# Health Legislation Amendment Bill 2026

## Consultation Paper

**Proposed amendments to the *Mental Health Act 2016*, *Hospital and Health Boards Act 2011*, *Pharmacy Business Ownership Act 2024*, *Tobacco and Other Smoking Products Act 1998*, *Public Health Act 2005* and *Public Health Regulation 2018***

February 2026

# Contents

# Purpose

Queensland Health is seeking stakeholder feedback on proposed amendments to the *Mental Health Act 2016, Hospital and Health Boards Act 2011, Pharmacy Business Ownership Act 2024, Tobacco and Other Smoking Products Act 1998, Public Health Act 2005,* and *Public Health Regulation 2018.* These amendments are proposed to be progressed in the Health Legislation Amendment Bill 2026 (Bill).

This paper summarises the proposed amendments and relevant background for each amendment. It aims to assist you to understand the proposals in the Bill and inform any feedback you may have on the amendments.

Submissions will inform Queensland Health's understanding of the level of support for the amendments, the underlying issues, and the considerations relevant to developing and implementing the amendments.

# Making a submission

You are welcome to comment on any of the proposed amendments outlined in this paper. However, you may prefer to focus your submission on the amendments most relevant to you or your organisation's role or interests.

Please submit your feedback on the amendments by

**5pm Tuesday 17 March 2026**

Please provide your submission via email to

**legislationconsultation@health.qld.gov.au**

Your views are valuable and may be referred to in material provided to Government in considering the proposals.

Your views may be referred to in public documents such as the explanatory notes for the Bill or material provided to a Parliamentary Committee. **If you do not wish for this to occur, please indicate this in your submission.**

If you have any questions or require further information about the proposed amendments, please send your queries to the email address **above**.

**This document is for consultation purposes only and does not represent Queensland Government policy**

# Terms used in this paper

| Term | Explanation |
|---|---|
| **Authorised doctor** | A registered medical practitioner appointed by an authorised mental health service administrator under the *Mental Health Act 2016* (MH Act), who can initiate involuntary treatment, make treatment authorities, and manage patient care. |
| **Authorised mental health service** | Health services authorised under the MH Act to provide care and treatment to persons with a mental illness. An authorised mental health service may be in the public or private sector. |
| **Authorised premises** | For the purposes of the *Pharmacy Business Ownership Act 2024* (PBO Act), premises are authorised premises if the premises are not located in, or directly accessible from, a supermarket, and meet the standards prescribed by regulation. |
| **Classified patient** | A person in custody (such as a prison, youth detention centre, or watch house) who is transferred to an authorised mental health service for assessment and then admitted, provided both the administrator of the authorised mental health service and the custodian of the person in custody have provided written consent. |
| **Commonwealth laws (or federal migration and extradition laws)** | For the purposes of this paper, refers to the *Migration Act 1958* (Cth) and the *Extradition Act 1988* (Cth). |
| **Compromised goods** | Legal smoking products that can be seized under the *Tobacco and Other Smoking Products Act 1998* (TOSP Act) alongside illicit tobacco and illicit nicotine products, including legal smoking products, hookahs and nitrous oxide bulbs and canisters. |
| **Compulsory acquisition** | A statutory power to take or acquire private land for public purposes, including the construction or expansion of hospitals. Also known as resumption of land. |
| **Constructing authority** | An entity, agency or authority that has the power to acquire land or easements, including under the *Acquisition of Land Act 1967*. |
| **Deportation** | The formal process used to expel non-citizens, including permanent residents, from Australia. A person may be deported under the Migration Act if they have been convicted of certain serious offences, acquitted of a serious offence due to unsoundness of mind or found to be unfit for trial in relation to a serious offence. |
| **Extradition** | The legal process by which Australian authorities apprehend and surrender a person to another jurisdiction for the purposes of criminal prosecution or to serve a prison sentence. Australian citizens and permanent residents can be extradited. |
| **Forensic orders** | A therapeutic order that can be made for a person with a mental illness or intellectual disability who is charged with a serious offence and is found to be of unsound mind at the time of the alleged offence |

| Term | Explanation |
|---|---|
| | or is unfit for trial. The order provides for involuntary treatment and care and, if necessary, detention in an authorised mental health service. The Mental Health Court can make the order, including in some cases, following a decision of the Supreme Court or District Court. Once made, the Mental Health Review Tribunal routinely reviews the order. |
| **Forfeiture decision** | Under the TOSP Act, this is a decision of the chief executive of Queensland Health to forfeit (or transfer ownership of) a thing to the State. These decisions relate to the forfeiture of a seized illicit tobacco product, illicit nicotine product (excluding a vaping good), a bong, ice pipe, or a component of a bong or ice pipe. A forfeiture decision results in the issuing of a notice about the decision, and gives rise to appeal rights to the Magistrates Court. |
| **Illicit nicotine products** | Vaping goods and other products prescribed by regulation made under the TOSP Act for this definition. Currently, the only illicit nicotine product prescribed by regulation are nicotine pouches. |
| **Illicit tobacco** | Under the TOSP Act, any smoking product that does not comply with Commonwealth requirements, such as packaging and warning label requirements. Includes illegally imported cigarettes and loose tobacco known as 'chop chop'. |
| **Information notice holders** | For the purpose of the MH Act, includes victims of unlawful acts, their relatives and other persons affected by an unlawful act. Information notice holders can apply to receive information notices about a person who committed the unlawful act and who is subject to a forensic order or treatment support order. |
| **Mental illness** | Defined in the MH Act as a condition characterised by a clinically significant disturbance of thought, mood, perception or memory. A decision that a person has a mental illness must be made in accordance with internationally accepted medical standards. |
| **Notifiable condition** | Medical conditions that pose a significant risk to public health, either due to their potential for spread, severity, or impact on vulnerable populations and which are prescribed under the *Public Health Act 2005*. |
| **Personal information** | For the purposes of the MH Act, includes:<br>• information or an opinion about an identified person or person who is reasonably identifiable from the information or opinion (as defined in section 12 of the *Information Privacy Act 2009*); or<br>• *confidential information* as defined in section 139 of the *Hospital and Health Boards Act 2011* which means:<br>o information acquired by a person in their capacity as a designated person, from which a person who is or has received a public sector health service could be identified; or<br>o information accessed by a prescribed health professional from an information system. |

| Term | Explanation |
|---|---|
| **Possession** | Under the TOSP Act, possessing an illegal product as part of a business activity. |
| **Practising pharmacist** | A person who is registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession with general registration. |
| **Removal** | Removal from Australia under the Migration Act. This occurs when an unlawful non-citizen must leave Australia, for example because their visa has expired or been cancelled, or because they have breached a visa condition. |
| **School health program providers** | A Hospital and Health Service (HHS), or an external provider engaged by the HHS, to carry out a school health program under the Public Health Act. |
| **Supermarket** | Defined in the PBO Act as premises used primarily for selling a range of food, beverages, groceries and other domestic goods. |
| **Supply** | Means selling, distributing, offering, exposing or attempting to supply an illegal product. |
| **Treatment authority** | A lawful authority under the MH Act to provide involuntary treatment and care to a person who has a mental illness and who does not have capacity to consent to treatment and care. Can be made by an authorised doctor if they consider that the treatment criteria (as defined in the MH Act) applies and there is no less restrictive way for the person to receive the treatment and care they require. Treatment and care may be provided in the community or as an inpatient in an authorised mental health service. The Mental Health Review Tribunal routinely reviews the authority, and it must be revoked if the treatment criteria no longer apply. |
| **Treatment support order** | An order which can be made by the Mental Health Court when a person with a mental illness is charged with a serious offence and is found to be of unsound mind at the time of the alleged offence or is unfit for trial. The order can only be made if the Court considers that a forensic order is not necessary to provide for a person's treatment and care needs. The order authorises involuntary treatment and care, usually while the person lives in the community or, if necessary, can authorise the person's detention in an authorised mental health service. Once made, the order is routinely reviewed by the Mental Health Review Tribunal. |
| **Tribunal** | The Mental Health Review Tribunal established under the MH Act. |
| **Vaping goods (vapes)** | Under the TOSP Act, includes vaping devices (hardware), vaping accessories (pods and cartridges), and vaping substances (liquids with or without nicotine). Offences apply for the commercial possession or supply of vaping goods (as an illicit nicotine product) that do not comply with the requirements under the *Therapeutic Goods Act 1989* (Cth). |

# Overview of proposed changes

The Bill proposes to amend the:

- ***Mental Health Act 2016*** to:
  - better support and protect healthcare staff by providing policy guidance regarding safety and security considerations relevant to supporting the admission of patients from custodial environments, including classified patients;
  - enable suspended criminal proceedings to resume promptly if a referral has not been made to the Mental Health Court;
  - clarify when the Tribunal must be notified of a change to a person's treatment authority or treatment support order;
  - transfer the responsibility for review of *forensic orders (Criminal Code)* from the Mental Health Review Tribunal (Tribunal) to the Mental Health Court to ensure consistent conditions can be applied to forensic orders, including a non-revocation period on suitable forensic orders;
  - enable the President of the Tribunal to authorise Tribunal members or staff to disclose personal information where necessary to lessen or prevent a serious risk;
  - clarify when a person may be detained for the purposes of conducting an examination to inform a psychiatrist report, or following the expiry of an examination order or court examination order; and
  - clarify the assistance and information that can be provided to Commonwealth agencies when removing someone on a forensic order or treatment support order from Queensland under federal migration or extradition laws, and the effect this has on the order.
- ***Hospital and Health Boards Act 2011*** to authorise Queensland Health to directly acquire land compulsorily for the purposes of health and ambulance services, to support the timely delivery of health infrastructure projects and advance the Hospital Rescue Plan;
- ***Pharmacy Business Ownership Act 2024*** to prohibit the online presence of a pharmacy business from being affiliated with the online presence of a supermarket;
- ***Tobacco and Other Smoking Products Act 1998*** to streamline the forfeiture of seized illicit tobacco and illicit nicotine products;
- ***Public Health Act 2005*** to:
  - require external providers delivering immunisation services under the Queensland School Immunisation Program to share student information with the engaging Hospital and Health Service for follow-up purposes when requested; and
  - allow the chief executive of Queensland Health to prescribe more granular requirements for the reporting of *pathology request notifiable conditions*; and
- ***Public Health Regulation 2018*** to prescribe hepatitis C as a *pathology request notifiable condition* for ribonucleic acid tests only.

# Navigation

The **below** is provided to help navigate the proposals and identify the amendments likely to be most relevant or impactful to you or your organisation. It is not an exhaustive list and feedback is welcome on all the proposals.

| Stakeholders | Amendment |
|---|---|
| Persons with a lived experience of mental illness and treatment under the Mental Health Act, and their families, carers, and support persons.<br>Administrators, clinicians, and other staff of authorised mental health services<br>Mental health, disability, and human rights advocacy groups<br>Law enforcement, emergency, and child safety agencies<br>Custodial centres<br>Victims of crime and other information notice holders | *Mental Health Act 2016* amendments |
| Hospital and Health Services<br>Landowners<br>Property lawyers and industry peak bodies<br>Local governments<br>Infrastructure industry peak bodies | *Hospital and Health Boards Act 2011* amendments |
| Pharmacy business owners and franchisors<br>Pharmacy peak bodies<br>Supermarkets | *Pharmacy Business Ownership Act 2024* amendments |
| Smoking product licence holders and peak retail associations<br>Public Health Units within Hospital and Health Services | *Tobacco and Other Smoking Products Act 1998* amendment |
| Schools and principals<br>Secondary education peak bodies<br>Hospital and Health Services<br>External providers of immunisation services | *Public Health Act 2005* amendments relating to the School Immunisation Program |
| Pathology laboratories<br>Patients with a history of hepatitis C<br>Hepatitis C advocacy, treatment, and research organisations<br>Custodial centres and support services | *Public Health Act 2005* and *Public Health Regulation 2018* amendments relating to prescribing specific tests for notifiable conditions |

# Proposed changes to the *Mental Health Act 2016*

The *Mental Health Act 2016* (MH Act) has three main purposes, which are to:

- improve and maintain the health and wellbeing of people who have a mental illness who cannot consent to treatment;
- divert people from the criminal justice system if a court finds them unfit for trial or of unsound mind; and
- protect the community if a person who has been diverted from the criminal justice system is at risk of harming others.

The MH Act promotes voluntary treatment wherever possible. However, if a person lacks the capacity to consent to treatment, the MH Act provides for the involuntary assessment, treatment and care of the person.

The MH Act also provides for the involuntary treatment and care of people with a mental illness or intellectual disability who have been diverted from the criminal justice system following a finding of unsoundness of mind at the time of an alleged offence.

The proposed amendments to the MH Act are described **below.**

## Strengthening protections for healthcare workers treating high-risk patients

### Background

Queensland inpatient mental health units provide specialised treatment for individuals experiencing acute and severe mental illness. Admission to an inpatient unit typically reflects a critical level of acuity, where a person's safety, wellbeing, or ability to function is significantly compromised. Inpatient settings offer more intensive levels of care, close monitoring, and therapeutic support to stabilise and support a person's recovery.

Certain patients are considered to be higher risk, meaning they pose a higher risk of harm towards others or to property. Higher-risk patients can include classified patients and patients on a forensic order, however, other involuntary and voluntary patients can also be considered higher-risk of harm to themselves or others.

Where higher risk patients are admitted to authorised mental health services, there is a need to ensure appropriate support and protections for health care workers.

## Proposed changes

**Require the Chief Psychiatrist to make a policy in relation to safety and security considerations for high-risk patients when being transferred from a custodial setting and treated in an authorised mental health service.**

It is proposed to amend section 305 of the MH Act to provide that the Chief Psychiatrist must make a policy in relation to safety and security issues for higher-risk patients, including classified patients, who are being admitted to an authorised mental health service from a custodial environment.

Any policy made by the Chief Psychiatrist under section 305 must be complied with by an authorised doctor, authorised mental health practitioner, administrator of an authorised mental health service, or other person performing a function or exercising a power under the Act.

This will be an opportunity to review operational processes supporting the admission of patients from custodial settings and ensure appropriate risk mitigation strategies are in place for the safety of patients and staff working in inpatient authorised mental health services.

# Enabling prompt resumption of suspended criminal proceedings

## Background

The Chief Psychiatrist can direct a psychiatrist's report to be prepared if a person is charged with a serious criminal offence and there are concerns about the person's fitness to stand trial or soundness of mind at the time of the alleged offence. The purpose of the report is to determine whether the matter should be referred to the Mental Health Court. The direction to prepare a report can be made at the request of the person, or someone on their behalf. It can also be made on the Chief Psychiatrist's own initiative, if it is in the public interest. Once the direction is made, the criminal proceedings for the alleged offence are suspended until the report is completed and considered by the Chief Psychiatrist, the person charged, and their legal or other representative.

Suspending criminal matters for a period is important to ensure that a person is not subject to criminal proceedings while there is uncertainty regarding their fitness for trial or soundness of mind, and to allow a person time to decide whether they wish to have their matter dealt with by the Mental Health Court or by a criminal court.

### Statutory timeframe for resumption of suspended criminal proceedings

The MH Act provides that suspended criminal proceedings can resume once the relevant processes under the MH Act have ended. This includes where the Chief Psychiatrist

decides, after receipt of a psychiatrist report, not to refer the person to the Mental Health Court.

To ensure there is adequate time for both the Chief Psychiatrist, and the person who has been charged with the serious offence (or their representative), to properly consider the psychiatrist's report, there is a minimum statutory timeframe of 28 days before a suspension can be lifted and the criminal proceedings can resume.

There is currently no flexibility for the person to request their criminal proceedings recommence earlier.

There have been instances where both the Chief Psychiatrist, and the person charged with an offence, have received the psychiatrist's report and decided not to refer the matter to the Mental Health Court early in the 28-day period, but the statutory timeframes have prevented the criminal proceedings from resuming promptly. This is despite the person charged with a serious offence, or their representative, wanting the suspension of their proceedings to end as soon as possible so the matter can be decided by a criminal court. This prevents a timelier hearing of the criminal proceedings, which is a particular concern when the person is in custody or where their matter could be listed and heard relatively quickly before a criminal court.

## Proposed changes

**Insert a mechanism to allow a person charged with a serious offence, or their representative, to request in writing, that the suspension of their criminal proceedings be ended where the Chief Psychiatrist has decided not to refer the matter to the Mental Health Court following receipt of a psychiatrist report.**

It is proposed to amend the MH Act to allow a person, or their representative, to make a written application to end the suspension of their criminal proceedings if the Chief Psychiatrist, and the person charged with the serious offence, decide to not refer the matter to the Mental Health Court after receiving and considering the psychiatrist's report. The effect of ending the suspension is that the criminal proceedings would resume.

This amendment will remove a barrier to the prompt resumption of suspended criminal proceedings. It will also give involuntary patients, with the relevant decision-making capacity, autonomy to decide how their criminal matters are determined in a timely manner.

# Clarify when the Mental Health Review Tribunal is notified of changes to treatment authorities or treatment support orders

## Background

The MH Act allows an authorised doctor to amend a treatment authority or treatment support order provided the amendment is not contrary to, and does not change, a decision or order made by the Tribunal or Mental Health Court. This requirement ensures that an authorised doctor does not act contrary to decisions and conditions placed on an order or authority.

This limitation does not apply where a patient has a community order or authority (meaning they receive treatment in the community), and there is a material change in their mental state, such that they require urgent treatment as an inpatient in an authorised mental health service.

In these circumstances, an authorised doctor may change the category of the order or authority to inpatient, so that the person can be admitted to an authorised mental health service and receive the appropriate treatment. When this occurs, the MH Act requires the authorised mental health service to give written notice of the change to the Tribunal who must conduct a review of the order or authority within 14 days. The purpose of this review is to ensure that the significant decision of making a person an inpatient, contrary to a Tribunal decision, can be reviewed to maintain the continued focus on least restrictive practices which is central to the operation of the MH Act.

There is some ambiguity in the current provisions as to whether the Tribunal must be notified of **any** change made to a treatment authority or treatment support order, or only changes made **contrary to** a decision or order made by the Tribunal or Mental Health Court. As a result, there may be confusion about when notification is required and consequently, unnecessary notifications being made to the Tribunal, which is an administrative burden. The intent of the provision is to ensure notification occurs where a significant change occurs, and to allow for subsequent review of that person's circumstances by the Tribunal to ensure that the changes are appropriate.

## Proposed changes

**Clarify that the Mental Health Review Tribunal is notified only of changes to a treatment authority or treatment support order which are contrary to the conditions of the authority or order.**

It is proposed to amend the MH Act to clarify when an authorised mental health service is required to notify the Tribunal of a change to a treatment support order or treatment authority made by an authorised doctor. The amendment will clarify that notification is only required

where the change is contrary to the original orders of the Tribunal or Mental Health Court due to an urgent escalation in the need for treatment and care of a patient.

The amendment will resolve the potential uncertainty regarding when notifications must be made and reduce the administrative burden related to unnecessary notifications.

The Tribunal and Mental Health Court usually make orders or authorities which allow an authorised doctor to admit a person as an inpatient in urgent circumstances. It is exceptionally rare for an order or authority to prevent an authorised doctor from changing the category to inpatient when a person requires inpatient treatment and care. As changes contrary to an authority or order should only occur in exceptional circumstances, it is important that the Tribunal has a role in reviewing the change to ensure that the changes made to a person's order or authority are appropriate and least restrictive. All other changes made by authorised doctors which are consistent with an order or authority are not intended to be reviewed by the Tribunal, as this would require the Tribunal to review decisions that they have already authorised.

# Transferring the responsibility for review of *forensic orders (Criminal Code)*

## Background

The Mental Health Court is empowered to make a forensic order for a person charged with a serious offence who was of unsound mind at the time of an alleged offence, or is unfit for trial. A forensic order allows for the involuntary treatment of a person for their mental illness or the involuntary care of a person with a cognitive or intellectual disability. If necessary, the order also authorises detention in an authorised mental health service.

When making a forensic order, the Mental Health Court must determine whether the order:

- provides for treatment of a person's mental illness, or the care of a person because of their intellectual or cognitive disability;
- should be of inpatient or community category; and
- should include conditions and recommendations about intervention programs.

The forensic orders that can be made by the Mental Health Court including a *forensic order (mental health)* and *forensic order (disability)*. The MH Act also provides for the Supreme Court and District Court (criminal courts) to make *forensic orders (Criminal Code)* following a finding that the person is not fit for trial, not sound of mind, or acquitted on the grounds of insanity.

When a criminal court makes a forensic order (Criminal Code), the criminal court must give notice of that decision to the Tribunal. The Tribunal must review the forensic order (Criminal Code) within 21 days and make either a new forensic order (mental health) or forensic order (disability) under the MH Act, replacing the forensic order (Criminal Code).

### Non-revocation period

If a person is charged with a prescribed offence[1] and the person was of unsound mind at the time of the alleged offence, or is found **permanently** unfit for trial, the Mental Health Court can specify a period of up to ten years during which the Tribunal cannot revoke the forensic order. This is known as a non-revocation period.

A non-revocation period provides victims and the broader community with certainty about the period a person charged with a serious offence will continue to receive treatment as a forensic patient.[2]

Unlike a forensic order made by the Mental Health Court, the criminal courts cannot make decisions regarding the type of forensic order a person requires or what conditions should apply. Criminal courts cannot specify a non-revocation period, and the Tribunal cannot, when reviewing a forensic order (Criminal Code), apply a non-revocation period.

Accordingly, someone charged with a prescribed offence, and dealt with under the Criminal Code, cannot be subject to all the potential conditions, including applying a non- revocation period, that may apply to a person whose forensic order is made by the Mental Health Court.

## Proposed changes

**Transfer responsibility for the initial review of *forensic orders (Criminal Code)* from the Mental Health Review Tribunal to the Mental Health Court so that consistent conditions, including a non-revocation period, can be applied to all forensic orders**

To ensure community expectations are met, particularly in relation to assurance for victims of prescribed offences, it is proposed to transfer responsibility for the review of forensic orders (Criminal Code) from the Tribunal to the Mental Health Court. This change will allow consistent conditions, including non-revocation periods where appropriate, to apply to all forensic orders.

The process for reviewing forensic orders (Criminal Code) as set out in Chapter 12, Part 4 of the MH Act will not change. The amendments will simply shift this process from the Tribunal to the Mental Health Court and will update other parts of the MH Act that refer to the Tribunal as the review body for forensic orders (Criminal Code) to instead refer to the Mental Health Court.

[1] Prescribed offences under the Mental Health Act include murder, manslaughter, attempted murder, grievous bodily harm and acts intended to cause grievous bodily harm, rape, attempted rape and assault with intent to commit rape.
[2] A person subject to a forensic order.

**Table 1:** Forensic orders under the *Mental Health Act 2016*

| Mental Health Court | | Supreme/ District Court |
|---|---|---|
| ***Forensic order (mental health)*** | ***Forensic order (disability)*** | ***Forensic order (Criminal Code)*** |
| Made where:<br>• a person's unsoundness of mind or unfitness for trial is due to a mental condition other than an intellectual or cognitive disability, or<br>• a person has a dual disability (a mental illness and an intellectual or cognitive disability).<br>Non-revocation period can be applied if the person:<br>• was unsound of mind at the time of the alleged offence; or<br>• is found permanently unfit for trial. | Made where:<br>• a person's unsoundness of mind or unfitness for trial is due to an intellectual or cognitive disability, and<br>• a person needs care for their intellectual or cognitive disability but does not need treatment and care for any mental illness.<br>Non-revocation period can be applied if the person:<br>• was unsound of mind at the time of the alleged offence; or<br>• is found permanently unfit for trial. | Made where:<br>• a jury finding that a person is not fit for trial, or not of sound mind during the trial; or<br>• a person has been acquitted on the grounds of insanity.<br>No non-revocation period can be applied. |
| Periodic reviews by the Mental Health Review Tribunal at least every 6 months | | Reviewed once by the Mental Health Review Tribunal within 21 days of its making and a replaced with a new *forensic order (mental health or disability) and* then reviewed periodically every 6 months as a forensic order (mental health or disability). |

# Allowing disclosure of personal information to respond to serious risk

## Background

The MH Act protects the personal information of individuals by limiting disclosure or use of information collected under the MH Act only to authorised disclosures and use, including where permitted or required by law. The MH Act does not have any specific provisions authorising disclosure when there is a serious concern about the safety of a person or the

broader public. In general, disclosure in these circumstances is managed under the *Hospital and Health Boards Act 2011* (HHB Act).

## Disclosure under the *Hospital and Health Boards Act 2011*

The HHB Act allows a designated person[3] or prescribed health practitioner to disclose confidential information where a Hospital and Health Service (HHS) chief executive believes, on reasonable grounds, that disclosure of confidential information is necessary to lessen or prevent serious risk to the life, health or safety of a person or public safety. The chief executive must authorise the disclosure in writing.

In certain circumstances, designated persons such as health practitioners in the department or a HHS, or the Chief Psychiatrist, may rely on the HHB Act to release information to prevent a risk to life, health or public safety. This may occur when the information obtained is both *confidential information* under the HHB Act and *personal information* under the MH Act. In these circumstances, the HHB Act can then be relied on to disclose information to lessen or prevent a serious risk because the MH Act allows disclosure or use of information where permitted by law.

## Mental Health Review Tribunal

The Tribunal is an independent statutory body created by the MH Act with the primary purpose of providing independent review of involuntary mental health treatment.

The Tribunal consists of the President, Deputy President and Members who include lawyers, psychiatrists and other persons with relevant qualifications and/or experience to exercise the Tribunal's jurisdiction. There is also an Executive Officer and other staff who provide support to the Tribunal.

Currently, Tribunal members and staff cannot disclose personal information protected by the MH Act where such a disclosure may be necessary to mitigate a serious threat to the life, health or safety of a person, or to public safety. Unlike department and HHS employees, and the Chief Psychiatrist, they are not designated persons for the purpose of the HHB Act and therefore cannot rely on the HHB Act as a basis for disclosure.

**Case Example**

In most Tribunal proceedings, a patient's treating team (who **are** considered designated persons under the HHB Act) are in attendance, and participate in the proceedings. Accordingly, they can appropriately use and disclose personal information to address any serious risk which may be identified during a proceeding. For example, if information was disclosed in a proceeding which indicated a potential risk to a child, a treating team could disclose that information to relevant child safety entities for their consideration and investigation. However, in proceedings such as an application for an examination authority, where treating teams within an authorised mental health service do not attend the proceedings

[3] A 'designated person' is defined in section 139A of the HHB Act and includes a public service employee employed in the department, a health service employee, the Chief Psychiatrist and another person prescribed by regulation.

but are involved in the application process, this mechanism for disclosure under the HHB Act is not available.

Similarly, there is no clear mechanism for disclosure where a serious risk arises outside a Tribunal proceeding. For example, where the behaviour of a previous patient poses a risk to the safety of Tribunal staff, there is no ability for staff to disclose personal information to relevant authorities to address the risk. This is because the information would have been gathered in the course of the Tribunal exercising its jurisdiction and is considered personal information, protected under the MH Act.

## Proposed changes

**Provide the President of the Mental Health Review Tribunal with the ability to authorise Tribunal members and staff to disclose personal information where necessary to address serious risk.**

It is proposed to provide that the President of the Tribunal can authorise the disclosure of any personal information that the Tribunal has acquired while performing its functions, if the President of the Tribunal:

- holds a reasonable belief that the disclosure is necessary to lessen or prevent a serious risk to public safety or the life, health or safety of a person; and
- authorises the disclosure in writing.

### What is a serious risk?

There is no definition of serious risk, but it is intended to include risks of injury, harm or death and significant danger. This can include a life-threatening situation or one that might reasonably be expected to result in serious injury or illness to any person, including the person to whom the information relates.

For example, if a person expresses an intention to harm themselves or another person, or gives cause for Tribunal staff to believe the person may harm themselves, Tribunal staff or another person.

A serious risk to public safety relates to broader safety concerns affecting a number of people.

The proposed amendment will ensure there is adequate protection of persons and the public from serious risks of harm and would be limited to the disclosure of information about a person that is necessary to lessen or prevent that harm. As the disclosure must be **necessary** to lessen or prevent the serious risk, the President's power only applies where the same effect could not be achieved through the release of de-identified versions of that information. The President of the Tribunal would still be required to consider whether it is necessary for the potential recipient of the information to have the specific personal information in order to lessen or prevent the serious risk. The need for the Tribunal to disclose under this amendment is expected to be rare.

**What personal information may be disclosed?**

Personal information is defined under the MH Act, and could include information about a person's:

- identity, background and age;
- contact details, current location or residential address;
- relationship status, next of kin and dependants;
- current health conditions, intellectual capacity, and mental illness; and
- mental health treatment and care, including any existing orders or authorities.

This disclosure power is proposed to be like the power available under the HHB Act and will support a consistent response to the sharing of information across entities operating under the MH Act. It will also bring Queensland in line with other Australian jurisdictions, where the relevant body that serves the same function as the Tribunal has the power to share information for safety reasons.

# Clarifying legal authority for detention

## Background

### Classified patient admission after court-ordered examination

A person charged with a simple offence can be ordered by the Magistrates Court to be examined without their consent for the purposes of deciding the person's treatment and care needs (known as an 'examination order'). The Mental Health Court can also order that a person be examined without their consent to inform consideration of a person's soundness of mind at the time of an alleged offence or their fitness for trial (known as a 'court examination order').

To facilitate these examinations, a person can be directed to attend an authorised mental health service, or they can be transported from a place of custody to an authorised mental health service.

Ordinarily, before a person with a custodial status can be admitted as an inpatient at an authorised mental health service, consents must be obtained from the administrator of the authorised mental health service and the custodian responsible for the person before the person was admitted, for example, the Queensland Police Service. These consents provide an authority to detain the person in an authorised metal health service as a **classified patient**.

**Who is a classified patient?**

A person who is transferred from custody in a prison, watch-house or youth detention centre to an authorised mental health service to receive treatment or care under the MH Act.

To allow sufficient time to obtain these written consents, the MH Act allows for the person to be detained for a period of up to seven days. While the person is detained before the consents required for a classified patient admission are completed, the MH Act recognises persons detained in these circumstances as classified patients and provides a process for a person who has been transported from a place of custody under an examination order or court examination order, to be immediately admitted as an inpatient if, after conducting the examination, an authorised doctor considers they require inpatient treatment and care.

Section 74(8) of the MH Act states that the person is detained "under the order" for a maximum of seven days while the written consents for their admission are being obtained. It is not clear whether the order referred to is the order that brought the person to the authorised mental health service (examination order or court examination order) which expires following completion of the examination, or another order (for example, related to the classified patient admission process). This wording has created some uncertainty as to the basis for the person's detention during this period.

## Proposed changes

**Clarify the basis of the legal authority to detain a person for up to seven days, following expiration of the examination order or court examination order, to obtain the necessary consents for their ongoing classified admission.**

To avoid confusion about the legal authority to detain a person for up to seven days after the expiry of an examination order or court examination order, it is proposed to amend the MH Act to clarify that there is a lawful basis for detention under the relevant section, despite the expiry of the examination order or court examination order the person was originally detained under.

### Chief Psychiatrist-initiated examination

If a person is charged with a serious offence, the Chief Psychiatrist may, on their own initiative, direct that a psychiatrist's report be prepared to provide an opinion on whether the person was of unsound mind at the time of the alleged offence or is unfit for trial.

After receiving the psychiatrist's report, there may be instances where another report is required to clarify or further investigate an issue raised. When this occurs, the Chief Psychiatrist may direct that a second psychiatrist's report be completed.

When a direction is given by the Chief Psychiatrist for a report, or second report, to be prepared, the person must attend an authorised mental health service for an examination to inform the report. If the person does not attend, the MH Act provides for the person to be involuntarily transported to an authorised mental health service for examination.

This authority to transport a person for examination does not include authority to detain the person in the authorised mental health service to facilitate the examination that is required to inform the preparation of the report ordered by the Chief Psychiatrist.

## Proposed changes

**Insert a clear legal authority to detain a person, for the time needed to complete an examination, or for up to three days, whichever is shorter, for the purpose of completing an examination for a psychiatrist's report.**

It is proposed to provide an authority to detain a person, for the period required to conduct an examination, or for up to three days, whichever is shorter, to conduct an examination to inform preparation of a psychiatrist's report ordered by the Chief Psychiatrist. It is intended that this power will also apply if the Chief Psychiatrist directs that a second psychiatrist's report is required.

It is anticipated that the full three days will be required in only rare circumstances. However, it is proposed allow a maximum period of three days to ensure there is sufficient time to appropriately consider the matters required to inform the psychiatrist's report. Examinations can be complex, involving several interviews with the person. Providing sufficient time for an appropriate examination to occur will ensure that a person's soundness of mind at the time of an alleged offence and their fitness for trial is properly examined and considered.

# Supporting safe transport for patients removed, deported or extradited from Queensland

## Background

Commonwealth migration and extradition laws authorise agencies such as Australian Border Force and the Australian Federal Police to apprehend, detain and either deport or remove a person, or extradite them from Australia. Authorised officers of these Commonwealth agencies can exercise their legislative functions even when a person is an involuntary patient in an authorised mental health service.

When a person receiving treatment under the MH Act is planned to be removed, extradited or deported, consideration should be given to the person's mental state at the time, and whether it is reasonably practicable to remove the person. This may require staff of an authorised mental health service, or others such as the Chief Psychiatrist, to provide information and assistance to authorised Commonwealth officers and other federal law enforcement officials. This includes by disclosing personal information to inform the Commonwealth agency with the planning or execution of the person's removal, and providing assistance when a person is being removed from an authorised mental health service.

### What personal information could be disclosed?

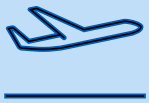
Personal information is defined by the MH Act. Examples of the types of personal information that may be relevant under this amendment includes information about a person's:

- mental illness or intellectual or cognitive disability;
- risk of harm to self or others;
- relevant trauma history; and
- ongoing treatment and care needs, including medications.

This personal information may be relevant to the planning and execution of a person's removal, given these processes can occur over a period of time and across different transitory locations, depending on the circumstances in which the person is being removed. For example, it could involve transferring the person through airports, hospitals, correctional facilities, detention centres and other states and/or countries.

There is no clear legislative authority which allows staff to share this information with authorised Commonwealth officers. There are concerns that this could potentially leave staff without adequate legal protection when sharing information to assist with planning, minimising harm and reducing risk as it is not clear whether the civil liability protections provided by the MH Act would apply.

## Proposed changes



**Insert an express authority which allows officials under the Mental Health Act, including staff of an authorised mental health service, to disclose relevant personal information and provide assistance to authorised Commonwealth officers operating under federal migration and extradition laws.**

It is proposed to provide an authority to allow officials, as defined under the MH Act, to disclose relevant personal information to inform the planning or execution of a person's removal from Queensland under federal migration or extradition laws. It is proposed to also provide that officials may assist or accompany authorised Commonwealth officers, where appropriate, in transporting a patient as part of this process. Officials include staff of an authorised mental health service or the Chief Psychiatrist, among others.

### Scope of assistance

It will not be the responsibility of the authorised mental health service to certify that a person is fit and safe to be extradited, removed or deported or to transport a person in Commonwealth agency detention as part or extradition, removal or deportation. Authorised Commonwealth officers will need to conduct their own risk assessments on the person's ability to be safely transported, informed by the information provided by an authorised mental health service and

are responsible for the safe transport of the person they are taking into detention under Commonwealth authority.

This amendment will ensure that Queensland officials acting in this capacity, will have clear authority under the MH Act, and will have the protections against civil liability provided for by the MH Act.

# Suspending and ending orders following a person's removal, deportation or extradition

## Background

When a person is subject to a forensic order or treatment support order, and is removed from Queensland under Commonwealth laws, the order continues to exist and operate, despite the person no longer being in Queensland. The only way to end a forensic order or treatment support order due to the person being out of Queensland is when the Tribunal has approved an application for someone to transfer out of Queensland to another mental health facility in Australia or out of the country, and a period of three years or any non-revocation period has expired.

If a person has been deemed missing for a period of more than three years, and the Tribunal is satisfied that the person is unlikely to return to Queensland or is presumed deceased, the MH Act provides a mechanism to revoke a forensic order or treatment support order.

When the person is transferred from Queensland or known to be missing, there are also mechanisms under the MH Act to suspend the need for periodic reviews of the relevant order until it has ended or been revoked. However, when a person is removed from Queensland under Commonwealth laws, they are not considered missing, nor have they been approved to transfer out of Queensland and accordingly, these mechanisms do not apply.

This means there is no clear ability to end or revoke forensic orders or treatment support orders in these circumstances, or to suspend the requirement for the Tribunal to periodically review their order. This creates an unnecessary administrative burden on authorised mental health services and the Tribunal which must continue to administer and review the order when the person subject to the order is no longer in the jurisdiction.

## Proposed changes

**Enable orders to end following a person's removal or deportation under Commonwealth laws and suspend periodic reviews in the Mental Health Review Tribunal for persons who have been removed, deported, or extradited.**

It is proposed to render certain orders ineffective and suspend the need for periodic reviews when a person is removed from Queensland under federal migration or extradition laws.

For a person who has been **deported or removed** from Queensland, it is proposed to amend the MH Act to provide that:

- forensic orders and treatment support orders end when the person has remained out of Queensland for a continuous three-year period, or on the last day of any non-revocation period that may apply; and
- periodic reviews of the orders are suspended while the person is out of Queensland.

For those persons subject to **extradition**, it is not considered appropriate to provide for the ending of forensic orders or treatment support orders. Unlike deportation and removal, extradition does not necessarily indicate that a person may not return to Queensland, as Australian citizens and permanent residents can be extradited. As such, for individuals that are extradited, it is proposed that:

- forensic orders and treatment support orders have no effect while the person is out of Queensland; and
- periodic reviews of the orders are suspended while the person is out of Queensland.

**Table 2:** Effect of proposed amendment

| | Removal or deportation | Extradition |
|---|---|---|
| **Effect of orders** | Orders **have no effect** while person is outside of Queensland | Orders **have no effect** while person is outside of Queensland |
| **End of orders** | Orders **end** when:<br>• the person has remained out of Queensland for a continuous three-year period; or<br>• on the last day of any non-revocation period. | Orders, although inactive, continue to exist and have force should the person return to Queensland. |
| **Periodic review of orders** | Suspended while the person is outside of Queensland.<br>Periodic reviews are reinstated once the administrator of an authorised mental health service becomes aware of the person's return to Queensland and notifies the Tribunal. | |

The amendments will also include requirements on the administrator of an authorised mental health service to notify the Chief Psychiatrist when a patient has been removed, deported, or extradited from an authorised mental health service.

Once the Chief Psychiatrist is satisfied that the person has been removed from Queensland, they must provide written notice to that effect to the Tribunal. If the Tribunal is satisfied that a person's removal, deportation, or extradition process has been completed, the requirement for periodic review of their order will cease.

The administrator of an authorised mental health service will also be required to provide written notice to the Chief Psychiatrist and the Tribunal if they become aware of the person's return to Queensland.

# Suspending and ending information notice requirements following a person's removal, deportation or extradition

## Background

The MH Act provides that certain people can apply to the Chief Psychiatrist for an information notice which allows them to obtain information about a relevant patient (known as '**information notice holders**')

**Who are information notice holders?**

Information notice holders include victims of unlawful acts, their relatives and other persons affected by an unlawful act.

These people can apply to receive information notices about a person who committed the unlawful act and who is subject to a forensic order or treatment support order.

Information notices provide updates to notice holders about a relevant patient, specifically, any periodic reviews of an order that are conducted, any transfer applications applied for, any decisions made by the Tribunal, instances where the patient is absent and is required to return to an authorised mental health service, and any appeal applications.

Information notices have ongoing effect until the relevant order ends, the patient transfers out of Queensland, the notice holder no longer wishes to receive the information, or the information notice is revoked by the Chief Psychiatrist. The requirements to provide information under a notice are also suspended if the patient has applied for and been granted approval to transfer out of Queensland, either interstate or internationally.

However, if the patient returns to Queensland before their forensic order or treatment support order ends, the information notice is reinstated on the day of their return, and the Chief Psychiatrist must give notice of this reinstatement to the notice holders within seven days of becoming aware of the patient's return.

Provisions about the duration of information notices do not currently contemplate a patient leaving Queensland other than because of international or interstate transfer decisions made under the MH Act.

## Proposed changes

**Provide for:**

- **information notice holders to be notified that the relevant patient has been removed, deported, or extradited from Queensland;**
- **information notice holders to be notified if the patient who was extradited from Queensland has returned to Queensland; and**
- **the end of information notices where the patient has been removed or deported from Queensland.**

It is proposed to amend the requirements under the MH Act relating to information notices to include the information that is to be provided, and when information notices cease, when a relevant patient is removed from Queensland under federal migration or extradition laws.

Any information notice associated with a patient who is **removed or deported** will end when they leave Queensland, and will be reinstated if they return to Queensland within three years or before the last day of any non-revocation period. This is considered necessary to ensure that information notice holders understand why they are not receiving information under their information notice, such as notification of periodic reviews.

If a patient has been **extradited** from Queensland, information notice holders will be notified that the patient has been extradited, and that the periodic reviews of the order are suspended while they remain outside Queensland. They must also be notified if the patient returns to Queensland. Given that patients who are extradited from Queensland are more likely to return, it is not considered appropriate to provide for the ending of information notices.

**Table 3:** Effect of amendments on information notices

| Removal or deportation | Extradition |
|---|---|
| Information notices **end** when the person is removed from Queensland and **reinstated** if the person returns within three years or before the last day of any non-revocation period that applies to their forensic order.<br>Information notice holders are notified:<br>• of the patient's removal or deportation;<br>• that information notices will end; and<br>• if the patient returns within the relevant period, that information notices will be reinstated. | Information notices **continue**. Information notice holders are notified:<br>• of the patient's extradition;<br>• that periodic reviews will be suspended; and<br>• if the patient returns to Queensland. |

# Proposed changes to the *Hospital and Health Boards Act 2011*

## Compulsory acquisition for health and ambulance services and related purposes

### Background

#### Compulsory acquisition for public purposes

The *Acquisition of Land Act 1967* (AL Act) governs the acquisition of land by constructing authorities, such as government agencies, for public purposes, such as roads, utilities and hospitals.

The AL Act establishes both the power to compulsorily acquire land and the procedural framework that must be followed. As an alternative to compulsory acquisition, land may also be acquired by agreement under the AL Act or through a standard commercial contract.

The compulsory acquisition process under the AL Act occurs in two stages. The first stage involves service of a Notice of Intention to Resume and an objection process. While negotiation is not a prerequisite to commencing this stage, there must be a willingness to negotiate acquisition by agreement. This stage is undertaken by a constructing authority.

In the second stage, the constructing authority applies to the relevant Minister for approval to take the land and then negotiates compensation with landowners. In certain circumstances—such as where there are objections or where native title is involved—the Minister makes a recommendation and refers the matter to the Governor in Council, which authorises the taking of land by gazette notice.

Land, including a person's residential property, may only be taken under the AL Act for a specified public purpose, including a purpose relating to health services.

**What is a purpose relating to a health service?**

Health services under schedule 1 of the AL Act include land taken for:

- ambulance services;
- health facilities, including health centres, community health centres and health clinics;
- hospitals and services related to the operation of hospitals; and
- community residential facilities, such as public aged care facilities.

#### Queensland Health's role

Queensland Health does not have any direct legislative powers to acquire land for purposes relating to health and ambulance services. This includes, for example, for expanding or building critical health infrastructure such as hospitals.

As the relevant department administering the AL Act, the Department of Natural Resources and Mines, Manufacturing and Regional and Rural Development (NRMMRRD) primarily manages the acquisition process, acting for the State, local governments and other agencies to acquire land for the purposes listed in schedule 1 of the AL Act.

While some entities can acquire land independently without NRMMRRD—for example, the Department of Transport and Main Roads—NRMMRRD supports most other authorities to manage acquisitions for a public purpose. In addition, the Minister for NRMMRRD is responsible for considering applications and supporting objection material before making a decision to take land under the AL Act.

The Queensland Government has an ambitious program of health infrastructure improvements under the Hospital Rescue Plan, including the planned expansion of a very significant number of hospitals and the building of new health services over the coming years. The Hospital Rescue Plan[4] sets out the Government's present priorities. Substantial investment was allocated to these projects in the last State budget—more than $18 billion.

In order to give Queensland Health and the Minister for Health and Ambulance Services greater autonomy to progress and approve land acquisitions, it is proposed to make amendments to ensure a direct legislative power to compulsory acquire land for health and ambulance services and related purposes, and to approve such acquisitions under the health portfolio.

## Proposed changes

**Amend the *Hospital and Health Boards Act 2011* to authorise Queensland Health to directly acquire land compulsorily for health and ambulance services and related purposes, in accordance with the *Acquisition of Land Act 1967,* and enable the Minister for Health and Ambulance Services to approve the taking of land for these purposes.**

It is proposed to amend the *Hospital and Health Boards Act 2011* (HHB Act) to enable Queensland Health to manage the end-to-end process for the acquisition of land identified for health and ambulance services and related purposes.

It is proposed that this power would enable Queensland Health to resume land broadly for health and ambulance services and related purposes to enable the efficient development and operation of these services. For example, to take land to:

- build a new public health facility or expand an existing hospital site;
- provide new or upgraded infrastructure services (including power, water and sewerage) to a new or existing hospital site;
- accommodate both public and privately-funded or delivered health and support services;

[4] Available to view at https://www.plan.health.qld.gov.au/.

- use for research and teaching facilities that support a public health facility;
- deliver incidental facilities to health and ambulance services such as a hospital car park, canteens, retail and commercial businesses and tenancies (for example, clinician suites, food and beverage outlets, gift shops onsite) etc;
- build roads, footpaths, public transport facilities and public open space required to deliver high quality and appropriate public health services; and
- reserve land for future health infrastructure.

It is also proposed that the Minister for Health and Ambulance Services act as if they were a *relevant Minister* under the AL Act and approve the taking of land under the HHB Act. The Minister would be required to publish a notice in the Government Gazette to give effect to the taking of the land.

The proposed amendment would allow for a health-focused approach to managing land acquisitions, enabling Queensland Health to directly manage major health infrastructure projects, prioritising these for the delivery of public health and supporting facilities.

# Proposed changes to the *Pharmacy Business Ownership Act 2024*

The *Pharmacy Business Ownership Act 2024* (PBO Act) created a licensing framework for the ownership of pharmacy businesses in Queensland.

The PBO Act also established the Queensland Pharmacy Business Ownership Council (Council), transferred responsibility for administration of pharmacy ownership regulation from Queensland Health to the Council, and made other reforms to support effective enforcement of pharmacy business ownership requirements.

The intent of the PBO Act is to ensure ownership of and interests in pharmacy businesses in Queensland are primarily restricted to pharmacists and pharmacist-controlled corporations, with limited exceptions for certain friendly societies and Mater Misericordiae Limited.

The PBO Act partially commenced in March 2024, primarily to establish the Council, and fully commenced in November 2025.

## Affiliation with online presence of supermarkets

### Background

Currently, the Council may grant an application or renewal application for a pharmacy business licence for a pharmacy business only if satisfied:

- the applicant is an eligible person, a fit and proper person to own a pharmacy business and does not already hold an interest in the maximum number of pharmacy businesses permitted under the PBO Act;
- the proposed licensed premises for the pharmacy business are **authorised premises**;
- each person who the Council is aware holds a material interest in the pharmacy business is a person who is permitted to hold a material interest in the pharmacy business and does not already hold an interest in the maximum number of pharmacy businesses permitted.

A pharmacy business licence can only be issued to a pharmacy business owner if the proposed premises for the business are authorised premises. Premises are authorised premises if the premises are not located in, or directly accessible from, a supermarket, and meet the standards prescribed by the *Pharmacy Business Ownership Regulation 2025*. This prohibits the Council from issuing a licence (including a renewal licence each year) if the pharmacy business is located in, or directly accessible from, a supermarket.

Most other Australian jurisdictions where licensing or registration is required to own a pharmacy business, have a similar prohibition on direct access from a supermarket, including

South Australia, Western Australia, New South Wales, the Australian Capital Territory and Tasmania.

### Community pharmacy model

The operation of pharmacy businesses in Australia has long relied on the community pharmacy model. This model involves the delivery of pharmacy services in local and accessible contexts, where owners of pharmacy businesses are practising pharmacists, who collaborate with other local health practitioners to service the community. The model relies on pharmacists being central to the decision-making and management of medications sold, to prioritise patient health and safety above profits.

### Online affiliation

The PBO Act does not prohibit connections between a pharmacy business and a supermarket in the online environment in the same way it prohibits connections between pharmacy businesses and supermarkets in the 'bricks and mortar' environment.

While the Council has regard to whether a pharmacy business is co-located with or accessible from a supermarket as part of considering if the premises is an authorised premises, there is no consideration of the online connections between pharmacy businesses and supermarkets.

Stakeholders have raised concerns that connections between the online platforms, apps and social media accounts of pharmacy businesses and supermarkets inappropriately blur the line between shopping for scheduled medicines and groceries, and conflict with Queensland's community pharmacy model.

## Proposed changes

**Amend the *Pharmacy Business Ownership Act 2024* to prohibit the online presence of a pharmacy business from being affiliated with the online presence of a supermarket.**

It is proposed to require the Council to be satisfied that, to the best of the Council's knowledge, the online presence of a pharmacy business applying for or holding a licence is not **affiliated** with the **online presence** of a supermarket.

**What does 'online presence' mean?**

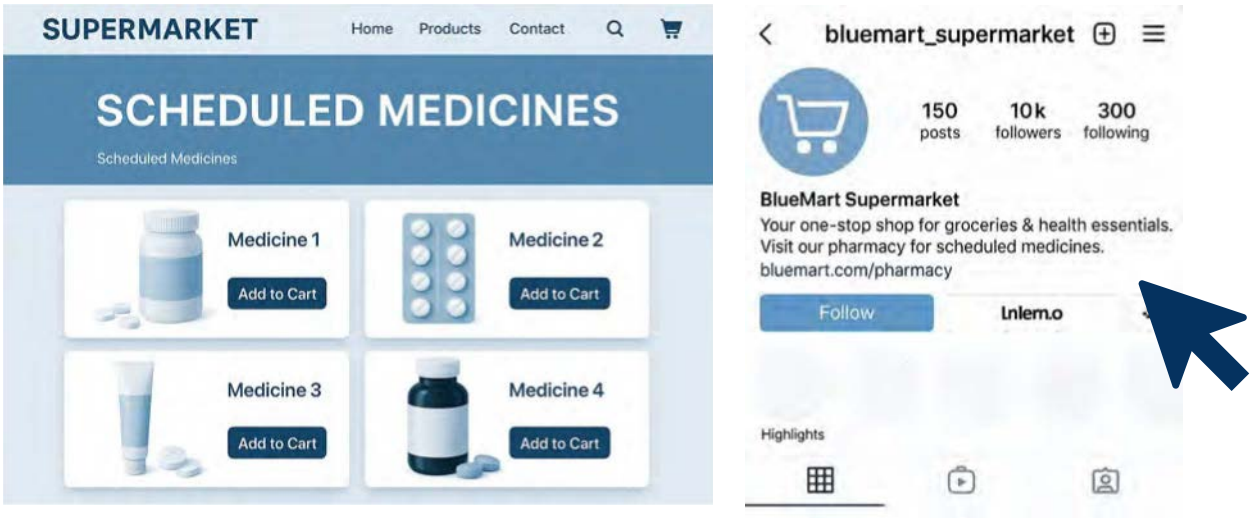
For the purposes of the amendment, online presence is intended to include websites, apps and social media accounts, including the use of shared or franchisor-owned websites.

**What does 'affiliated' mean?**

'Affiliated' is intended to mean a formal or recognised connection between two or more businesses or their related entities. This connection can involve shared ownership, partnership, sponsorship or membership.

Examples include a link from the website or app of a supermarket to the website or app of a pharmacy business or the franchisor of a pharmacy business, and may include the ability to collect items purchased online from a pharmacy business at a supermarket.

**Figure 1:** Affiliation between online presence of pharmacies and supermarkets




The proposed amendments will allow the Council to consider whether, to the best of the Council's knowledge, the online presence of a pharmacy business is affiliated with the online presence of a supermarket, and refuse, suspend or cancel a licence if such affiliation exists.

## Question

| | |
|---|---|
| ? | If providing a submission on this proposal, please consider whether the proposed meaning of '**affiliated**' above is appropriate. If not, please provide your reasoning. |

# Proposed changes to the *Tobacco and Other Smoking Products Act 1998*

## Forfeiture and destruction of seized illicit tobacco and all illicit nicotine products

### Background

The objective of the *Tobacco and Other Smoking Products Act 1998* (TOSP Act) is to improve public health by reducing public exposure to tobacco, other smoking products and illicit nicotine products. The TOSP Act does this in a variety of ways, including by restricting the supply and possession of illicit tobacco and illicit nicotine products.

**What are illicit tobacco and illicit nicotine products?**

**Illicit tobacco** includes any smoking product that does not comply with Commonwealth requirements, such as packaging requirements and warning labels. This includes illegally imported cigarettes and loose tobacco known as 'chop chop'.

**Illicit nicotine products** include vaping goods and other products prescribed by regulation for this definition such as nicotine pouches.

Vaping goods include vapes and items such as vaping devices (hardware), vaping accessories (pods, cartridges), and vaping substances (liquids with or without nicotine).

Offences apply for the commercial possession or supply of vaping goods that do not comply with the requirements under the *Therapeutic Goods Act 1989* (Cth).

The TOSP Act includes offences that prohibit the possession and supply of illicit tobacco and illicit nicotine products as part of a business activity and powers for authorised officers to seize these products as evidence of an offence.

Once seized, different procedures apply depending on the type of product that is seized, including whether a forfeiture decision is relevant.

**What is a forfeiture decision?**

A forfeiture decision is a decision of the chief executive of Queensland Health to forfeit (or transfer ownership of) a thing to the State. These decisions relate to the forfeiture of seized illicit tobacco, illicit nicotine products (excluding vaping goods), bongs, ice pipes, or components of bongs or ice pipes. A forfeiture decision results in the issuing of an information notice about the decision and gives rise to appeal rights to the Magistrates Court if a former owner wishes to contest the seizure and forfeiture.

## Forfeiture of illicit tobacco and illicit nicotine products

Currently, the TOSP Act grants the chief executive of Queensland Health the power to forfeit *relevant products* (illicit tobacco and illicit nicotine products that are not a vaping goods) to the State. To exercise this power, the chief executive must be satisfied the thing is a relevant product and reasonably believes it is necessary to keep the thing to prevent it being used to commit the offence for which it was seized (a 'forfeiture decision').

However, before making a **forfeiture decision**, the chief executive must give the owner of the seized thing an opportunity to respond to a show cause process. A notice must be issued, outlining the chief executive's belief that the seized thing is illicit tobacco or an illicit nicotine product, and that retaining it is necessary to prevent further offences. The notice must also state the intention to forfeit it to the State and provide the owner 28 days to submit a written response for the chief executive to consider (**show cause**).

Individuals also have the **right to appeal** forfeiture decisions to the Magistrates Court, by filing a notice of appeal with the court registrar within 28 days after receiving written notice of the forfeiture decision, or after becoming aware of it.

The chief executive cannot proceed with the forfeiture if a legal proceeding involving the seized item is ongoing and must wait until the proceeding, including any appeal, has concluded.

This results in Queensland Health holding the seized products to not only process them, but to account for these show cause and appeal timeframes. These products are also retained as physical primary evidence for any legal proceedings.

## Immediate forfeiture and destruction of vaping goods

On 16 June 2025, the *Health Legislation Amendment Act 2025* received assent. This Act amended the TOSP Act to allow the chief executive of Queensland Health to promptly forfeit vaping goods upon seizure, without the show cause and appeal processes that otherwise apply to other items currently forfeited under the TOSP Act. These amendments empowered Queensland Health to mitigate significant storage problems relating to vaping goods.

If the chief executive decides seized vaping goods are forfeited to the State, the chief executive must give the former owner written notice of the decision and the reasons for the decision. However, the chief executive is not required to provide procedural fairness, and can immediately forfeit and destroy the seized vaping goods, even if a proceeding involving the vaping goods has started. In these circumstances, Queensland Health uses secondary evidence to demonstrate that vaping goods were seized.

As a result of not requiring a forfeiture decision, a person is also denied the right to seek an appeal of the decision through the Magistrates Court under the TOSP Act.

## Compromised goods

On 24 November 2025, the *Tobacco and Other Smoking Products (Dismantling Illegal Trade) Act 2025* further amended the TOSP Act to introduce the concept of 'compromised goods'.

This term covers legal smoking products, hookahs and nitrous oxide bulbs and canisters that can be seized if found alongside illicit tobacco or illicit nicotine products. Pursuant to these changes, compromised goods can be destroyed following the same forfeiture process as the products they were seized alongside. Currently, the processes that apply to the destruction of compromised goods vary depending on whether vaping goods were found at the same premises.

**What happens to seized compromised goods?**

Where found alongside **vaping goods**, the compromised goods can be forfeited and destroyed immediately with the vaping goods.

Where seized alongside **illicit tobacco** or **illicit nicotine products that are not vaping goods** (for example, nicotine pouches), the show cause and appeal processes applying to those products apply and the compromised goods are stored until a forfeiture decision is made and the related illicit products are destroyed.

Where such products are clearly illicit, have been seized as evidence of an offence, and are highly unlikely to be returned to their former owner, there is limited utility in Queensland Health storing the products for a legislated period prior to forfeiture and destruction. As such, there is little utility in retaining the show cause process and storing these products.

There are also opportunities to reduce the complexities in the forfeiture process for seized compromised goods found alongside illicit products, noting that sometimes legally held goods (found with vaping goods) are destroyed before illicit tobacco, which are subject to a show cause process.

## Proposed changes

**Streamline the forfeiture of illicit tobacco and all illicit nicotine products by removing the show cause and appeal processes under the *Tobacco and Other Smoking Products Act 1998*.**

It is proposed to amend the TOSP Act to consolidate forfeiture processes by allowing seized illicit tobacco and illicit nicotine products to be immediately forfeited and destroyed. This will result in the immediate forfeiture of compromised goods found alongside all related illicit products.

This will ensure Queensland Health has greater capacity to seize more illicit products and will create an efficient process for the management of seized illicit products.

# Proposed changes to the *Public Health Act 2005* and the *Public Health Regulation 2018*

## Queensland School Immunisation Program

### Background

#### School Immunisation Program

The School Immunisation Program is a key part of Queensland's preventative health strategy. It provides free immunisations to adolescents in years 7 and 10, targeting an age group that may otherwise have limited engagement with healthcare services. The School Immunisation Program is a proven, safe, and cost-effective public health intervention that benefits not only individual students but their families and the community.

HHSs are responsible for delivering the program, either directly or through an engaged external provider, with program funding provided by Queensland Health.

School health program providers, including HHSs, are engaged to deliver the immunisation clinics on site at secondary schools. HHSs are also responsible for monitoring outcomes of the program, irrespective of whether the delivery of immunisation services is outsourced to an external provider.

#### Adolescent immunisations and participation in the program

Under the program, year 7 students are offered the human papillomavirus (HPV) and combined diphtheria, tetanus, and pertussis (dTpa) immunisations, while year 10 students are offered the meningococcal ACWY and meningococcal B immunisations. There is an increased risk of contracting these diseases during adolescence such that immunisation at these age groups aims to provide protection prior to exposure.

Year 7 and 10 students receive a consent form and information sheet with details about the immunisations offered and the diseases they prevent. The information included in the consent form helps school health program providers to:

- confirm students' identities during an immunisation clinic at the school;
- upload data to the Australian Immunisation Register;
- schedule and manage clinics, including catch-up sessions for students who are absent;
- follow up on missing consent forms; and
- monitor and evaluate program delivery.

School immunisation providers can request student information at any time, including where consent forms have not been returned. The *Public Health Act 2005* (PH Act) requires a

school's principal to provide student information to approved school health program providers for the purposes of following up with parents of students.

**What student information is provided?**

This includes the:

- name and date of birth of a student;
- name, telephone number, email address and postal address of a parent; and
- other information prescribed by the *Public Health Regulation 2018* about a student, for example, the sex of the student and which class or group they are in.

This ensures all parents are offered the opportunity for their child to participate in the program, noting there may be a range of reasons that consent forms are not returned. These may include misplaced forms, language barriers, or limited awareness of the adolescent immunisation schedule. Follow up may also assist parents in making decisions about their child's immunisations.[5]

**Delivering immunisation services in secondary schools reduces barriers to accessing free, safe, and effective immunisations, helping to improve health outcomes across Queensland.**

## Latest data on adolescent immunisation

Globally, the incidence of many vaccine-preventable diseases has increased since 2022. Following the COVID-19 pandemic, service interruptions, vaccine fatigue, and reduced acceptance resulted in reduced immunisation coverage rates.

Consistent with this global trend, immunisation rates have declined in Australia after several years of steady improvement. As part of this, Queensland's immunisation rates have also fallen, including for adolescents. This is also reflected in a decreasing uptake of immunisations offered under the program.

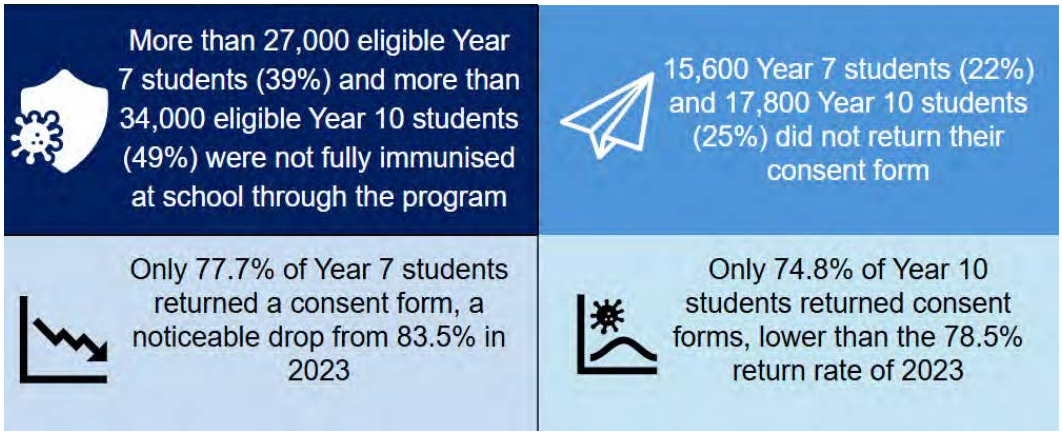
Without a returned consent form, students cannot be immunised under the program, regardless of eligibility. In 2024, approximately 15,000 students in year 7 and 18,000 students in year 10 did not return a consent form and therefore missed out on immunisation at school as part of the program. Unreturned consent forms are the key contributor to declining participation.[6]

The decline in program participation places Queensland students at greater risk of contracting vaccine-preventable diseases. This demonstrates a need to remove barriers for follow up and increase opportunities for parents to be informed about the immunisations available under the program.

[5] Parents who return a consent form with 'No to Immunisation' for all immunisations are not contacted for follow up.
[6] Queensland Health, Annual Reports 2019 – 2024, School Immunisation Program.

In 2024, immunisation uptake among year 7 students declined substantially under the program, driven primarily by a decrease in consent form return rates. A decline in consent form return rates was also observed in year 10 students.

**Figure 2:** Key statistics from 2024




### Collection of information by school health program providers

The PH Act allows a school health program provider to request and receive student information from school principals. However, when a HHS outsources the delivery of the program to an external provider, the external provider becomes the sole entity recognised as the school health program provider under the PH Act. As such, external providers cannot share this information with the HHS. This prevents HHS staff from conducting follow-up activities such as contacting parents, clarifying consent, or scheduling catch-up immunisations, despite HHSs retaining responsibility for program outcomes.

## Proposed changes

**Permit external providers engaged by an HHS to provide student information to the HHS when requested to enable the HHS to conduct follow-up activities.**

It is proposed to amend the PH Act to require external providers delivering the program to share student information with the engaging HHS for follow-up purposes when requested.

The amendment would be limited to:

- ensure HHS employees can only access the shared personal information for the program's purposes;
- restrict use of the information to the sole purpose of administering the program; and
- ensure that the information shared is consistent with what would have been provided to a HHS if the immunisation services were delivered by the HHS directly.

HHS employees handling the information will continue to be bound by the confidentiality provisions in the HHB Act and handling requirements under the *Information Privacy Act 2009*, providing strong safeguards for student information.

This amendment aims to remove a barrier to program participation and allow for greater follow up of non-returned consent forms.

# Prescription of conditions for specific test types

## Background

The PH Act establishes a regulatory framework that provides for the identification of **notifiable conditions** and mechanisms to prevent or minimise the adverse health impacts of these conditions.

**What are 'notifiable conditions'?**

Notifiable conditions are those that pose a significant risk to public health, either due to their potential for spread, severity, or impact on vulnerable populations. The list of notifiable conditions and the circumstances in which they are notifiable (for example, provisional diagnosis, pathology request, positive diagnosis, etc) are set out in schedule 1 of the *Public Health Regulation 2018* (PH Regulation).

In addition to Queensland's notifiable conditions, the Communicable Diseases Network Australia (CDNA) is responsible for overseeing national efforts against a range of infectious and notifiable diseases, including issuing national guidelines for testing, treatment, prevention and notification for monitoring purposes.

### Notification of notifiable conditions

Doctors, people in charge of hospitals and directors of pathology laboratories are required to notify Queensland Health when specified notifiable conditions criteria are met.

In particular, notifications are required when:

- a pathology request is received for certain conditions (known as a ***'pathology request notifiable condition'***); and
- a pathology test returns a positive diagnosis for certain conditions (known as a ***'pathological diagnosis notifiable condition'***).

Schedule 1 of the PH Regulation lists over 100 conditions that are notifiable to Queensland Health, detailing when the different conditions are required to be notified.

**Table 4:** Prescribed conditions

| Notifiable conditions that must be reported when the **pathology request** is received | Notifiable conditions that must be reported when the pathology test returns a **positive diagnosis** |
|---|---|
| Anthrax | Cholera |
| Avian influenza | COVID-19 |
| Severe acute respiratory syndrome (SARS) | Dengue |
| Japanese encephalitis | Malaria |
| Rabies | Tuberculosis |

Notifiable conditions that are required to be reported at the time the pathology request is received by the pathology laboratory are also required to be reported following a positive diagnosis.

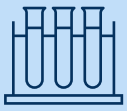
### Reducing pathology request notifications

Currently, when a condition is prescribed as a *pathology request notifiable condition*, all pathology test requests for that condition are legally notifiable. There is no lawful way to specify or limit which test types must be notified, even where only some results have clear public health value.

This means that pathology laboratories must notify all pathology test requests that relate to a notifiable condition, and that Queensland Health cannot lawfully require notification of only specific test types that are essential for public health monitoring, case management and broader public health responses.

Different test types perform different functions. For example, some pathology tests are looking for signs of past infection, rather than the specific diagnostic markers of a current infection. As pathology testing techniques improve and new techniques are used to target efficient diagnosis of notifiable conditions, receiving notification of all pathology requests can become unnecessary, redundant and duplicative.

## Proposed changes



**Enable a condition prescribed as a *pathology request notifiable condition* to be notifiable only when a particular test type is requested.**

It is proposed to amend the PH Act to include a regulation-making power that enables the chief executive of Queensland Health to prescribe a condition as a *pathology request notifiable condition* and to specify which test requests are notifiable for that condition.

This will remove unnecessary reporting requirements for pathology laboratories and Queensland Health by requiring notification of only certain test types, ensuring that only

clinically meaningful information is collected. It will also future-proof Queensland's notifiable conditions framework to accommodate changing laboratory data requirements and testing techniques.

# Prescribing hepatitis C as a *pathology request notifiable condition* for RNA test requests

## Background

Hepatitis C is a blood-borne viral infection in the liver caused by the hepatitis C virus. If left untreated, hepatitis C can cause chronic liver disease, cirrhosis and liver cancer.

While hepatitis C is treatable, the condition is recognised as one that can substantially impact public health, as it is readily transmissible and can cause serious long-term health consequences if transmitted.

**At the end of 2024, it was estimated that over 62,000 Australians have an active hepatitis C infection,[7] including 12,300 Queenslanders.[8]**

### Diagnosis of hepatitis C

Hepatitis C is diagnosed using two tests: an antibody test and a ribonucleic acid (RNA) test.

<table>
<tr><td colspan="2">  <br>Antibody test<br>This test is an initial screening test which shows whether or not a person has antibodies to the hepatitis C virus by detecting whether the person has had an immune response to the virus and produced antibodies against the virus.</td></tr>
<tr><td>A positive antibody test result does not automatically mean a person has hepatitis C. It may mean they had hepatitis C in the past and have been cleared of the virus, either naturally or through treatment.<br><br>Usually a RNA test follows a positive antibody test result, to determine if the person’s positive result reflects a current infection and if the person should be offered treatment for an active infection.</td><td>A negative antibody test result means the person does not have hepatitis C and has not been exposed to it in the past.</td></tr>
<tr><td colspan="2">  <br>RNA test<br>This test looks at the genetic material within a blood sample to see if there is genetic material from an active hepatitis C infection in the blood.</td></tr>
<tr><td>A positive RNA test result shows that a person is currently hepatitis C positive.</td><td>A negative RNA test result means the person does not currently have hepatitis C, but does not indicate past exposure.</td></tr>
</table>

[7] Burnet Institute and Kirby Institute, *Australia’s progress towards hepatitis C elimination: Annual report 2025*, https://www.burnet.edu.au/media/elyikgbr/2025-australias-progress-towards-hep-c-elimination-fullreport.pdf.
[8] Epidemiology and Research unit, Public Health Intelligence Branch, Department of Health.

A positive antibody test result indicates whether a person has **ever been exposed** to the virus, but only a positive RNA test confirms whether an infection is **current**.

## Hepatitis C as a notifiable condition

Hepatitis C is currently prescribed in the PH Regulation as both a *pathological diagnosis notifiable condition* and a *controlled notifiable condition*, but is not listed as a *pathology request notifiable condition* in schedule 1 of the PH Regulation. As such, pathology laboratories are only required to notify of a positive diagnosis.

In January 2023, the national body responsible for coordinating responses to infectious and notifiable diseases, the CDNA, revised the national hepatitis C case definitions to allow reinfections of hepatitis C to be counted. Counting hepatitis C reinfections requires the application of complex criteria including confirmation of previous negative RNA results.

Currently, only positive results of antibody and RNA tests are notified to Queensland Health. Without the notification of test requests for RNA and results of both positive and negative RNA testing, Queensland Health cannot determine if a new positive RNA result represents an ongoing infection, or a reinfection. Queensland Health cannot fully implement the reinfection component of the case definition without additional and substantial manual processes.

Additionally, access to pathology request information and both positive and negative RNA results is necessary to differentiate between individuals who may have ongoing active infection versus those who have cleared hepatitis C either through treatment or spontaneously.

Notification of pathology requests will enable Queensland Health to identify individuals through notification data who may benefit from support to engage in care and curative treatment, for example, those with chronic or longstanding hepatitis C infections.

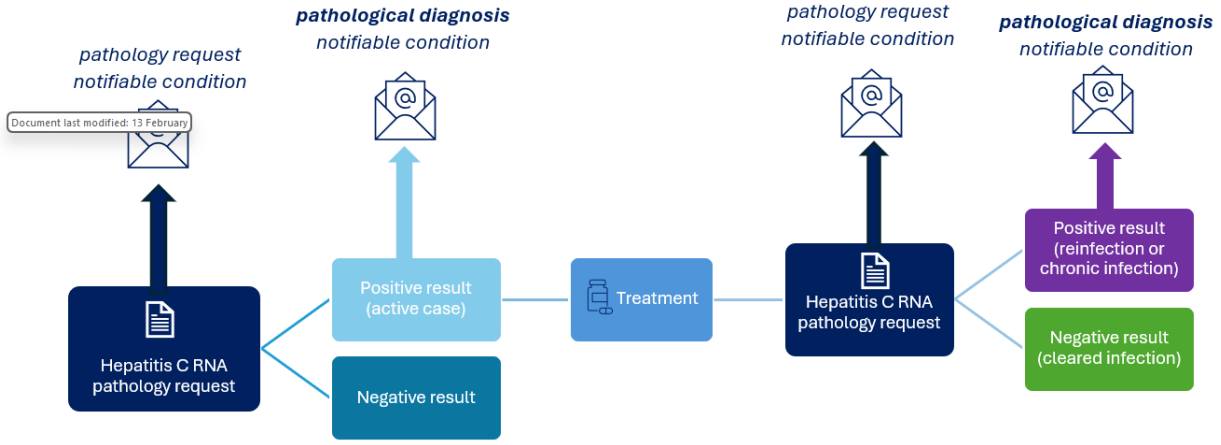
**Table 5:** Comparison of notification pathways

| Current state | Proposed future state |
|---|---|
| **Queensland Health is notified of:**<br>• Positive results from antibody test<br>• Positive results from RNA tests | **Queensland Health will be notified of:**<br>• Pathology requests for hepatitis C RNA tests<br>• Positive results from antibody test (where requested)<br>• Positive results from RNA tests |
| **Issues with this approach**<br>Queensland Health only receives positive results:<br>• There is no way to identify if someone is being tested for hepatitis C RNA until a positive diagnosis for an RNA test is reported. | **Why this approach works**<br>RNA testing provides greater insights:<br>• Public health units receive information about RNA testing and results, noting this gives the best information about current hepatitis C status for classifications and for providing links to care and treatment. |

| | |
|---|---|
| • Public health units cannot confirm if a RNA test has been ordered to check for an active case after a positive antibody result. | • Queensland Health receives a notification of each pathology request submitted for RNA testing, ensuring visibility of individuals being tested for hepatitis C.<br>• Public health units can match pathology requests to notified positive results to distinguish between active infections and cleared cases.<br>• Negative results are identified if no positive notification is received following the initial notification of a pathology request. |

The **below** diagram demonstrates how, by being notified of RNA test requests in addition to any positive results, Queensland Health can follow the case history of a person and identify the result of each test (positive or negative) requested to understand if it is an active or cleared case or a reinfection.

**Figure 3:** Proposed notification process for RNA testing only

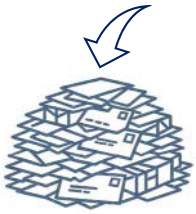



The ability to identify negative RNA results as part of a person's testing history is a critical step in improving the monitoring of hepatitis C and linkage to care, and is a frequent recommendation in Australian and overseas literature.[9]

## Number of notifications

While it may seem from the diagram above that an additional notification burden is being placed on pathology laboratories to report when they first receive the pathology request and again following a positive result, the ability to confine notifications down to RNA test requests means fewer notifications will be made for hepatitis C than if all pathology tests received are notifiable (antibody **and** RNA test **requests** in addition to all **positive results**). This will reduce the number of high-volume, low-value notifications made.

[9] Armstrong, AE., et al, 2025, *Enhancing notification-driven linkage to care for people living with hepatitis C in Queensland: system constraints and solutions*. Communicable Diseases Intelligence, 30 Jul 2025;49, https://pubmed.ncbi.nlm.nih.gov/40738149/.



Reducing the number of notifications is important in the context of how the notifiable conditions framework is intended to operate, given most notifiable conditions are rare conditions. Other *pathology request notifiable conditions* prescribed in the PH Regulation are limited to **rare and/or high-consequence diseases** such as avian influenza, rabies and smallpox. These other conditions are notified to ensure a rapid public health response.

In contrast, the purpose of making hepatitis C notifiable is to strengthen broader public health actions, public monitoring, and linkages to care, particularly in priority populations or settings where public health benefit is greatest.

The difference in the number of notifications for hepatitis C in comparison to the other *pathology request notifiable conditions* will be notable given the prevalence of hepatitis C. By limiting notifications to pathology test requests for detecting hepatitis C RNA, tens of thousands of potential notifications about the receipt of antibody pathology requests will not be reportable.

## Past consultation

In September 2025, Queensland Health consulted on a proposal to prescribe hepatitis C as a *pathology request notifiable condition*. It was intended at that time that **all** test requests received by a pathology laboratory for hepatitis C would be notifiable in addition to positive diagnosis results. However, feedback from this public consultation process identified that not all test requests are useful and that only a RNA test request should be notified.

It was also noted that if antibody tests were required to be notified as well as RNA tests, it would represent a significant administrative burden for both pathology laboratories and public health units responsible for managing and responding to notifiable conditions. For example, in 2024, public pathology laboratories performed over 73,000 antibody tests in Queensland.[10]

43 stakeholders responded to the public consultation on the earlier proposal to prescribe hepatitis C as a *pathology request notifiable condition*. Queensland Health acknowledges and thanks those stakeholders who provided feedback.

As a result of the feedback provided, further policy work was undertaken to instead consider amendments to the PH Act to allow for specific types of pathology tests to be notified and to limit the notification for hepatitis C to RNA test requests.

[10] Public Health Intelligence Branch, Population Health Division, Department of Health. Note this does not include private pathology laboratory data.

## Proposed changes

**Amend the *Public Health Regulation 2018* to prescribe hepatitis C as a *pathology request notifiable condition* by reference to RNA test requests only.**

The amendment will mean Queensland Health will be notified when a pathology laboratory receives a request to test for hepatitis C RNA. Limiting the notification for hepatitis C pathology requests to RNA test requests only will provide visibility of all individuals undergoing RNA testing and enable public health units to understand a person's case history for case classification and monitoring purposes.

In addition to the amendment, Queensland Health will update reporting arrangements with pathology laboratories to ensure all negative RNA results are routinely provided.

Following notice of a request, Queensland Health will receive either the positive result (through existing pathological diagnosis notifications) or the negative result (which will be identified if no positive notification is received following the initial pathology request).

This will ensure Queensland Health receives a notification when a pathology request is received, and the positive and negative results of RNA testing. This will reduce manual search processes, improve public health data, enable compliance with the CDNA case definitions, and improve the timely public health follow up of active, untreated infections in the community. This will ultimately strengthen Queensland's hepatitis C monitoring and enable effective linkage to care for people living with chronic hepatitis C.[11]

It will also ensure the Notifiable Conditions Register (which records all notifications) is complete, with the recorded outcome of RNA test requests.

[11] Armstrong, AE., et al, 2025, *Enhancing notification-driven linkage to care for people living with hepatitis C in Queensland: system constraints and solutions*. Communicable Diseases Intelligence, 30 Jul 2025;49, https://pubmed.ncbi.nlm.nih.gov/40738149/.