adding that the Minister for Health, Mr Greg Hunt, had asked the Royal Australasian College of Physicians, to provide him a report "about the treatment of gender dysphoria in children", because he and others know that this is a very controversial and at the moment unexplored area.

He went on to state:

> "As the national association of practising psychiatrists, we have called for a national organisation or committee to look at this area with the national health and medical research council, the medical boards, the AMA and the professional organisations that treat children in this area to come up with a set of guidelines that can guide the country, because it is a very controversial area – the difference between the affirmation model of treatment and the more conservative model of treatment. It has not been resolved. It is way too premature to put legislation before there is any resolution in the field about what is the best way forward."

Both men considered the Bill was in essence premature and it is a matter that needs to be looked at in greater detail before legislative action occurs. A resolution in relation to this matter would be to pursue the actions suggested by Professor Parkinson and Dr Morris and then be dealt with at a COAG level. States may well produce different legislation, which creates confusion and fails to provide consistent guidance.

Fifthly, the structure of Part 5 was dissected by the Queensland Law Society, particularly in relation to the terms of 213 F(1) and 213 F(3).

The LNP Members will elaborate on that matter during the Second Reading debate in the House, but suffice it to say that on the one hand the Government's provision as to what is a conversion therapy and therefore subjecting the person to a term of up to 18 months' imprisonment could well be excused under Sub 3. The language used in the clauses is of such a nature that it makes it difficult for legal advice to be provided and this could prove a disincentive for health service providers who may simply walk away. In doing so outcomes could be adverse and potentially dangerous.

The recommendation by the Committee that clause 213 F(1) be amended to assist in determining what is conversion therapy is of little value. The risk is that any amendment may significantly change the terms of s213 F(1) to the point that the new clause needs to be thoroughly scrutinised by a committee. Clause 28 is poorly drafted and could lead to sad consequences.

Dated the 20th February 2020

Mark McArdle
Deputy Chair
State Member for Caloundra

Marty Hunt
State Member for Nicklin

HEALTH LEGISLATION AMENDMENT BILL 2019

STATEMENT OF RESERVATIONS

BY THE LNP MEMBERS OF THE COMMITTEE

Whilst agreeing to the passing of the Bill by the House, the LNP Members have reservations in relation to Parts 2 and 3 of the Bill, where there are amendments to the Ambulance Service Act 1991 and to the Hospital and Health Boards Act 2011 relating to the need for legislative requirement that HHS's and the Queensland Ambulance Service "collaborate".

In particular the LNP Members point to the failure of the Health Minister to have the Hospital and Health Services and the Queensland Ambulance Service through the LASN's "collaborate" without reverting to legislation.

The government relies upon a report entitled "Advice on Queensland Health's governance Framework" published in June 2019.

On page 4 there is a list of seven inquiries, and we particularly refer to the "Hunter Review" 2016 entitled "Review of the Department of Health structure, governance arrangements and higher level organisational capability."

It is concerning that only three and a half years later, a new review had to be undertaken for the worrying reason that the Queensland Ambulance Service and the HHS were not collaborating.

We note on page 6 the report states:

> "However, the Minister has overall responsibility and accountability for Queensland's public health system through the Department and the 16 HHS boards."

The portfolio over which the Minister has responsibility includes Health and the Queensland Ambulance Service, in which there is one Director General and one Commissioner for the Queensland Ambulance Service, yet they cannot "collaborate" to have the two services work as one.

It is concerning that the Minister has to rely upon legislation to force collaboration between the two entities. It raises questions about the Governance model between the Minister's, the Director General's and the Commissioner for Ambulance Service's offices that this has to be the outcome.

In particular, clauses 4 and 9 require the Ambulance Service and the Hospital and Health Services to "collaborate" "to manage the interaction between the services".

The report referred to earlier contains some 28 recommendations. One really has to ask the question what on earth has the Minister, Director General and Commissioner been doing for the past five years.

The question we have, is why the Minister, who is solely responsible for the operation of Queensland Health and Queensland Ambulance Service, one Director General and one Commissioner for Ambulance Services, cannot devise a strategy of collaboration that does not require legislation.

A major issue facing Queensland Health, the HHS's and the Queensland Ambulance Service and how their interaction or lack of it, is off stretcher times at emergency departments and ramping. This emergency department is one place where there is consistent interaction between the HHS's and the Queensland Ambulance Service.

This is a major public concern and statistics on the Queensland Health website indicate hospital off stretcher times and ramping is leaving paramedics at ED's for lengthy periods of time, and not being "on the road" attending to the next sick or injured Queenslander. There are other areas of interface as well relating to information sharing and technology.

The question of ramping was the subject of a report in July 2012 entitled "Metropolitan Emergency Department Access Initiative", which contained some 15 recommendations. Its implementation led to a significant drop in ramping and an increase in utilisation of paramedics' time and resources.

One of the key findings of the report was that internal hospital processes for the management of ED capacity issues were inconsistent across metropolitan hospitals. The report at page 17 states:

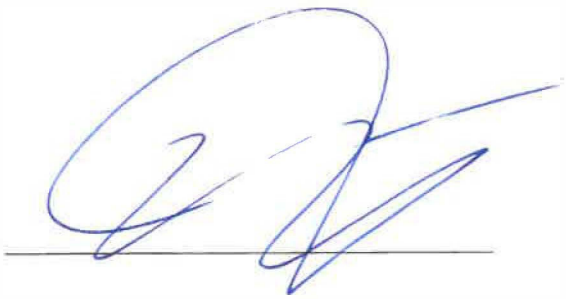
> "Queensland Health has developed a performance and accountability framework for the new HHS's which outlines a range of system-wide strategic directives and priorities. Included in these priorities are a commitment to achieving key elements of the national health reform agenda including the National Emergency Access Target (NEAT) and the National Elective Surgery Target (NEST)."

This was a process, along with others, that was successful. We question why and how we have gotten to a point where ramping and collaboration had been successful during 2012-2015 but has fallen apart so badly under Labor.

There are clearly other issues at stake here and the LNP Members refer to the section of the report relied upon by the Government, commencing on page 34, headed "Industrial Relations and Human Resource Management", where it is clear the unions are wanting more control of the workforce. There is no doubt the Minister, the Director General and the Commissioner for Ambulance Services need to explain the extraordinary circumstances that compel legislation to achieve what should flow naturally, particularly given the interface between HHS's and QAS paramedics.

The LNP Members will provide further details during the Second Reading Debate.

Dated the 20th February 2020



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